



WISCONSIN CHRONICLES ON BLACK HEALTH DISPARITIES



HIV/AIDS: 25 Year Review



Inside this issue:

HIV/AIDS Timeline	2
Publisher's Corner HIV/AIDS Terminology Glossary	3
Poor Health Outcomes for Black Children	4
Blacks and Kidney Disease Quality of Life for Black Stroke Survivors	5
Breast Cancer Prostate Cancer	6
Seat Belt Rates for Blacks Health Impact, Lack of Grocery Stores Black Drug for Heart Disease	7
Black Premature Birth Rates	8
Wisconsin Health Disparities Data Collection for Disparities	9
Congressional Bill Alert Hospitalization Disparity Rates	10
US Census on Uninsured Health Rates	11
Noted Black Who Have Died Due to AIDS	12

June marked a milestone in the health world this year. Twenty-five years ago, what we now know as HIV was first diagnosed and made public by the U.S. Department of Health and Human Services (DHHS). There has been much confusion and discovery regarding the virus since then. It began as something that was suspected to be isolated to "gay" white males, but the span of susceptible populations was soon expanded to cover anyone practicing unsafe sex, intravenous drug users, blood transfusion patients and infants born to women who were infected by the virus.

HIV/AIDS has now progressed to become a chronic and deadly disease that African Americans are infected by in the highest numbers.

Today more than 40 million people worldwide are infected with HIV. In 2005, Sub-Saharan Africa accounted for 66% of the world total new HIV infections.

In America, about 1.3 million people are living with the disease and half are African Americans. This means that African Americans are eight times more likely to get infected than whites. Yet, African Americans only make up 13% of the total U.S. population.

African American women are getting infected at shockingly high rates, accounting for 68% of all newly diagnosed HIV positive cases within the female

population. These occurrences are being attributed to heterosexual contact.

The high HIV infection rates among African Americans is not the only concern, the population is also disproportionately affected by AIDS (the deadly result of the virus) as well. Per CDC's most current data, HIV/AIDS was the second leading cause of death for all African Americans aged 35 - 44 in 2002. It was the leading cause of death for African American women ages 25 - 34 in this same year.

African American children are not immune to this disparity. In 2004, African American children were infected with HIV four times more than white children. Additionally, 66% of teen cases are African Americans.

The HIV/AIDS data for African Americans in Wisconsin is just as discouraging as the national data. The specific data for Wisconsin includes; the cumulative through 2004 distribution of reported AIDS cases was 30.6 for African Americans, the distribution of new AIDS cases reported in 2004 for African Americans was 40.1%, the adult and adolescent annual AIDS case rate per 100,000 population reported in 2004 was 28.8 for African Americans compared to 2.0 for whites and the distribution of person estimated to be living with AIDS at the end of 2004 was 36.7%.

In summary, African Americans are impacted by HIV/AIDS in the following ways:

- More illness
- Shorter survival times
- More deaths

In 1998, the Minority AIDS Initiative was created in the United States after African American leaders seeing HIV/AIDS at a level denoting a "state of emergency" and the Congressional Black Caucus pressured the DHHS to address the issue. It has been close to ten years since then, yet the problem has now surpassed the epidemic level.

The HIV/AIDS disparity between the black and general population can be attributed to many factors. While debates, theorizing and data collection continue in this regard, many continue to get infected, suffer from the disease and die. Whether the rise is attributed to the re-entry of black males from prisons to the communities or the 'down low' phenomena no longer matters.

The more immediate power to change this disparity lies within the black community. The power rest on the shoulder of individuals. While the slow governmental process works and while medical advancements continue to take the necessary years for sound (continue on page twelve)

Newsletter Staff

Publisher

Dr. Patricia McManus, Executive Director - Black Health Coalition of Wisconsin

Editor

Clarene Anderson, Consultant

Review Team

Jim Addison, Program Coordinator - Black Health Coalition of Wisconsin

Bevan K. Baker, Commissioner of Health - City of Milwaukee Health Department

Georgia Cameron, Board Vice-President Black Health Coalition of Wisconsin

Gregory Fanning, Board President - Black Health Coalition of Wisconsin

Rachel Morgan, Program Coordinator - Black Health Coalition of Wisconsin

Dr. Earnestine Willis - Medical College of Wisconsin

"Of all of the forms of injustices, injustices in health care is the most shocking and inhumane.

-Dr. Martin Luther King Jr.



HIV/AIDS Time Line



June 5, 1981 - 1st cases, of what would later be called HIV, was reported in the "Morbidity and Mortality Weekly Report" by the Center for Disease Control and Prevention. Five cases of Pneumocystis pneumonia in otherwise healthy gay men in Los Angeles. Associated Press and LA Times run stories on the same day.

July 3, 1981 - The New York Times runs "Rare Cancer Seen in 41 Homosexuals" article.

1982 - The U.S. CDC formally establishes the term Acquired Immune Deficiency Syndrome (AIDS); refers to four "identified risk factors" of male homosexuality, intravenous drug abuse, Haitian origin and hemophilia A.

First U.S. Congressional hearings on HIV/AIDS.

"GIRD" or "gay-related immune deficiency" increasingly used by the media and health care professionals, mistakenly suggesting inherent link between homosexuality and the syndrome.

1983 - The U.S. Public Health Service issues recommendations for preventing transmission of HIV through sexual contact and blood transfusions.

U.S. CDC adds female sexual partners of men with AIDS as fifth risk group.

1984 - CDC states that abstention from intravenous drug use and reduction of needle-sharing "should also be effective in preventing the transmission of the virus."

1995 - First International AIDS Conference held in Atlanta. Hosted by the U.S. Department of Health and Human Services (DHHS) and the World Health Organization (WHO)

At least one HIV/AIDS case has been reported from each region of the world.

First HIV test licensed by the FDA, detects antibodies to HIV. Blood banks begin screening the U.S. blood supply.

Ryan White, an Indiana teenager with AIDS, is barred from school; goes on to speak out publicly against AIDS stigma and discrimination.

1986 - AZT, the first drug used to treat AIDS, begins clinical trials.

U.S. Surgeon General Koop issues "Surgeon General's Report on AIDS", calling for education and condom use.

Robert Wood Johnson Foundation creates "AIDS Health Services Program", providing funding to hard hit U.S. cities; program is a precursor to Ryan White CARE Act.

1987 - First antiretroviral drug—Zidovudine or AZT - approved by U.S. FDA.

U.S. adds HIV as a "dangerous contagious disease" to its immigration exclusion list; mandates testing of all applicants.

U.S. CDC holds its first National Conference on HIV and communities of color.

The National Black Leadership Commission on AIDS, the National Minority AIDS Council and the National Task Force on AIDS Prevention form in the U.S.

1988 - World AIDS Day first declared by World Health Organization (WHO) on December 1.

1990 - Ryan White dies at the age of 18. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 is enacted by the U.S. Congress, providing federal funds for community-based care and treatment services.

1991 - NBA legend Earvin "Magic" Johnson announces that he is HIV-positive and retires from basketball.

Red ribbon introduced as the international symbol of AIDS awareness

1992 - FDA licenses first rapid HIV test, which provides results in as little as ten minutes.

AIDS becomes number one cause of death for U.S. men ages 25 to 44.

1994 - U.S. Public Health Service recommends use of AZT by pregnant women to reduce perinatal transmission of HIV

AIDS becomes the leading cause of death for all Americans ages 25 - 44; remains so through 1995.

U.S. FDA approves an oral HIV test, the first non-blood based antibody test for HIV.

1995 - First protease inhibitor, saquinavir, approved in record time by the U.S. FDA.

1996 - U.S. FDA approves HIV urine test and first HIV home testing and collection kit.

HIV no longer leading cause of death of all Americans ages 25 - 44; remains leading cause of death for African Americans in this age group.

1998 - Minority AIDS Initiative created in U.S., after African American leaders declare a "state of emergency" and Congressional Black Caucus (CBC) calls on the Department of Health and Human Services to do the same.

2002 - HIV is the leading cause of death worldwide, among those aged 15 - 59.

Approval of OraQuick Rapid HIV-1 Antibody Test, by U.S. FDA; first rapid test to use finger prick.

2006 - June 5 marks a quarter century since first AIDS case reported.

FDA HIV/AIDS Time Line

1981 - 1990: This decade saw the first report of AIDS and its identification as a retrovirus, approval of the first immunoassay test, (continued on page eight)

Publisher's Corner

Patricia McManus, PhD., RN

Publisher - Executive Director, Black Health Coalition of Wisconsin

These are very exciting times. Even in the mist of health disparities in the African American community that are incomprehensible, there is still hope. There is hope because of the history of a people who have survived despite the obstacles. This newsletter is a testament to the ability of our community to continue to build on its assets and show resiliency in face of adversity. The BHC has received an overwhelming response to our first newsletter. This response validates what we knew to be a need within our community and for the larger community. There has been so much discussion about the elimination of health disparities. The concept is especially linked to attempts at getting money or the ability to hold on to the money one currently has. How to deal with health disparities has been discussed at the national, state and local levels. However, there is the question as to who has the information to deal with such disparities. On almost any indicator of health disparity that one can name, African Americans rank 1st if not second. But, rarely, is the African American community seen as a part of the solution. This project would clearly suggest that such a supposition has flaws. The production of these newsletters serve the purpose of keeping the issue at the forefront of discussion, and gets the community to wondering what role they can play in reducing the disparity. Individuals, families, communities, institutions and systems all have a responsibility to address these issues. Let's do this together.

The editor of this newsletter, Clarene Anderson, continues to do a phenomenal job. She is a very special person with both passion and skills to make this perfect. Please enjoy this issue of the newsletter and continue to provide needed feedback.



HIV/AIDS Terminology Glossary

AIDS: Acquired immune deficiency syndrome. A disease of the body's immune system caused by HIV. Characterized by the death of CD4 cells (an important part of the body's immune system), which leaves the body vulnerable to life-threatening conditions such as infections and cancers.

Acquired: means that the disease is not hereditary but develops after birth from contact with a disease causing agent.

Immunodeficiency: means that the disease is characterized by a weakening of the immune system.

Syndrome: refers to a group of symptoms that collectively indicate or characterize a disease. In the case of AIDS this can include the development of certain infections and/or cancers, as well as a decrease in the number of certain cells in a person's immune system.

Acute HIV Infection: Also known as primary HIV infec-

tion or acute retroviral syndrome (ARS). The period of rapid HIV replication that occurs 2 to 4 weeks after infection by HIV. Acute HIV infection is characterized by a drop in CD4 cell counts and an increase in HIV levels in the blood.

Antiretroviral (ARV): A medication that interferes with the ability of retrovirus (such as HIV) to make more copies of itself.

Antiretroviral Therapy (ART): Treatment with drugs that inhibit the ability of retroviruses (such as HIV) to multiply in the body.

Antiviral: A natural or man-made substance that can kill or stop the growth of a virus.

End-Stage Disease: The final period or phase in the course of a disease that leads to a person's death.

HAART: Highly active antiretroviral therapy. When a combination of drugs (sometimes called a drug cocktail or multidrug therapy) are used to combat HIV.

HIV: Human immunodeficiency virus. The virus that causes AIDS. HIV-1 is the form prevalent worldwide and is the one mostly found throughout the United States and Europe. HIV-2 is the form that is found primarily in West Africa. People who are infected with HIV are known as being HIV-positive.

Intravenous Immunoglobulin (IVIG): A solution of antibodies taken from healthy donors and injected into the veins of people with low or abnormal antibody production to help protect them from infections.

Immune Response: The body's defensive reaction to a foreign invader, such as a virus, bacteria, or fungus.

Immune System: The collection of cells and organs whose role is to protect the body from foreign invaders.

Immunocompromised: Unable to mount a normal immune response because of an impaired immune system.

Immunodeficiency: Inability to produce normal amounts of antibodies, immune cells, or both.

Immunosuppressant: Inability of

the immune system to function normally.

Immunotherapy: Treatment to stimulate or restore the body's immune system to fight disease.

Long-term Nonprogressor: An HIV-positive individual with low, steady levels of HIV in the blood and a nearly normal CD4-cell count-potentially for more than 10 to 15 years.

Opportunistic Infection: An infection that arises when the immune system is compromised - as by HIV. Such infections are the primary causes of AIDS-related deaths.

Rapid Test: A type of HIV-1 ELISA test that can detect antibodies to HIV in the blood in less than 30 minutes with greater than 99% sensitivity and specificity.

Sexually Transmitted Disease (STD): Any infection spread by the transmission of organisms from person to person during sexual contact.

Therapeutic HIV Vaccine: Any HIV vaccine used for the treatment of an HIV-infected person. Therapeutic HIV vaccines are (continued on page five)

Milwaukee Public Schools Superintendent Details Poor Health of Milwaukee Children

The Superintendent of the Milwaukee Public Schools (MPS) presented the health needs of his student population to the larger community by authoring an article in the Milwaukee Journal Sentinel in June. Just before schools closed for the summer, the article clearly spoke to the needs that the Superintendent believed his system was forced to address before they could begin the education process.

Although race was not mentioned in the article specifically, recent population data for the city of Milwaukee included 40.2% Blacks and 44.7% whites. MPS is made up of predominantly black students. Septem-

ber 2005 district numbers for MPS included 58.4% black students and 13.3% white students. Thus the foundation for this being an issue of importance when looking at black health disparities.

Within his article, Sup. Andrekopoulos denotes the following sad realities for children in Milwaukee:

-Forty-one percent of children in Milwaukee live in poverty; triple the state total and fourth highest in the nation.

-Untreated tooth decay reaches epidemic proportions in the City of Milwaukee. In 2005, 572 Head Start children were

screened, and 61% were found to have untreated decay with 10% needing urgent dental care.

-The rate of lead poisoning among Wisconsin children is more than twice the national average. And in some Milwaukee neighborhoods, nearly 1 out of every 4 children have elevated lead levels. Lead poisoning has been associated with behavior and health problems and school performance and learning problems. (An average of 7 IQ points can be lost due to lead poisoning.)

-In 2003, asthma surveillance in Milwaukee Public Schools

indicated an asthma prevalence rate of at least 14% - higher than the prevalence rate range of 5.3% to 13% in the 22 states measured by the CDC's Behavioral Risk Factor Surveillance System survey.

These were all listed as obstacles that a child born in Milwaukee would have to overcome to grow up healthy.

Sources: "Not everyone's growing up healthy", *Milwaukee Journal Sentinel* June 10, 2006

Case Western Reserve University, web blog June 13, 2006

National Study Highlights Poor Health Outcomes for Minority Children

Researchers, from the Center for Advancement of Underserved Children (Medical College of Wisconsin/Children's Hospital of Wisconsin) presented an abstract of disparaging findings regarding the health of minority children at the 2006 annual meeting of the Pediatric Academic Society. The findings were based on the researchers review of data from the National Survey of Child-

hood Health. This phone survey consisted of random phone calls to parents of 102,353 children between the ages of 0-17.

One focus area of the research was oral health. Within this area, the rates for children having teeth in less than excellent condition was 60% higher for African Americans in comparison to white children.

Having an usual source of health care was another focus area. The rate was 90% for white children and only 77% for African American children.

Despite the necessary statistical adjustments to the data, the minority groups still continued to have poor health and dental outcomes. Subgroups within these areas including the children being overweight, having asthma, activity limitations and

behavioral/speech or emotional problems.

The striking disparities for African American children were in care for asthma, behavioral problems, skin disorders, speech problems and unmet prescription needs.

Source: Glenn Flores, MD & Sandy Thomany-Korman, MS, Medical College of Wisconsin, www.mcw.edu May 16, 2006

Black Children with Special Needs Not Receiving Proper Care

In a study featured in the April issue of *Pediatrics*, researchers from the Center for Advancement of Underserved Children (Medical College of Wisconsin/Children's Hospital of Wisconsin) noted that Black and Hispanic parents are twice as likely as white parents to be dissatisfied with the care of their children with special health care needs.

These findings were derived

from the researchers studying outcomes data on 38,886 Children with Special Health Care Needs (CSHCN). A disparity also exist for the parents ease of using the health care services; one-third reported by black or Hispanic parents and less than one-fourth for white parents.

The disparities with Hispanic parents was largely attributed to language barriers. Once the language barrier was removed,

the disparity ended as well. But this was not the case for black parents. The need for family-centered care was identified as the key factor in addressing this disparity with the black parents and making the services easier to use.

The distinguishing characteristics of family-centered care include:

adequate listening, respect, trust and participatory decision-

making.

Some problem access factors for blacks include;

attitudes, discrimination, transportation barriers, waiting times and limited availability of specialize providers or service in minority communities.

Source: *Pediatrics*, April 2006 Emmanuel M. Ngui, DrPH & Glenn Flores, MD, FAAP www.mcw.edu May 16, 2006

Blacks and Kidney Disease

It seems that high blood pressure (hypertension) and diabetes have been accepted as norms within the black community. We have seemingly accepted them as requisites to being black. This is a sad, and oftentimes deadly, reality.

A recent article by Glenn Ellis on BlackDoctor.org speaks to this danger. Specifically as it relates to kidney transplants. Uncontrolled high blood pressure and diabetes are leading causes to kidney failure.

Once a black person is in need of a kidney transplant, their lives become in greater jeopardy due to the long waiting list. According to the article, of the more than 50,000 patients currently waiting for a kidney transplant in the United States, one-third are African Americans. The percentage of African Americans is even higher than the national average in some regions. This percentages become more alarming in some major cities where African Americans make up more than

half the number of patients on the waiting lists for kidney transplants.

Further data shows that one in every three people with kidney failure is African American, compared to only one in eight in the general population.

The best ways for our communities to fight these percentages is eliminating our risks factors for developing high blood pressure and diabetes, controlling the diseases if we have them and no longer allow them to be

acceptable norms within the black community.

It is also important that more blacks register for kidney donation to increase the pool of potential matches for those who are in need of a transplant. It is estimated that 16 people die each day because a suitable kidney match is not secured in time.

Source: *African-Americans and Kidney Transplantation*, BlackDoctor.org July 5, 2006

Surviving a Stroke is of Little Consequence For Blacks

Cardiovascular diseases are leading causes of death for most populations, this includes the incidences of heart attacks and strokes. Unfortunately, blacks suffer strokes at much higher numbers than the general population, this may be attributed to the higher incidence of hypertension (high blood pressure) for blacks. A report published in a recent issue of *Stroke* also states that

the quality of life is far worse for black stroke survivors in comparison to whites.

The research was conducted by a medical team at the U.S. Centers for Disease Control and Prevention. They analyzed federal data from the Household Component of the Medical Expenditure Panel Survey. This Survey was conducted in 2000 and 2002 and targeted 39,680 adults, including 1,040 who

had already survived a stroke.

Far less people are dying from strokes, which means more people are living with the after affects of suffering from a stroke. Because a stroke deals with damage to brain functioning, some lessening of quality of life is naturally expected with all survivors. The data denotes this as more of an area of concern for blacks. Some experts attribute this to not enough patients

receiving IPA at the earliest stages of a stroke. This is a powerful colt-busting drug that can significantly lower the lingering effects of a stroke.

Source: *Stroke*, September 1, 2006

HIV/AIDS Terminology Glossary (continued from page three)

designed to boost an individual's immune response to HIV infection in order to better control the virus. Currently being tested in clinical trials.

Vertical Transmission (perinatal transmission): The passing of HIV from a pregnant mother to her unborn child.

Viral Load: The amount of HIV particles found in the blood.

Wasting: The involuntary loss of 10% of baseline body weight. It usually involves loss of lean body muscle - in addition to fat and can be a life-threatening condition.

Window Period: The time period between when a person's infection with HIV and the appearance of detectable anti-HIV antibodies. Because antibodies to HIV take some time to form,

an HIV antibody test will not be positive immediately after a person is infected. The time delay typically ranges from 14 - 21 days, but varies for different people. Nearly everyone infected with HIV will have detectable antibodies by 3 months after infection.

Sources: HIV Plus, July 2006

Center for Disease Control and Prevention

National Institute of Health

A complete HIV/AIDS glossary can be obtained at:

http://www.aidsinfo.nih.gov/ContentFiles/GlossaryHIV-relatedTerms-FifthEdition_en.pdf

Black Women At Higher Risk for Breast Cancer

A report in the June 2006 issue of the *Journal of the American Medical Association*, is attributing the high incidences of breast cancer in black women to biological factors as opposed to low screening rates.

Black women suffer from more aggressive and deadly forms of cancer. Previous studies have linked this disparity to black women receiving fewer mammography screenings. Thus when cancer is detected it is typically in the late stages and too advanced for successful treatment.

Annual breast cancer rates for black women compared to white women have been 15.4 deaths per 100,000 population, versus 9.3 respectively. This data reflects women younger than 55 years of age. These statistics within themselves are alarming, but a better perspective is seen when you take into

consideration that more white women are diagnosed with the disease than are black women.

The new findings are based on results from the Carolina Breast Cancer Study by the University of North Carolina's Lineberger Comprehensive Cancer Center. This research included 496 women who had been diagnosed with breast cancer. The focus of the research was the analysis of certain proteins in the tumors taken from these women.

A progressive form of cancer was found in 39% of the younger black women, 14% in the older black women and 16% in non-black women of varying ages. This genetic profiling can help scientist target drug therapies based on the cancer subtypes.

Although this discovery is exciting news, it is only the first step. The creation of the targeted

drug therapies will take many years to develop and gain FDA approval. Until then, women will continue to receive the conventional chemotherapy.

The study was not clear as to whether this genetic disposition was attributed to inherited predisposition or some environmental factor that black women are exposed to.

The elimination of access barriers is still crucial to ending this disparity. This includes the need for early and consistent mammography screenings for black women. The importance of care clinicians fully explaining the importance of their recommended therapies and providing their patients with whatever support they need to complete the treatment.

It is recommended that women get a mammogram every 1-2 years, based on medical recommendation, from ages 40-49.

Yearly screenings should occur from age 50 onward. Women younger than 40 should determine with their care provider when a baseline exam should be completed. Having a family history of breast cancer will necessitate more aggressive screening timelines.

Sources: *Journal of the American Medical Association*, June 2006

Annals of Internal Medicine, April 18, 2006

"Not everything that is faced can be changed, but nothing can be changed until it is faced."

-James Baldwin

Black Women are Targeted in the Fight Against Prostate Cancer

The numbers of black men who are diagnosed with prostate cancer continues to rise. This is a gender specific disease, as women do not have a prostate, but the Prostate Health Education Network (PHEN) is soliciting the help of black women to fight the disease. The organization is counting on the power of black women to educate black men on the importance of the disease. Especially on the aspects of early detection and treatment.

PHEN holds its first annual African American Prostate Cancer Disparity Summit this September, in conjunction with the national observance of Prostate Cancer Awareness month, with this initiative being the main focal point. The President and Founder of PHEN, Thomas A. Farrington, credits his wife for "forcing him" to get an exam. The push from his wife is credited for saving his life as the screening detected prostate cancer. This is the energy behind the initiative and a real reminder of the power of the black women when it comes to fighting the disease.

PHEN is asking women to arm themselves with as much knowledge as they can about prostate cancer so that they then can educate their husbands, significant others, fathers, sons and/or family members.

Key points for black women to focus on include: prostate cancer risk factors, screening guidelines, treatment options and post treatment care information.

According to PHEN, the prostate cancer mortality rate for black men is 140% higher than white males. Black women are seen to be the missing link in beginning to turn this disparity around.

Sources: *African American Prostate Cancer Disparity Summit Targets Women*, BlackPR.com Press Release, July 15, 2006

The Prostate Health Education Network, www.prostatehealthed.org

Seat Belt Usage Lower for Blacks

More efforts need to focus on increasing seat belt usage of blacks based on a study conducted by the Meharry Medical College and State Farm Alliance. The study suggests that more states adopting the 'primary' seat belt law would help to eliminate these occurrences.

In states that have the 'primary' seat belt law, a motorist can be

stopped and ticketed solely because they are not wearing their seat belt. In states that do not have this law, a motorist can only be pulled over and ticketed for not having a seat belt on when they are first stopped for some other violation. Data shows that seat belt usage rates are equal between whites and blacks in states that have the 'primary' seat belt law.

This becomes a matter of health importance when you look at data on fatal motor vehicle crashes. According to the U.S. National Highway Traffic Safety Administration (NHTSA), some 5,267 black were killed in 2002 in motor vehicle accidents.

The avoidance of fatal accidents is worth addressing, but this issue becomes a sensitive subject within the black com-

munity due to the history of racial profiling and targeted enforcement of the 'primary' law in minority communities.

Source: American Journal of Preventive Medicine, August 2006

"Race and Ethnicity in Fatal Motor Vehicle Traffic Crashes 1999-2004", NHTSA May 2006

Lack of Grocery Stores Lead to Early Deaths for Blacks

Researchers have termed areas with scant grocery stores as "food deserts". This according to a report (*Examining the Impact of Food Deserts on Public Health in Chicago*) that was featured in a July issue of the Chicago Sun-Times.

These "food deserts" were identified in Chicago, but the concept holds true for many black communities across the country. This research is key to better understanding the poor health outcomes within black communities. It is difficult for individuals and families to purchase and consume healthy

food when the stores are not located within close distance that would allow for easy access. In contrast to this, what is oftentimes plentiful in these neighborhoods are fast-food restaurants.

The impact of this disparity is manifested in higher rates with chronic conditions like diabetes, cancer, and heart disease and can ultimately be a contributing factor to untimely deaths due to poor diets. The individuals also tend to be more obese and have hypertension at higher rates.

The research noted that blacks

have to travel the farthest to reach a grocery store. For those who depend on public transportation, the process of securing healthy food for the family becomes even more difficult. The "food deserts" are most often seen in communities with a high concentration of single mothers and children.

The researcher for the report, Mari Gallagher, had plans to conduct a similar study in Detroit.

Many large/chain grocery stores moved out of depressed communities due to said financial losses. The report gives a

new perspective on a major contributor to health disparities. True efforts to end the disparities can not properly address the disparities without the replacement of grocery stores in black communities being an integral part. Additionally, the development of more community gardens and other creative ways to make healthy foods accessible has to be looked at as well.

Source: "Early deaths tied to lack of grocery stores", Chicago Sun-Times, July 18, 2006

Black-focused Drug for Heart Disease Debated

The new wave of genetic based researching to fight diseases has yielded a drug specifically tailored for blacks. The drug, BiDil (bye-DILL) was approved (June 2005) by the U.S. Food and Drug Administration (FDA) as a treatment for heart failure in blacks. This approval is significant because it marks the first time a drug was approved for use by an exclusive racial or ethnic group.

Blacks tend to suffer more than whites from heart disease, thus this kind of discovery could be key to lessening the disparity. Especially since blacks do not respond as well to more conventional treatments.

Gary Puckrein, executive director of the National Minority Health Month Foundation has views regarding BiDil that differ from Pamela Sankar, an associate professor of medical ethics

at the University of Pennsylvania and Jonathan Khan, an associate professor at the Hamline School of Law in Minnesota.

Puckrein applauds the usage of BiDil to fight the heart disease disparity, but Sankar and Khan criticized the FDA for approving the drug and asserted that the study used as the basis for the approval did not prove that BiDil works better for blacks in com-

parison to whites. They rather see the drug as a treatment that should not be exclusively given to blacks.

BiDil is a combination of two existing drugs, hydralazine and isosorbide dinitrate. Headaches and dizziness are some of the common side effects from BiDil.

Sources: Robert Wood Johnson Foundation, Disparities Bulletin August 16, 2006

FDA Press Release June 23, 2005

More Black Babies are Born Prematurely

Despite efforts by organizations such as the March of Dimes, the rate of babies being born premature continues to rise. Based on current trends, one in eight babies are born prematurely. This accounts for more than 500,000 babies annually.

A healthy birth occurs when an infant is born after at least 37 weeks of pregnancy. An infant is considered premature if they are born before this time. Infants born after only 32 weeks or less of development are seen to be at greater risk for health problems and even survival. Infants born prematurely experience disabilities that can include cerebral palsy and retardation.

It is a sad situation anytime a baby is born prematurely, especially if they experience health problems. Unfortunately this is the reality for more black infants than white infants, the disparity is 17.8% and 11.5% respectively. This disparity can be a direct result of the diseases that black women are affected by more than white women, such as hypertension, diabetes and lupus. A life-course perspective has also been researched as the cause for poor birth outcomes among black women. This perspective looks at how the level of stress that black women experience over the course of their lives impacts their pregnancies. The stresses, like racism and poverty, cause long term wear and tear on the body and oftentimes lead to premature births and/or infant deaths.

A study by the Virginia Commonwealth University gives more clues as to why black infants experience higher prematurity rates. The researchers discovered an association between a gene variation that is seen more in individuals of African descent and attribute it to being a cause of premature births. This genetic discovery can help better identify at risk women and provide better monitoring and therapeutic measures.

The Institute of Medicine is urging more federal research into the causes of premature births and the identification of more useful strategies to prevent them. In the interim of the fulfillment of its request, the Institute has recommended the following preventive strategies:

- More pregnant women receive a first-trimester ultrasound exams.
- Specialist should strengthen guidelines that reduce the number of multiple births as a result of infertility treatment.

Sources: Institute of Medicine, July 2006

Black Women Give Birth Prematurely More than Others, Associated Press, July 16, 2006

Genetics Linked to Premature Births, Study Shows Jet, September 11, 2006

Born Too Soon, Essence November 2005

Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective, Maternal and Child Health Journal Volume 7, Number 1



HIV/AIDS Timeline (continued from page two)



and approval of AZT, the first drug to treat AIDS, and the first drugs for treatment and prevention of certain opportunistic infections, and a mechanism for the expanded access to promising therapies prior to approval.

1991 - 1994: These years saw the creation of the National Task Force on AIDS Drug Development, a large scale expanded access to pre-approved HIV therapies, and approval of a number of new drugs. Accelerated approval permitted earlier approval of therapies based on surrogate marker activity. The first non blood-based collection system was approved to test for HIV, and the female condom was approved, providing women with a barrier product that didn't rely on a women's partner to use.

1995 - 1999: The final years of the century saw approval of first protease inhibitor, a new class of drugs for treating HIV, the first home-use AIDS test kit, the first antigen test kit to screen blood donors for HIV-1, and the first viral load test.

2000 - present: In the first years of the century, new formulations and combinations of medications were approved to reduce pill burden. HIV genotyping was approved to help improve treatment outcomes. The first nucleic acid test for plasma screening, the first rapid HIV test for use in outreach settings, the first fusion inhibitor for treatment of HIV/AIDS, and the first generic version of an HIV therapeutic agents were also approved.

Sources: HIV Plus, *25 Years & Counting* July 2006

Kaiser Family Foundation, *The Global HIV/AIDS Epidemic: A Timeline of Key Milestones*

U.S. Food and Drug Administration, *FDA HIV/AIDS Time Line—A Chronology of Significant Events*

Further Evidence of Wisconsin Health Disparities

The existence of racial health disparities in Wisconsin is further evidenced in a report recently published by the Population Health Institute of the University of Wisconsin's School of Medicine and Public Health. Within the report, researchers compare the disparities on a national level with those that exist within Wisconsin. The introduction of the report references the state's health plan, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*, and the U.S. Department of Health and Human Services' (DHHS) plan, *Healthy People 2010*. Each plan has the elimination of health disparities as a major goal. The year 2010 is quickly nearing, yet we are a long way from the elimination of health disparities on statewide and national levels.

Based on the results of the report, in comparison to other states, Wisconsin does not perform well in terms of health disparities. Key findings in the report with regard to Wisconsin health disparities include:

- The mortality rate for African American infants in Wisconsin is nearly three times the rate of white infants.
- Young African American males die at a rate that is four times higher than that of young African American females. This compares to the mortality rate for young white males only being 2.8 times that of white women of the same age.
- Wisconsin has a relatively large disparity in African American and white mortality rates, with African Americans having an approximately 80% greater rate than whites.

Source: *Using Measures of Disparities as Indicators of the Health of Wisconsin* - Brief Report by The University of Wisconsin, School of Medicine and Public Health August 2006

Data Collection Improvements Encouraged to Help Eliminate Disparities

A recent article by The Commonwealth Fund outlined current challenges and gave proposed solutions as it relates to the collection data on patient race, ethnicity and primary language. Although there is a growing body of data regarding health disparities, there is much confusion on how the data is collected and exactly what should be collected. This is an area of importance as it pertains to eliminating racial health disparities because data becomes the justification point for funding allocations as well as the basis for the establishment and enforcement of new policies.

The Fund's article was based on results from a study that the organization supported. A key point of the study finds data collection efforts are inconsistent across health care organizations, hampered by a widespread lack of understanding about the most effective strategies. Often times, data in reference to patient's race and ethnicity are assumed by health care organizations. The authors of the study assert that this information should be self-reported by the patients themselves or their family members as opposed to generic and closed-ended questions, thus yielding more accurate information. Self-reported information generally gives more clues on the beliefs, health care use patterns and common perspectives to a certain community. This in turn gives the provider a better understanding of the patient in the efforts of providing the most appropriate care.

One point of confusion regarding the collection of disparities data is that some health care organizations wrongfully believe that it is illegal to collect race/ethnic specific data. The study reinforced the fact that no federal statutes currently exist that prohibits the collection of such information. In contrast to this, they assert that the Centers for Medicare and Medicaid Services and other government agencies may begin requiring it.

Another hindrance point can be attributed to patients not fully understanding why the information is being asked and then not fully cooperating in the process. Patients have to be assured that the information will not be used in a way that would be punitive to them.

The following is the uniform framework for collecting race, ethnicity and primary language data as suggested by the study:

1. A rationale for why the patient is being asked to provide information about race, ethnicity, and language.
2. A script for staff to use so that questions are asked in a uniform fashion.
3. A method for allowing patients to self-identify race, ethnicity, and language using their own words rather than a pre-established set of categories.
4. A standardized approach for "rolling up" granular response to the Office of Management and Budget categories for analytical and reporting purposes.
5. Assurance that the data will be held confidential and a limited number of people will have access to the data, as well as a mechanism to guarantee this claim.

Again, this framework can only be used as an effective tool to address racial health disparities when it is fully adopted by all health care organizations. Then providers can more accurately identify health care disparities and put into place efforts to improve the health of minorities.

Sources: *Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions*, The Commonwealth Fund, August 2006

Robert Wood Johnson Foundation, Quality Health Care News Digest, August 31, 2006

*** Congressional Health Disparities Bill Alert ***

Senate Majority Leader Bill Frist (Republican - Tenn.) introduced legislation on September 29, 2006 that would allocate approximately \$500 million to fund programs to help eliminate racial and ethnic health disparities. This bill is co-sponsored by Senator Edward Kennedy (Democrat - Mass.), Senator Barack Obama (Democrat—Ill.) and Senator Jeff Bingaman (Democrat - N.M.). The funds are projected to be used to increase research, improve education and patient-provider communication. The legislation includes mandates for:

- The creation of grant programs, include one to further hospital-based research on health care disparities.
- Hospitals to improve the collection of data on patient demographics such a race, ethnicity, geographic location and income levels.
- The Food and Drug Administration (FDA) panel to issue recommendations on minority-related health issues.

The bill would also restore funds to disparities related programs, such as those that increase minority enrollment in medial schools. Approval of the bill is being sought when Congress reconvenes in November.

Please contact your congressperson and the Congressional Black Caucus Braintrust (202-225-1790) to ensure the passage of this legislation.

Source: Robert Wood Johnson Foundation, Online News Digest - Disparities, October 2, 2006

Government Releases Hospitalization Disparity Report

The Agency for Healthcare Research and Quality (AHRQ) released a statistical brief in July 2006 regarding potentially preventable hospitalizations for minorities compared to whites in 2003. AHRQ asserts that looking at demographics from hospital admissions gives critical insights into healthcare quality when the identification is made of admissions that could have been prevented if the individuals would have had access to and usage of preventive care through primary physicians.

The discouraging results of the report include:

- In 2003, racial and ethnic disparities existed in the rates of preventable hospitalizations, with blacks generally having the highest rates and Hispanics the second highest rates.
- The disparities were greatest for hospitalizations for chronic conditions such as diabetes, hypertension, and asthma. Compared with non-Hispanic whites, rates for admission for these conditions were about 3 to 5 times greater among blacks, and approximately 2 to 3 times greater for Hispanics.
- Compared with non-Hispanic whites, blacks had higher rates of preventable hospitalizations for 15 to 17 indicators, and Hispanics had higher rates of preventable hospitalizations for 14 to 17 indicators.
- Blacks had the highest rates of preventable hospitalizations for all indicators related to diabetes and circulatory diseases. Hospitalization rates for hypertension and for diabetes without complications were 5 times higher for blacks than for non-Hispanic whites. Hospitalization rates for pediatric asthma, adult asthma, perforated appendix, dehydration, and low birth weight were also highest among blacks.
- The rate of hospitalization for uncontrolled diabetes without complications was almost 5 times higher for blacks (relative rate of 4.98) and 3.6 times higher in Hispanics (relative rate of 3.56), as compared with non-Hispanic white patients.
- Blacks were nearly 5 times more likely to be hospitalized for hypertension than were non-Hispanic whites. Hispanics were more than 2.4 times more likely than non-Hispanic whites to be hospitalized for hypertension.

Although a review of hospitalization rates can be a good indicator of disparities, this process is not all inclusive as many states do not collect information on race and ethnicity from hospitals. AHRQ asserts that within the states that do collect this information, some of the hospitals do not code the information accurately.

Source: *Racial and Ethnic Disparities in Potentially Preventable Hospitalizations*, by Healthcare Cost and Utilization Project - Agency for Healthcare Research and Quality July 2006

U.S. Census Bureau Released Updated Uninsured Data

Disturbing data on the number of uninsured Americans was recently released by the U.S. Census Bureau. According to the report, 46.6 million Americans were without health insurance in 2005. This number reflects 1.3 million more uninsured compared to the 45.3 million in 2004. This number has risen by 7 million since 2000.

This is not an issue that the government or society can brush off and attribute to non-productive citizens, as the increase of the uninsured was among working adults. These are individuals that are working hard each day, but either the employer does not offer health insurance or the employee can not afford their share of the cost as they have to decide between health coverage or having money to meet daily living expenses.

This is a problem for all Americans, but even more so for minority adults according to a recent study by The Commonwealth Fund. Its report finds uninsured rates for Hispanic and African American adults are one-and-a-half to three times greater than that rate for white adults. During the same reporting year as the Census report, the Fund found that only 20% of working-age whites were uninsured while 33% of working-age African Americans and 62% of Hispanics were without coverage. It also found that African Americans were significantly more likely than whites to visit the emergency room for non-urgent care and to experience serious problems with medical bills and medical debt. This added to a population that is already known to have higher incidences of chronic diseases and poor access to primary care.

Further evidence of the uninsured disparity is reported by The Urban Institute in a April 2006 Discussion Paper on this subject. The chief focus of its report is the racial and ethnic differences in insurance coverage and health care access and use. The reporting period varies from the Census report, but the results are still very similar. A few of its findings include:

- Low-income black and white children were equally likely to be uninsured, but black children were 24 percentage points more likely to have public coverage and 19 percentage points less likely to have employer-sponsored coverage.
- Black and Hispanic adults were less likely than white adults to have a usual source of health care or to have seen a physician in the past twelve months.

Key points from the U.S. Census report include:

General Data

- The number of people with health insurance coverage increased by 1.4 million to 247.3 million between 2004 and 2005, and the number without such coverage rose by 1.3 million.
- Between 2004 and 2005, people covered by employment-based health insurance (174.8 million) declined from 59.8 percent to 59.5 percent.
- The proportion and number of uninsured children increased between 2004 and 2005, from 10.8 percent to 11.2 percent and from 7.9 million to 8.3 million respectively.

Race Specific Data

- Black households had the lowest median income in 2005 (\$30,858) among race groups. The median income for non-Hispanic white households was \$50,784.
- Poverty rates remained statistically unchanged for blacks (24.9 percent), but decreased for non-Hispanic whites (8.3 percent in 2005, down from 8.7 percent in 2004)
- The uninsured rate, as well as the number of uninsured, remained statistically unchanged in 2004 to 2005 for non-Hispanic whites (at 11.3 percent and 22.1 million) and for blacks (at 19.6 percent and 7.2 million).

Clearly the American health care system does not work. Far too many Americans do not have affordable and comprehensive health insurance coverage and access to needed health care. The need for a universal health plan continues to mount, yet little is being done on a national level to truly address this crisis. In the meantime, many states are putting in place laws as create alternates. This includes Maine, Massachusetts and Vermont. New Jersey also gives a model by its expansion of the age limit for coverage to dependents.

Sources: U.S. Census Bureau August 26, 2006

Health Care Disconnect: Gaps in Coverage and Care for Minority Adults, The Commonwealth Fund, August 2006 Issue Brief

Statement from Karen Davis, President - Commonwealth Fund August 29, 2006

Racial and Ethnic Differences in Insurance Coverage and Health Care Access and Use, Urban Institute, April 2006

Black Health Coalition of Wisconsin
2801 West Wisconsin Avenue
Milwaukee, Wisconsin 53208

Phone: 414-933-0064
Fax: 414-933-0084
E-mail: BHCPMc@aolc.om

"America's new frontier is not the wilderness, or the air, or the sea; it is the inner cities, the barrios, the reservations, where disparities persist and where dreams are dim."

-David M. Satcher, M.D., Ph.D.

**WE ARE ON THE WEB @
WWW.BHCW.ORG**

NOTABLE BLACKS

WHO HAVE DIED



DUE TO AIDS

Max Robinson (1939—1988), News Anchored

Alvin Ailey (1931 - 1989), Dancer & Choreographer

Arthur Ashe (1943 - 1993), Tennis Player & Social Activist

Eric 'Eazy E' Wright (1963-1995), Rapper



HIV/AIDS: 25 Year Review (continued from cover page)



researching , individual lifestyle changes can put the brakes on this fast moving train in hopes of derailing the toll of HIV/AIDS.

The black community can no longer be in denial or ignorance about HIV/AIDS. The stigma associated with the disease only leaves the door open for more individuals to get infected. The black community can no longer wait on others to make the difference. Knowledge is power and the time is overdue for the black community to stand up and protect itself.

Although there are millions infected with the disease, there are millions more who are not. Those who are infected must commit to not spreading the disease to others and those who are not infected must commit to protecting themselves from getting the virus.

Key strategies for lessening the toll of HIV/AIDS in the African American community include:

- If already infected, do not pass the virus on to anyone else
- Break the silence! Talk openly about HIV/AIDS so that it is no longer a 'hush, hush' matter
- Get tested on a regular basis
- Practice safe sex
- Don't share injection drug works (i.e. needles or syringes)
- Maintain overall good health practices
- Learn as much as you can about HIV/AIDS

Sources: Kaiser Family Foundation
Center for Disease Control and Prevention