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KY AETC Kentucky AIDS Education & Training Center

The Promise and Limitations of Ending the HIV Epidemic in the U.S.

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Disclosures

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Objectives

Upon completion of this educational activity, you will be able to:

- Review the Ending the HIV Epidemic Plan
- Describe threats to successfully ending the HIV epidemic in the United States

Presentation Outline

Threats to ending HIV in the United States:

- Failure to address the social determinants of health
- Inability to address overlapping epidemics
- Inability of scientific advances to be directed to those where need is greatest
- Political ideology vs science
- Mistrust
- Funding & commitment to end the HIV epidemic over time

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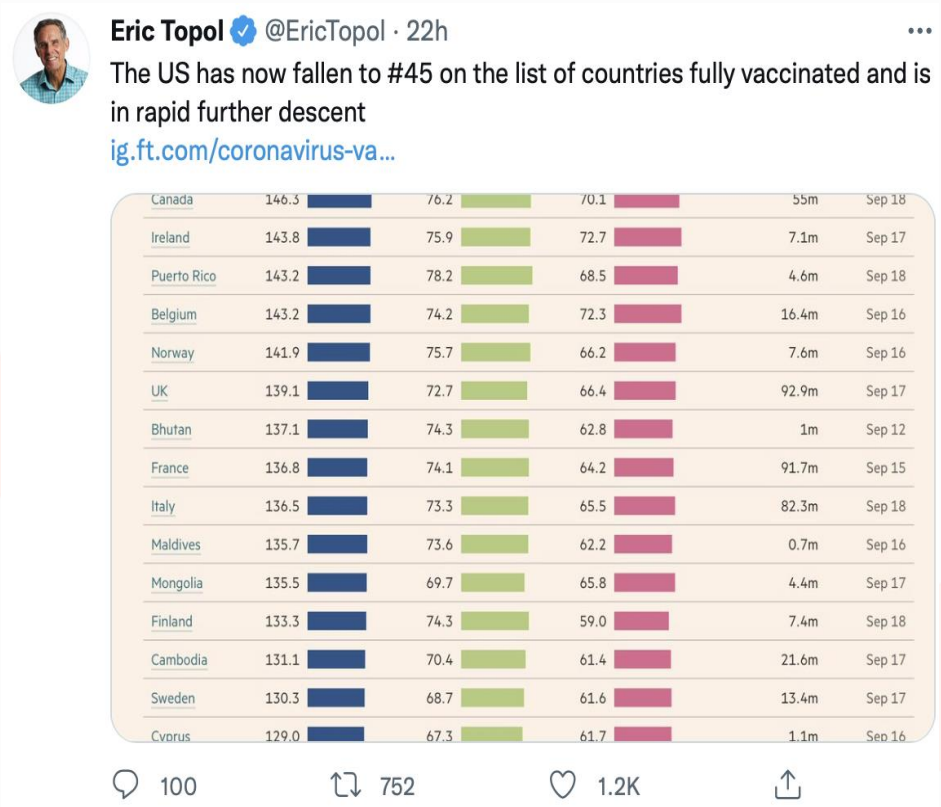
Having the necessary scientific tools are not always enough to end an epidemic



1. PREVENTION AND CARE EFFORTS WILL NOT HAVE A LASTING IMPACT WITHOUT ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

"….while health care accounts for some 10 to 20 percent of the determinants of health, socioeconomic factors and factors related to the physical environment are estimated to account for up to 50 percent of the determinants of health"

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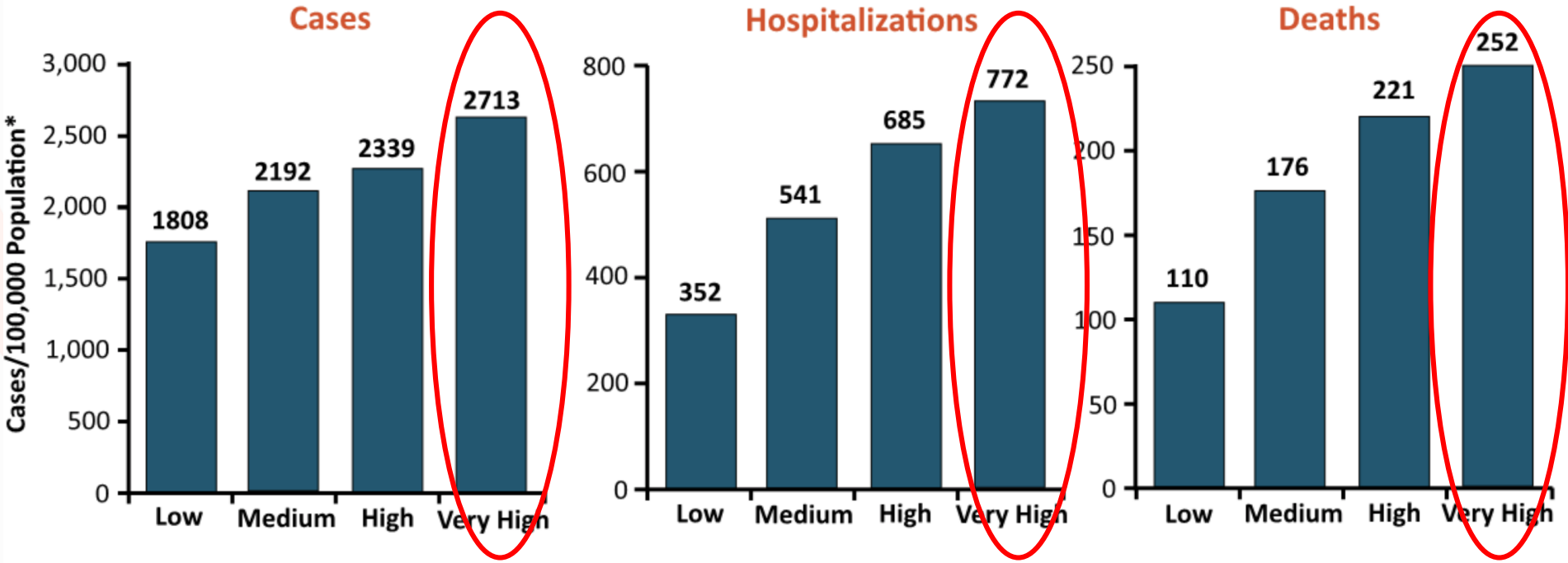
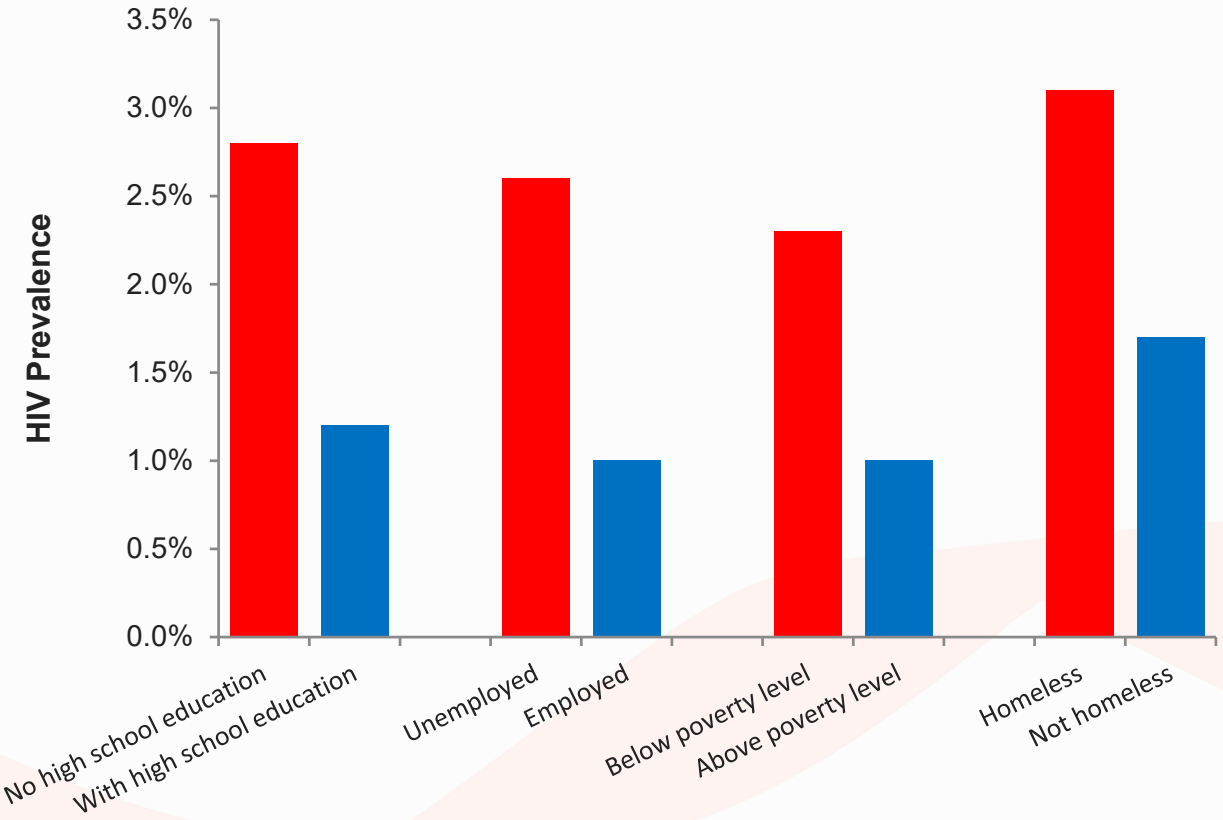
COVID-19 Cases, Hospitalizations, and Deaths by Poverty Level in NYC



*Age-adjusted. Last updated June 16, 2020. Neighborhood poverty is based on the percent of a ZIP code's population living below the Federal Poverty Level. Low poverty: < 10%; Medium poverty: 10% to 19.9%; High poverty: 20% to 29.9%; Very high poverty: 30% or more.

HIV Infection Among Heterosexuals in Urban Areas, by Socio-Economic Indicators, 2006-2007, N=14,837



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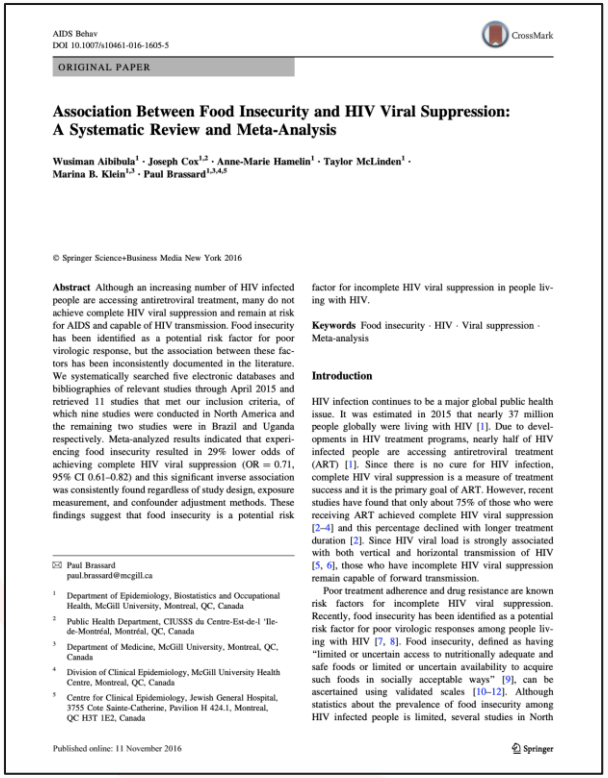
*CDC. Characteristics Associated with HIV Infection Among Heterosexuals in Urban Areas with High AIDS Prevalence --- 24 Cities, United States, 2006--2007. MMWR 2011;60:1045-1049.

Associations between food insecurity and viral suppression

Food insecurity ⟶ 29% lower viral suppression (OR=0.71, 95%CI 0.61-0.82)



AIDS Behav
DOI 10.1007/s10461-016-1605-5

CrossMark

ORIGINAL PAPER

Association Between Food Insecurity and HIV Viral Suppression: A Systematic Review and Meta-Analysis

Wusiman Aibibula[1] · Joseph Cox[1,2] · Anne-Marie Hamelin[1] · Taylor McLinden[1] · Marina B. Klein[1,3] · Paul Brassard[1,3,4,5]

Abstract Although an increasing number of HIV infected people are accessing antiretroviral treatment, many do not achieve complete HIV viral suppression and remain at risk for AIDS and capable of HIV transmission. Food insecurity has been identified as a potential risk factor for poor virologic response, but the association between these factors has been inconsistently documented in the literature. We systematically searched five electronic databases and bibliographies of relevant studies through April 2015 and retrieved 11 studies that met our inclusion criteria, of which nine studies were conducted in North America and the remaining two studies were in Brazil and Uganda respectively. Meta-analyzed results indicated that experiencing food insecurity resulted in 29% lower odds of achieving complete HIV viral suppression (OR = 0.71, 95% CI 0.61–0.82) and this significant inverse association was consistently found regardless of study design, exposure measurement, and confounder adjustment methods. These findings suggest that food insecurity is a potential risk factor for incomplete HIV viral suppression in people living with HIV.

Keywords Food insecurity · HIV · Viral suppression · Meta-analysis

Introduction

HIV infection continues to be a major global public health issue. It was estimated in 2015 that nearly 37 million people globally were living with HIV [1]. Due to developments in HIV treatment programs, nearly half of HIV infected people are accessing antiretroviral treatment (ART) [1]. Since there is no cure for HIV infection, complete HIV viral suppression is a measure of treatment success and it is the primary goal of ART. However, recent studies have found that only about 75% of those who were receiving ART achieved complete HIV viral suppression [2–4] and this percentage declined with longer treatment duration [2]. Since HIV viral load is strongly associated with both vertical and horizontal transmission of HIV [5, 6], those who have incomplete HIV viral suppression remain capable of forward transmission.

Poor treatment adherence and drug resistance are known risk factors for incomplete HIV viral suppression. Recently, food insecurity has been identified as a potential risk factor for poor virologic responses among people living with HIV [7, 8]. Food insecurity, defined as having "limited or uncertain access to nutritionally adequate and safe foods or limited or uncertain availability to acquire such foods in socially acceptable ways" [9], can be ascertained using validated scales [10–12]. Although statistics about the prevalence of food insecurity among HIV infected people is limited, several studies in North

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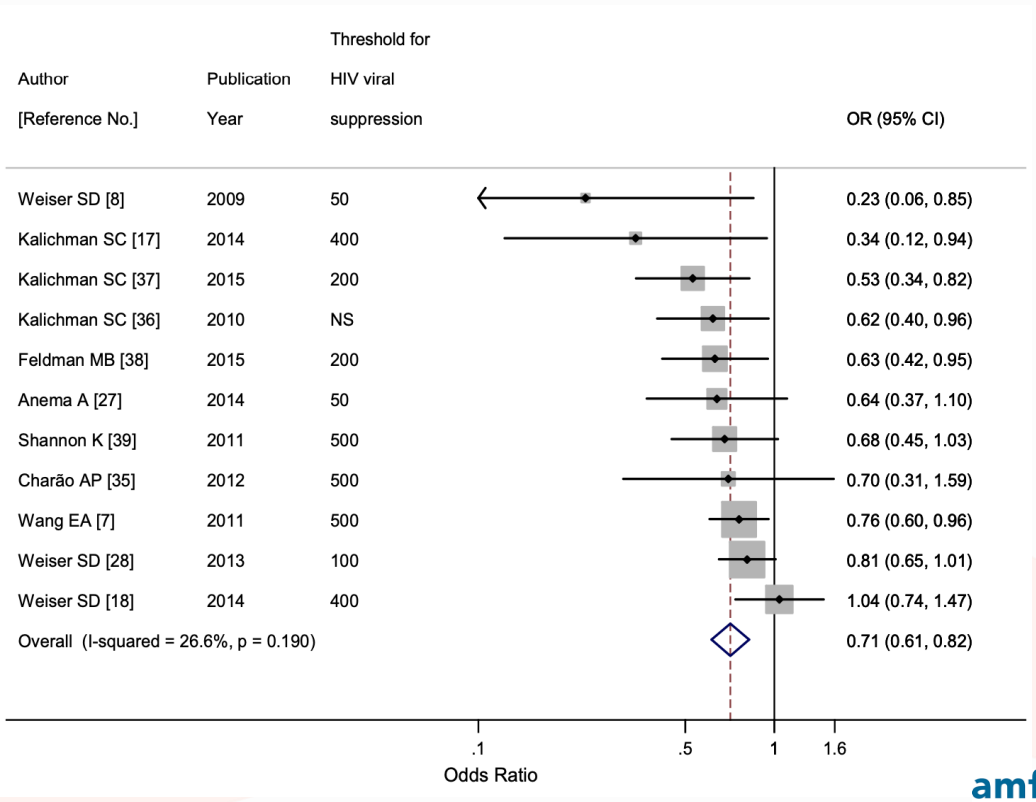

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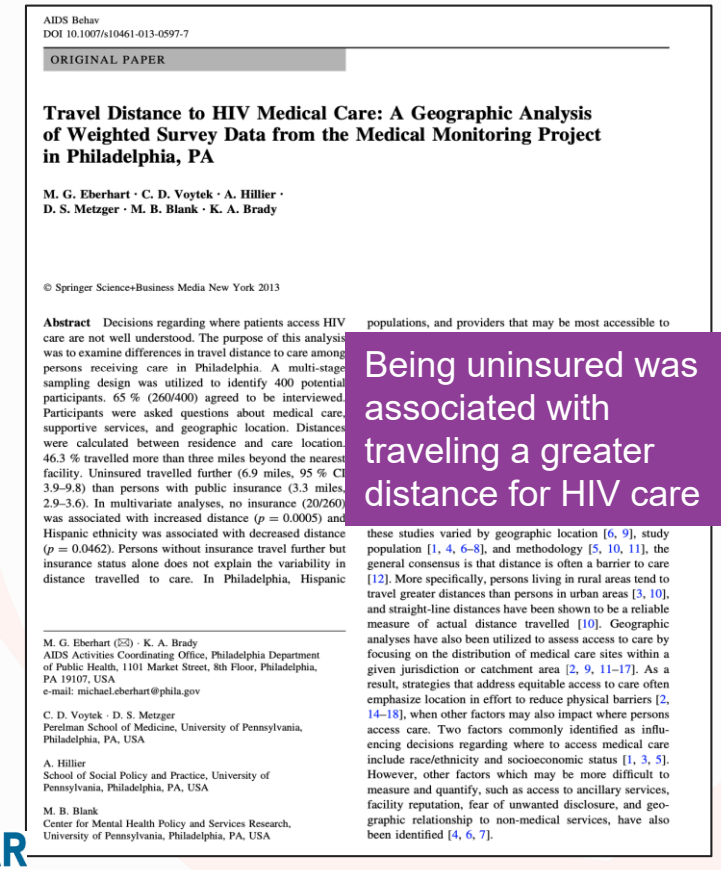
Associations between distance to HIV care and insurance/ viral suppression



AIDS Behav
DOI 10.1007/s10461-013-0597-7

ORIGINAL PAPER

Travel Distance to HIV Medical Care: A Geographic Analysis of Weighted Survey Data from the Medical Monitoring Project in Philadelphia, PA

M. G. Eberhart · C. D. Voytek · A. Hillier · D. S. Metzger · M. B. Blank · K. A. Brady

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Abstract Decisions regarding where patients access HIV care are not well understood. The purpose of this analysis was to examine differences in travel distance to care among persons receiving care in Philadelphia. A multi-stage sampling design was utilized to identify 400 potential participants. 65 % (260/400) agreed to be interviewed. Participants were asked questions about medical care, supportive services, and geographic location. Distances were calculated between residence and care location. 46.3 % travelled more than three miles beyond the nearest facility. Uninsured travelled further (6.9 miles, 95 % CI 3.9–9.8) than persons with public insurance (3.3 miles, 2.9–3.6). In multivariate analyses, no insurance (20/260) was associated with increased distance ($p = 0.0005$) and Hispanic ethnicity was associated with decreased distance ($p = 0.0462$). Persons without insurance travel further but insurance status alone does not explain the variability in distance travelled to care. In Philadelphia, Hispanic

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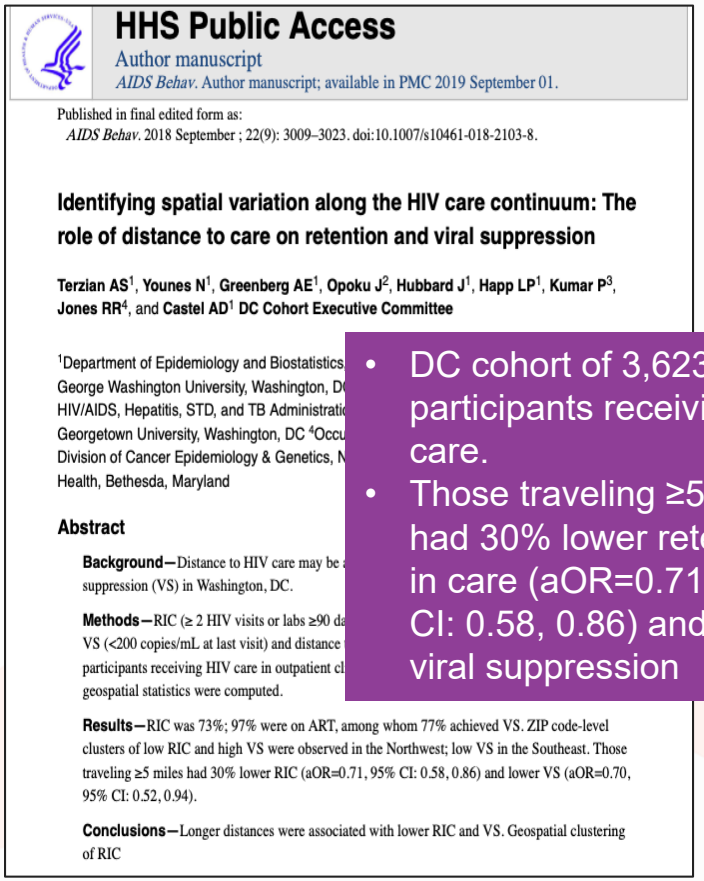
populations, and providers that may be most accessible to these studies varied by geographic location [6, 9], study population [1, 4, 6–8], and methodology [5, 10, 11], the general consensus is that distance is often a barrier to care [12]. More specifically, persons living in rural areas tend to travel greater distances than persons in urban areas [3, 10], and straight-line distances have been shown to be a reliable measure of actual distance travelled [10]. Geographic analyses have also been utilized to assess access to care by focusing on the distribution of medical care sites within a given jurisdiction or catchment area [2, 9, 11–17]. As a result, strategies that address equitable access to care often emphasize location in effort to reduce physical barriers [2, 14–18], when other factors may also impact where persons access care. Two factors commonly identified as influencing decisions regarding where to access medical care include race/ethnicity and socioeconomic status [1, 3, 5]. However, other factors which may be more difficult to measure and quantify, such as access to ancillary services, facility reputation, fear of unwanted disclosure, and geographic relationship to non-medical services, have also been identified [4, 6, 7].

Being uninsured was associated with traveling a greater distance for HIV care



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Identifying spatial variation along the HIV care continuum: The role of distance to care on retention and viral suppression

Terzian AS[1], **Younes N**[1], **Greenberg AE**[1], **Opoku J**[2], **Hubbard J**[1], **Happ LP**[1], **Kumar P**[3], **Jones RR**[4], and **Castel AD**[1] **DC Cohort Executive Committee**

[1]Department of Epidemiology and Biostatistics, George Washington University, Washington, DC; HIV/AIDS, Hepatitis, STD, and TB Administration; Georgetown University, Washington, DC [4]Occu... Division of Cancer Epidemiology & Genetics, N... Health, Bethesda, Maryland

Abstract

Background—Distance to HIV care may be a... suppression (VS) in Washington, DC.

Methods—RIC (≥ 2 HIV visits or labs ≥90 da... VS (<200 copies/mL at last visit) and distance ... participants receiving HIV care in outpatient cl... geospatial statistics were computed.

Results—RIC was 73%; 97% were on ART, among whom 77% achieved VS. ZIP code-level clusters of low RIC and high VS were observed in the Northwest; low VS in the Southeast. Those traveling ≥5 miles had 30% lower RIC (aOR=0.71, 95% CI: 0.58, 0.86) and lower VS (aOR=0.70, 95% CI: 0.52, 0.94).

Conclusions—Longer distances were associated with lower RIC and VS. Geospatial clustering of RIC

- DC cohort of 3,623 HIV+ participants receiving care.
- Those traveling ≥5 miles had 30% lower retention in care (aOR=0.71, 95% CI: 0.58, 0.86) and lower viral suppression

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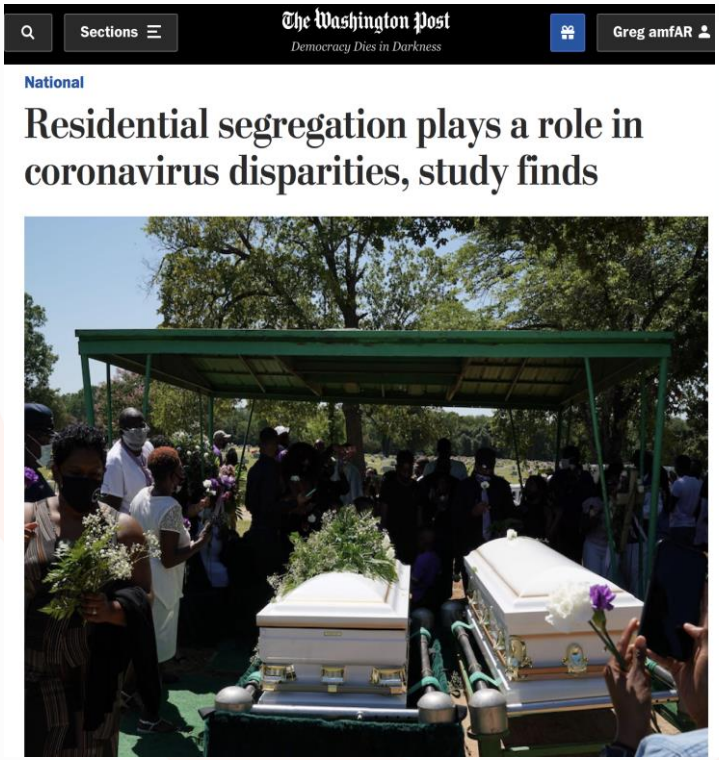
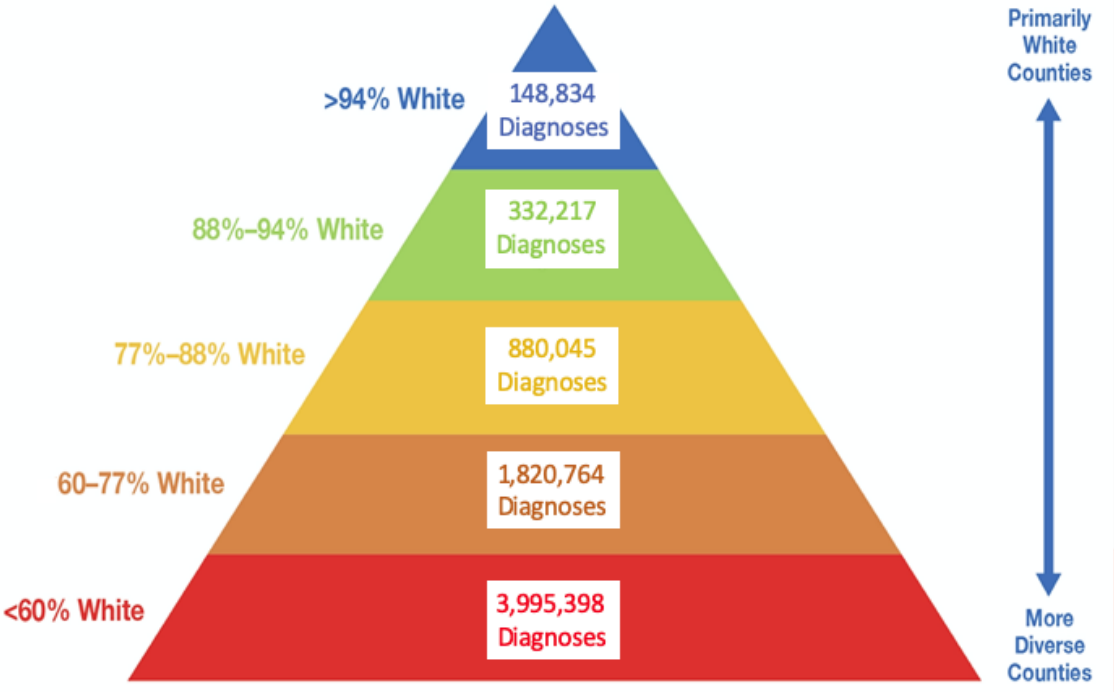
COVID-19 and Residential Segregation





(Millett et al, 2020)

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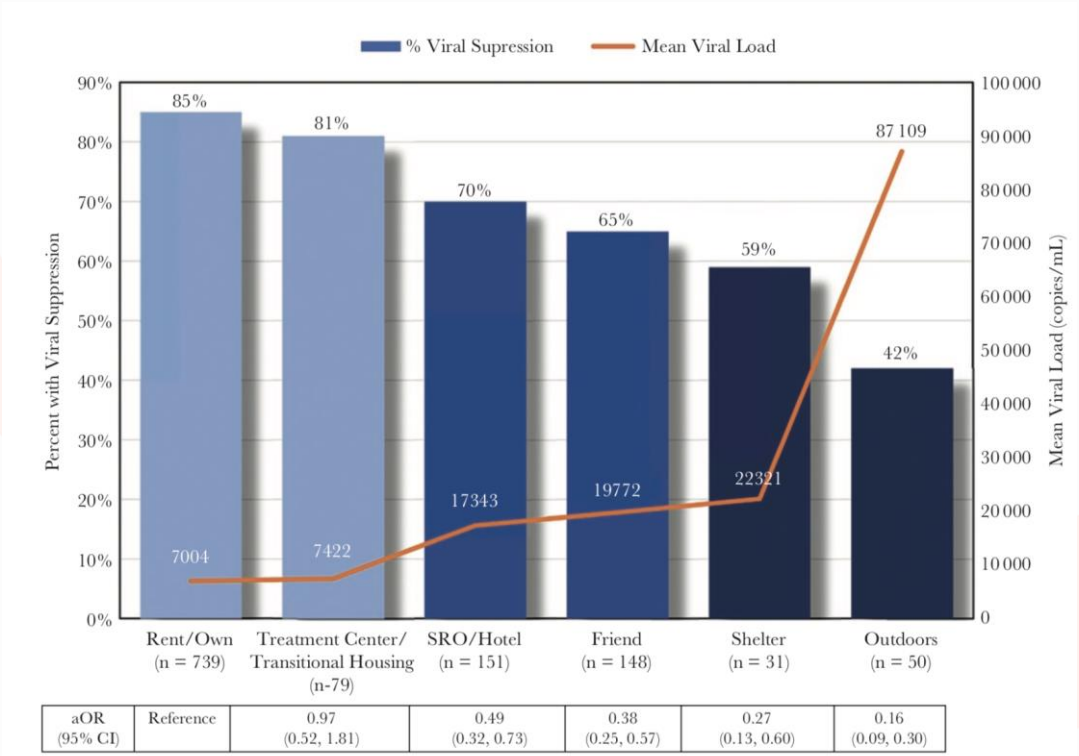
Homelessness is Associated with Higher Viral Load and Higher Mortality Rates



aOR (95% CI)	Reference	0.97 (0.52, 1.81)	0.49 (0.32, 0.73)	0.38 (0.25, 0.57)	0.27 (0.13, 0.60)	0.16 (0.09, 0.30)

(Clemenzi-Allen, 2019)

CONCISE COMMUNICATION

Homelessness at diagnosis is associated with death among people with HIV in a population-based study of a US city

Matthew A. Spinelli[a], Nancy A. Hessol[b], Sandy Schwarcz[c], Ling Hsu[c], Maree-Kay Parisi[c], Sharon Pipkin[c], Susan Scheer[c], Diane Havlir[a] and Susan P. Buchbinder[c]

Objective: San Francisco, California, has experienced a 44% reduction in new HIV diagnoses since 2013 supported by its 'Getting to Zero' initiative; however, the age-adjusted mortality rate in people with HIV (PWH) has not decreased. We sought to identify factors associated with death among PWH in San Francisco.

Design: Population-based incidence-density case–control study.

Methods: Among PWH in the San Francisco HIV surveillance registry, a random sample of 48 decedents from 1 July 2016 to 31 May 2017 were each matched to two to three controls who were alive at the date of death (108 controls matched on age and time since diagnosis). Covariates included demographics, substance use, housing status, medical conditions, and care indicators from the study population. We used matched-pair conditional logistic regression to examine factors associated with mortality.

Results: Of the 156 PWH in the study, 14% were African-American, 14% Latino, and 8% female sex. In adjusted analysis, factors associated with higher odds of death included: homelessness at HIV diagnosis [adjusted odds ratio (AOR) = 27.4; 95% confidence interval (CI) = 3.0–552.1], prior-year IDU (AOR = 10.2; 95% CI = 1.7–128.5), prior-year tobacco use (AOR = 7.2; 95% CI = 1.7–46.9), being off antiretroviral therapy at any point in the prior year (AOR = 6.8; 95% CI = 1.1–71.4), and being unpartnered vs. married/partnered (AOR = 4.7; 95% CI = 1.3–22.0).

Conclusion: People homeless at HIV diagnosis had 27-fold higher odds of death compared with those with housing; substance use and retention on antiretroviral therapy in the prior year are other important intervenable factors. New strategies to address these barriers, and continued investment in supportive housing and substance use treatment, are needed.

AIDS 2019, **33**:1789–1794

Keywords: antiretroviral therapy, HIV, homelessness, mortality, preventable mortality, substance use

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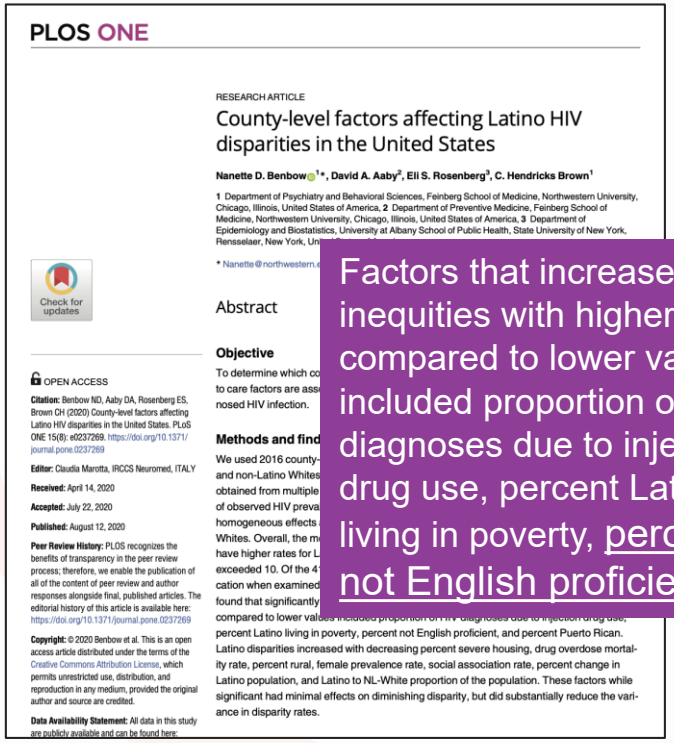
Non-English Speakers and HIV/ COVID-19 risk



PLOS ONE

RESEARCH ARTICLE

County-level factors affecting Latino HIV disparities in the United States

Nanette D. Benbow[1]*, David A. Aaby[2], Eli S. Rosenberg[3], C. Hendricks Brown[1]

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OPEN ACCESS

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Data Availability Statement: All data in this study are publicly available and can be found here:

Abstract

Objective

To determine which co
to care factors are ass
nosed HIV infection.

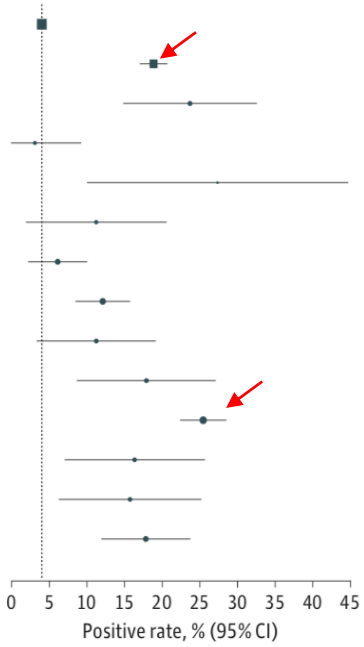
Methods and find

We used 2016 county-
and non-Latino Whites
obtained from multiple
of observed HIV preva
homogeneous effects
Whites. Overall, the m
have higher rates for L
exceeded 10. Of the 4
cation when examined
found that significantly
compared to lower values included proportion of HIV diagnoses due to injection drug use, percent Latino living in poverty, percent not English proficient, and percent Puerto Rican. Latino disparities increased with decreasing percent severe housing, drug overdose mortality rate, percent rural, female prevalence rate, social association rate, percent change in Latino population, and Latino to NL-White proportion of the population. These factors while significant had minimal effects on diminishing disparity, but did substantially reduce the variance in disparity rates.

Factors that increased inequities with higher compared to lower values included proportion of HIV diagnoses due to injection drug use, percent Latino living in poverty, percent not English proficient

igure 2. Proportion of Patients Testing Positive for Severe Acute Respiratory Syndrome Coronavirus 2 SARS-CoV-2) by Language

Language	No. tested	Positive rate, % (95% CI)
English	1154	4 (3.8-4.2)
Non-English	347	18.6 (16.8-20.3)
Amharic	21	23.3 (14.6-32.1)
Arabic	1	3.1 (0-9.2)
Cambodian/Khmer	7	26.9 (9.9-44)
Korean	5	11.1 (1.9-20.3)
Mandarin/Cantonese	9	6.1 (2.2-9.9)
Other	38	11.9 (8.4-15.5)
Russian	7	11.1 (3.4-18.9)
Somali	12	17.6 (8.6-26.7)
Spanish	199	25.1 (22-28.1)
Tagalog	10	16.1 (7-25.3)
Tigrinya	9	15.5 (6.2-24.8)
Vietnamese	29	17.6 (11.8-23.4)



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2. WE IGNORE MULTIPLE OVERLAPPING EPIDEMICS AT OUR PERIL

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World Health Organization Model of Non-communicable vs. Infectious Diseases

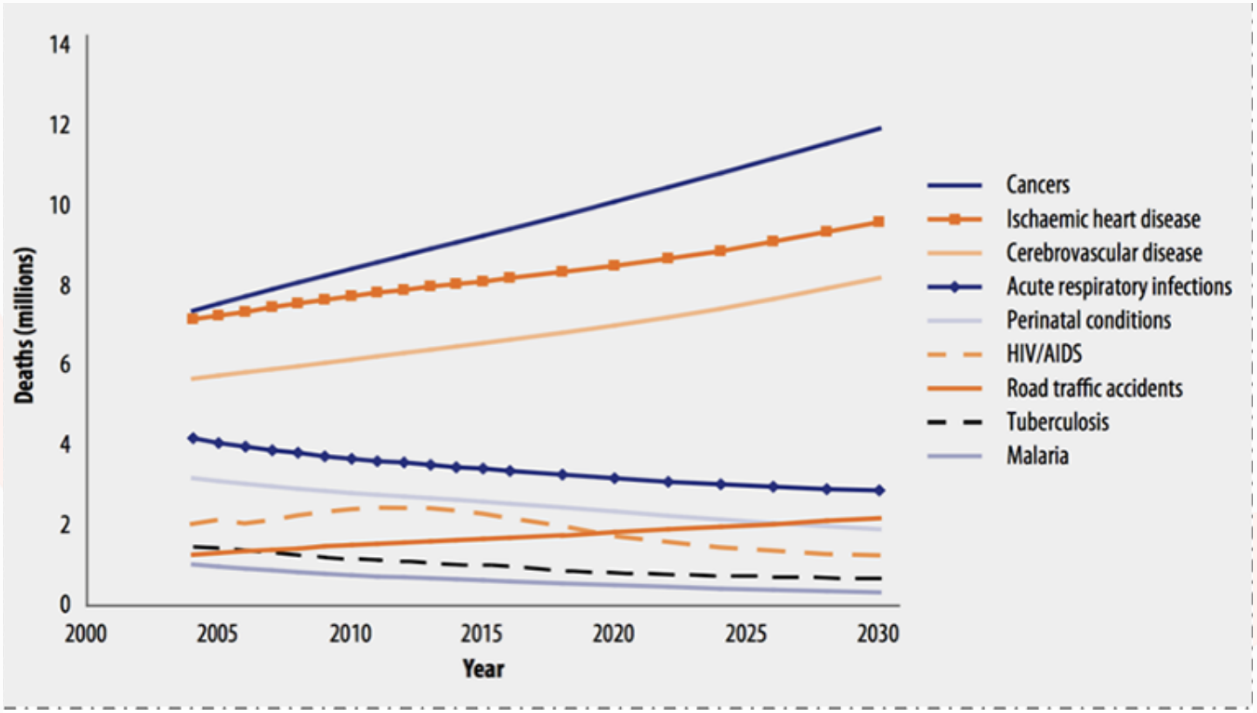
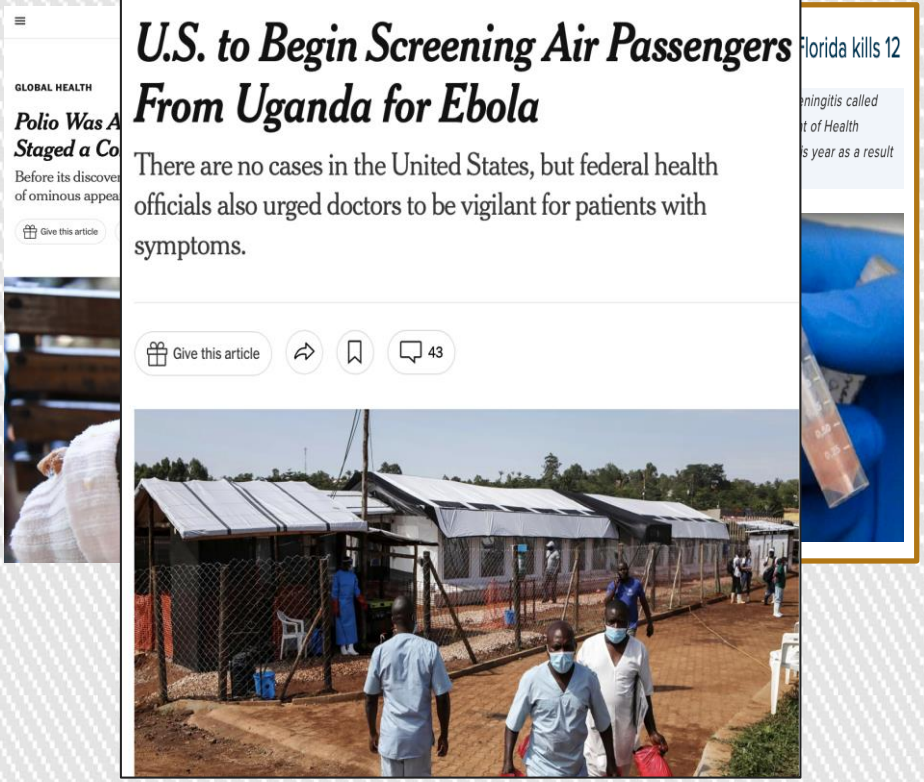
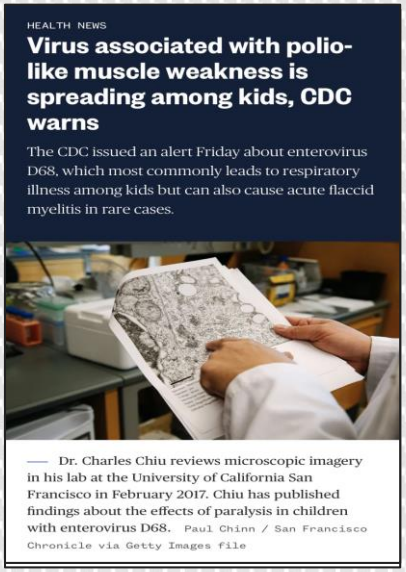


Figure 2. Projected global deaths for selected causes, 2004-2030. Global Burden of Disease: 2004 Update. World Health Organization. Source: http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf?ua=1 Accessed June 30, 2016.

"The beginnings of public health were rooted in preventing infectious disease and promoting sanitation. Now that we have largely eradicated many of these infectious conditions in the United States and in other high-resource countries, humans are living long enough to die from non-communicable diseases, or NCDs ."

Overlapping Infectious Disease Threats





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COVID-19 Lockdown & HIV Viral Suppression

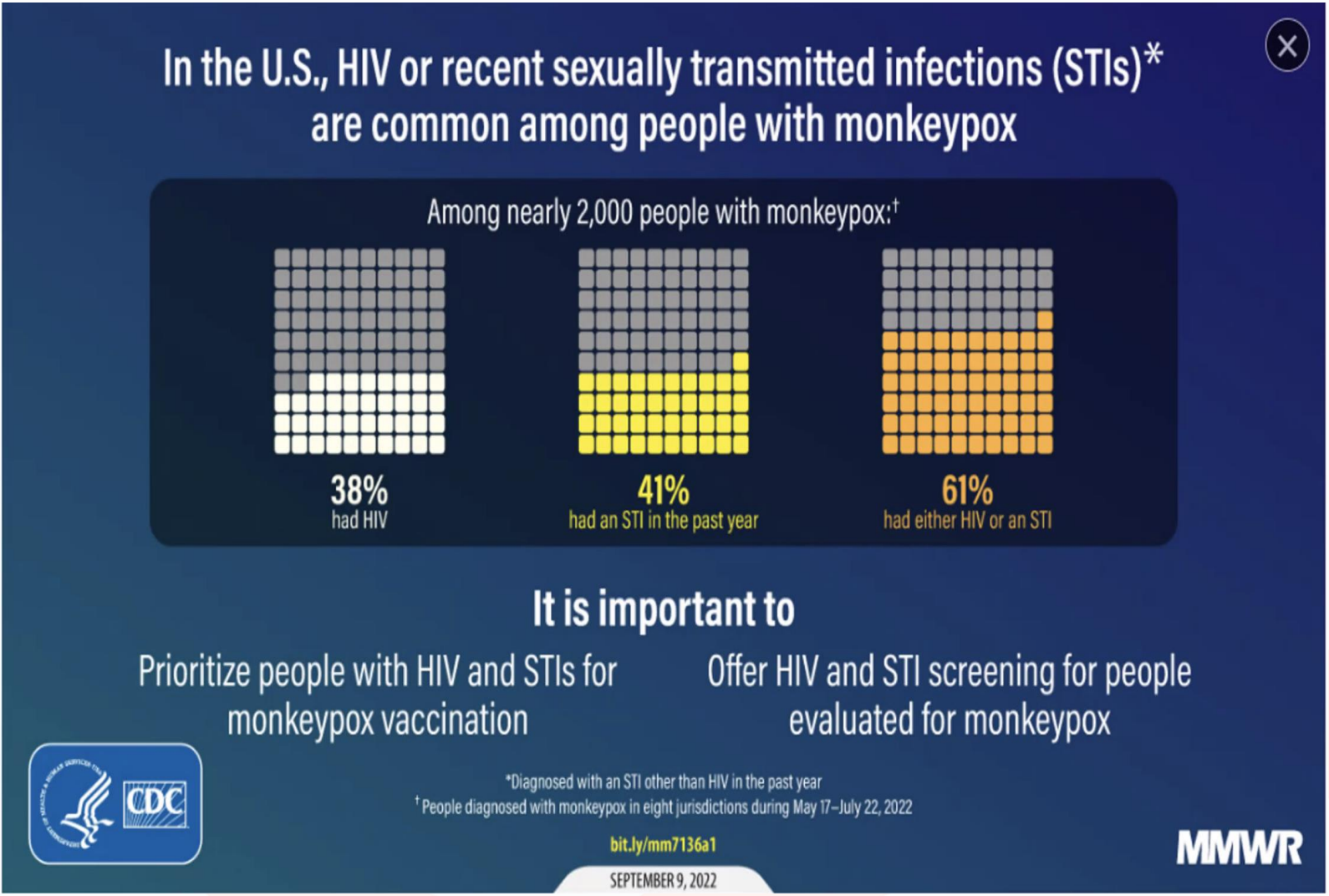
Viral suppression rates in a safety-net HIV clinic in San Francisco destabilized during COVID-19

Matthew A. Spinelli[a], Matthew D. Hickey[a], David V. Glidden[b], Janet Q. Nguyen[a], Jon J. Oskarsson[a], Diane Havlir[a] and Monica Gandhi[b]

Table 1. Factors associated with unsuppressed viral load and no-show visits before and after shelter-in-place/COVID-19[a].

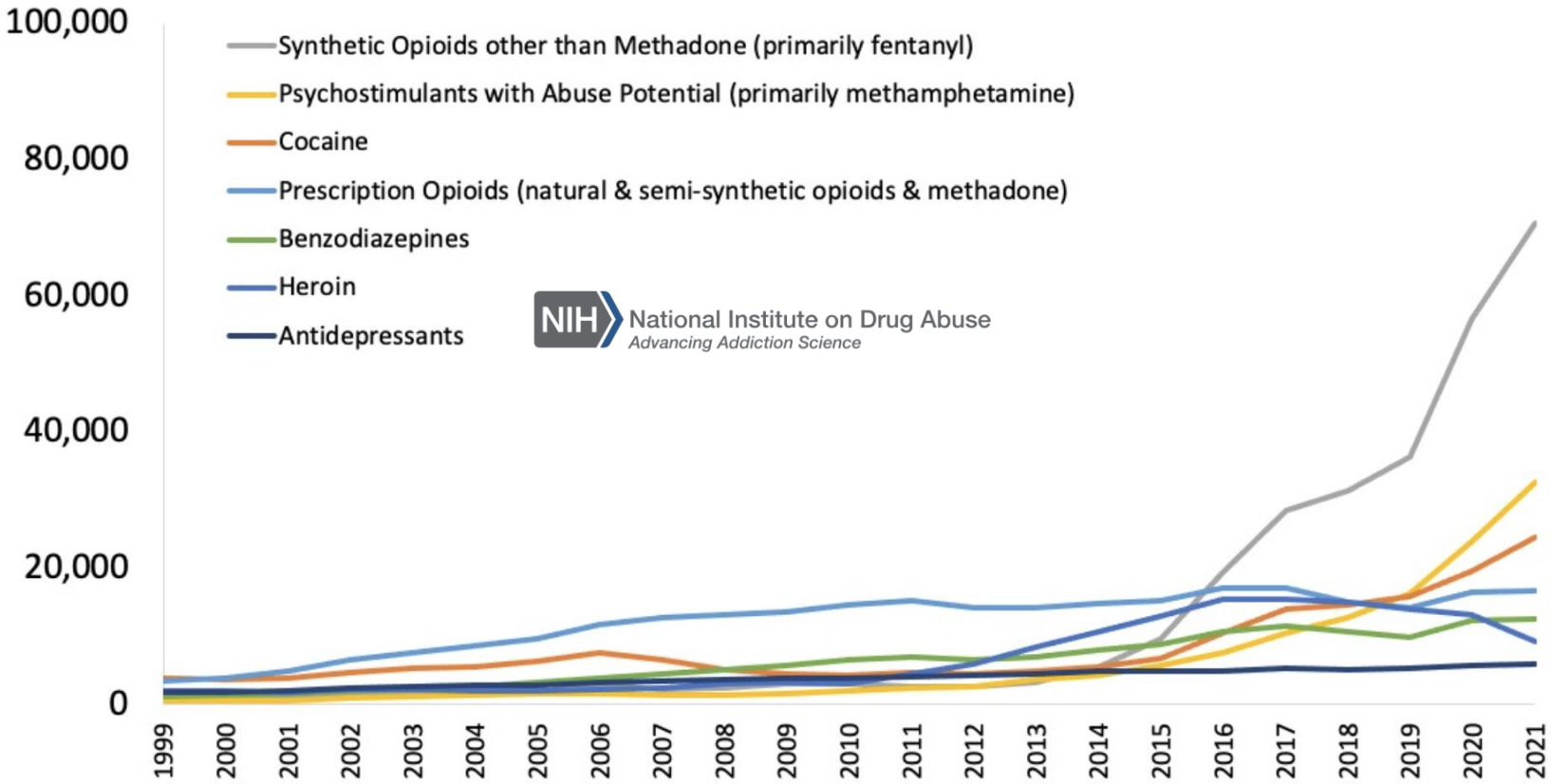
Factor	Unsuppressed viral load adjusted odds ratio; 95% Confidence Interval	No-show visit Adjusted odds ratio; 95% confidence interval
Post-COVID-19 vs. pre-COVID-19	1.31; 1.08–1.53	0.91; 0.77–1.09
Age under 35[a]	1.29; 1.11–1.51	1.57; 1.28–1.93 (Pre-COVID-19) 1.11; 0.82–1.51 (Post-COVID-19)
Female vs. male birth sex	0.94; 0.77–1.15	0.99; 0.80–1.21
Race/ethnicity vs. white		
Black	1.60; 1.33–1.91	1.14; 0.94–1.38
Latin	1.04; 0.63–1.34	1.06; 0.88–1.27
Asian	0.92; 0.63–1.34	1.16; 0.82–1.64
Other	0.96; 0.78–1.19	0.97; 0.77–1.24
Homeless housing status[a]	2.27; 1.91–2.71 (Pre-COVID-19) 3.36; 2.74–4.12 (Post-COVID-19)	1.15; 0.95–1.32 (Pre-COVID-19) 0.64; 0.48–0.85 (Post-COVID-19)
Telephone vs. in-person visits (post-COVID-19 only)	–	0.56; 0.36–0.86

[a]Each factor was tested for an interaction with the pre/post COVID-19 time interval indicator. Adjusted odds ratios and 95% confidence intervals are presented separately for before and during COVID-19 time intervals if the test of interaction *P*-value was <0.1 [6].



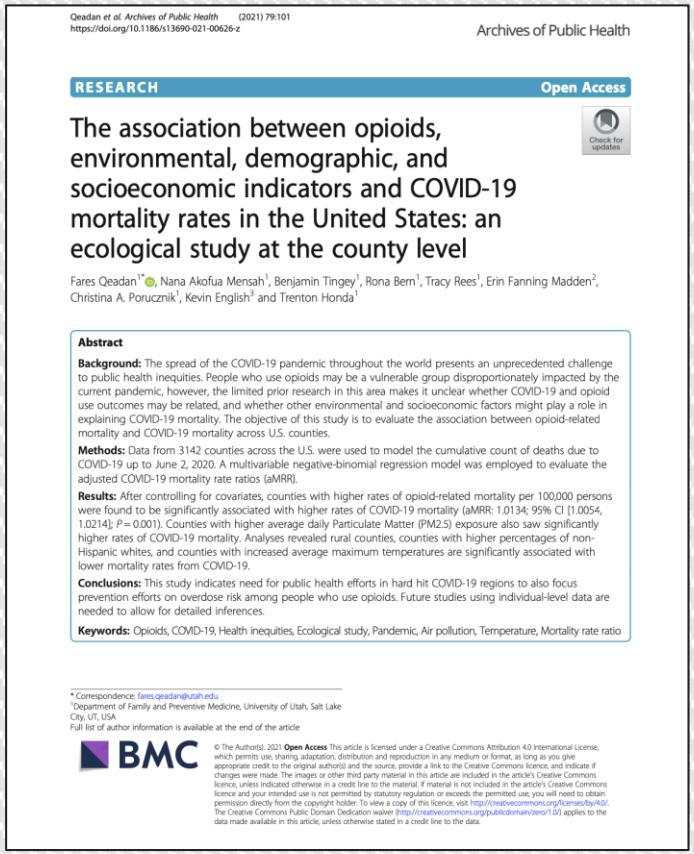
- **41% STI in past year**
- **61% had STI or HIV**
- **38% HIV+**

Figure 2. National Drug-Involved Overdose Deaths*, Number Among All Ages, 1999-2021



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

Association between Opioid Mortality Rate and COVID-19 Mortality at the County-Level



Qeadan *et al. Archives of Public Health* (2021) 79:101
https://doi.org/10.1186/s13690-021-00626-z

Archives of Public Health

RESEARCH Open Access

The association between opioids, environmental, demographic, and socioeconomic indicators and COVID-19 mortality rates in the United States: an ecological study at the county level

Fares Qeadan[1*], Nana Akofua Mensah[1], Benjamin Tingey[1], Rona Bern[1], Tracy Rees[1], Erin Fanning Madden[2], Christina A. Porucznik[1], Kevin English[3] and Trenton Honda[1]

Abstract

Background: The spread of the COVID-19 pandemic throughout the world presents an unprecedented challenge to public health inequities. People who use opioids may be a vulnerable group disproportionately impacted by the current pandemic, however, the limited prior research in this area makes it unclear whether COVID-19 and opioid use outcomes may be related, and whether other environmental and socioeconomic factors might play a role in explaining COVID-19 mortality. The objective of this study is to evaluate the association between opioid-related mortality and COVID-19 mortality across U.S. counties.

Methods: Data from 3142 counties across the U.S. were used to model the cumulative count of deaths due to COVID-19 up to June 2, 2020. A multivariable negative-binomial regression model was employed to evaluate the adjusted COVID-19 mortality rate ratios (aMRR).

Results: After controlling for covariates, counties with higher rates of opioid-related mortality per 100,000 persons were found to be significantly associated with higher rates of COVID-19 mortality (aMRR: 1.0134; 95% CI [1.0054, 1.0214]; $P = 0.001$). Counties with higher average daily Particulate Matter (PM2.5) exposure also saw significantly higher rates of COVID-19 mortality. Analyses revealed rural counties, counties with higher percentages of non-Hispanic whites, and counties with increased average maximum temperatures are significantly associated with lower mortality rates from COVID-19.

Conclusions: This study indicates need for public health efforts in hard hit COVID-19 regions to also focus prevention efforts on overdose risk among people who use opioids. Future studies using individual-level data are needed to allow for detailed inferences.

Keywords: Opioids, COVID-19, Health inequities, Ecological study, Pandemic, Air pollution, Temperature, Mortality rate ratio

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[1]Department of Family and Preventive Medicine, University of Utah, Salt Lake City, UT, USA
Full list of author information is available at the end of the article

Table 2 Adjusted estimates of variables impact on COVID-19 mortality[a]

Variables	Adjusted MRR[b] (95% CI)	*P*-value
Opioid Mortality Rate per 100,000 persons	**1.0134 (1.0054, 1.0214)**	**0.001**
Opioid Prescribing Rate per 100 persons	1.0005 (0.9979, 1.0031)	0.69
Ratio of ≥65 years old to < 25 years old	1.0564 (0.8082, 1.3809)	0.69
% Black	**1.0323 (1.0255, 1.0390)**	**< 0.001**
% Non-Hispanic White	**0.9828 (0.9767, 0.9889)**	**< 0.001**
% Rural	**0.9951 (0.9917, 0.9986)**	**0.01**
log (Median Household Income)	**6.2034 (3.5170, 10.9419)**	**< 0.001**
log (Median Home Value)	*0.7907 (0.6062, 1.0332)*	*0.09*
Population Density (persons/100 mile^2)	**1.0050 (1.0019, 1.0082)**	**0.002**
% Unemployed	**1.0591 (1.0008, 1.1208)**	**0.047**
% Diabetic	*1.0414 (0.9948, 1.0904)*	*0.08*
Hypertension Hospitalizations Rate	1.0095 (0.9834, 1.0362)	0.48
% Smokers	1.0030 (0.9708, 1.0363)	0.85
% Excessive Drinking	1.0136 (0.9832, 1.0450)	0.38
% With access to place of physical activity	0.9986 (0.9942, 1.0030)	0.53
% Health practitioners	1.0249 (0.9808, 1.0709)	0.27
% Sales/office workers	1.0083 (0.9797, 1.0379)	0.57
% Transportation/trucking workers	*1.0178 (0.9996, 1.0363)*	*0.055*
% Education workers	0.9933 (0.9608, 1.0269)	0.69
Average maximum temperature (°F)	**0.9784 (0.9682, 0.9889)**	**< 0.001**
Average Daily $PM_{2.5}$ (μg/m3)	**1.0695 (1.0194, 1.220)**	**0.01**

[a] Negative binomial regression model. R^2: 0.79. Chi-squared Goodness of Fit p-value: 0.70; [b] Mortality rate ratio

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AETC AIDS Education & Training Center Program Southeast

Overlapping Epidemics: HIV+ MSM diagnosed with MPX by race/ethnicity

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Weekly / Vol. 71 / No. 36 September 9, 2022

HIV and Sexually Transmitted Infections Among Persons with Monkeypox — Eight U.S. Jurisdictions, May 17–July 22, 2022

Kathryn G. Curran, PhD[1]; Kristen Eberly, MPH[1]; Olivia O. Russell, MPH[2]; Robert E. Snyder, PhD[3]; Elisabeth K. Phillips, MPH[3]; Eric C. Tang, MD[3]; Philip J. Peters, MD[1,3]; Melissa A. Sanchez, PhD[4]; Ling Hsu, MPH[4]; Stephanie E. Cohen, MD[4]; Ekow K. Sey, PhD[3]; Sherry Yin, MPH[3]; Chelsea Foo, MPH[3]; William Still, MS[2]; Anil Mangla, PhD[2]; Beitrani Saafir-Callaway, PhD[2]; Lauren Barrineau-Vejtajova, MPH[2]; Cristina Meza, MPH[2]; Elizabeth Burkhardt, MSPH[2]; Marguerite E. Smith, MS, MPH[4]; Patricia A. Murphy, MPH[4]; Nora K. Kelly, MPH[4]; Hillary Spencer, MD[1,10]; Irina Tabidze, MD[11]; Massimo Pacilli[12]; Carol-Ann Swain, PhD[12]; Kathleen Bogucki, MPH[12]; Charlotte DeBarba, MPH[12]; Deepa T. Rajulu, MS[12]; Andre Dailey, MSPH[1]; Jessica Ricaldi, MD, PhD[1]; Leandro A. Mena, MD[1]; Demetre Daskalakis, MD[1]; Laura H. Bachmann, MD[1]; John T. Brooks, MD[1]; Alexandra M. Oster, MD[1]; Monkeypox, HIV, and STI Team

High prevalences of HIV and other sexually transmitted infections (STIs) have been reported in the current global monkeypox outbreak, which has affected primarily gay, bisexual, and other men who have sex with men (MSM) (*1–5*). In previous monkeypox outbreaks in Nigeria, concurrent HIV infection was associated with poor monkeypox clinical outcomes (*6,7*). Monkeypox, HIV, and STI surveillance data from eight U.S. jurisdictions* were matched and analyzed to examine HIV and STI diagnoses among persons with monkeypox and assess differences in monkeypox clinical features according to HIV infection status. Among 1,969 persons with monkeypox during May 17–July 22, 2022, HIV prevalence was 38%, and 41% had received a diagnosis of one or more other reportable STIs in the preceding year. Among persons with monkeypox and diagnosed HIV infection, 94% had received HIV care in the preceding year, and 82% had an HIV viral load of <200 copies/mL, indicating HIV viral suppression. Compared with persons without HIV infection, a higher proportion of persons with HIV infection were hospitalized (8% versus 3%). Persons with HIV infection or STIs are disproportionately represented among persons with monkeypox. It is important that public health officials leverage systems for delivering HIV and STI care and prevention to reduce monkeypox incidence in this population. Consideration should be given to prioritizing persons with HIV infection and STIs for vaccination against monkeypox. HIV and STI screening and other recommended preventive care should be routinely offered to persons evaluated for monkeypox, with linkage to HIV care or HIV preexposure prophylaxis (PrEP) as appropriate.

Eight health departments matched probable and confirmed cases of monkeypox† diagnosed through July 22, 2022, and occurring among persons aged ≥18 years, to local HIV and STI surveillance data using individually established methods that included various personal identifiers (e.g., name,

* Eight state and city or county jurisdictions independently funded for HIV surveillance: California (including Los Angeles County and San Francisco), District of Columbia, Georgia, Illinois (including Chicago), and New York (excluding New York City).

† https://www.cdc.gov/poxvirus/monkeypox/clinicians/case-definition.html

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1148 Detection of a Highly Divergent Type 3 Vaccine-Derived Poliovirus in a Child with a Severe Primary Immunodeficiency Disorder — Chongqing, China, 2022

1151 Detection of Higher Cycle Threshold Values in Culturable SARS-CoV-2 Omicron BA.1 Sublineage Compared with Pre-Omicron Variant Specimens — San Francisco Bay Area, California, July 2021—March 2022

1155 *Orthopoxvirus* Testing Challenges for Persons in Populations at Low Risk or Without Known Epidemiologic Link to Monkeypox — United States, 2022

1159 QuickStats

Continuing Education examination available at https://www.cdc.gov/mmwr/mmwr_continuingEducation.html

U.S. Department of Health and Human Services
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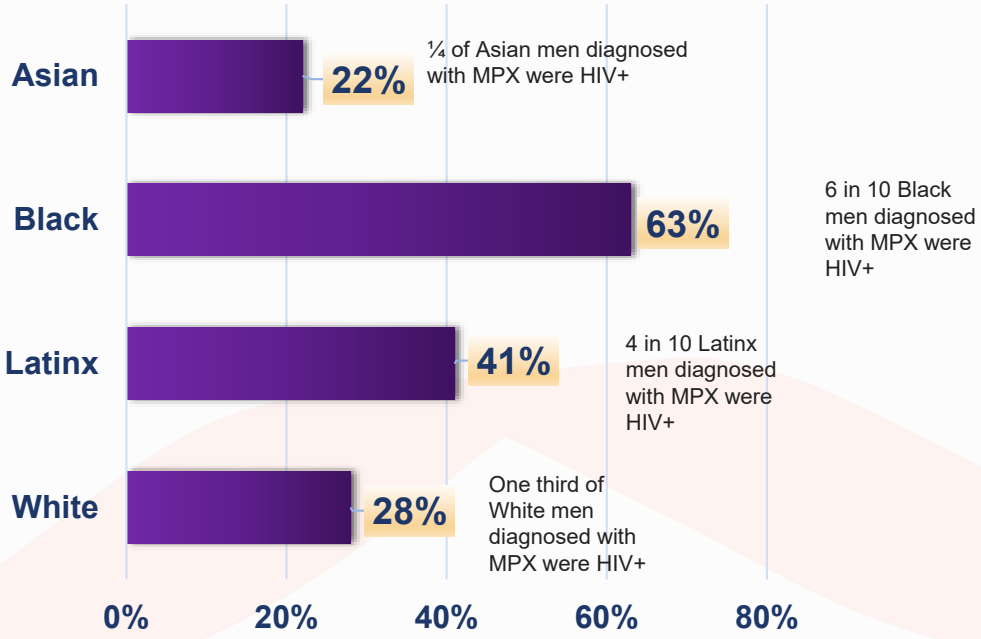
- N= 1969
  - 755 HIV+ (38%)



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3. SCIENTIFIC ADVANCES ARE NOT IMPACTFUL IF THEY FAIL TO REACH THE MOST AFFECTED POPULATIONS

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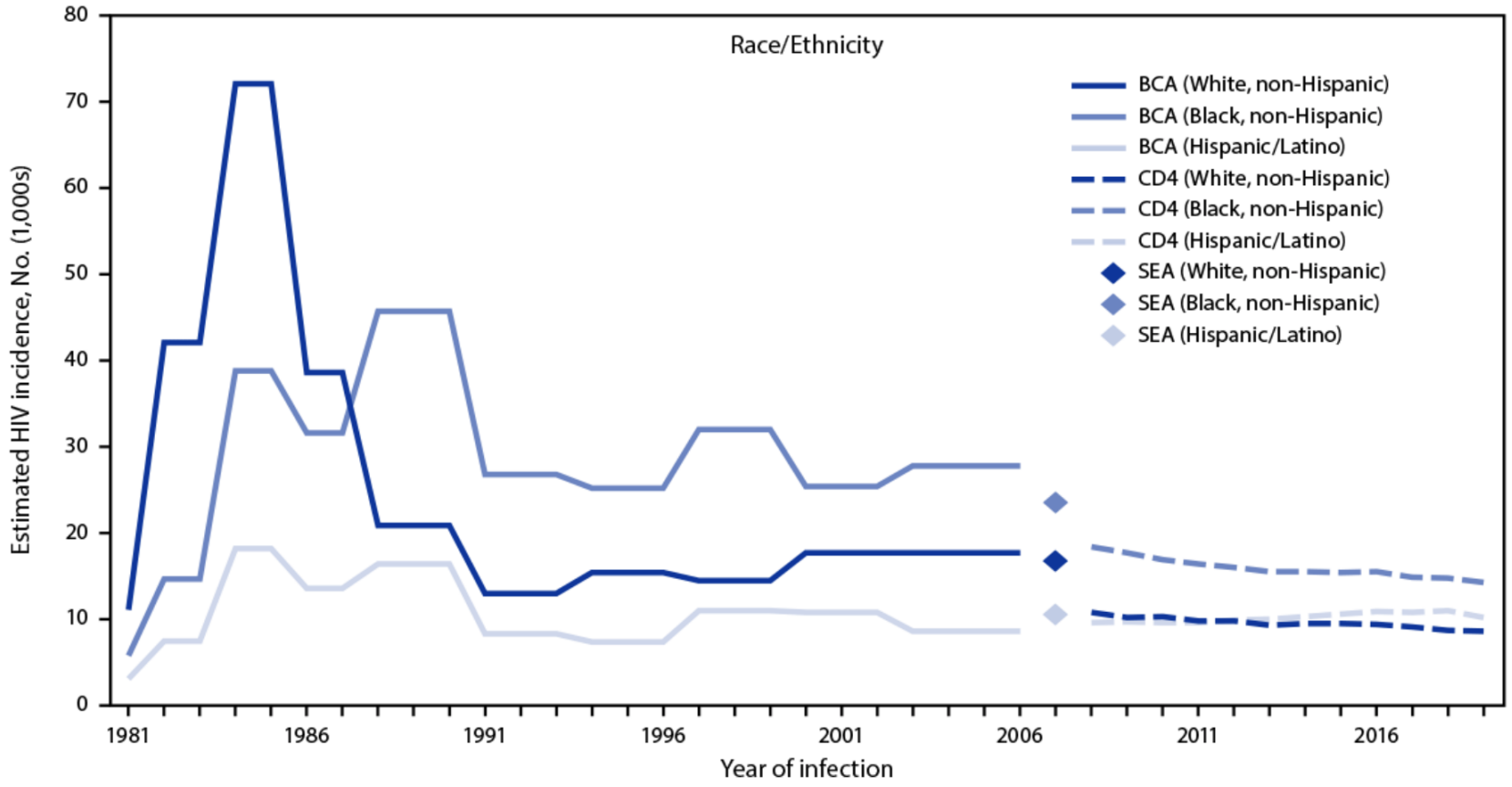
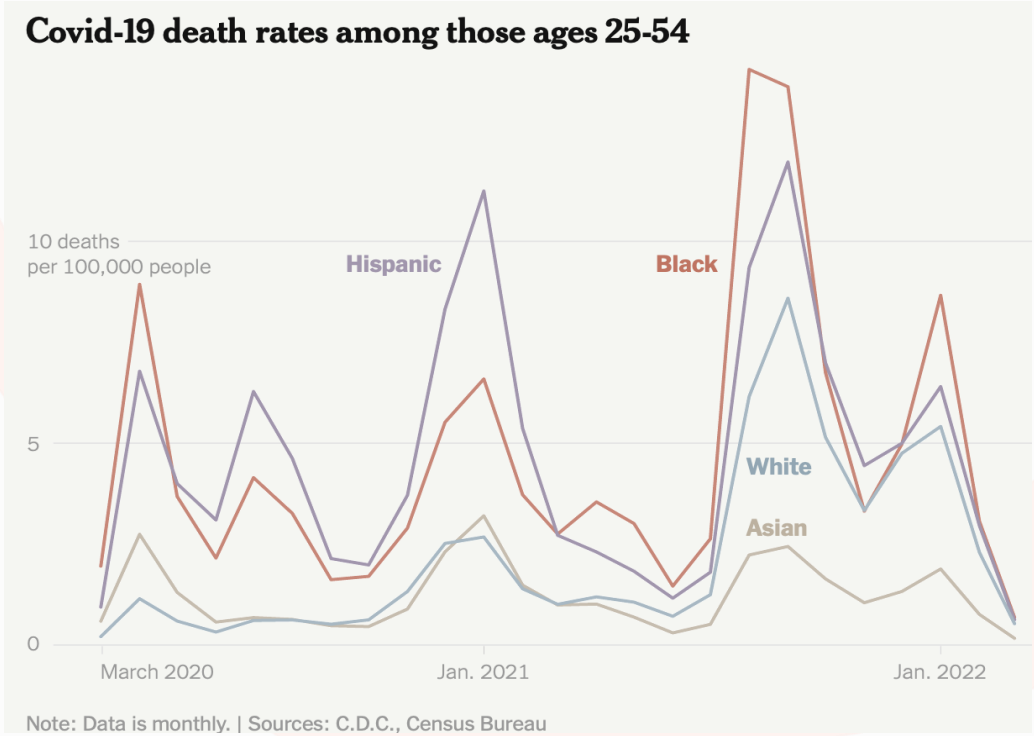
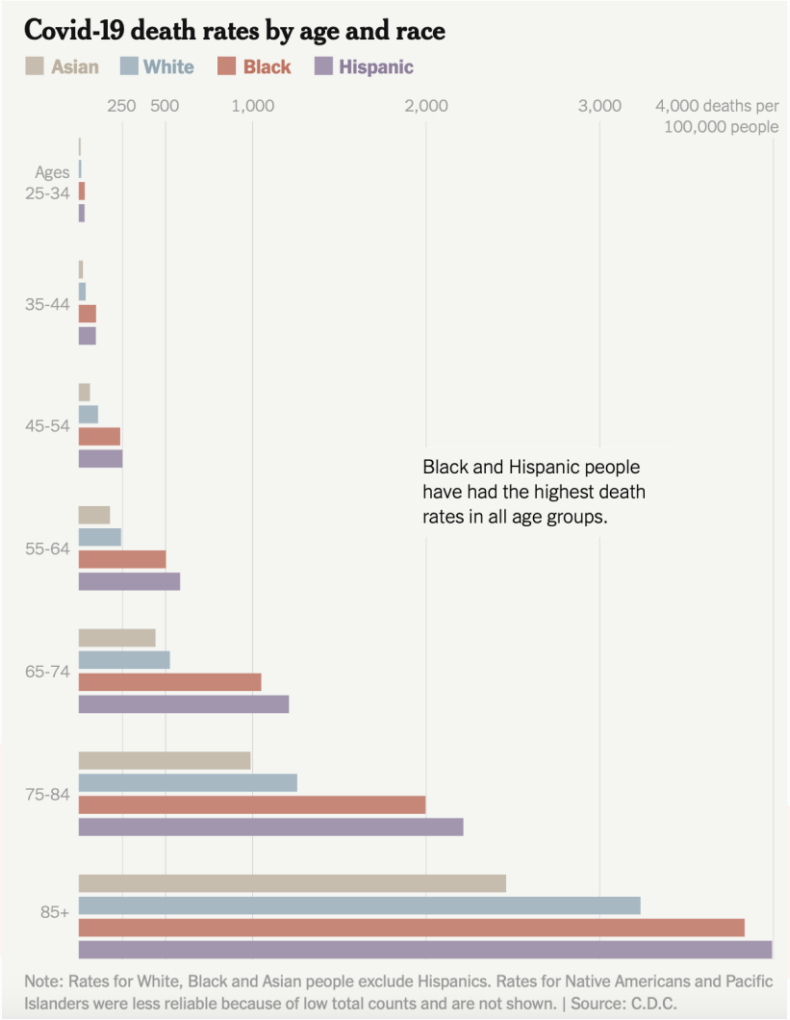
FIGURE 2. Estimated HIV incidence* among persons aged ≥13 years, by selected race/ethnicity† and transmission category§ — United States, 1981–2019



One Million COVID Deaths by Race/ Ethnicity

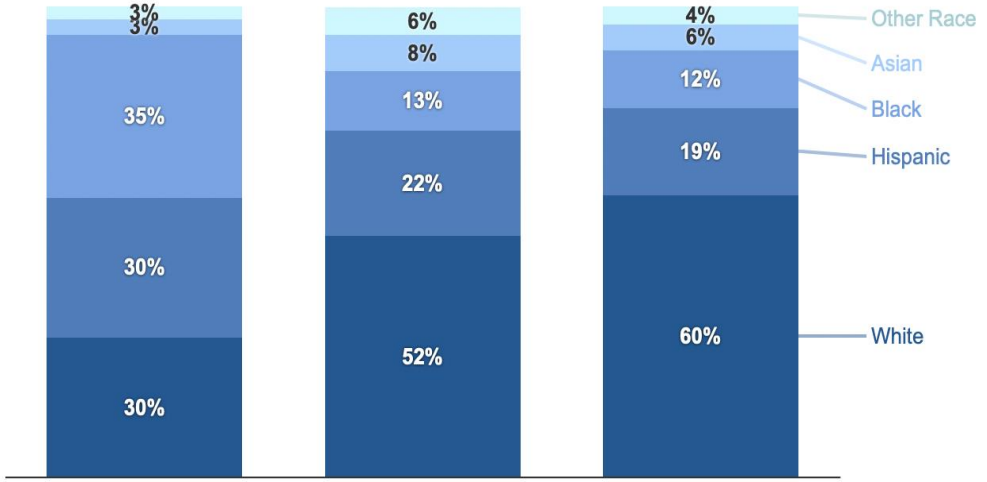




Black and Latinx MSM less likely to access MPOX vaccines despite greater risk of infection

Figure 2

Racial/Ethnic Distribution of MPX (Monkeypox) Cases and Vaccinations in the U.S. as of September 2022



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White People Get Bigger Share of Monkeypox Shots, Early Data Show

While most cases are concentrated among people of color, White people are getting most of the shots.

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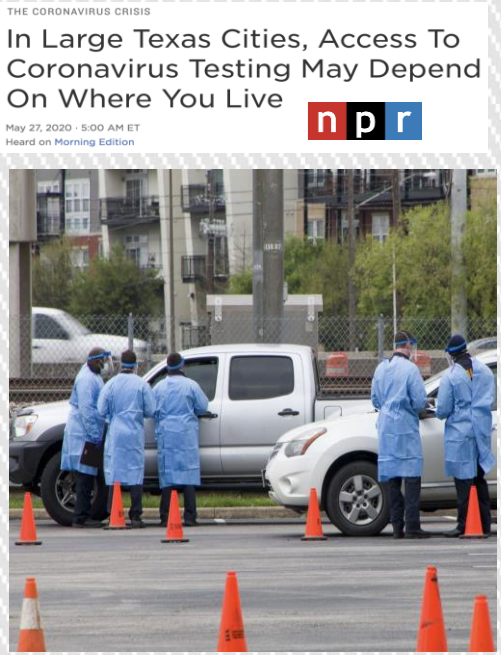
Access to New Technologies: COVID-19 Testing



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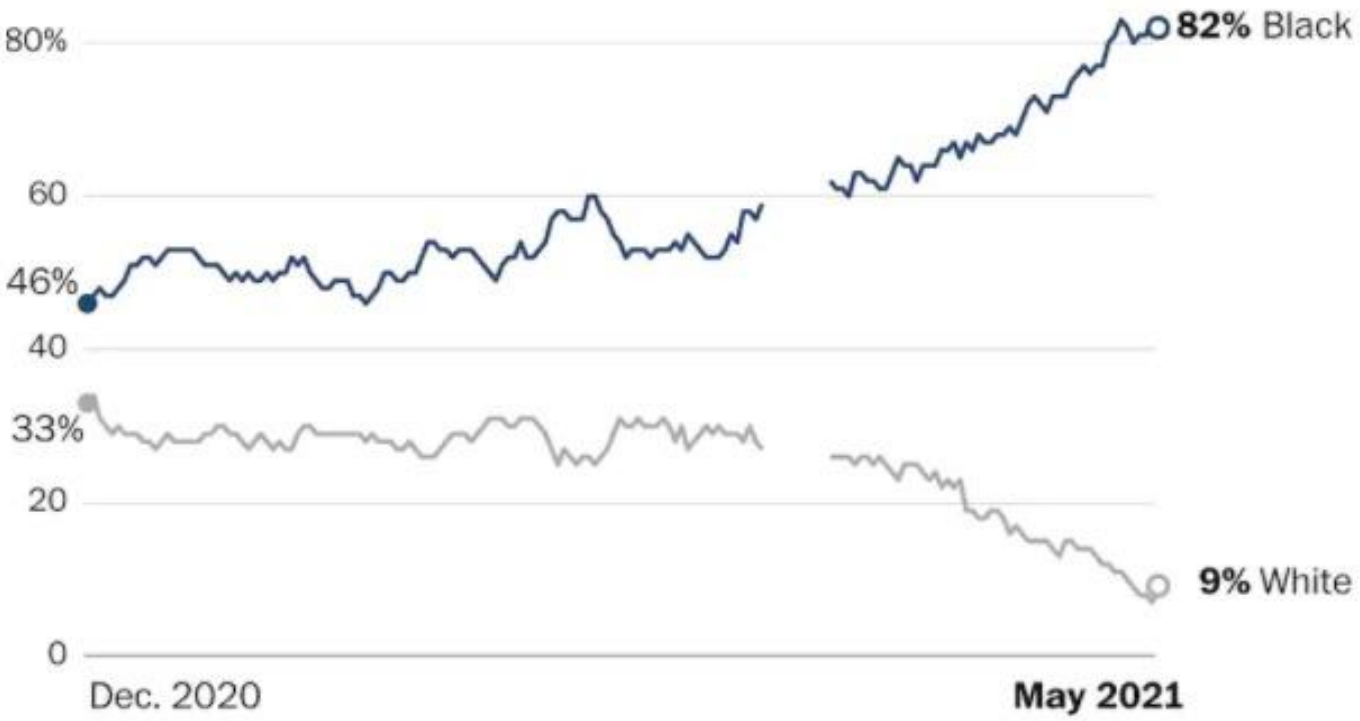
Racial gap in D.C. coronavirus infections widens

With vaccination rates higher among White residents, the share of infections among Whites has plummeted while rising sharply for Black people. This chart reflects a rolling 10-day average on the share of cases by race.



Note: Daily new-case counts not available in March.

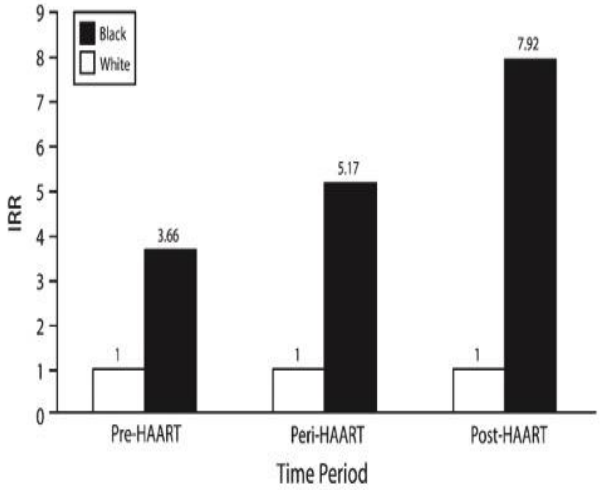
Source: D.C. government data

DAN KEATING/THE WASHINGTON POST

New Technology & Access: HIV Antiretroviral Treatment and HIV Prevention

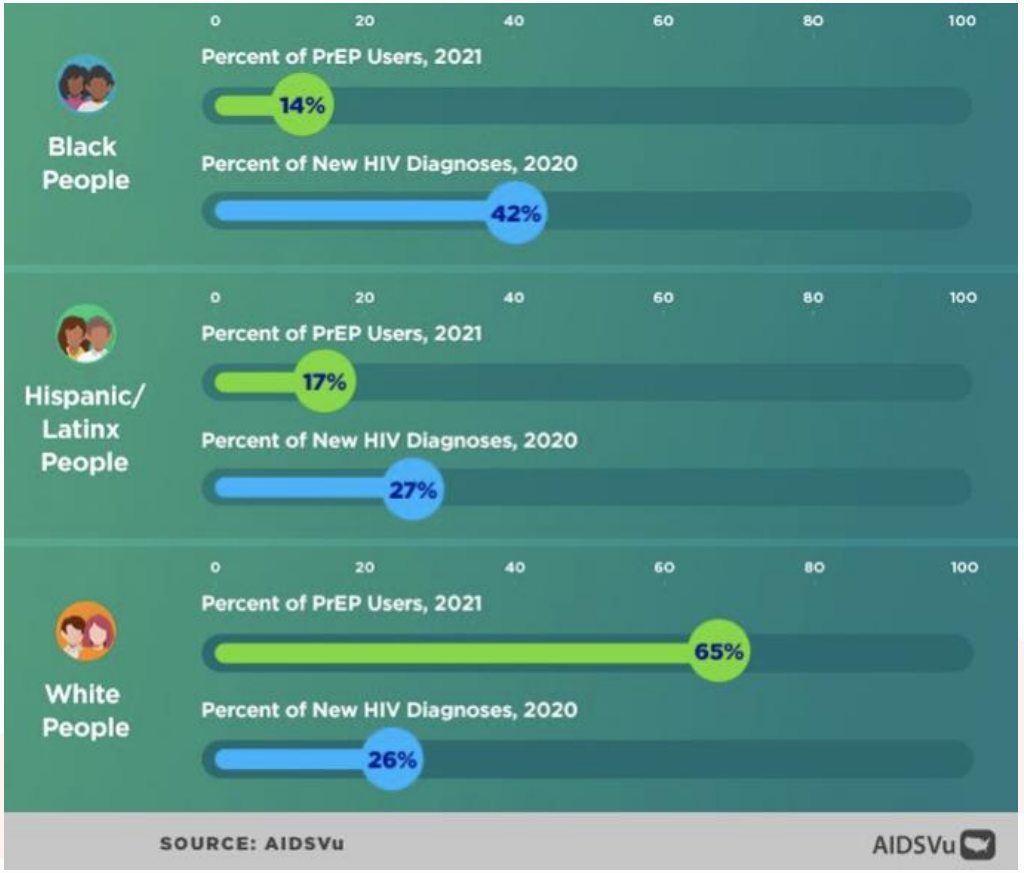
Mortality incident rate-ratios between blacks and whites have **increased** since availability of ART

- Reason: Less access to healthcare in racial minority communities



Note. HAART = highly active antiretroviral therapy; IRR = incident rate ratio. For each period, the results from the model were adjusted for age, gender, and urbanicity. Whites were the reference group.

(Levine et al, 2007)



Disparities have worsened in the past 40 years of the HIV pandemic

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Weekly / Vol. 70 / No. 22 June 4, 2021

Estimated Annual Number of HIV Infections — United States, 1981–2019

Karin A. Bosh, PhD[1]; H. Irene Hall, PhD[1]; Laura Eastham, MPH[1]; Demetre C. Daskalakis, MD[1]; Jonathan H. Mermin, MD[2]

The first cases of *Pneumocystis carinii* (*jiroveci*) pneumonia among young men, which were subsequently linked to HIV infection, were reported in the *MMWR* on June 5, 1981 (*1*). At year-end 2019, an estimated 1.2 million persons in the United States were living with HIV infection (*2*). Using data reported to the National HIV Surveillance System, CDC estimated the annual number of new HIV infections (incidence) among persons aged ≥13 years in the United States during 1981–2019. Estimated annual HIV incidence increased from 20,000 infections in 1981 to a peak of 130,400 infections in 1984 and 1985. Incidence was relatively stable during 1991–2007, with approximately 50,000–58,000 infections annually, and then decreased in recent years to 34,800 infections in 2019. The majority of infections continue to be attributable to male-to-male sexual contact (63% in 1981 and 66% in 2019). Over time, the proportion of HIV infections has increased among Black/African American (Black) persons (from 29% in 1981 to 41% in 2019) and among Hispanic/Latino persons (from 16% in 1981 to 29% in 2019). Despite the lack of a cure or a vaccine, today's HIV prevention tools, including HIV testing, prompt and sustained treatment, preexposure prophylaxis, and comprehensive syringe service programs, provide an opportunity to substantially decrease new HIV infections. Intensifying efforts to implement these strategies equitably could accelerate declines in HIV transmission, morbidity, and mortality and reduce disparities.

To estimate annual HIV incidence among persons aged ≥13 years in the United States during 1981–2019, CDC applied mathematical modeling to data reported to the National HIV Surveillance System. Three eras of HIV incidence estimates were used based on changes in methodology and available data (*3*,*4*).* The cumulative number of HIV infections over the period was estimated by summing annual incidence estimates. The distributions of HIV incidence were compared overall and by sex at birth, race/ethnicity, and transmission category for the period examined at the beginning (1981), at the peak number of annual infections (1984–1985), and at the end of the study period (2019). Trends in the annual number of HIV infections over the entire period were assessed for selected racial/ethnic groups and transmission categories.† For racial/ethnic groups, only trends among Black, Hispanic/Latino, and White persons were described.§ Increases or decreases in the numbers and proportions are reported for relative changes of ≥5%.

* HIV incidence estimates for 1981–2006 were derived from the extended back-calculation approach applied to HIV surveillance data reported to CDC through June 2007. HIV incidence in 2007 was estimated using the stratified extrapolation approach applied to HIV surveillance data reported to CDC through June 2011 (https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-17-4.pdf). HIV incidence estimates during 2008–2019 were derived from the CD4 model applied to HIV surveillance data reported to CDC through December 2020.

† Transmission categories were assigned on the basis of sex at birth, regardless of gender identity.

§ Trends were not assessed for racial/ethnic groups other than White, Black, and Hispanic/Latino because of changes in data collection that were required in 2003 to align with revised standards for classification of federal data on race and ethnicity for other racial categories, as well as the small number of infections.

INSIDE

807 COVID-19 Severity and COVID-19–Associated Deaths Among Hospitalized Patients with HIV Infection — Zambia, March–December 2020
811 Impact of Policy and Funding Decisions on COVID-19 Surveillance Operations and Case Reports — South Sudan, April 2020–February 2021
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Continuing Education examination available at https://www.cdc.gov/mmwr/mmwr_continuingEducation.html

U.S. Department of Health and Human Services
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TABLE. Estimated HIV incidence among persons aged ≥13 years, by selected characteristics — United States, 1981, 1984–1985, and 2019

Characteristic	No. (%) 1981*	1984–1985*	2019†
Sex at birth			
Male	18,600 (93)	115,500 (89)	28,400 (82)
Female	1,500 (8)	15,100 (12)	6,400 (18)
Race/Ethnicity			
American Indian/ Alaska Native	0 (—)	400 (0)	230§ (1§)
Asian¶	N/A	N/A	550 (2)
Asian/Pacific Islander¶	0 (—)	900 (1)	N/A
Black/African American	5,800 (29)	38,800 (30)	14,300 (41)
Hispanic/Latino**	3,100 (16)	18,200 (14)	10,200 (29)
Native Hawaiian/ Other Pacific Islander¶	N/A	N/A	—††
White	11,100 (56)	72,100 (55)	8,600 (25)
Multiple races¶	N/A	N/A	900 (3)
Transmission category§§			
Male-to-male sexual contact	12,500 (63)	75,800 (58)	23,100 (66)
Injection drug use	4,400 (22)	32,000 (25)	2,500 (7)
Male-to-male sexual contact and injection drug use	2,400 (12)	11,400 (9)	1,400 (4)
Heterosexual contact¶¶	400 (2)	8,000 (6)	7,800 (22)
Total	**20,000 (100)**	**130,400 (100)**	**34,800 (100)**

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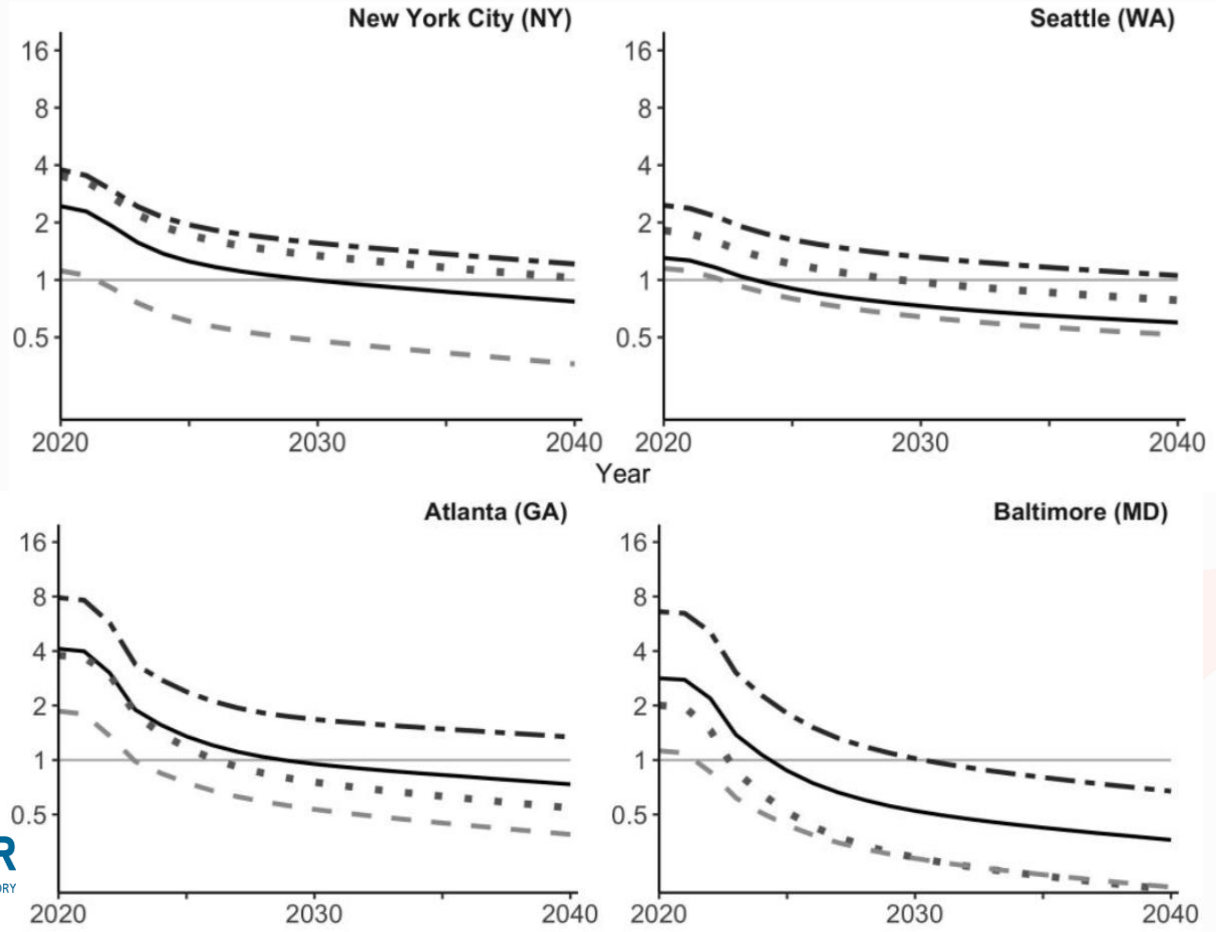
We are on track to end the HIV epidemic… with White Americans



(Zang et al, 2020)

4. DIMINISHING TRUST IN SCIENCE/PUBLIC HEALTH WITH GREATER CREDENCE PAID TO IDEOLOGY VS. FACTS

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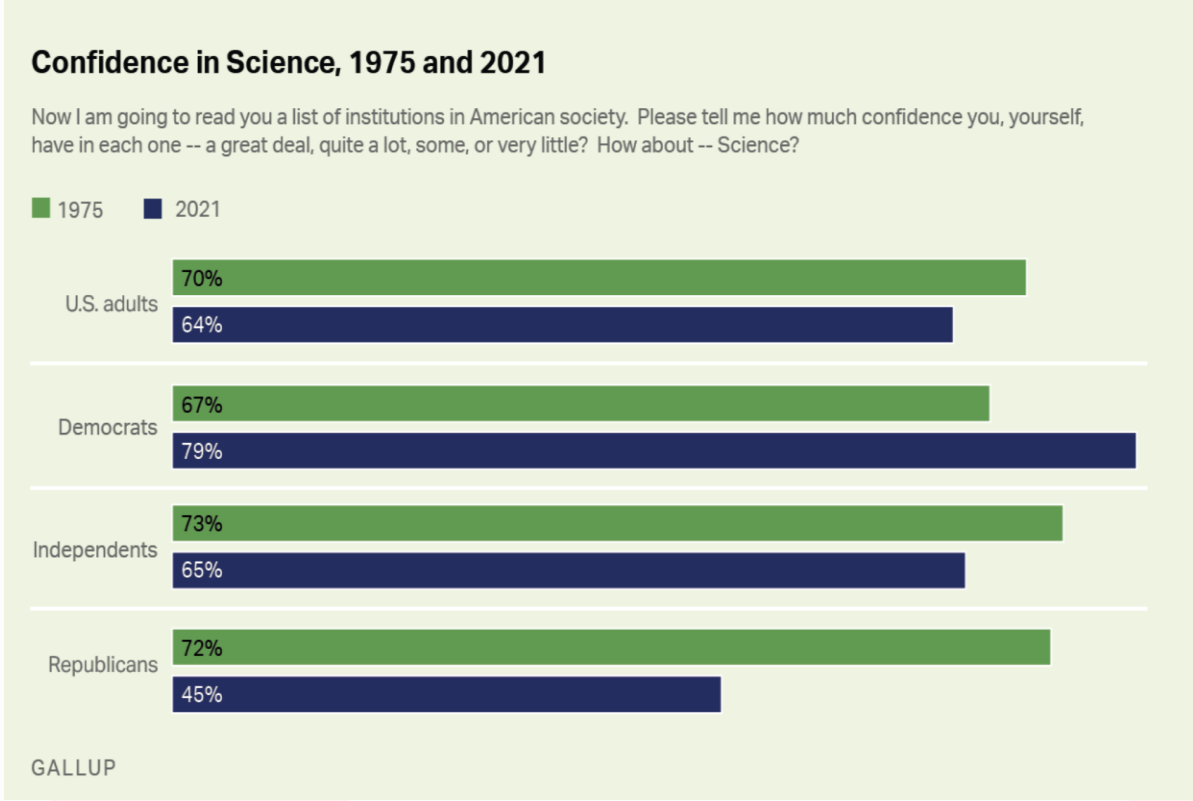
Confidence in Science has Decreased



The Politization of Science and Healthcare

Vox

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A wave of anti-vaccine legislation is sweeping the United States

The anti-vaccine movement is gaining strength even after 1 million Americans have died of Covid-19.

By Dylan Scott | @dylanlscott | Oct 6, 2022, 10:15am EDT

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Thao Nguyen
USA TODAY

Published 11:47 p.m. ET Feb. 21, 2023 | Updated 10:41 a.m. ET Feb. 22, 2023

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Texas Judge Says HIV Drug Mandate Violates Religious Freedom

- Ruling in federal court in Texas concerns Gilead PrEP drugs
- Company said it didn't want to subsidize 'homosexual behavior'

THE TEXAS TRIBUNE

MENU

Devin Mathieu and his partner, Claudia Dambra, discuss someone who might need a package containing life-saving harm reduction supplies in their apartment on Sept. 16. Annie Mulligan for The Texas Tribune

Texas bans many proven tools for helping drug users. Advocates are handing them out anyway.

AP

Bill would ban companies that offer trans care from TennCare

By KIMBERLEE KRUESI February 14, 2023

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KARA HARTNETT

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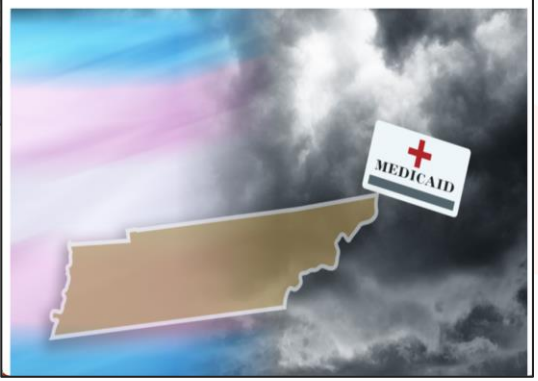

Harassment and Threats Directed at Health Officials

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Harassment of doctors is on the rise. Here's how to stop it.

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Contributing News Writer

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HEALTH

Embattled Public Health Workers Leaving At 'Steady And Alarming' Rate

November 25, 2020 · 1:13 PM ET

Heard on All Things Considered

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US Adults' Beliefs About Harassing or Threatening Public Health Officials During the COVID-19 Pandemic

Rachel J. Topazian, BA; Emma E. McGinty, PhD, MS; Hahrie Han, PhD; Adam S. Levine, PhD; Kelly E. Anderson, PhD, MPP; Rachel Presskreischer, PhD, MS; Colleen L. Barry, PhD, MPP

Abstract

IMPORTANCE The rise in attacks on public health officials has weakened the public health workforce and complicated COVID-19 mitigation efforts.

OBJECTIVE To examine the share of US adults who believed harassing or threatening public health officials because of COVID-19 business closures was justified and the factors shaping those beliefs.

DESIGN, SETTING, AND PARTICIPANTS The Johns Hopkins University COVID-19 Civic Life and Public Health Survey was fielded from November 11 to 30, 2020, and July 26 to August 29, 2021. A nationally representative cohort of 1086 US adults was included.

MAIN OUTCOMES AND MEASURES Respondents were asked how much they believed that threatening or harassing public health officials for business closures to slow COVID-19 transmission was justified. Adjusted differences in beliefs regarding attacks on public health officials were examined by respondent sociodemographic and political characteristics and by trust in science.

RESULTS Of 1086 respondents who completed both survey waves, 565 (52%) were women, and the mean (SE) age was 49 (0.77) years. Overall, 177 respondents (16%) were Hispanic, 125 (11%) were non-Hispanic Black, 695 (64%) were non-Hispanic White, and 90 (8%) were non-Hispanic and another race. From November 2020 to July and August 2021, the share of adults who believed harassing or threatening public health officials because of business closures was justified rose from 20% (n = 218) to 25% (n = 276) (P = .046) and 15% (n = 163) to 21% (n = 232) (P = .01), respectively. In multivariable regression analysis, respondents who trusted science not much or not at all were more likely to view threatening public health officials as justified compared with who trusted science a lot (November 2020: 35% [95% CI, 21%-49%] vs 7% [95% CI, 4%-9%]; P < .001; July and August 2021: 47% [95% CI, 33%-61%] vs 15% [95% CI, 11%-19%]; P < .001). There were increases in negative views toward public health officials between November 2020 and July and August 2021, among those earning $75 000 or more annually (threatening justified: 7 [95% CI, 1-14] percentage points; P = .03), those with some college education (threatening justified: 6 [95% CI, 2-11] percentage points; P = .003), those identifying as politically independent (harassing justified: 9 [95% CI, 3-14] percentage points; P = .01), and those trusting science a lot (threatening justified: 8 [95% CI, 4-13] percentage points; P < .001).

CONCLUSIONS AND RELEVANCE While antagonism toward public health officials was concentrated among those doubting science and groups most negatively affected by the pandemic (eg, those with lower income and less education), the findings of this study suggest that there has been a shift toward such beliefs within more economically advantaged subgroups and those more

(continued)

Key Points

Question What factors shape US adults' beliefs regarding whether threatening or harassing public health officials was justified during the COVID-19 pandemic?

Findings In this survey study of 1086 US adults, the share who believed that harassing or threatening public health officials because of business closures was justified rose from 20% to 25% and 15% to 21%, respectively, from November 2020 to July and August 2021. There were increases in negative views over time among higher earners, political independents, those with more education, and those most trusting of science.

Meaning These findings suggest that restoring trust in public health officials will require strategies tailored to engage diverse viewpoints.

+ Invited Commentary
+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Anti-mask hysterics at Tennessee school board meeting show how basic public health is now polarizing

Viral clips show anti-maskers melting down as a school board implemented a commonsense mask mandate.

By Aaron Rupar | @atrupar | Aug 11, 2021, 4:30pm EDT

SHARE

Natalie Allison
@natalie_allison

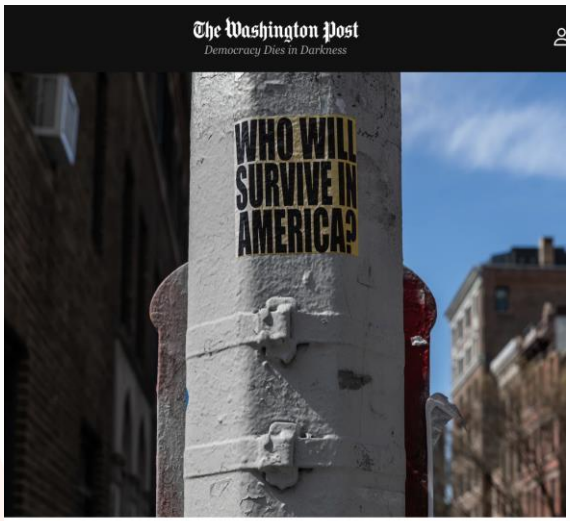
The parking lot after a school board meeting last night in Franklin, the wealthiest place in Tennessee. Parents harassed medical professionals who had spoken in favor of masks in schools. "We know who you are. You can leave freely, but we will find you."

From **Matt Masters**

9:30 AM · Aug 11, 2021

Harassment of Health Officials in TN

Political Affiliation and COVID-19 Vaccination/ Mortality Impact



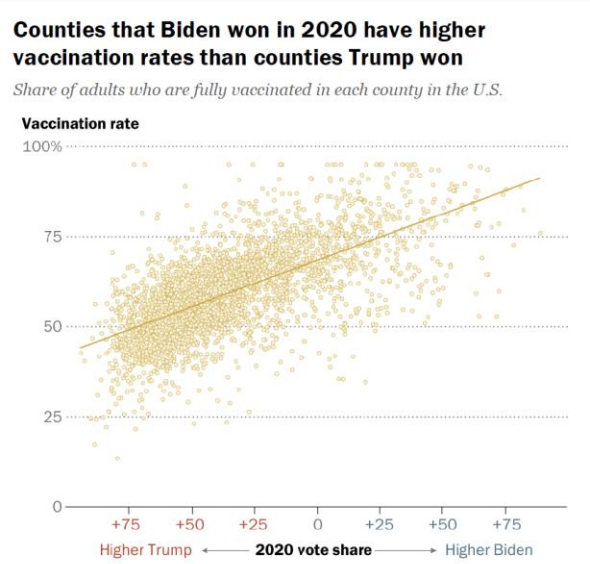
An ominous sign hangs near Washington Square Park in New York on March 24, 2020, at the beginning of pandemic lockdowns seeking to stop the spread of the coronavirus. The virus spread anyway. (Jeenah Moon/For The Washington Post)

HEALTH

Whites now more likely to die from covid than Blacks: Why the pandemic shifted

By Akilah Johnson and Dan Keating

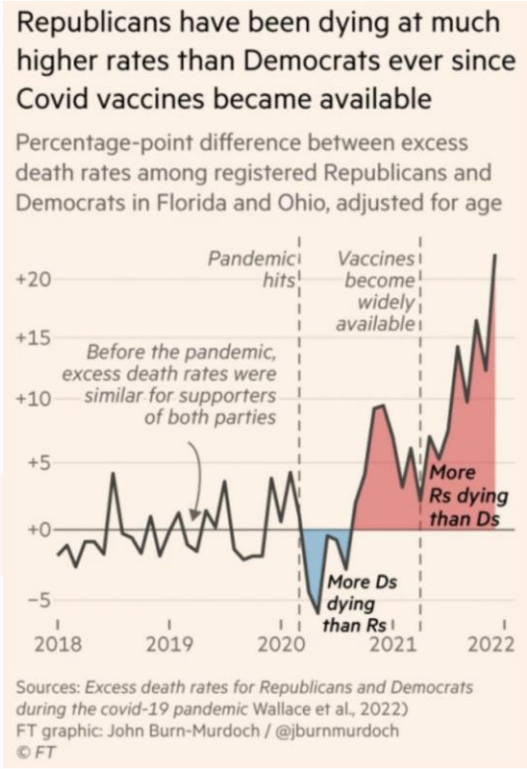
October 19, 2022 at 6:00 a.m. EDT



Notes: 165 counties (about 4% of the U.S. population) are excluded because they have reported fewer than 80% of the vaccinations within their jurisdiction to the CDC. Excludes Alaska, where election results are not reported at the county level. The fitted line shows the relationship between the vaccination rate in each county and the shares of the two-party vote that went to Trump vs. Biden in that county.

Source: Pew Research Center analysis of Centers for Disease Control and Prevention vaccination data as of Feb. 28, 2022. See methodology for details.

PEW RESEARCH CENTER

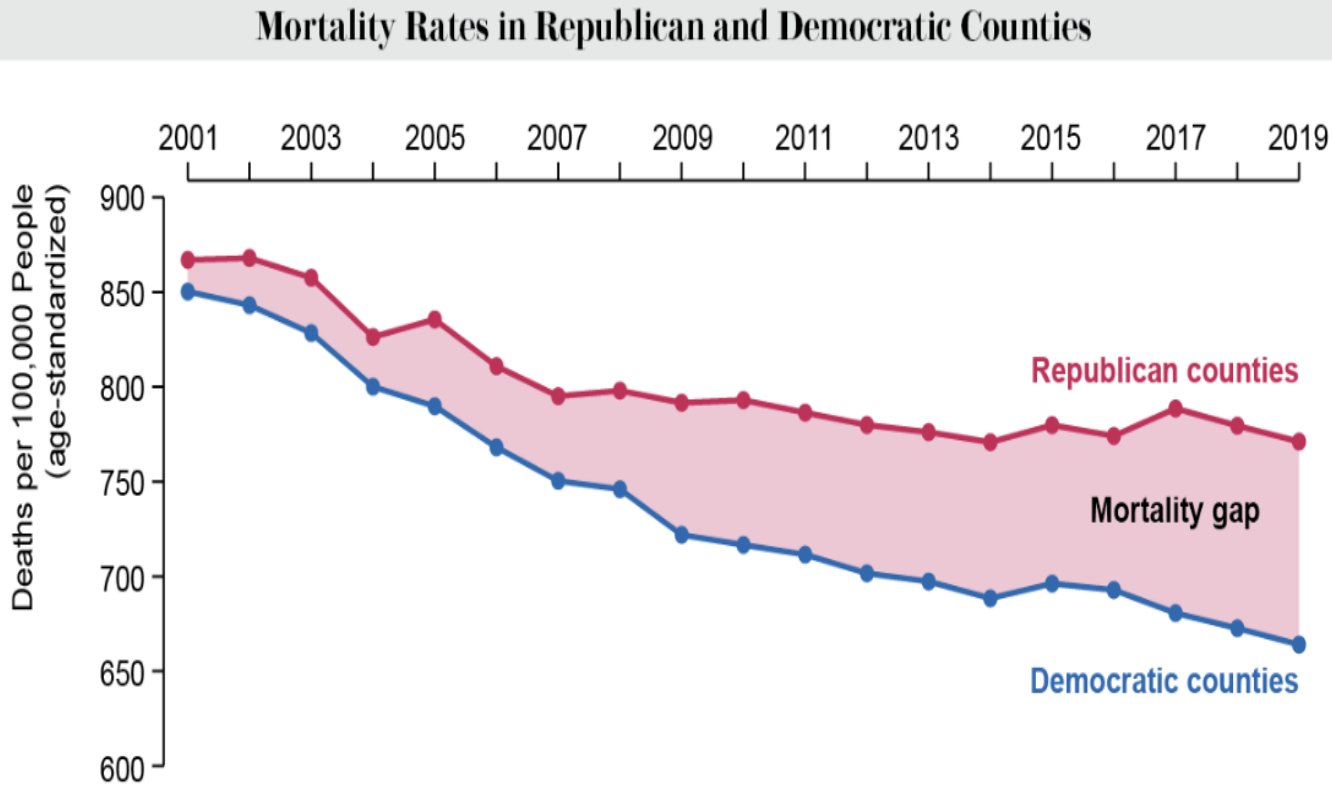


Sources: *Excess death rates for Republicans and Democrats during the covid-19 pandemic* Wallace et al., 2022)

FT graphic: John Burn-Murdoch / @jburnmurdoch

© FT

Consequences of the ideological gap predates COVID-19



Credit: Amanda Montañez; Source: "Political Environment and Mortality Rates in the United States, 2001-19: Population Based Cross Sectional Analysis," by Haider J. Warraich et al., in *BMJ*, Vol. 377. Published online June 7, 2022

Ideology, policies, and mortality, 1999-2019

PLOS ONE

RESEARCH ARTICLE

U.S. state policy contexts and mortality of working-age adults

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OPEN ACCESS

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Data Availability Statement: The policy data is publicly available on the Harvard Dataverse at https://dataverse.harvard.edu/dataset.xhtml?persistentId=doi:10.7910/DVN/TZTW1J. Mortality data are available through an approved data-use agreement with the U.S. National Center for Health Statistics. To apply for the data used in this study, contact nvssrestricteddata@cdc.gov.

Funding: This article was supported by a grant from the National Institute on Aging to JKM (grant R01AG05581). www.nih.nia.gov. The funder had no role in study design, data collection and

Abstract

The rise in wor
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- Changing all policy domains in all states to a fully conservative orientation might have cost 217,635 lives in 2019
- A fully liberal orientation might have saved 171,030 lives

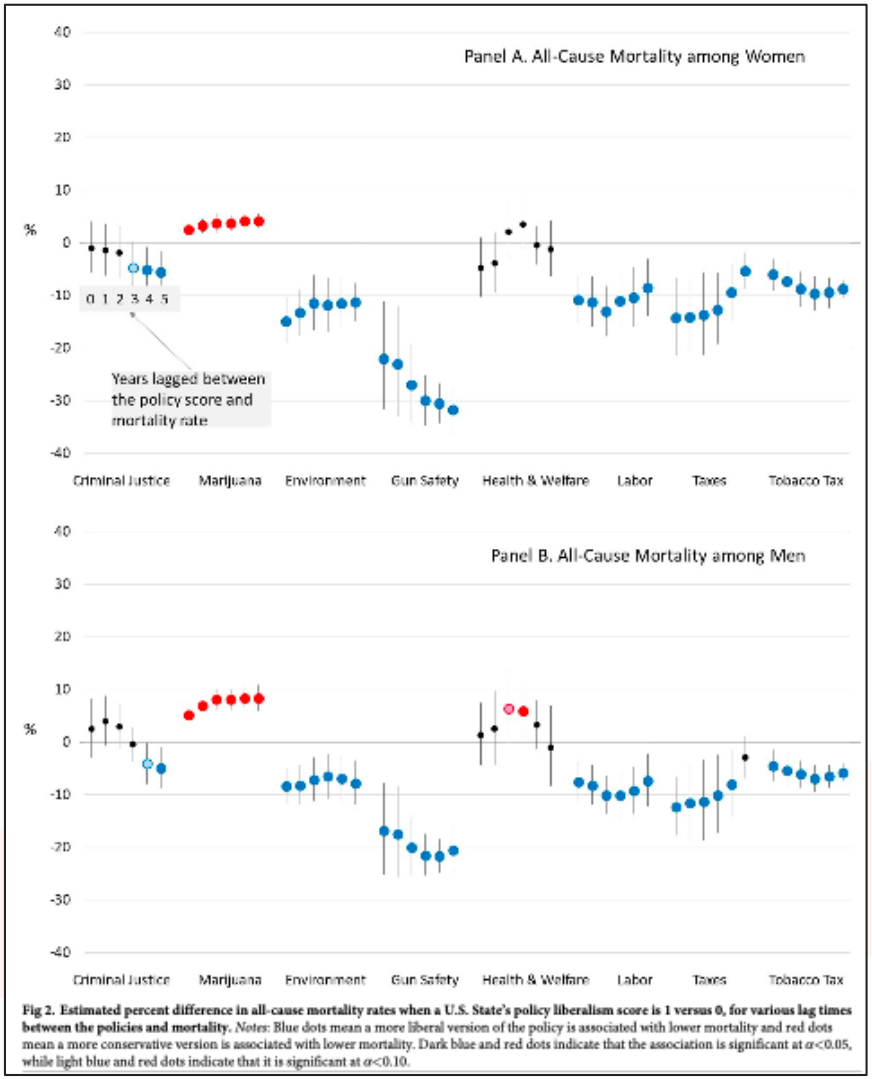

Fig 2. Estimated percent difference in all-cause mortality rates when a U.S. State's policy liberalism score is 1 versus 0, for various lag times between the policies and mortality. *Notes*: Blue dots mean a more liberal version of the policy is associated with lower mortality and red dots mean a more conservative version is associated with lower mortality. Dark blue and red dots indicate that the association is significant at $\alpha<0.05$, while light blue and red dots indicate that it is significant at $\alpha<0.10$.

5. KEEPING HIV ‘ENDED’ WILL REQUIRE PERSISTENCE AND FUNDING

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MAKING AIDS HISTORY

HIV Priorities Change from Administration to Administration

- **Priority:** First domestic HIV plan; increase in domestic HIV prevention; establishes ONAP; Minority AIDS Initiative launched; implements Americans with Disabilities Act

- **Priority:** Global HIV (Introduces PEPFAR program)
- **De-prioritized:** Domestic HIV programs/ research; ONAP left unstaffed for period of presidency

- **Priority:** Domestic HIV: National HIV/AIDS Strategy and Affordable Care Act;
- **De-prioritized:** PEPFAR (flat funded/ established Global Health Initiative)

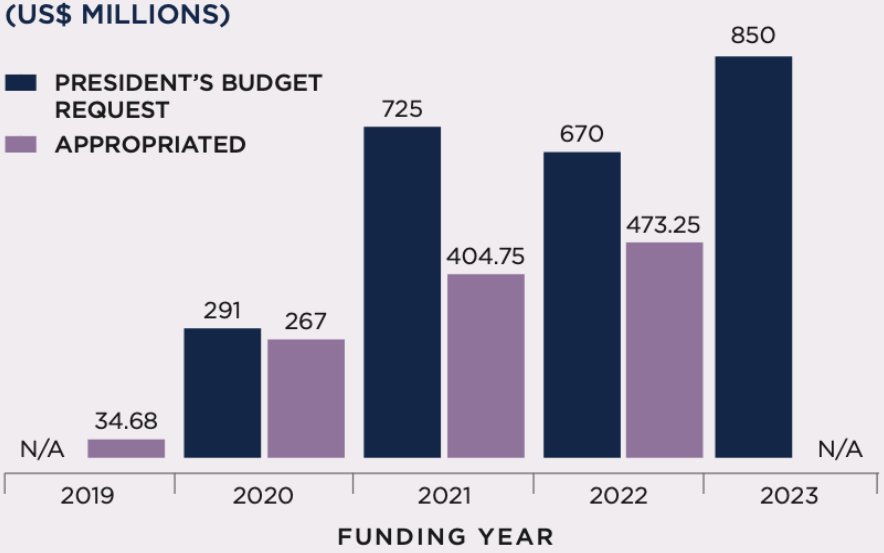
- **Priority:** Domestic HIV: EHE initiative
- **De-prioritized:** National HIV/AIDS Strategy to a HHS 'Plan'; ONAP defunct; Affordable Care Act (dismantling); PEPFAR (gutted in WH budgets)

The State of the Economy can affect Federal HIV Funding

FALLING FURTHER BEHIND

ENDING THE HIV EPIDEMIC INITIATIVE FUNDING: REQUESTED VERSUS APPROPRIATED

(US$ MILLIONS)

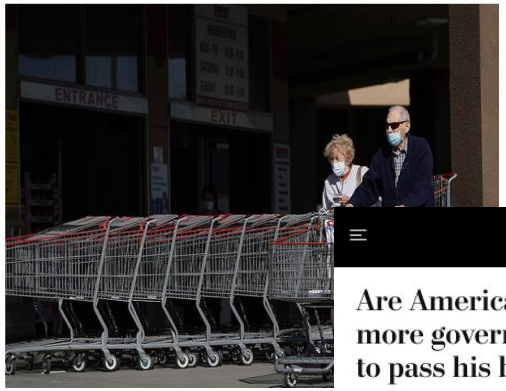


SOURCE: *Ending the HIV Epidemic (EHE) Funding Tracker*, Kaiser Family Found. tbl. 1 (Nov. 12, 2021); *Domestic HIV Funding in the White House FY 2023 Budget Request*, Kaiser Family Found. tbl.2 (Mar. 30, 2022). Note: FY 2019 funding was re-allocated funds to launch the Initiative, but not appropriated for this purpose. Congress has not yet appropriated funding for FY 2023.

FINANCE

U.S. inflation hit a new 40-year high last month of 8.6 percent

America's rampant inflation is imposing severe pressures on families, forcing them to pay much more for food, gas and rent.



The Washington Post
Democracy Dies in Darkness

Are Americans growing warier of more government just as Biden tries to pass his big agenda?

Analysis by Dan Balz
Chief correspondent

October 16, 2021 at 12:13 p.m. EDT

State-specific Factors that Affect Efforts to End HIV

HEALTH NEWS

NEWS

Tennessee says it's cutting federal HIV funding. Will other states follow?

The Tennessee Department of Health says it will no longer accept federal grant money to prevent or treat HIV. Experts worry the state has set itself up for a major outbreak.

EXCLUSIVE

NEWS

OUT NEWS

How Tennessee axed millions in HIV funds amid scrutiny from far-right provocateurs

Tennessee decided to scrap $8.3 million in federal grants to combat HIV after right-wing personalities targeted gender dysphoria treatment for minors in the state.

The Washington Post
Democracy Dies in Darkness

HIV at center of latest culture war after Tennessee rejects federal funds

The red-state pushback reflects growing tensions over federal priorities over public health issues

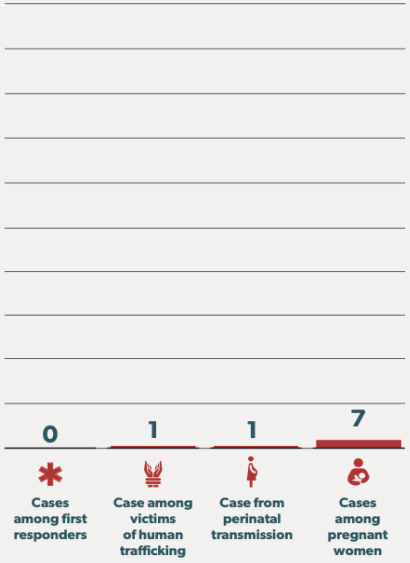
AETC AIDS Education & Training Center Program Southeast

A Dangerous Precedent: Tennessee Rejects Federal Funds for HIV Prevention

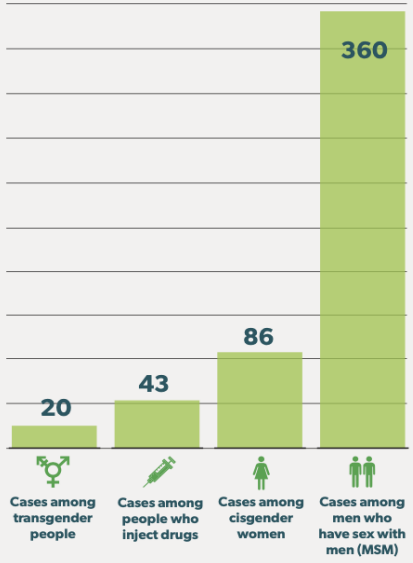
On January 17, 2023, health officials in Tennessee announced their intention to reject federal funding for HIV services including testing kits, condoms, medication to prevent acquisition of the virus, and all HIV surveillance in the state. Last year, these funds totaled $8.3 million. State officials have indicated that they aim to maintain the same level of funding, but shift the priorities of the program to prevent HIV among first responders, mothers and children, and victims of human trafficking. These populations do not align with those most vulnerable to HIV infection in Tennessee.

By limiting HIV prevention activities to only 2% of those "at risk," the missed prevention opportunities in the Tennessee state officials' plan could end up **adding $255 million in HIV treatment costs** per year for the state.*

At most, narrowly focusing HIV prevention efforts on the priority populations identified by state officials could prevent an estimated 9 HIV cases per year:



In contrast, preventing new HIV cases among those populations most at risk in Tennessee could prevent an estimated 509 cases of HIV per year:



* Calculated as the lifetime treatment costs of failure to prevent 500 net HIV cases [509 cases - 9 cases] each year under the Tennessee state officials' plan [$510,000 x 500 = $255 million in additional treatment costs].

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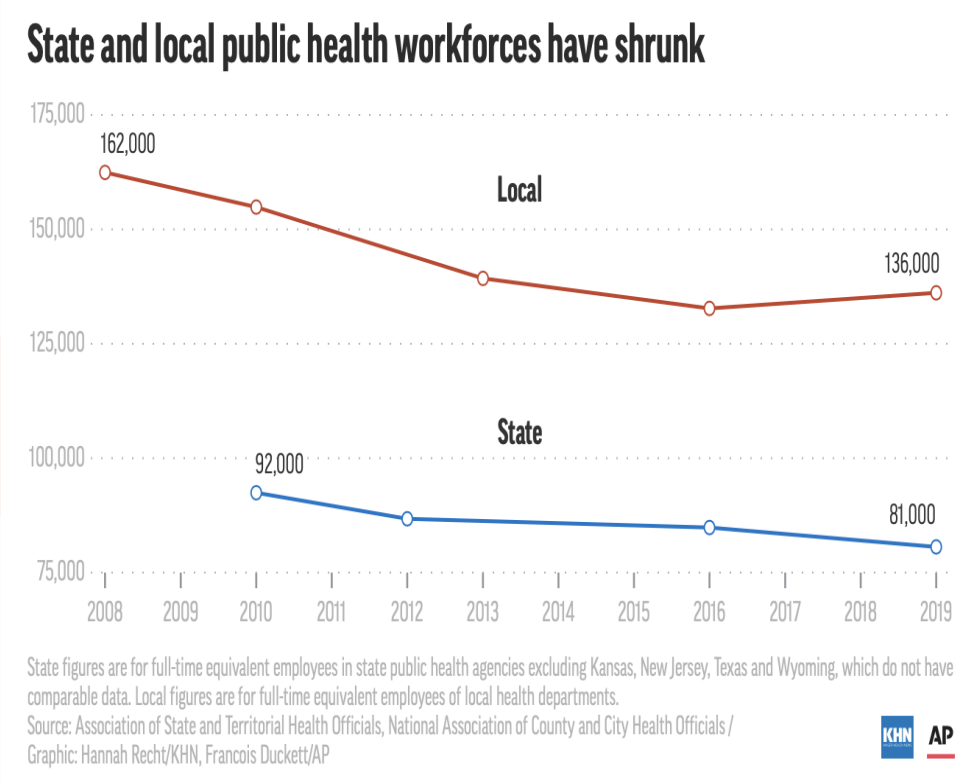
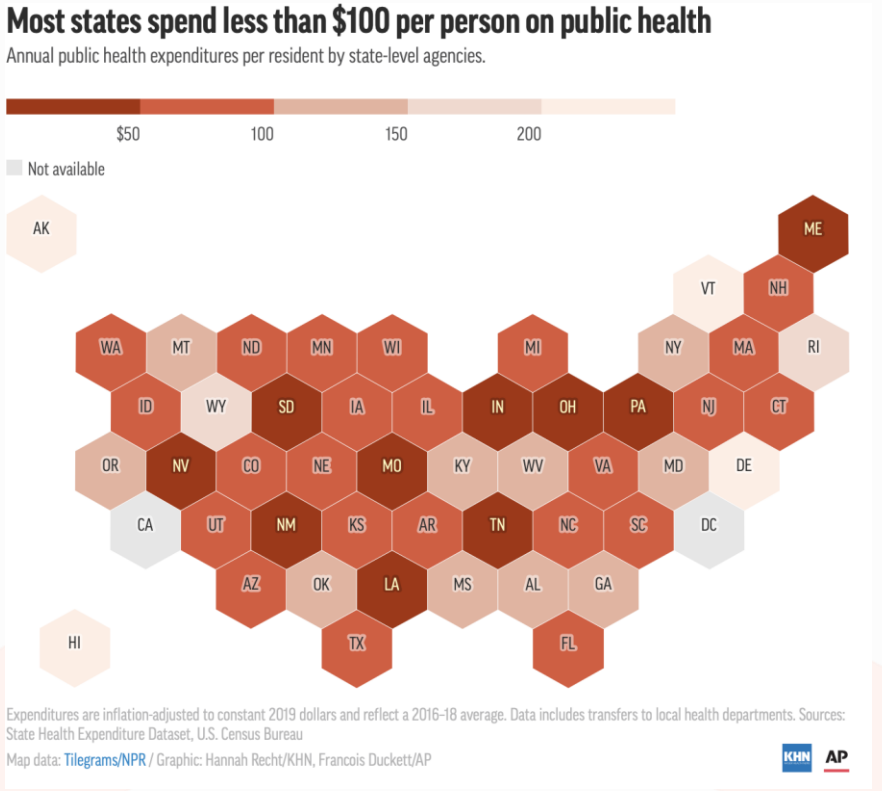
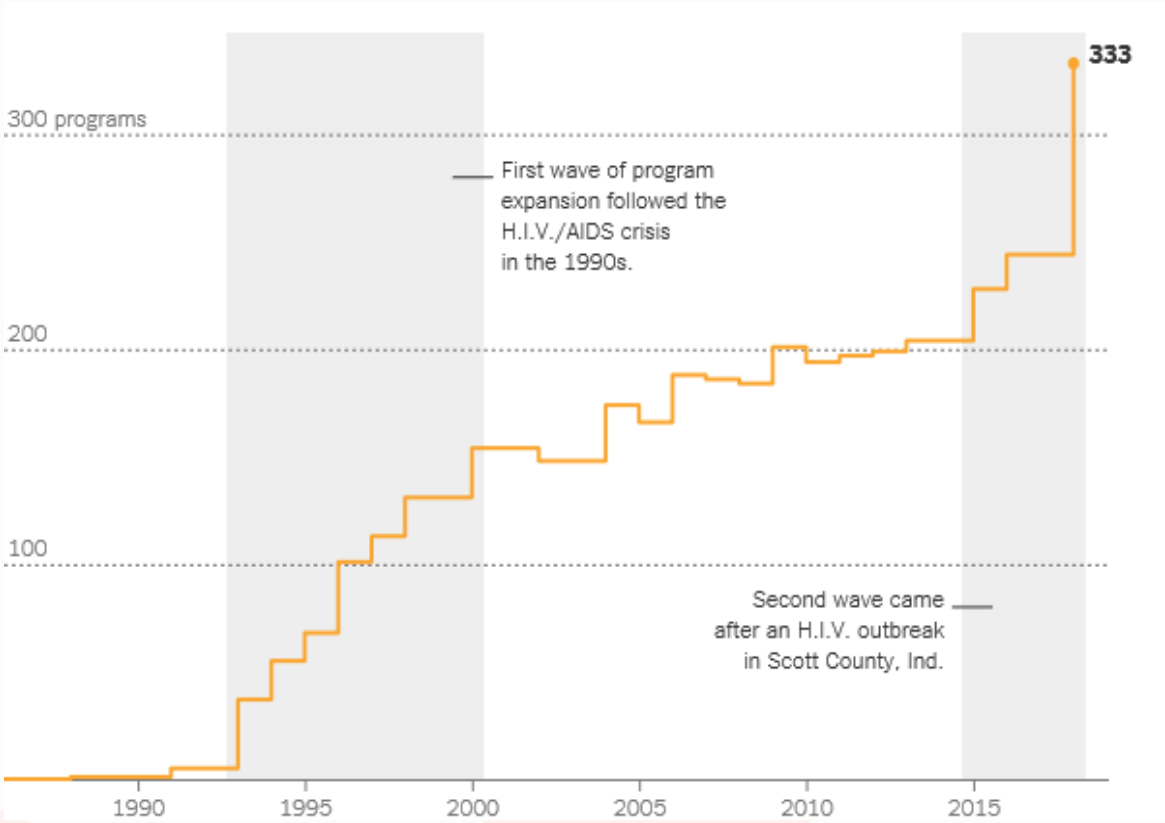
Public Health workforce attrition/ nominal state spending





Increase in SSPs in the United States after Scott County Outbreak



Sources: Centers for Disease Control and Prevention, Harm Reduction International, North American Syringe Exchange Network. Figure created by New York Times, April 27, 2018.

Syringe Services Programs Rolled Back in Indiana and West Virginia Despite HIV/ HCV Outbreaks

An Indiana county just halted a lifesaving needle exchange program, citing the Bible

The program has overwhelming evidence behind it. But that wasn't enough to save it.

By German Lopez | @germanrlopez | german.lopez@vox.com | Oct 20, 2017, 1:00pm EDT

The New York Times

Why a City at the Center of the Opioid Crisis Gave Up a Tool to Fight It

By JOSH KATZ APRIL 27, 2018

abc NEWS

West Virginia health data reveals surge in hepatitis C cases

West Virginia Health Department data reveals chronic hepatitis C cases in the state's largest county have soared to the highest levels in five years, months after a public syringe exchange was closed

By **The Associated Press**
October 1, 2019, 10:55 AM • 1 min read

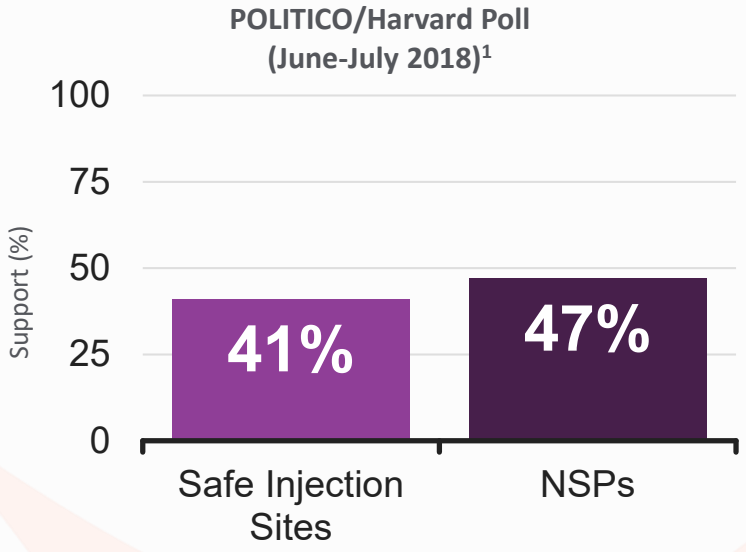
CHARLESTON, W.Va. -- West Virginia Health Department data reveals hepatitis C cases in the state's largest county have soared to the highest numbers in years, months after a program offering clean needles was suspended.

The Charleston Gazette-Mail reported Monday that more than 1,100 new chronic cases of the disease were recorded in Kanawha County in 2018.

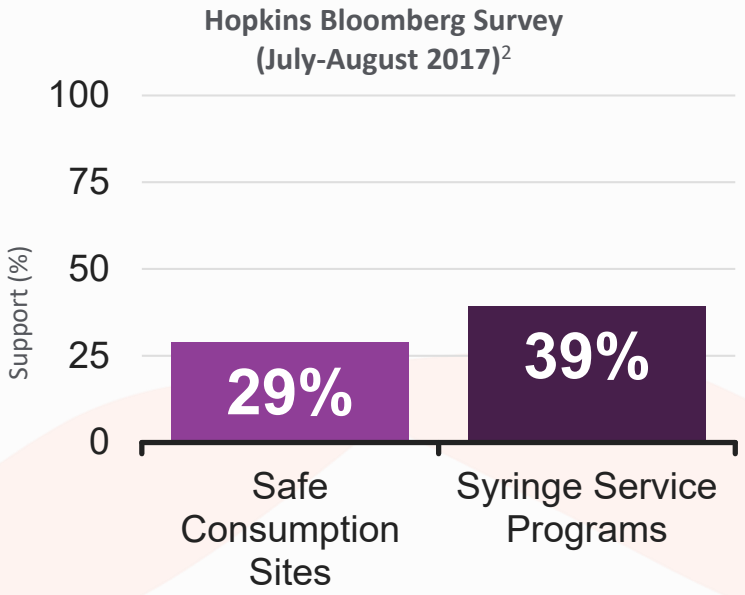
Local clinic director Letitia Tierney says the area is nearing a hepatitis C outbreak and a potential HIV outbreak due to needle sharing. Officials didn't immediately release HIV numbers.

National Polls and Harm Reduction Interventions

Do you support legalizing safe injection sites and NSPs?



Do you support legalizing safe consumption sites and syringe service programs in your community?



NSP=needle-and-syringe exchange program.

1. POLITICO/Harvard T.H. Chan School of Public Health. https://static.politico.com/50/19/6924fa8d4f238f1b9fc155a275a3/drug-pricing-poll.pdf.
2. McGinty EE, et al. *Prev Med*. 2018;111:73-77.

Inflexible Dedicated Funding Streams

npr

A Surge In Meth Use In Colorado Complicates Opioid Recovery

By EDITOR • JUL 14, 2018

POLITICO

HEALTH CARE

Meth and cocaine complicate Trump's war on drugs

npr

Federal Grants Restricted To Fighting Opioids Miss The Mark, States Say

June 13, 2019 · 5:00 AM ET

Crowe says his organization has received just over $327,300 from key federal grants designed to curb the opioid epidemic. While the money was a godsend for his county, he says methamphetamine remains a major problem.

And here's the hitch: Crawford County, which lies south of Lake Erie, on the Ohio state line, can't use the federal opioid grants to treat meth addiction.

"Now I'm looking for something different," Crowe says. "I don't need more opiate money. I need money that will not be used exclusively for opioids."

> "I don't need more opiate money. I need money that will not be used exclusively for opioids.
>
> David Crowe, executive director of Crawford County Drug and Alcohol Executive Commission

The federal government has doled out at least $2.4 billion in state grants since 2017, in hopes of stemming an opioid epidemic that killed 47,600 people in the U.S. in that year alone.

6. REGIONAL DIFFERENCES WILL CREATE A PATCHWORK OF LOCATIONS WHERE HIV IS EXPANDING VS CONTROLLED

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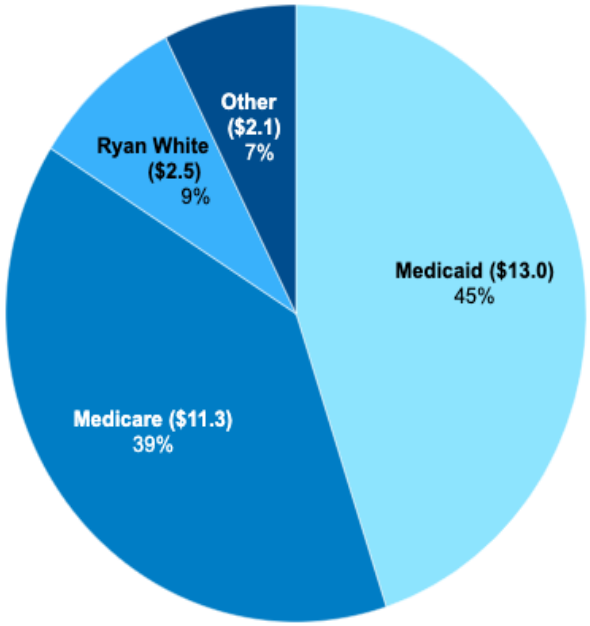
MAKING AIDS HISTORY

The Increasing Centrality of Medicaid Expansion in Combatting HIV

Total Federal Funding = $29 billion



NOTE: Total Medicaid funding includes only federal spending. A small amount of VA prevention funding is included in "other" as it was not possible disaggregate care and prevention funding for that account (possibly around $18m). Several accounts in "other" are amounts that have been carried forward from FY17.
SOURCE: Calculation based on KFF review of Congressional Budget Justifications, other budget documents, and personal agency correspondence • PNG

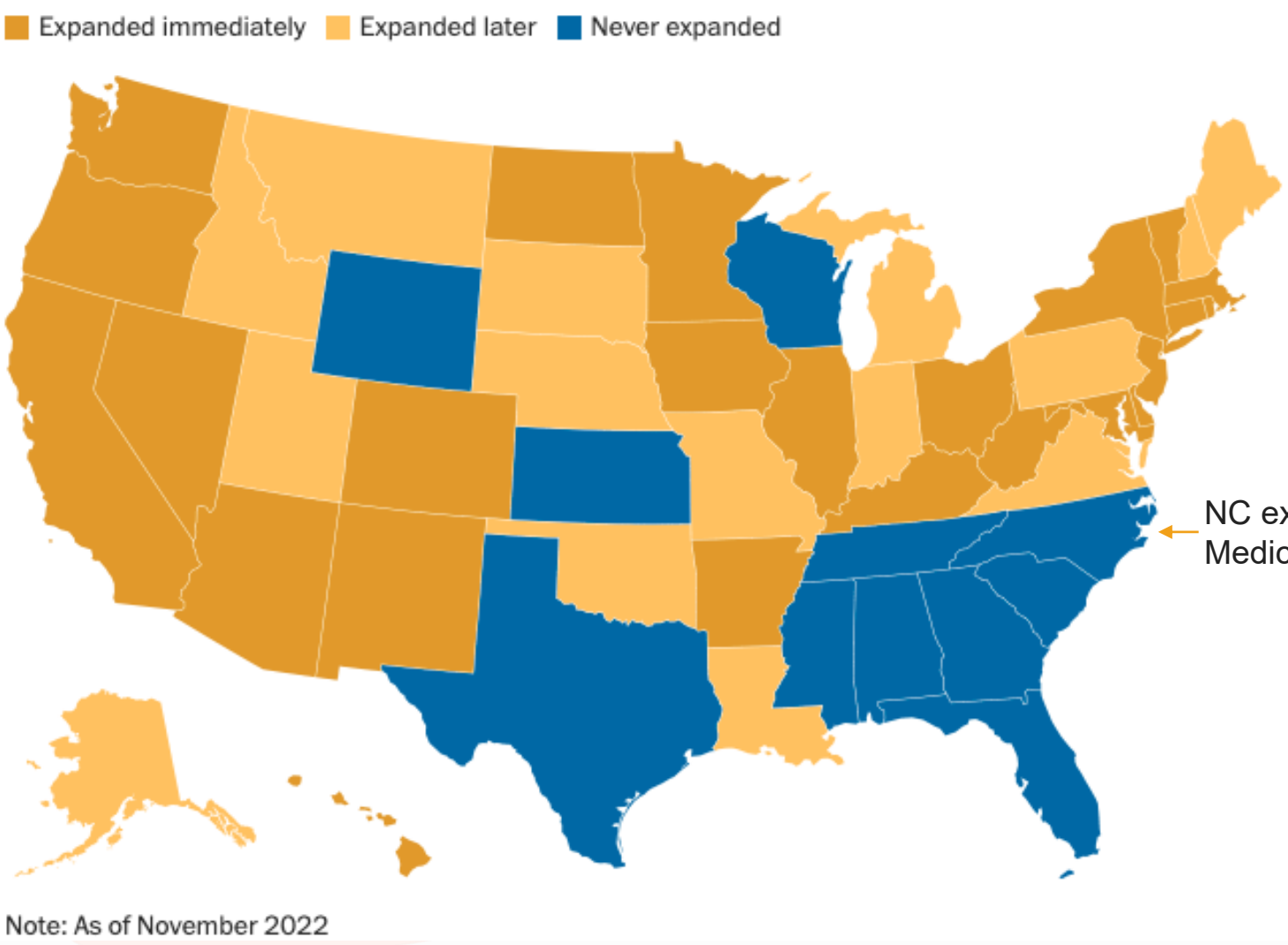
KFF

Several research studies have shown that HIV-related health outcomes or health services improved because of the ACA and Medicaid expansion.

- Increase in HIV testing in Medicaid expansion states, 2010–2017 (Gai et al, AJPH, 2019)
- ACA insurance enrollment associated with undetectable viral load (Furl et al, BMC Infect Dis, 2018)
- Greater access to opioid addiction medications in Medicaid expansion states, 2011–2016 (Sharp et al, AJPH, 2018)
- Ten-year decrease in HIV diagnoses after Medicaid expansion in Louisiana, 2016–2018 (Louisiana Dept of Health, 2019)
- Greater sustained viral supression among PLWH in Medicaid expansion states, 2015 (Crepaz et al, CDC HIV Prevention Conf, 2019)
- Fourfold increase in PrEP uptake among Medicaid recipients, 2012–2015 (Laufer et al, MMWR, 2015)

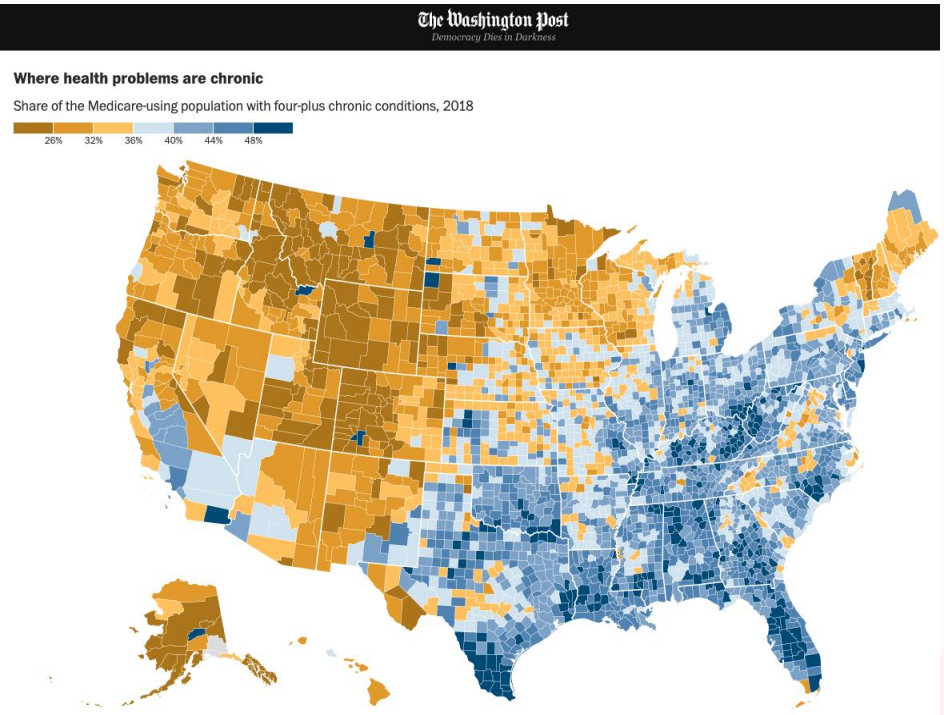
Most Medicaid-expansion holdouts are in the South

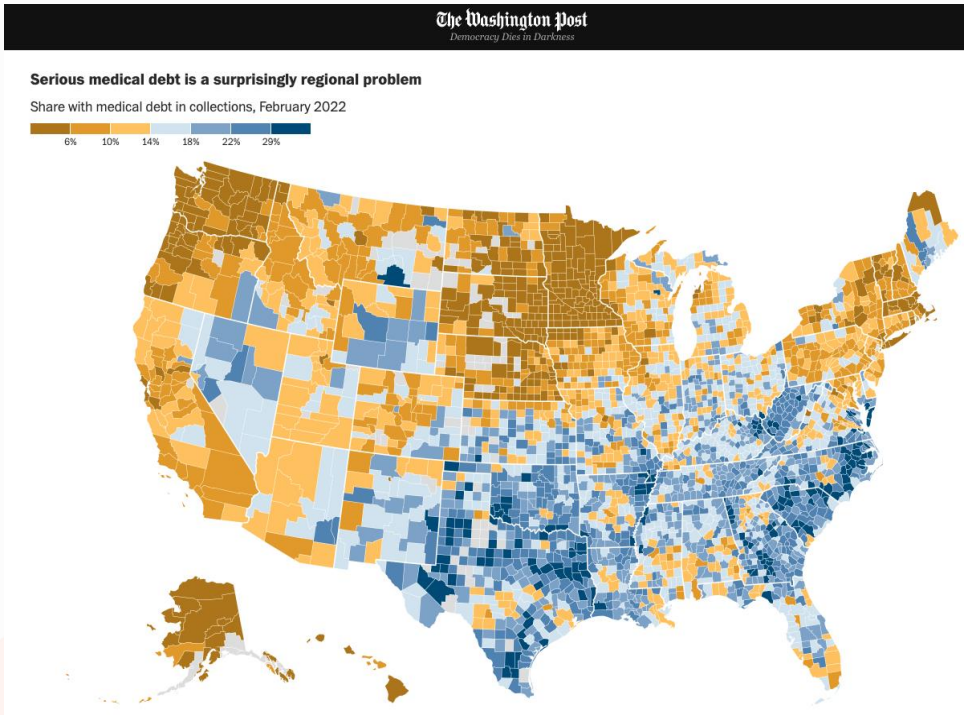
Medicaid expansion relative to the 2014 rollout



Note: As of November 2022

Chronic Health Problems & Medical Debt Concentrated in Certain Regions

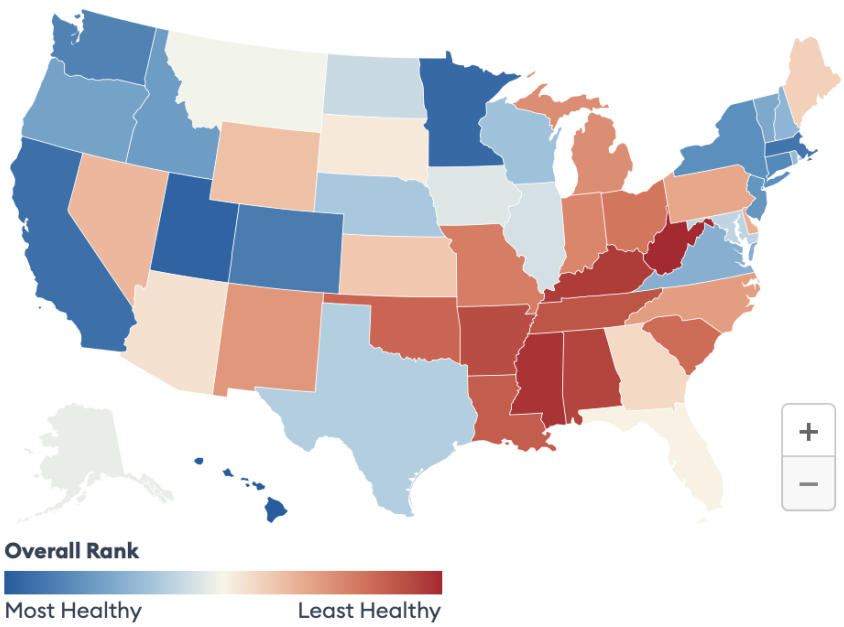




Regional differences in overall health likely indicators of where we end (or do not end) HIV

States With the Least Healthy Populations

A Forbes Advisor analysis found that West Virginia residents are the least healthy in the nation. To see each state's overall ranking and two of the metrics considered, hover over each state.



Source: Forbes Advisor • Get the data • Embed

Forbes ADVISOR

States With the Least Healthy Populations

Search in table

Page 1 of 5

Rank	State	Disease Prevalence & Mortality Rate Score[1]	Substance Abuse Score[2]	Lifestyle Habits & Health Outlook Score[3]
1	West Virginia	100.00	75.31	98.31
2	Mississippi	94.66	48.15	100.00
3	Kentucky	78.44	51.85	97.19
4	Alabama	80.34	24.69	94.38
5	Arkansas	89.69	40.74	92.13
6	Tennessee	76.15	54.32	86.52
7	Louisiana	65.08	70.99	91.57
8	Oklahoma	68.89	50.62	87.64
9	South Carolina	69.66	40.74	78.09
10	Ohio	75.00	61.11	80.34

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AETC AIDS Education & Training Center Program Southeast

Thank You!

Gregorio Millett
amfAR
Greg.Millett@amfAR.org
202 331 8600

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AETC Program
National Centers and National HIV Curriculum

- National Coordinating Resource Center serves as the central web based
- repository for AETC Program training and capacity building resources; its
- website includes a free virtual library with training and technical assistance
- materials, a program directory, and a calendar of trainings and other events.
- Learn more: https ://aidsetc.org
- •National Clinician Consultation Center provides free, peer to peer,
- expert advice for health professionals on HIV prevention, care, and treatment
- and related topics. Learn more: https ://nccc.ucsf.edu
- •National HIV Curriculum provides ongoing, up to date HIV training and
- information for health professionals through a free, web based curriculum;
- also provides free CME credits, CNE contact hours, CE contact hours, and
- maintenance of certification credits. Learn more: www.hiv.uw.edu