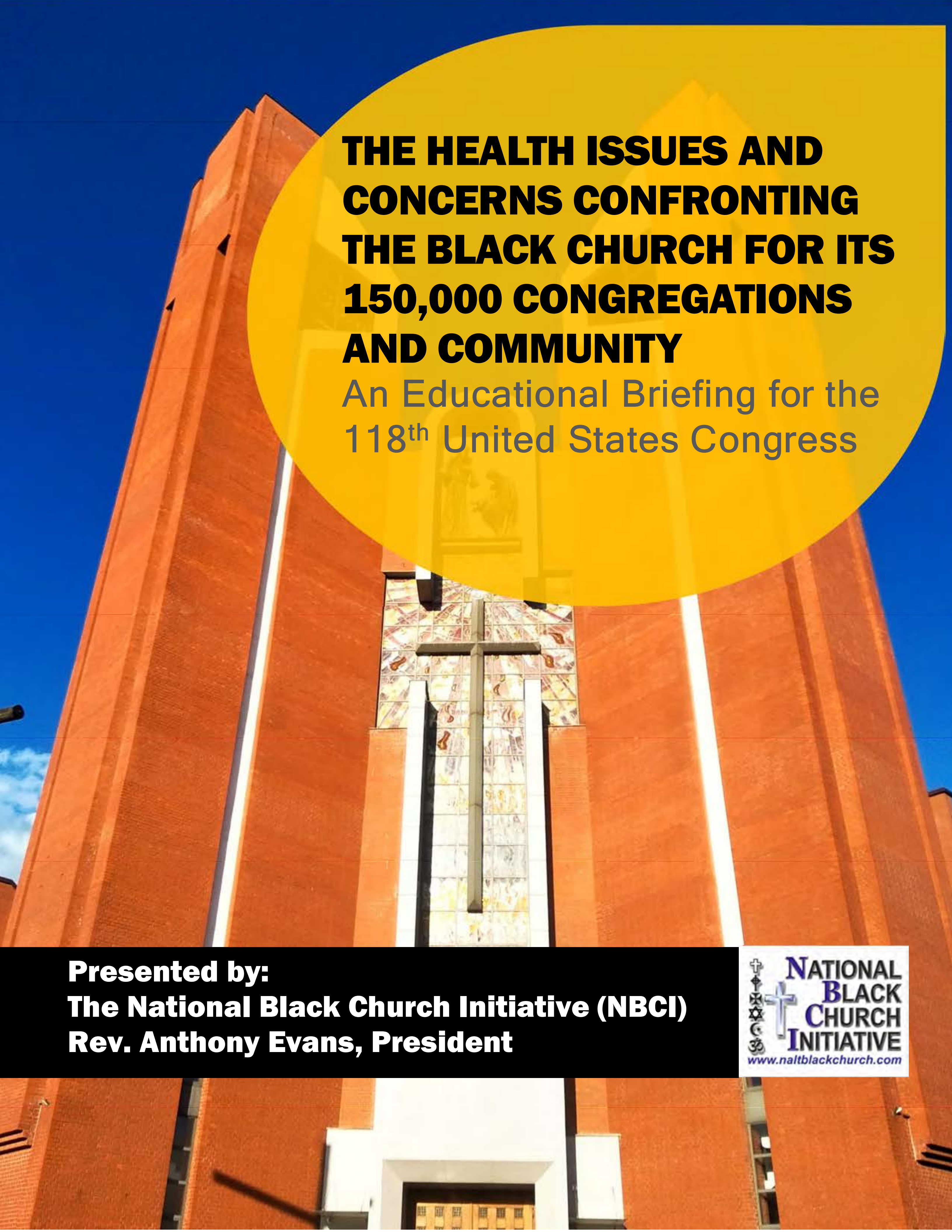


THE HEALTH ISSUES AND CONCERNS CONFRONTING THE BLACK CHURCH FOR ITS 150,000 CONGREGATIONS AND COMMUNITY

An Educational Briefing for the 118th United States Congress

Presented by:
The National Black Church Initiative (NBCI)
Rev. Anthony Evans, President

NATIONAL BLACK CHURCH INITIATIVE
www.naltblackchurch.com

Introduction

This working booklet will help you understand the health challenges faced by African Americans. There are 41.6 million African Americans (13.6%) in this country and have been here since 1619 or even sooner depending on different historical accounts. This means people of African descent and those of the African diaspora have been a part of the United States for well over 400 years. They are not only citizens but founders, fathers and mothers of this great democracy who, to this day are despised and discriminated against. Racism remains our blanket of true patriotism.

To that end, this is an educational booklet will serve as a guide to those members of Congress and their staff who need to understand the magnitude of the black health challenges and historical gap and access to care. We, as ministers of Christ, have come to Capitol Hill as a part of civil duty to inform and educate about the health dilemma of our 30 million church members. We represent every congressional district in the country and do remains willing to work with every representative of our great democracy.

We are here to build a working relationship to help foster heal our country.

In addition, this booklet gives an overview of the health challenges we as ministers of Christ face daily advocating for our members. COVID has taken over a million of our country's men and women – many of the 1.1 million people who have died from COVID are seniors, African American, and Latinos. Unfortunately, this pattern is historic in nature. Thus, from this health education booklet, that African Americans after 400 years still to this day is the least healthy group of Americans with the worst health outcomes in every major chronic health category.

And yes, you would agree with us that we cannot be a great nation if congress allow 41 million Americans to continue to be sick.

Please know, we are not here to start an endless debate on who is to be blamed. This question has already been answered. We are here to develop a mutually respectful relationship with both sides of the isles working to creating innovative solutions to the health challenges of African Americans and other ethnic groups while at the same time building a towards a 21st-century clinical research-based healthcare delivery system for all.

Letter to Congress

Dear members of the 118th Congress:

Today, we are on Capitol Hill to fulfill our civic responsibility to inform and educate this body on the health challenges of 41 million African Americans. They are members of our congregations, and they are faced with some of the greatest health challenges ever noted in our nation's history, especially after COVID that has already claimed over 1 million American sacred lives.

As you know, African Americans and seniors are the predominant the victims of COVID, and the pandemic continues despite President Biden's upcoming declaration in May 2023 COVID pandemic will be ended. COVID has illuminated and brought to the forefront the health challenges of African Americans that this nation cannot continue to ignore.

As clergy, we are faced with these challenges on a daily basis. This is why we are morally compelled to visit your offices with the pledge of working with you and your staff to generate with some creative and innovative solutions to the issues surrounding, but not limited to immunization, cardiovascular diseases, diabetes, AIDS, opioids – pain, mental health, blood diseases, gun violence and etc… and the list goes on.

We are eager to work with you and the staff on possible solutions and we come up with some ideas as well. We believe this will be a great educational lesson for all and our democracy.

All of our actions should not anyway be considered not be lobbying effort this great body-US Congress. This is an educational exercise and to fulfill our nation's highest civil duty in helping to solve the problems of our citizens and country. In the immortal words of President Kennedy " Ask not what your country can do for you – ask what you can do for your country,"

About National Black Church Initiative

The National Black Church Initiative (NBCI) is a coalition of 150,000 African American and Latino churches working to eradicate racial disparities in healthcare, technology, education, housing, and the environment. The mission of NBCI is to provide critical wellness information to all its members, congregants, churches, and the public. NBCI utilizing faith and sound health science and partners with major organizations and officials reduce racial disparities in the variety of areas cited above. NBCI's programs are govern by credible statistical analysis, science-based strategies and techniques, and methods that work and offers faith-based, out-of-the-box and innovative solutions to stubborn economic and social issues.

Thanks

The Black Church of American

The Washington Post
Democracy Dies in Darkness

Black communities endured wave of excess deaths in past 2 decades, studies find

The loss of life came at a staggering cost, medically and economically

By Akilah Johnson

Lauri Powell massages her sister Aysha-Samon Stokes during labor at a Los Angeles birthing center in South Los Angeles on Mother's Day. For African Americans, infant mortality is a leading cause of excess death and years of life lost. (Sarah Reingewirtz/Getty Images)

May 16, 2023 at 11:00 a.m. EDT

America's Black communities experienced an excess 1.6 million deaths compared with the White population during the past two decades, a staggering loss that comes at a cost of hundreds of billions of dollars, according to two new studies that build on a generation of research into health disparities and inequity.

In one study, researchers conclude that the gap in health outcomes translated into 80 million years of potential life lost — years of life that could have been preserved if the gap between Black and White mortality rates had been eliminated. The second report determined the price society pays for failing to achieve health equity and allowing Black people to ~~die prema~~turely: $238 billion in 2018 alone.

“This is our collective challenge as a country because it hurts all of us deeply,” said Marcella Nunez-Smith, associate dean for health equity research at Yale University and co-author of the study on excess deaths and years of life lost. “All of the potential. Which one of those people whose life was cut short was on the way to some scientific discovery that would transform all of our lives or create beautiful art and music? Who among them was going to be a spiritual or religious leader? Not to mention the economic impact.”

The reasons for the excess deaths and resulting economic toll are many, including mass incarceration, but the root is the same, according to the reports published Tuesday in the influential medical journal JAMA: the unequal nature of how American society is structured.

That includes access to quality schools, jobs with a living wage, housing in safe neighborhoods, health insurance and medical care — all of which affect health and well-being. For centuries, Black people were legally deprived of these benefits, and researchers said we have yet to fully ameliorate the effects.

“Just to illustrate the issue, one of the clearest examples of structural racism was in 1935 when the Social Security Act was passed,” said Thomas LaVeist, dean of the Tulane University School of Public Health and Tropical Medicine and the lead author of the study on the economic implications of health disparities. “They intentionally left outdomestic workers and farmworkers who were disproportionately Black. That hasn’t been fully unraveled.”

And the shorter life expectancy of Black Americans means they do not derive what they have invested in Social Security. People born in 1960 can start receiving their full Social Security benefits at age 67, but according to the Centers for Disease Control and Prevention, Black men born that year had an average life expectancy of just 61 years.

Not only is that person paying into a system they are not fully benefiting from but society is also losing “because that person isn’t there as part of the economy,” LaVeist said. “We’ve paid for schooling for this person, who gets a job and pays taxes and dies prematurely. The investment in that person is never recovered by society.”

That comes at a significant cost in military readiness, in workforce fitness, in dollars and cents.

Researchers explored the economic burden caused by health inequities when someone dies prematurely or must pay out-of-pocket costs and third-party payments to health-care providers for emergency room visits, ambulance services, or vision and dental care.

They also calculated the economic toll when people can’t work because they or relatives are sick, or when employees show up to work but are less productive because they’re not well.

Expanding their analysis to a broader population, the researchers concluded that the failure to achieve health equity in 2018 cost the nation $1.03 trillion. That price tag includes the burden experienced by American adults older than 25 who do not have a college degree and by Native American, Asian, Black, Latino and Pacific Islander people.

More than two-thirds of the economic burden experienced by communities of color was attributed to premature deaths, with most of those untimely deaths coming from the Black community. Meanwhile, “adults with a 4-year-college degree had zero premature death costs,” the report said.

For nearly 40 years, study after study examining disparate health outcomes in the Black community have started by referencing a landmark study on Black and minority health that came to be known as the “Heckler Report,” so named because it was written when Margaret Heckler was President Ronald Reagan’s health secretary. The two studies released Tuesday are no exception in citing that report, which attributed 60,000 excess deaths a year to health disparities as it became a clarion call to the nation.

“It’s not just the ’85 report, it’s going back to ‘The Philadelphia Negro’ with W.E.B. Du Bois,” which was published 124 years ago and was the first ethnography to outline problems faced by the Black community, said Darrell Hudson, who researches health disparities at Washington University in St. Louis. “The outcome is not new. Our understanding of the mechanisms, policies and practices have evolved.”

In the decades since, modern medicine has witnessed major scientific discoveries and technological breakthroughs, but those advances haven’t benefited everyone equally. When taken together, researchers say, the reports released Tuesday dispel several myths about how society has — and has not — responded to the alarm sounded more than a generation ago.

“We tend to have this idea as we move through time, we’re constantly improving,” said Jessica Owens-Young, an assistant professor in the Department of Health Studies at American University, where she researches health equity. But, she said, “we can’t always assume that as we continue to innovate that is going to promote and protect people’s health.”

Nunez-Smith, who was chair of President Biden’s Covid-19 Health Equity Task Force, said the report on excess deaths dispenses with the notion that the root causes of racial health disparities reflect “some deterministic factor that race is biological.”

Nunez-Smith and the other researchers analyzed death certificates from 1999 through 2020 to reach their conclusions about excess deaths — the observed number of deaths vs. what would be expected if Black and White death rates were the same.

From 1999 to the early 2010s, the report found that the gap in excess deaths narrowed, dropping by about 48 percent for Black men and about 61 percent for Black women compared with their White counterparts. But then progress plateaued, the excess burden of death stubbornly persisting until it ballooned in 2020.

Excess mortality during the first year of the coronavirus pandemic, the report said, exceeded that of any previous year of the study.

Infants bore the brunt of excess deaths and years of life lost along with adults older than 50. The death gap between men and women widened sharply, according to the report.

The leading causes of excess death and years of life lost, according to the study, include infant mortality, heart disease and cancer.

“These findings indicate that current efforts to curb or eliminate mortality disparities have been minimally effective, and progress, when made, has been fragile,” the report concluded.

The numbers represent something else, said Harlan Krumholz, a cardiologist at the Yale School of Medicine and co-author of the excess death study: a greater need to recognize “where we’re failing and the magnitude of the problem.”

“Why don’t we accept that this is really racism as cause of death?” Krumholz asked. “What other health problem has created that kind of loss?”

The study shows that, except for ages 1 to 10, Black males experienced the highest rates of excess death and years of life lost, a finding that Derek Griffith, director of Georgetown University’s Center for Men’s Health Equity in the Racial Justice Institute, said reinforces the need to consider the ways “anti-Black racism is gendered and use that as foundation for how we need to intervene.”

Griffith said the report mentions “structural racism, but it’s too blunt of an instrument. Anti-Black racism manifests in stereotypes and tropes. It’s that cultural narrative that shapes why it makes it okay for us to have these patterns.”

Many of those stereotypes are viewed through a gender lens, he said.

Research shows Black boys are often viewed as older, stronger and less innocent than their peers. Black men are seen as criminals, intellectually inferior, “deadbeat dads.” Black women are reduced to racist caricatures of lasciviousness, aggressiveness, the “welfare queen.”

“We don’t tend to think about the structural drivers of racial inequity in a way that is precise enough,” Griffith said. He noted that talking about Black men’s poor health outcomes often “gets uncomfortable. We try to deal with this as a race pattern without dealing with the gender pattern.”

Those differences are evident in how men are socialized to handle stress and their health. Also, researchers said, many government and health programs tend to be geared toward helping single mothers, but those same services aren’t available for men and single fathers.

“Over time, we find that socioeconomic status doesn’t protect in the same way it does for other people, especially for Black men who report more discrimination the more income and education they have,” Hudson, of Washington University, said.

Often, to seek out upward mobility, Black people have to cross boundaries, navigating mostly White spaces to get an education, earn a living, take out a loan, raise a child. That can prove caustic, Hudson said, because if someone is constantly crossing boundaries, they are constantly experiencing stress — or anticipating it.

Stress is a physiological reaction, hard-wired. At the first sign of danger, the brain sounds an alarm, setting off a torrent of neurological and hormonal signals that flood the bloodstream. Overexposure to those hormones wears down the body, causing it to become sicker and age quicker, or "weather."

While weathering isn't specific to race, it is believed to take a particular toll on Black people because of the unique, unrelenting stress caused by racism. Research shows Black people have much higher rates of hypertension, obesity, diabetes and strokes than White people do, and they develop those chronic conditions up to 10 years earlier.

"Our bodies are not sophisticated enough to discern that this is not a lion on the savanna but someone who just looked at you funny," said Hudson, who calls it "the cost of upward social mobility."

But there is reason for hope, and it can be found in the period during the coronavirus pandemic when the gap between Black and White death rates began to shrink and even flip. In 2021, White people had the second-biggest drop in life expectancy, losing a full year while Black people lost 0.7 years, according to the CDC.

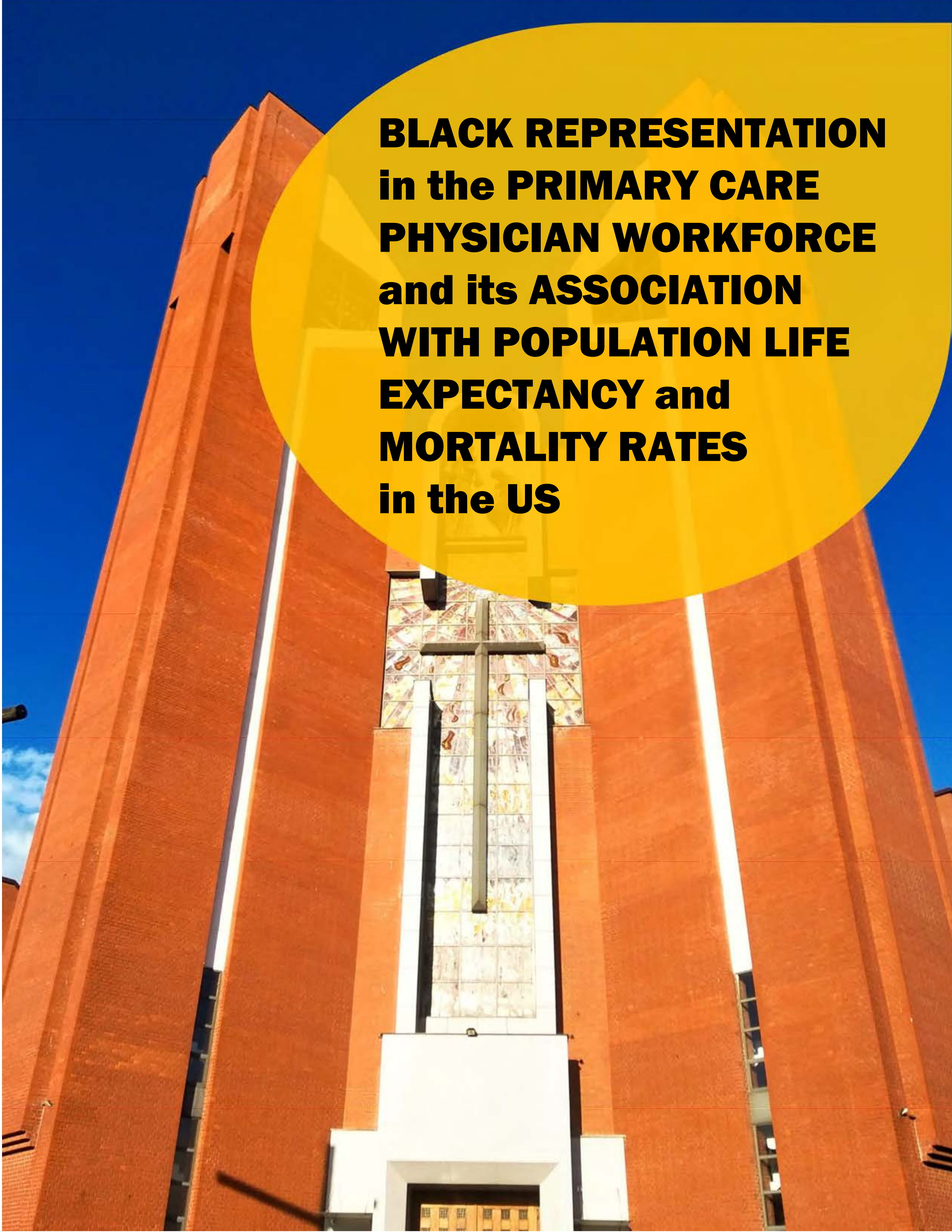
"And why was that happening?" asked Reed Tuckson, co-founder of the Black Coalition Against Covid. There are two reasons, he said. "One, of course, was the destructive messaging that came from many White political leaders but also the impact of the mobilization of Black faith and community-based organizations and social and fraternal organizations."

Tuckson, an internist and former D.C. public health commissioner, said the herculean efforts by the Black community "to fight for our lives" despite having meager resources show that it is past time for the federal government "to find a way to create sustainable, predictable funding at scale to support the Black community and its institutions."

"We have shown that we can catch up despite running a race with an anvil on our backs," he said.

By Akilah Johnson
Akilah Johnson is a national reporter exploring the effect of racism and social inequality on health for The Washington Post. She joined The Post in 2021 after working at ProPublica, where she won a George Polk award, National Magazine award, and was Pulitzer finalist for examining covid-19's toll on Black Americans. Twitter

Table of Contents



BLACK REPRESENTATION in the PRIMARY CARE PHYSICIAN WORKFORCE and its ASSOCIATION WITH POPULATION LIFE EXPECTANCY and MORTALITY RATES in the US

Original Investigation

Equity, Diversity, and Inclusion

April 14, 2023

Black Representation in the Primary Care Physician Workforce and Its Association With Population Life Expectancy and Mortality Rates in the US

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Key Points

Question Is Black representation in the US primary care physician (PCP) workforce associated with population health outcomes?

Findings In this cohort study of survival outcomes for 1618 US counties, Black PCPs operated in less than half of all counties during each of 3 time points assessed (2009, 2014, and 2019). On average, every 10-percent increase in county-level Black PCP representation was associated with 31-day higher age-standardized life expectancy among Black individuals. Higher Black PCP representation levels were also associated with lower all-cause mortality rates among Black individuals and with reduced mortality rate disparities between Black and White individuals.

Meaning These findings suggest that greater representation of Black PCPs in the PCP workforce is associated with improved survival-related outcomes for Black individuals.

Abstract

Importance Studies have suggested that greater primary care physician (PCP) availability is associated with better population health and that a diverse health workforce can improve care experience measures. However, it is unclear whether greater Black representation within the PCP workforce is associated with improved health outcomes among Black individuals.

Objective To assess county-level Black PCP workforce representation and its association with mortality-related outcomes in the US.

Design, Setting, and Participants This cohort study evaluated the association of Black PCP workforce representation with survival outcomes at 3 time points (from January 1 to December 31 each in 2009, 2014, and 2019) for US counties. County-level representation was defined as the ratio of the proportion of PCPs who identifed as Black divided by the proportion of the population who identified as Black. Analyses focused on between- and within-county influences of Black PCP representation and treated Black PCP representation as a time-varying covariate. Analysis of between-county influences examined whether, on average, counties with increased Black representation exhibited improved survival outcomes. Analysis of within-county influences assessed whether counties with higher-than-usual Black PCP representation exhibited enhanced survival outcomes during a given year of heightened workforce diversity. Data analyses were performed on June 23, 2022.

Main Outcomes and Measures Using mixed-effects growth models, the impact of Black PCP representation on life expectancy and all-cause mortality for Black individuals and on mortality rate disparities between Black and White individuals was assessed.

Results A combined sample of 1618 US counties was identified based on whether at least 1 Black PCP operated within a county during 1 or more time points (2009, 2014, and 2019). Black PCPs operated in 1198 counties in 2009, 1260 counties in 2014, and 1308 counties in 2019—less than half of all 3142 Census-defined US counties as of 2014. Between-county influence results indicated that greater Black workforce representation was associated with higher life expectancy and was inversely associated with all-cause Black mortality and mortality rate disparities between Black and White individuals. In adjusted mixed-effects growth models, a 10% increase in Black PCP representation was associated with a higher life expectancy of 30.61 days (95% CI, 19.13-42.44 days).

Conclusions and Relevance The findings of this cohort study suggest that greater Black PCP workforce representation is associated with better population health measures for Black individuals, although there was a dearth of US counties with at least 1 Black PCP during each study time point. Investments to build a more representative PCP workforce nationally may be important for improving population health.

Introduction

Various studies have shown correlations between higher primary care service availability and better population health outcomes.[1-11] For example, Basu et al[1] demonstrated that higher county-level primary care physician (PCP) supply is associated with increases in life expectancy and decreases in cardiovascular, cancer, and respiratory cause-specific mortality. Despite the established public health benefits for primary care, access to primary care services remains uneven across the nation, partly due to an insufficient number and uneven distribution of PCPs.[12] However, PCP workforce shortfalls are just one facet of existing accessibility challenges. Patients in the health care safety net—that is, those with geographic, financial, insurance-related, linguistic, racism- or discrimination-related, and other barriers—experience disproportionate difficulties in accessing primary care and other essential health services.[13-19] Life expectancy disparities between Black and White individuals have persisted for decades and have improved only modestly over time.[20-22] While primary care availability appears to be important for everyone, some studies stratified by race suggest that there may be a more powerful inverse association between access and mortality for Black individuals.[2,6]

Prior work suggests that racial and ethnic minority PCPs provide a disproportionately large share of care nationally to racial and ethnic minority individuals, low-income and uninsured patients, and other historically underserved groups.[23,24] Accordingly, building a more racially and ethnically diverse physician workforce has been cited as a means for expanding access to high-need specialties; providing more culturally competent care to racial, ethnic, and linguistic minority populations; offering patients greater choice for seeking care in line with their preferences; strengthening care quality; reducing health disparities; and better meeting the needs of the nation's diverse populace.[23-31] However, Black individuals and other racial and ethnic minority individuals have historically been underrepresented in the majority of health professions that require multiple years of advanced training, including medicine.[32-34]

Beyond the moral imperative to create equitable health career opportunities for all and to build a more diverse, representative physician workforce, the literature on the beneficial health outcomes from doing so primarily appears to focus on care access and utilization, patient adherence, physician communication, and patient experience of care measures.[35-39] Evidence around any potential gains in clinical and public health outcomes from diversifying the physician workforce is more limited, and existing work in this area often focuses specifically on physician-patient racial concordance.[25,40-42] As such, this investigation explores whether there is a county-level association between the degree of Black representation in the primary care workforce and key population health markers, including all-cause mortality rates, age-adjusted life expectancy, and all-cause excess mortality rates, a measure of health disparities between Black and White individuals.

Methods

This cohort study was deemed exempt from institutional review board review under US Department of Health and Human Services regulations by the Alpha Independent

Review Board. Informed consent was waived because it was not practicable to obtain consent from large numbers of physicians for a retrospective study. Data in the American Medical Association (AMA) Physician Masterfile are commonly used for research and other purposes, and physicians may opt out from their information being listed in this data set. The study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

Independent Variables

This investigation was modeled partly after work by Basu et al[1] to assess how primary care accessibility relates to public health outcomes, but this study examined the influence of Black representation levels. Specifically, PCPs were defined as the number of non–federally employed physicians, excluding medical residents, actively practicing in the contiguous US, Alaska, and Hawaii in the outpatient setting in general practice, family medicine, general internal medicine, and general pediatrics. Practice information was acquired from the AMA Physician Masterfile for 3 years (January 1 to December 31 for 2009, 2014, and 2019), and physician race and ethnicity data were retrieved from the Association of American Medical Colleges (AAMC) databases, which compile self-reported information from multiple sources, as described previously.[33,43] The AAMC race and ethnicity data are presented as a single variable with the following categories: American Indian or Alaska Native, Asian or Asian American, Black or African American, Hispanic or Latino (of any race), Native Hawaiian or other Pacific Islander, White, and other; the latter category includes individuals either identifying with more than 1 race and ethnicity descriptor and those with unknown or unclassifiable information on race and ethnicity. County-level population data on race and ethnicity were sourced from the 2009 to 2019 American Community Survey 5-year estimates.[44] Black representation levels in the PCP workforce were measured using the following formula:

$$\text{Community representativeness ratio} = \frac{\left(\dfrac{\text{No. of Black PCPs in a cou}}{\text{All PCPs in a county}}\right.}{\left(\dfrac{\text{No. of Black individuals in a}}{\text{All individuals in a cou}}\right.}$$

The community representativeness ratio is 1.0 when county-level Black representation levels in the PCP workforce match the proportion of community members identifying as Black. A representativeness ratio greater than or less than 1.0 indicates overrepresentation or underrepresentation of Black individuals in the PCP workforce relative to the community, respectively. This approach to measuring Black representation levels is advantageous because it is insensitive to both population and workforce magnitude, aiding in the comparison of counties of different size, and it is similar to the measure used in a recent publication looking at the racial and ethnic diversity of the health workforce.[45] However, the ratio presented here uses a slightly different denominator—the whole population, rather than the working-age population—as the current study focused on population-level health care access instead of occupational opportunity. Both measures align with how the AAMC defines minority group underrepresentation in medicine and how this topic has been studied previously.[33,46,47]

Outcomes

County-level, age-standardized life expectancy at birth and all-cause mortality rates (primary study outcomes) for 2009, 2014, and 2019 were derived from deidentified death records obtained through a data use agreement with the National Center for Health Statistics, using population counts from the US Census Bureau. Death records report race as a single variable (nonbridged), inclusive of Hispanic or Latino and non-Hispanic or non-Latino ethnicity, following 1997 guidelines from the Office of Management and Budget.[48] Life expectancy and all-cause mortality rates were calculated for entire county populations and county Black populations using an approach aligned with the University of Wisconsin Population Health Institute[49] County Health Rankings and Roadmaps program and using the equations presented in Arias et al.[50] Life expectancy was defined as the estimated mean number of years a person could expect to live (from birth), according to age-specific mortality rates. A measure of the all-cause mortality rate disparity between Black and White individuals was also included as a study outcome variable. This disparity was calculated using the method applied by Benjamins et al[51] to assess relative inequities between Black and White individuals using mortality rate ratios among these populations.

Covariates

Following the example established by prior work, county-level covariates (Table 1) included the following: rural or urban designation,[53] percentage living under the poverty threshold,[54] percentage of uninsured individuals,[55] median age,[56] percentage who identified as Hispanic,[56] ratio of men per 100 women,[56] percentage with less than a high school degree,[57] median home value,[58] unemployment percentage,[59] percentage of Medicare-enrolled individuals,[60] age-adjusted percentage of adult tobacco smokers,[49] percentage of adults with obesity,[49] average daily density of fine particulate matter (air pollution),[49] and number of hospital beds.[61]

Statistical Analysis

This longitudinal analysis examined whether between- and within-county influences of Black PCP representation (as a time-varying covariate) were associated with county-level life expectancy and age-adjusted all-cause mortality rates for Black individuals, after controlling for covariates.[1] Because Basu et al[1] found that alternative geographic levels of study such as primary care service area and hospital referral region showed similar health care–seeking patterns, this study focused solely on county-level analyses. The combined sample comprised 1618 counties identified as having at least 1 Black PCP during 1 or more study time points (ie, 2009, 2014, or 2019) to ensure the use of nonzero representativeness ratios.

After testing several models for the level 1 residuals (eg, homoscedastic, autoregressive error structure, etc), mixed-effects growth models with an unstructured residual covariance matrix were used (1) to regress life-expectancy, age-adjusted all-cause mortality rates, and a log-transformed measure of mortality rate disparity between Black and White individuals on the log-transformed representativeness ratio within each county and (2) to estimate the between- and within-county components of variation for these outcomes, treating the Black representativeness ratio as a time-varying covariate.[62] The outcome of all-cause mortality rate disparity between Black and White individuals and the aforementioned Black representativeness ratio were log-transformed to reduce positive skewness. To examine whether the associations between Black PCP representation and health outcomes were contingent on county poverty levels as a social determinant of health, moderation analysis assessed the statistical interaction of Black PCP representation with poverty. The association between the total number of PCPs per 100 000 population and each survival outcome also was tested to determine whether differences arose when comparing results for Black PCP representation vs all PCPs. *P* values were 2 sided, with α set to .05 to determine statistical significance. Sensitivity analyses and diagnostics examined (1) whether results met model-based assumptions and (2) if findings remained consistent when extreme residual observations or outliers were removed or when assessing the alternate representation ratio with the corrective constant. All analyses were performed in SAS, version 9.4 (SAS Institute). Data analyses were performed on June 23, 2022.

Results

Black Representation in the PCP Workforce

In this cohort study, Black PCPs comprised 6.3% of the combined sample (present in 1618 counties), and most counties (55.8%) with at least 1 Black PCP were urban. Median representativeness ratios (95% CIs) ranged from 0.69 (0.63 to 0.74) in 2009 to 0.85 (0.80 to 0.92) in 2019, suggesting that Black PCPs tended to be underrepresented relative to the county-level Black population. The percentage of Black PCPs for each time point was 5.7%, 6.3%, and 6.7%, respectively, whereas Black individuals comprised between 13.0% and 13.4% of the total US county-level population from 2009 to 2019 (Figure 1). In examining each time point, the number of counties with at least 1 Black physician was 1198, 1260, and 1308 counties in 2009, 2014, and 2019, respectively—consistently less than half of all 3142 Census-defined US counties as of 2014. There was a 9.8% increase in the number of US counties with 1 or more Black PCPs across this period. The percentage of US counties with 1 or more physician (irrespective of race and ethnicity) ranged from 90.9% to 94.2% in 2009, 2014, and 2019.

Association of Black PCP Workforce Representation With Life Expectancy and All-Cause Mortality

Small improvements in age-adjusted life expectancy and mortality rates were seen nationally for Black individuals and for the US population between 2009, 2014, and 2019. Analyses were limited to the subset of 1618 counties with at least 1 Black PCP to ensure the use of nonzero representativeness ratios. In mixed-effects growth models, between-county influences of Black PCP representation indicated that a 10% increase in Black representation levels was associated with higher life expectancy for Black individuals by 30.61 days (95% CI, 19.13 to 42.44 days) ([0.88 × log(1.10)] × 365 = 30.61 days; statistical guidelines were used for interpreting log-transformed estimators in general linear and/or linear mixed models, while multiplying the final value by 365 to convert life expectancy to days based on a standard, 365-day calendar year[64]) and lower all-cause mortality among Black individuals by 12.71 deaths per 100 000 (95% CI, −14.77 to −10.66) (Table 2). A 10% higher level of Black representation in the PCP workforce also was associated with an estimated 1.2% lower disparity between Black and White all-cause mortality rates (95% CI, −1.29% to −1.05%), meaning that higher Black representation was associated with smaller mortality differences between Black and White individuals. Additionally, within-county influences suggested that during a given year of heightened workforce diversity, counties with higher-than-typical representativeness (relative to their average, underlying level of Black PCP representation) exhibited reduced mortality (−35.34 [95% CI, −58.86 to −11.81]) and a relatively smaller difference in all-cause mortality rates between Black and White individuals (−2.44 [95% CI, −3.65 to −1.23]).

Moderation Analysis

In examining the statistical interaction between Black PCP representation and poverty (0.04 [95% CI, 0.01-0.07]; Table 2), increases stemming from the between-county influence of Black physician representation were associated with enhanced life expectancy among Black individuals across all levels of poverty. Yet enhanced life expectancy was greater among US counties with high poverty, relative to counties with low to average poverty (Figure 2).

Association Between Total PCPs and Outcome Measures

Mixed-effects growth models indicated that after controlling for study covariates, only the within-county influence of the total number of PCPs per 100 000 population was inversely associated with disparities in all-cause mortality rates between Black and White individuals (−1.16 [95% CI, −2.04 to −0.28]; Table 3).

Discussion

In this cohort study, moderate workforce diversity gains occurred in the 10-year period from 2009 to 2019, with a 9.8% increase in the number of US counties with 1 or more Black PCPs. In 2019, US Census population estimates reported that more than 70% of all US counties (excluding Puerto Rico) had 1 or more Black residents; however, the results of this study suggested that over half of all US counties had no Black PCPs during each time point. Among the counties that did, Black PCPs tended to be underrepresented relative to the Black county-level population (ie, median representativeness ratios <1.00). Comparatively, the percentage of US counties with 1 or more PCP (irrespective of race and ethnicity) ranged from 90.9% to 94.2% in 2009, 2014, and 2019.

This longitudinal study used multilevel or mixed-effects growth models to examine counties with 1 or more Black PCPs to determine whether increases in Black PCP representation levels were associated with better mortality outcomes among Black individuals. Greater Black PCP representation levels were associated with longer life expectancy and were inversely associated with all-cause mortality rates for Black individuals. Greater representation also was associated with a smaller difference in all-cause mortality rates between Black and White individuals. Moderation analysis suggested that the association between Black PCP representation and life expectancy was greater in counties with high poverty levels compared with counties with low or average poverty levels. Primary care availability, as measured by the total number of PCPs per 100 000 population, did not have a statistically significant association with life expectancy or mortality rates among Black individuals after controlling for other covariates, while within-county influences were associated with a reduced difference in all-cause mortality rates between Black and White individuals. Taken together, these findings suggest that Black PCP workforce representation levels are relevant to and potentially affect Black population health.

This investigation builds on prior work demonstrating the importance of primary care as well as the value of diversity, inclusion, and equity in the PCP workforce. Primary care physicians are a source of continuous, comprehensive care for their patients, serving to prevent and manage disease across the lifespan and coordinating the care provided to their patients elsewhere in the health care system. In addition, PCPs promote patient physical, mental, and general health and well-being; engage patients in actively participating in the management of their own health; often address the broader determinants of health within patients' environment; and work to ensure equitable patient access to necessary health resources.[66,67] Various studies have shown correlations between the higher availability of primary care services and desired population health outcomes, such as lower all-cause and cause-specific mortality.[1-11] Racial differences frequently observed in population health outcomes studies are generally considered to result from fixable health system factors, such as differences in the availability and quality of care.[68-70] Race as a study variable, in and of itself, is not considered a biological determinant of health outcomes; rather, it is a social construct that serves as a proxy measure for the structural inequities inherent in our society, and specifically in the health system.[69,70] Empirical evidence shows that individuals belonging to minority racial and ethnic groups experience discrimination within the US health care system that adversely affects their access to, utilization of, experience in receiving, and outcomes from health care services.[17,19,71-73]

Physician-patient race concordance for Black individuals appears to often be associated with improved outcome metrics in some of these arenas, and some Black patients may prefer to seek care from racially concordant physicians due in part to the value placed on certain shared aspects of culture and experience.[23,35,37-39,74,75] Although building a more diverse and representative physician workforce should not be a means to reinforce care segregation or to deemphasize the need to strengthen all physicians' cultural competency, it does broaden patients' choices for selecting PCPs and may offer outcome benefits for Black and other racial and ethnic minority patients.[35,37-39,42] A more diverse workforce in research and leadership roles, able to leverage a wide array of personal and professional experiences in such positions, can additionally aid in shaping more broadly relevant and inclusive research and policy agendas.[28]

However, Black individuals are underrepresented in the majority of health professions that require multiple years of advanced training, including medicine, and numerous barriers limit the entry of Black students into medical careers.[32-34,76-78] Potential interventions to address this include implementing changes in the processes for admissions, hiring, and promotions at universities, such as holistic review, and efforts to better nurture an educational and training environment that is structured for inclusion.[79,80] The Health Resources and Services Administration, the primary federal agency supporting health care delivery to geographically isolated and medically underserved individuals, offers resources to support building an increasingly diverse national health workforce through its Health Careers Opportunity Program, Scholarships for Disadvantaged Students program, and Centers of Excellence program.[32] Efforts to expand structural diversity within the health workforce, meaning to improve the numeric or proportional racial and ethnic mix of practicing PCPs, can be complemented by other strategies. These include strengthening cultural competency curricula and implementing educational approaches that elevate the principles of diversity, equity, and inclusion, such as engaging health professional students and trainees in diverse learning experiences in terms of race and ethnicity and gender (curricular diversity) and providing opportunities for students and trainees to interact with peers from different racial and ethnic backgrounds than themselves (interactional diversity).[81,82] Example programs include Doctors Back to School from the AMA[83] and the Action Collaborative for Black Men in Medicine from the AAMC,[84] in partnership with the National Medical Association.

Limitations

This study has several limitations. Although Basu et al[1] found that health care–seeking patterns were similar across different levels of geography, this study was performed solely at the county level, and people do not necessarily seek primary care solely in their county of residence. Further, geographic proximity to health care is not equivalent to access. Since race and ethnicity was captured as a single variable in the PCP data set used for this analysis, this means that only physicians who self-identified as Black were characterized as such. In addition, life expectancy and mortality are multifactorial concepts, and mortality data categorized using race and ethnicity–based markers do not describe homogenous populations. This study attempted to control for important covariates with potential to confound the results (eg, health insurance access) but additional cultural factors likely play a role, including language and immigration status, although these are difficult to account for with currently available data. The associations identified between Black representation and the study outcomes do not imply causation. This study also does not investigate whether physician-patient racial concordance is occurring during care delivery. County-level Black representation in the physician workforce may serve as a marker for other community-based and health system factors that affect living environments and health outcomes for Black individuals.

Conclusions

In this longitudinal cohort study of the PCP workforce in US counties where there were Black PCPs, higher levels of Black representation within the physician workforce were observed to be directly associated with longer life expectancy and inversely associated with all-cause mortality rates and all-cause mortality rate disparities for Black individuals. Hence, Black representation levels likely have relevance for population health, supporting the need to expand the structural diversity of the health workforce. Future investigations may examine the likely myriad factors behind this finding, the extent to which physician-patient racial concordance plays a role in this observation, and the effects that efforts to diversify the health workforce ultimately have on population health.

Back to top

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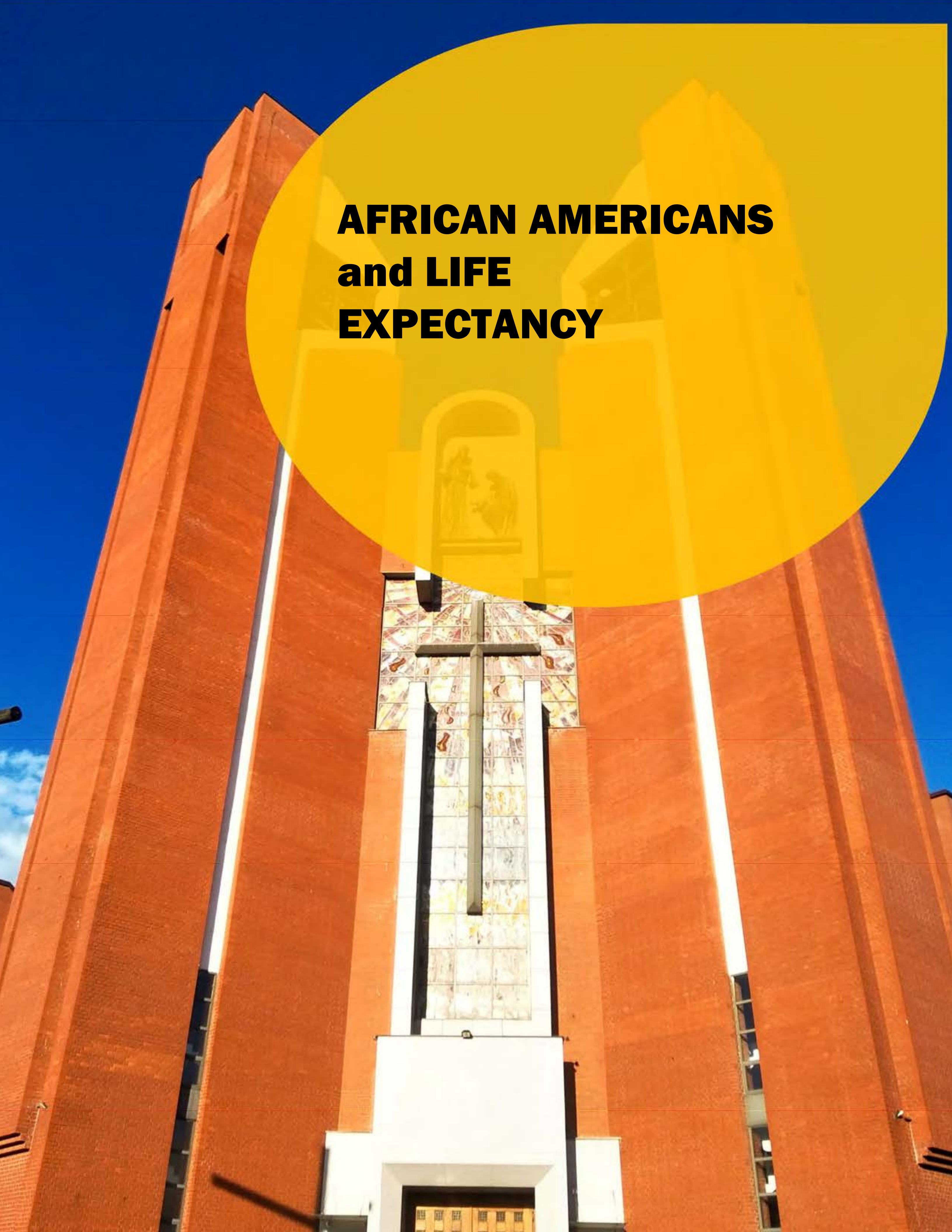


AFRICAN AMERICANS and LIFE EXPECTANCY

Why is life expectancy so low in Black neighborhoods?

Earlier this year, the National Center for Health Statistics (NCHS) published data showing a 1.5-year decline in national life expectancy in 2020, largely due to the COVID-19 pandemic, which took the lives of approximately 375,000 Americans that year. The NCHS reported that white Americans' life expectancy declined by 1.2 years; for Black Americans, that number was 2.9 years.

This racial disparity in life expectancy is a lagging indicator of disparities that have existed throughout the pandemic. According to the most recent Centers for Disease Control and Prevention data, Black people are 1.1 times more likely than white people to contract COVID-19; 2.8 times more likely to be hospitalized with the virus; and two times more likely to die from it. These disparities help to explain why, when adjusting for age, Black people account for 22.1% of the nation's COVID-19 deaths despite only comprising 12.8% of the population.

The causes of these racial disparities are hotly debated, and many fixate on the role of individual behavior—for example, a recent Brookings analysis cited vaccine hesitancy as a key driver of disparate death rates. But while personal behavior matters, social determinants of health at the local level play an outsized role.

Because de jure and de facto segregation concentrated Black Americans in specific locales, racial injustices have occurred through place-based discrimination: disproportionate exposure to pollution and hazardous waste, harmful zoning practices, and post-disaster displacement, to name a few. Rather than blaming Black people for their suffering, the conditions of place must be examined to understand the mechanics of racial discrimination that contribute to that suffering.

TWO FINDINGS HIGHLIGHT HYPERLOCAL VARIATION IN LIFE EXPECTANCY PRIOR TO THE PANDEMIC

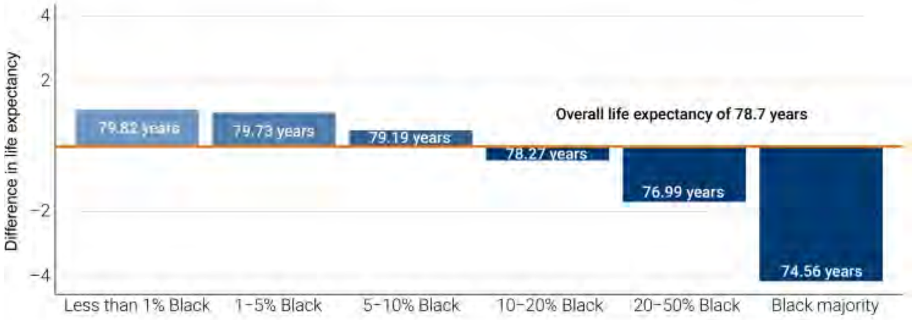
Finding #1: Neighborhood life expectancy correlates with neighborhood demographics

We compared life expectancy across neighborhoods where the population of Black residents ranged from less than 1% to over 50%. The graph below shows that at the national level, neighborhood life expectancy decreases as the Black population percentage increases.

Neighborhoods with a 10% Black population or higher have an overall life expectancy lower than the national average of 78.7 years. Black-majority neighborhoods have a lower life expectancy by approximately 4.1 years, and neighborhoods with a Black population of less than 1% have a higher life expectancy by around one year compared to the national average.

Figure 1. Black majority neighborhoods have decreased life expectancy

Life expectancy by neighborhood type



Source: Brookings analysis of CDC's 2010-2015 U.S. Small-area Life Expectancy Estimates Project (USALEEP) and 2011-2015 ACS data

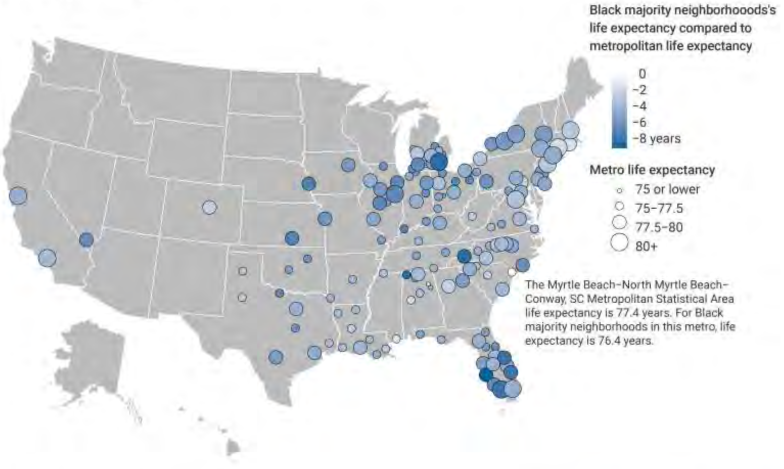
Brookings Metro

Throughout the pandemic, most geographic analyses of differing health outcomes focused on comparing different states, metro areas, and counties. The comparisons are important, but these geographic areas are not homogenous units. There can often be as many stark differences found *within* a metro area as are found *across* metro areas—a fact underscored in our second finding below.

Finding #2: Neighborhood life expectancy disparities exist relative to the surrounding metro area.

We found that Black-majority neighborhoods had relatively lower life expectancy when compared to the aggregate metro area in which those neighborhoods were located. As shown in the map below, the difference in life expectancy between a Black-majority neighborhood and its surrounding metro area can be as high as nine years.

Map 1. Black-majority neighborhoods' life expectancy compared to metro life expectancy



The Myrtle Beach-North Myrtle Beach-Conway, SC Metropolitan Statistical Area life expectancy is 77.4 years. For Black majority neighborhoods in this metro, life expectancy is 76.4 years.

Source: Brookings analysis of CDC's 2010-2015 U.S. Small-area Life Expectancy Estimates Project (USALEEP) and 2011-2015 ACS data

Brookings Metro

Both findings illuminate the fact that racial gaps in life expectancy manifest as place-based problems. But one alternative way of interpreting these findings is that Black people might carry life expectancy decline with them into the neighborhoods they live in, such that the crucial variable is the people, not the place. Supporters of this view could point to the fact that there are persistent (though narrowing) nationally aggregated racial gaps in life expectancy that extend backward for many decades.

While there is some credence to this view, we don't think it tells the full story. For example, recent research comparing states found that "geographic inequality in mortality for midlife Americans increased by about 70 percent between 1992 and 2016"—underscoring the significance of place as a driver of outcomes. Additional research using experimental and quasi-experimental methods further highlights the role of neighborhoods as a driver of health and well-being outcomes.

In our recent report on social determinants of health, we identified two place- specific factors that help explain disparities in health outcomes: housing insecurity (including rates of foreclosure and eviction) and exposure to environmental hazards (particularly toxic air), which are both more common in Black neighborhoods. Social determinants related to labor markets— including labor force participation, employment conditions, and access to employer-sponsored health care—are additional factors that are often highly correlated with neighborhood characteristics and location.

Thus, a better interpretation for neighborhood-level differences in life expectancy is that whiteness bestows a noticeable social and economic premium on localities, including neighborhoods—where whiteness is understood not as an intrinsic individual characteristic but rather as a social construct that enables various systemic and structural advantages for these neighborhoods compared to Black neighborhoods.

As an initial example of these structural advantages and disadvantages, previous Brookings research found persistent devaluation of homes in Black-majority neighborhoods, even when controlling for objective metrics such as home size and neighborhood amenities. Contrary to what other researchers have claimed, additional research by our team clearly demonstrates that these disparities are not driven by socioeconomic factors but are instead the result of racial bias, as these neighborhoods are systematically viewed as less safe and of lesser quality based on racial makeup.

As a result of this bias and devaluation, once-successful Black neighborhoods often undergo cycles of disinvestment and disrepair, priming them for gentrification. In addition to undermining Black wealth for individuals and the community, this devaluation also erodes tax revenue via property tax, which compromises the ability of localities to adequately fund public goods and services. White neighborhoods benefit from the opposite dynamic, wherein homes are overvalued relative to the tax-assessed value. Our team has also established evidence that these same undervaluation issues are found in regards to Black businesses.

This interpretation of white privilege as a spatial phenomenon rather than an individual characteristic helps to explain why life expectancy in white *neighborhoods* is higher even as there have been persistent declines in life expectancy for white *people* in recent years. For example, from 2013 to 2014, life expectancy decreased for white people but increased for Black people—yet this does not show up at the neighborhood-level analysis. And from 2014 to 2015, there was a national aggregate life expectancy decline of 0.2%—but when disaggregated by race, Black people had a lower decline (0.1%) than white people (0.2%).

Thus, we believe that neighborhood-level differences in life expectancy connect to residential segregation, which is often driven by income and wealth stratification reflecting a legacy of systemic racism.

RESIDENTIAL SEGREGATION IS THE HIGHEST IT HAS BEEN IN DECADES

Pundits and politicians often speak about racial progress as though it is an inevitable march in the right direction. But at least on some metrics, we have lost ground compared to previous decades. This is especially the case when it comes to racial integration in major metro areas.

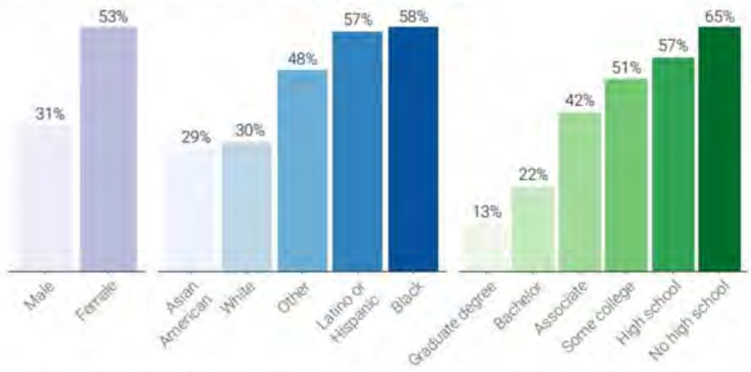
According to research from the University of California, Berkeley's Othering & Belonging Institute, "81 percent of metropolitan regions with a population above 200,000 were more segregated in 2019 than they were in 1990." The report found that these segregation patterns both reflect and extend the systemic racism encoded in 20th century law: "83 percent of neighborhoods that were given poor ratings (or 'redlined') in the 1930s by a federal mortgage policy were as of 2010 highly segregated communities of color." These patterns directly shape the financial characteristics of these neighborhoods, with the report finding that "neighborhood poverty rates are highest in segregated communities of color (21 percent), which is three times higher than in segregated white neighborhoods (7 percent)."

In her new book, Georgetown Law professor Sheryll Cashin describes these segregation patterns as "a system of residential caste that harms those who cannot buy their way into bastions of affluence." In the context of our research, we add that this racialized residential caste system affects which neighborhoods can buy their way into better communal health outcomes. Since neighborhoods are often the starting point of the social determinants of health we explored in our report, accessing "better" neighborhoods— neighborhoods with cleaner air quality, more green space, higher public expenditure on public goods—can add years of life.

To be clear, we believe there are many social and political benefits to having more racially integrated neighborhoods. And we strongly object to the many ways that white enclaves of wealth use restrictive zoning, real estate steering, and other such practices to make it harder for Black people to move into the neighborhood. But Black people should not have to attach themselves to places that benefit from white privilege in order to flourish. Living in a Black- majority neighborhood should not be a death sentence imposed via lack of public investment and the kinds of "boundary maintenance, opportunity hoarding and stereotype-driven surveillance" patterns that Cashin describes.

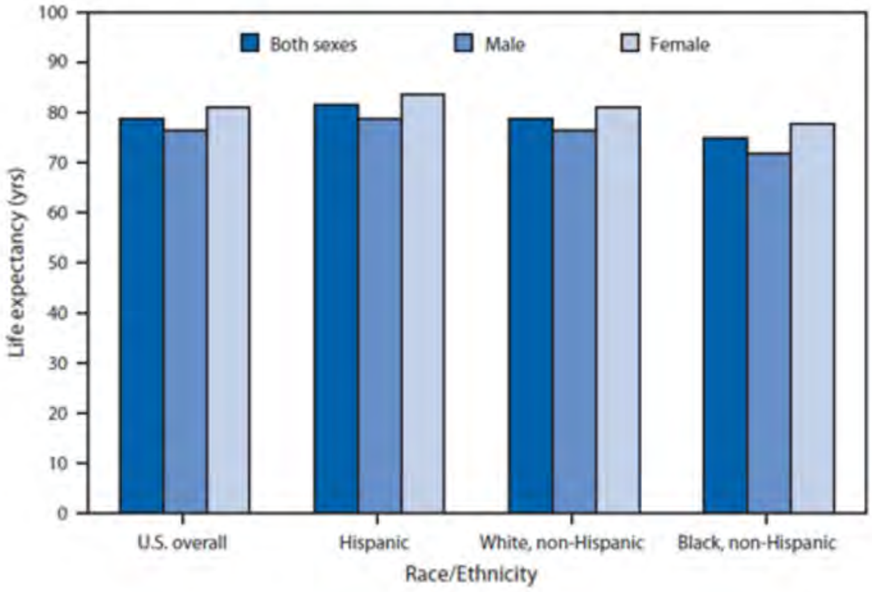
Chart 2. Families headed by women, Black, and Latino or Hispanic individuals and individuals without a high school diploma are more likely to be struggling

Share of families with children that are struggling by household head

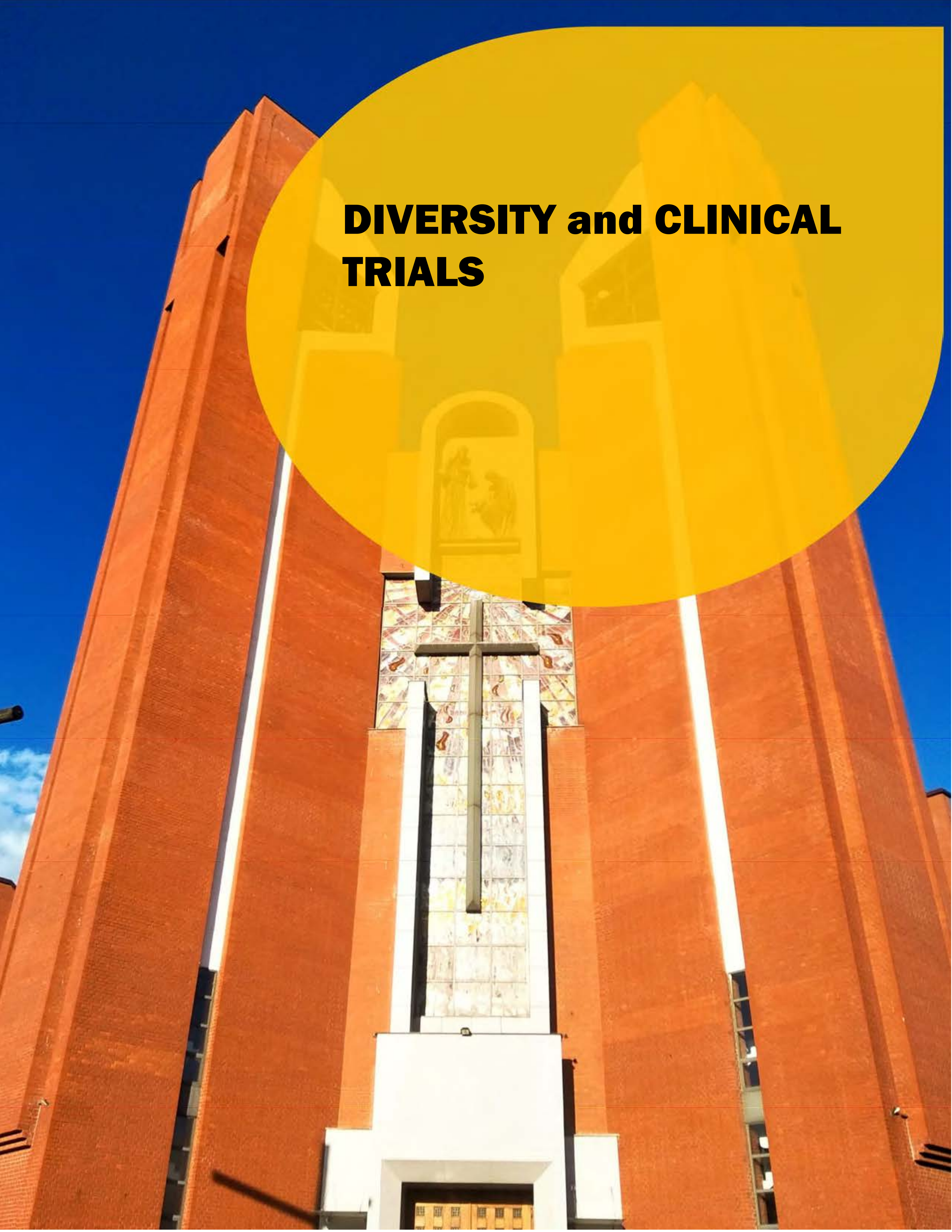


Source: Brookings analysis of American Community Survey 2019 data and Economic Policy Institute Family Budget Calculator data.

As we slowly recover from the intersecting health and economic crises caused by the COVID-19 pandemic, it is essential to advocate for the kind of public investment that will create greater equity and allow for everyone to live healthily—regardless of their race or place.

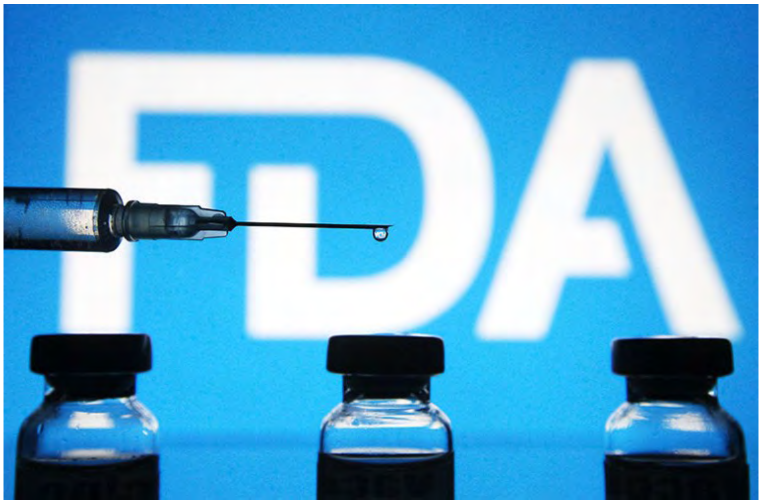


DIVERSITY and CLINICAL TRIALS



NBCI supports the FDA to require diversity plan for clinical trials

US regulatory agency makes ‘big change’ to increase the number of participants from under-represented groups in drug testing.



The US Food and Drug Administration regulates products

The US Food and Drug Administration (FDA) will soon require researchers and companies seeking approval for late-stage clinical trials to submit a plan for ensuring diversity among trial participants.

The fraught quest to account for sex in biology research

Many scientists have applauded the move, which was laid out in a spending bill signed into law by US President Joe Biden in December 2022. They say that broadening participant pools is important to make medicines more effective across the whole population. But they are not yet convinced that the FDA will adequately enforce the new requirement.

Nonetheless, “this is the biggest change in the regulatory landscape for clinical-trial diversity in the last three decades”, says Thomas Hwang, a physician at the Dana-Farber Cancer Institute in Boston, Massachusetts, who has expertise in pharmaceutical regulation[1].

Stalled efforts

The diversity requirement arrives in the wake of a 2022 report from the US National Academies of Sciences, Engineering and Medicine, which found that, although the representation of white women in clinical trials has improved, progress has "largely stalled" for minority racial and ethnic groups. Older adults, pregnant people and individuals with disabilities remain severely under-represented — and, in some cases, excluded — from US clinical research, the report found. For example, a recent analysis of new cancer therapeutics approved by the FDA between 2012 and 2017 found that 79% of the clinical trials that were used to support the FDA's decisions adequately represented women — but only 27% adequately represented older adults, and only 11% met the bar for minority racial and ethnic groups[2]. (In this case, 'adequately represented' means that the percentage of, say, women enrolled in a cancer trial approximately matches the proportion of women in the United States who have that type of cancer.

COVID vaccines safely protect pregnant people: the data are in

When the make-up of a pool of participants doesn't reflect the population that could benefit from a particular drug, it suggests that the clinical-research findings will not be relevant for everyone, says Marian Knight, a perinatal epidemiologist at the University of Oxford, UK. It also undermines trust in the medical establishment, she adds.

During the early stages of the COVID-19 pandemic, for example, some pregnant people were reluctant to get vaccinated because many of the trials that tested the jabs did not include participants who were pregnant, she says. There ended up being a disproportionate number of COVID-19-related deaths in pregnant people compared with the rest of the population, perhaps as result of vaccine hesitancy, says Knight, who co-authored a 6 February analysis3 in *The BMJ* urging researchers to include more pregnant individuals in clinical trials.

To comply with the diversity requirement, researchers and pharmaceutical firms will need to list their demographic goals for the participant pool, their rationale for the goals and an explanation of how they intend to meet them. This process looks promising, says Jennifer Miller, a bioethicist at Yale School of Medicine in New Haven, Connecticut, and a co-author of the cancer-therapeutics analysis. "This is the first time we're going to have companies proactively plan enrolment targets and submit them to regulators."

Challenges ahead

Before the requirement takes effect, however, the FDA must first finalize its draft guidance, and then offer the public an opportunity to comment. These steps could take more than two years.

Aside from the time until implementation, researchers are concerned about a provision in the December spending bill that allows the FDA to waive the need for a diversity-action plan in certain circumstances; for example, during public-health emergencies, or if a disease or condition is not considered prevalent in the general population. This broad waiver authority takes the teeth out of the legislation, Hwang says.

The researcher fighting to embed analysis of sex and gender into science
Scientists say it's unclear how strictly the FDA will enforce the requirement, and what options it has if a researcher fails to follow through on their action plan. "Monitoring and enforcing laws has been a challenge for the FDA in the past," says Miller.

Charles Kohler, a spokesperson for the FDA, says that the agency is committed to ensuring that trial participants reflect the populations that are likely to use the product, and that it is currently reviewing the powers that it was granted by the December legislation.

Once the FDA implements its diversity requirement, it will be up to companies and researchers to recruit people to take part in their trials. To achieve their goals, they will have to focus on the structural problems that underlie the lack of diversity in clinical-trial populations, Miller says. For instance, they'll need to consider relocating research sites to places that are more accessible for members of under-represented groups and should try to build trust in local communities made wary by past instances of exploitative medical research.

By itself, the legislation won't be sufficient to address long-standing disparities in clinical-trial enrolment, Hwang says. But Knight says: "It's fantastic the FDA is taking the approach." It could even inspire countries such as the United Kingdom to introduce similar requirements, she adds. "Having these kinds of levers is the way to make researchers think about diversity."

National Black Church Initiative National Clinical Trails Strategic Plan
https://blackchurchclinicaltrials.com/

BIO's diversity in clinical trials website
About Clinical Trials: The Power of Participation | BIO Clinical Trials (ctpop.org)

AHRQ Agency for Healthcare Research and Quality

Agency for Healthcare Research and Quality: A Profile

The Agency for Healthcare Research and Quality (AHRQ) is the lead Federal agency charged with improving the safety and quality of healthcare for all Americans. AHRQ develops the knowledge, tools, and data needed to improve the healthcare system and help consumers, healthcare professionals, and policymakers make informed health decisions.
Select for print version (PDF, 258 KB).

What is the Agency for Healthcare Research and Quality?

What We Do

- AHRQ invests in research on the Nation's health delivery system that goes beyond the "what" of health care to understand "how" to make health care safer and improve quality.
- AHRQ creates materials to teach and train health care systems and professionals to put the results of research into practice.
- AHRQ generates measures and data used by providers and policymakers.

In 1999, an Institute of Medicine report, "To Err Is Human," documented serious patient safety problems in our health care system. In the intervening years, AHRQ has led the Nation in responding to those issues and improving the safety of health care. Using AHRQ's research and how-to tools, the U.S. health care system prevented 1.3 million errors, saved 50,000 lives, and avoided $12 billion in wasteful spending from 2010–2013. But, even with these successes, safety is far from optimal, and AHRQ's work continues.

What are AHRQ's areas of focus?

- **AHRQ invests in research on the Nation's health delivery system that goes beyond the "what" of health care to understand "how" to make health care safer and improve quality..**

  - There aren't enough specialists to treat everyone who needs care, especially in rural and underserved communities. AHRQ funded an innovative model, called Project ECHO (Extension for Community Healthcare Outcomes), for training and supporting primary care clinicians in rural communities to provide specialized care for their patients. This model has flourished, receiving ongoing funding from the State of New Mexico, spreading to other States, and expanding from its initial focus on hepatitis C into new clinical areas, including mental health and substance abuse, and HIV. It has also been adopted by the Veterans Health Administration as a tool for expanding access to high-quality care for veterans across the country.

  - AHRQ's Re-Engineered Discharge (RED) is a structured protocol and suite of implementation tools that helps hospitals rework their discharge processes to reduce readmissions by determining patients' needs and carefully designing and communicating discharge plans. Hospitals using these tools have seen a 30 percent reduction in hospital readmissions and emergency rooms visits.

  - AHRQ recently funded three Centers of Excellence to study how high-performing health care systems promote evidence-based practices in delivering care. Health systems in the United States vary tremendously in their ability to produce outcomes that patients care about, such as those for cardiovascular risk factors. However, we know very little about which systems are doing a good job, or about how those systems are achieving superior outcomes. The AHRQ project will help close this research gap and produce information that can be used by health systems throughout the United States to improve patient outcomes.

- **AHRQ creates materials to teach and train health care systems and professionals to put the results of research into practice.**

  - AHRQ supported the development of the Comprehensive Unit-based Safety Program (CUSP), a highly effective method of preventing healthcare-associated infections (HAIs). CUSP combines improvement in safety culture, teamwork, and communication together with a checklist of proven practices for preventing HAIs. AHRQ has promoted the use of CUSP in a series of nationwide projects that addressed various HAIs and produced CUSP toolkits to help clinicians prevent these infections. CUSP was implemented in more than 1,000 U.S. intensive care units (ICUs) to prevent deadly central line-associated bloodstream infections (CLABSI). ICUs that used CUSP methods and tools were able to reduce these bloodstream infections by 41 percent, preventing over 2,100 CLABSI cases, saving more than 500 lives, and avoiding more than $36 million in excess costs. CUSP tools are free, and available on the AHRQ Web site to be adapted and used based on the specific setting.

    - In 2015 AHRQ launched an initiative to directly bring the latest scientific research, tools, and support to over 5,000 primary care physicians that will improve the care for over 8 million Americans. AHRQ awarded seven large grants to establish EvidenceNOW, an initiative aligned with Million Hearts® that will provide practice support to over 5,000 primary care physicians with the goal of improving the heart health of millions of patients and improving the capacity of the practices to incorporate new research findings and information into practice.
    - AHRQ, in conjunction with the Department of Defense, developed TeamSTEPPS®, a training program designed for health care professionals to improve patient safety, communication, and teamwork skills. AHRQ has trained more than 1,500 individual organizations in the United States through this program and is continuing to provide free training around the country. To increase training capacity, AHRQ has shared the curriculum and tools with the Centers for Medicare & Medicaid Services (CMS), which has tasked the Nation's Quality Improvement Organizations to disseminate this training further throughout the country.
- **AHRQ generates measures and data used by providers and policymakers.**
    - Data from AHRQ's Healthcare Cost and Utilization Project helped to highlight a jump in hospitalizations among Medicare, Medicaid, and private-pay patients for overuse of opioids. AHRQ showed that hospitalization rates more than doubled between 1993 and 2012, when there were more than 700,000 Americans hospitalized for opioid overuse. This warning contributed to HHS' launch of a major multipronged initiative to reduce opioid abuse in 2015.
    - AHRQ created and maintains the gold-standard suite of surveys, called the Consumer Assessment of Healthcare Providers and Systems, which provide valid assessments of patients' experience of care in hospitals, nursing homes, and doctors' offices. The hospital industry, patients, and CMS chose the hospital version of the AHRQ survey to be the measure for all of the patient experience elements for CMS' Hospital Quality Initiative. CMS incorporates these results into the Hospital Compare Web tool and its five-star rating system.
    - AHRQ's Medical Expenditure Panel Survey data helped the Medicaid and CHIP Payment and Access Commission develop estimates of eligibility for Medicaid and the Children's Health Insurance Program; the Congressional Budget Office also uses AHRQ data in its estimates of the budgetary impact of many Congressional proposals.

Top of Page

How will AHRQ make health care safer and better tomorrow?

AHRQ is beginning work to tackle some of the health care system's greatest challenges, including:

- Reducing antibiotic overuse and eliminating health care-associated infections.
- Improving care for people with multiple chronic conditions.
- Incorporating the latest research findings into electronic health records to facilitate clinical decisionmaking.
- Discovering how to better provide opioid addiction treatment services in rural communities.

The 2022 National Healthcare Quality and Disparities Report: We Still Have Much Work to Do

Ph.D., M.H.S.A.

Dr. Valdez is Director of AHRQ. Ph.D., M.H.S.A.

What does healthcare in the United States look like?

The answer, of course, is complicated. It depends on one's perspective. But regardless of how one attempts to address the question, a mixed picture emerges, signaling a great deal that still needs to be done to ensure that patients receive the healthcare they need and deserve.

Bringing this picture into focus is central to AHRQ's annual publication of the National Healthcare Quality and Disparities Report (NHQDR)—a Congressionally mandated summary of health and healthcare delivery status in the United States. The newly released 2022 NHQDR is the broadest, deepest, and most comprehensive yearly account of the state of American healthcare—and it crystalizes the achievements and challenges we face, especially among racial and ethnic minorities and underserved communities.

As in the past, the newest NHQDR highlights areas in which the healthcare delivery system has made important advances. Mortality from HIV/AIDS, for example, has declined steadily since early 2000. Significant improvements have occurred for people receiving care at home. And decades of basic and clinical research have yielded many effective ways to prevent or treat breast cancer. Between 2000 and 2020, the breast cancer death rate decreased by approximately 29 percent.

But the NHQDR also documents many troubling trends in healthcare quality and delivery. To begin with, life expectancy declined by 1.8 years in 2020 compared with 2019. The decline was more remarkable for Hispanic and non-Hispanic Black people than non-Hispanic White people. The sharp drop in life expectancy is partly due to the outsized impact of COVID-19, but COVID-19 does not explain why the life expectancy in the United States has fallen behind that of other countries.

In addition, the NHQDR underscores shortcomings in the healthcare delivery system's capacity to deliver safe, high-quality care. In January 2022, the number of healthcare workers employed in hospitals was 2 percent lower than in January 2020, before the COVID-19 pandemic. During the same time period, the decline was 12.1 percent among nursing home workers. Professions such as phlebotomists, medical assistants, and licensed vocational nurses account for many of the lost healthcare workers. However, these professions play a critical role in delivering healthcare services; losing them from the healthcare workforce may signal future difficulty in meeting demand for services.

What are we to make of this very mixed picture?

First, I encourage you to take a careful look at the data and information in the NHQDR, especially the report's new Portrait of American Healthcare. You may also want to review the report's deep dive into data on four special emphasis topics that are priorities for the Biden-Harris administration: maternal health, child and adolescent mental health, substance abuse disorders, and oral health. Excerpts from the compelling data in both sections are listed below.

As you'll see, the NHQDR is not prescriptive. Nor does it assign blame. Its purpose is to document U.S. healthcare quality and disparities so that everyone—policymakers, health system leaders, researchers, clinicians, and patients—can have a deeper understanding of the challenges we face, as well as the opportunities for making lasting improvements in healthcare delivery.

AHRQ's mission is to assist healthcare professionals and health system executives pursue excellence in healthcare for the American people by producing the evidence needed to improve care for all. I believe the 2022 NHQDR provides a valuable roadmap to achieving these goals.

Key Trends Noted in the NHQDR's Portrait of American Healthcare

- Before and during the COVID-19 pandemic, 135 rural hospitals closed between 2010 and 2020, threatening rural residents' access to services provided by those hospitals.
- The percentage of people with health insurance coverage has increased greatly in the past decade. However, those gains vary by race and ethnicity. Non-Hispanic American Indian or Alaska Native groups and Hispanic groups are significantly less likely to be insured.
- Disparities data show that in 2020, among adolescents ages 12–17 years, non-Hispanic White adolescents (7.4 deaths per 100,000 population) were more likely to die from suicide than Hispanic (5.0 deaths per 100,000 population) or non-Hispanic Black (4.6 deaths per 100,000 population) adolescents.
- The fourth-leading cause of death in the United States in 2020, after heart disease, cancer, and COVID-19, was unintentional injuries. Drug overdoses were the most common cause of unintentional injuries, accounting for more than 40 percent of unintentional injury deaths. As highlighted below, mortality rates for this condition continue to rise.
- Data increasingly showed that social, economic, environmental, and community conditions—together known as social determinants of health—may substantially influence the population's health more than care delivered by practitioners and healthcare systems. We know that healthcare organizations will increasingly need to address the social needs that patients bring to their healthcare encounters due to these social drivers of care. These societal conditions and challenges pose barriers to providing adequate care to all.

Highlights from the NHQDR's Four Special Emphasis Topics

- **Maternal health:** The United States has the highest maternal mortality rate of industrialized countries, and the 2022 NHQDR shows that this rate is increasing. The overall maternal mortality rate in 2020 was 23.8 deaths per 100,000 live births, up from 20.1 deaths in 2019 and 17.4 deaths in 2018.
- **Child and adolescent mental health:** Nearly 20 percent of American children have a mental, emotional, developmental, or behavioral disorder. Rates of emergency visits with principal diagnoses related to mental health increased by 24.6 percent for children up to 17 years old between 2016 and 2018. The report also finds that suicidal behaviors among high school students increased more than 40 percent in the decade up to 2019. Despite these troubling trends, the NHQDR shows limited access to mental health services.
- **Substance use disorders:** The opioid epidemic has cost more than $400 billion yearly in lost productivity, healthcare expenses, criminal justice costs, and losses from motor vehicle crashes. Although the rise in opioid-related deaths had briefly flattened between 2017–2018, rates of overdose deaths involving any opioid have begun to rise again, increasing by 36.8 percent between 2019 and 2020. Our challenges with alcohol misuse

also loom large; in 2020, the percentage of people aged 12 and over who needed treatment for alcohol misuse and who received such treatment at a specialty facility was less than 10 percent for people at all income levels.

- **Oral health:** Approximately one in seven people were unable to get or delayed getting needed dental care due to cost in 2019, a rate far higher than the percentage of people unable to get or get needed medical care due to cost. The data also indicate that access to oral healthcare and outcomes has improved for children, not adults. This may be explained by the fact that Medicaid and the Children's Health Insurance Program (CHIP) provides comprehensive dental coverage for children. In contrast, Medicaid, in the majority of States, does not provide this benefit for adults, nor does Medicare.

BILL: S.4170 - NBCI SUPPORTS RESEARCH in NON-ADDICTIVE PAIN and INNOVATIVE MEDICATION ASSISTANCE TREATMENTS

NBCI supports Research Non-Addictive Pain and Innovative Medication Assistance Treatments

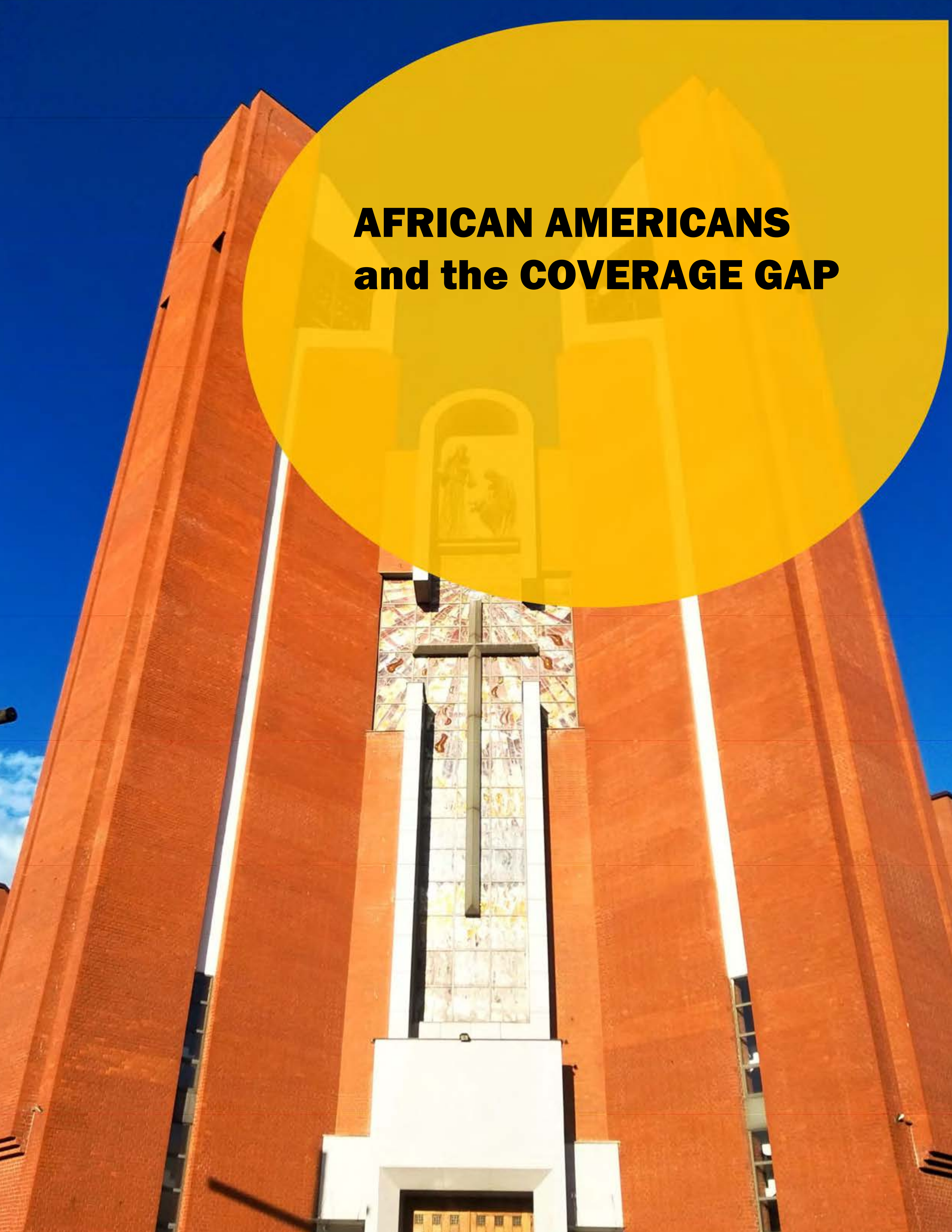
Here is a link to the bill: https://www.congress.gov/117/bills/s4170/BILLS-117s4170is.pdf

NBCI support what BIO is saying about the need to reauthorize the legislation: BIO worked with Congress in 2018 to advance proposals to help advance the research and development of non-addictive pain and innovative medication assistance medicines many of these ideas were included in the enacted SUPPORT act. The SUPPORT Act is up for reauthorization, and we would like to see the bill broadened to address substance abuse writ large.

It is important to note that while helpful, it is BIO's view that innovation in these spaces will be stymied, and premium care will not be provided to a majority of Americans until addiction is recognized and treated as a disease and brought into the mainstream health care systems and associated oversight and that innovative medicines are part of that available care when appropriate. You can see from our emerging company financial trend reports on Pain and Addiction (updated this month) and Depression that the level of investment is inverse to the public health need which supports the fact that the policies are misaligned

Here is the link to the recent BIO report on pain and addiction R&D.
New BIO Analysis Reveals Declining Pain Drug Pipeline and Underinvestment in New Addiction Therapies

AFRICAN AMERICANS and the COVERAGE GAP



African Americans and the Coverage Gap

What is the Medicaid 'coverage gap' and who does it affect?

So there is still a coverage gap in 11 states: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota (until July 2023), Tennessee, Texas, and Wyoming.?

Q. I keep hearing about the "coverage gap" in states that are not expanding Medicaid. Can you explain what that means and who it affects?

A: We'll get into the details below, but the short answer is that people with income below the poverty level are not eligible for the Affordable Care Act's (ACA) premium tax credits (premium subsidies), and if they're in a state that has refused to expand Medicaid eligibility under the ACA, they may not be eligible for Medicaid either. That leaves them in a situation in which they're living in poverty but also ineligible for financial assistance with their health insurance.

To clarify, the coverage gap is currently only a problem in 11 states, and it's entirely caused by those states' decision to not expand Medicaid. The ACA did not create any sort of coverage gap; it was purposely designed to ensure that there would be no coverage gaps for low-income Americans, even for recent immigrants (as long as they're lawfully present in the US).

Now, for the details:

When the Affordable Care Act was written, a cornerstone of the legislation was the expansion of Medicaid to adults under age 65 with household incomes up to 138% of federal poverty level/FPL. (Note that children were already eligible for Medicaid with household income above that threshold; different Medicaid eligibility rules exist for people aged 65 and older, including both income and asset limits.)

Technically the law expands Medicaid for adults to 133% of FPL (states can also opt to set a higher threshold), but the legislation includes an income calculation methodology that disregards the top five percentage points, so a household can have an income of up to 138% of FPL and still qualify for expanded Medicaid, since the 5% disregard brings their income down to 133% of FPL.

Originally, the law required states to expand Medicaid to continue to receive federal Medicaid funding. But very little of the total burden was placed on the states: The federal government paid the full cost of Medicaid expansion for the first three years (2014 through 2016), and then the states began to pay a small portion, ramping up to 10% by 2020 and remaining at that level going forward.

The federal government will always pay at least 90% of the cost of covering the newly eligible population, assuming the ACA remains in place. And states that newly expand Medicaid after the spring of 2021 are able to receive even more federal Medicaid funding for two years, as a result of the American Rescue Plan (described in more detail below).

Expansion is optional, and some states continue to say no

But in 2012, the Supreme Court, while upholding the rest of the ACA, struck down the Medicaid expansion requirement, leaving it up to each state to decide whether to participate. As of late 2022, 38 states plus the District of Columbia had expanded Medicaid. South Dakota will join them as of July 2023, under the terms of a ballot measure those voters approved in the 2022 election.

There are still 12 states where Medicaid eligibility has not been expanded under the ACA (this will be 11 once South Dakota's Medicaid expansion takes effect), although Wisconsin has a unique situation and does not have a coverage gap: Wisconsin essentially implemented a partial Medicaid expansion — without the enhanced federal funding they'd receive if they fully expanded Medicaid. So there is still a coverage gap in 11 states: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota (until July 2023), Tennessee, Texas, and Wyoming.

But Medicaid expansion continues to slowly spread across the remaining states, as we knew it would. Voters in Oklahoma and Missouri approved Medicaid expansion ballot measures in 2020, so Medicaid expansion just took effect in those two states in 2021. And as noted above, the same thing happened in South Dakota in the 2022 election, paving the way for Medicaid expansion in that state by mid-2023. North Carolina is also a state to watch for Medicaid expansion, as the legislature came close to agreeing on an expansion plan in 2022 and is expected to reconsider this in 2023.

American Rescue Plan provides additional funding to entice holdout states to expand Medicaid

The American Rescue Plan (ARP), enacted in March 2021, provides two years of additional federal funding for states that newly expand Medicaid. The federal government already pays 90% of the cost of covering the population that's eligible due to the ACA's expansion of Medicaid, but it pays a varying percentage of the cost of covering each state's additional Medicaid population — normally ranging from 50% to about 75%.

Due to the COVID pandemic, the federal government has already given states an extra 6.2% in federal matching funds. And if any of the remaining states expand Medicaid, the ARP will give them an additional 5% in federal matching funds for two years. Some of the holdout states have actively considered Medicaid expansion as a result, despite years of rejecting it.

But as of late 2022, a year and a half after the ARP was enacted, only Oklahoma and Missouri had expanded coverage (both are receiving the additional ARP funding as a result), and they both had already scheduled Medicaid expansion to take effect in

2021, with the process already underway before the ARP was enacted. South Dakota will join them as of the summer of 2023, but is also only doing so because voters passed a ballot measure; the state legislature did not make the choice to expand Medicaid to take advantage of the additional federal funding.

Medicaid eligibility varies depending on where you live

In the states where Medicaid eligibility has been expanded, adults under the age of 65 (who meet the immigration status requirements) are eligible for Medicaid with a household income up to 138% of FPL are eligible for Medicaid. (Note that Washington, D.C. has a higher income cap for Medicaid eligibility, at 215% of the poverty level. And Connecticut offers Medicaid to parents of minor children with household income up to 160% of the poverty level).

But in the states that have not expanded Medicaid, eligibility is still based on pre-ACA guidelines. In most cases, that means Medicaid is only available to people with disabilities, low-income children and pregnant women, and extremely low-income parents. In Alabama, for example, Medicaid is available for parents with a household income of up to 18% of FPL (13% plus the 5% income disregard). For a family of three, that's $4,145 in *annual* income in 2022. If the family's income exceeds that amount, the parents would not qualify for Medicaid.

And Medicaid is generally not available at all to childless adults in states not expanding Medicaid, regardless of how low their income is. (This chart has income limits for Medicaid in each state, and contact information for each state's Medicaid Department is available here.)

The coverage gap: No realistic access to health insurance

The "coverage gap" exists because the ACA's premium tax credits (premium subsidies) are only available for people with a household income of *at least* 100% of FPL, up to 400% of FPL. (Note that the American Rescue Plan has eliminated the upper income limit for premium subsidy eligibility, and the Inflation Reduction Act extended that provision through 2025.)

Premium subsidies are not available below 100% of FPL, because when the ACA was written, Medicaid expansion was an integral part of the law: It was assumed that subsidies would not be needed below 100% of FPL, since Medicaid would be available instead.

So in states that are not expanding Medicaid, virtually all non-disabled childless adults with incomes below 100% of FPL, as well as a large number of parents with incomes below 100% of FPL, are not eligible for any financial assistance to help them afford health insurance. Premium subsidies are not available to them through the exchange/marketplace, and they don't qualify for Medicaid unless they meet the stringent existing guidelines.

According to Kaiser Family Foundation data, there are about 2.2 million people in the coverage gap across the 11 states that have not expanded Medicaid.

The majority of the people in the coverage gap are in Texas, North Carolina, Florida, and Georgia — more than 1.6 million of the people in the coverage gap are in those four states.

Households with incomes below 100% of FPL generally cannot afford to pay full price for health insurance. In most cases, they will remain uninsured, simply because they have no other alternatives. Unfortunately, this disproportionately impacts people of color, particularly in the southern United States where almost all of the states have maintained their pre-ACA Medicaid eligibility guidelines.

Possible solutions if you're in the coverage gap

If you're in the coverage gap, Medicaid isn't available, and ACA-compliant coverage can only be purchased at full price – generally an unrealistic option, given that everyone in the coverage gap has an income below the poverty level. There are a few possible solutions, not all of which are adequate or realistic:

For coverage

- Read this article, about strategies for avoiding the coverage gap.

- You could move to a state that has expanded Medicaid, but that may be easier said than done for people with low-wage jobs, few assets, and few prospects elsewhere.

- You could increase your income to at least the federal poverty level (FPL), in order to obtain subsidized health coverage (if that happens mid-year, you'll qualify for a special enrollment period during which you can enroll in a subsidized plan). Again, this is easier said than done depending on one's circumstances. Navigators have been invaluable in helping poor people tally up income from varied sources in order to get their total income up to the poverty level, where subsidies become available.

- You can purchase a non-ACA compliant plan, which includes things like short-term health insurance, accident supplements, critical illness coverage, discount plans, direct primary care plans, or health care sharing ministry plans. Although in most cases – with the exception of short-term insurance and health care sharing ministries – these were never intended to be stand-alone coverage, and some are not regulated by state insurance departments or subject to state/federal insurance laws.

For care

- Free clinics and federally funded community health centers provide a wide range of preventive and primary care services for people in the coverage gap. More than a million low-income, uninsured Americans rely on community health centers that offer care on a sliding fee scale. And the ACA provided funding to increase the number of community health centers across the country. For many in the coverage gap, a community health center is their only realistic access to care, although treatment is limited to primary care.

- You can rely on EMTALA for emergency situations. Emergency departments cannot turn patients away due to inability to pay. However, emergency departments are only required to stabilize patients; there's no provision for ongoing treatment under EMTALA. And the emergency department can still send you a bill that can be sent to collections if it’s not paid (they cannot, however, withhold future emergency stabilization treatment due to past-due prior bills).

HEALTH INSURANCE and AFRICAN AMERICANS

Health Insurance and African Americans

The Black adult uninsured rate dropped from 24.4 percent in 2013 to a low of 13.7 percent in 2016, before rising slightly to 14.2 percent in 2019. The Latinx/Hispanic uninsured rate decreased from 40.2 percent in 2013 to a low of 24.9 percent in 2018 but has since edged upward to 25.7 percent in 2019 (Table 1).Jun 9, 2021

Health Coverage by Race and Ethnicity, 2010-2021 | KFF

Summary

Health coverage plays a major role in enabling people to access health care and protecting families from high medical costs. People of color have faced longstanding disparities in health coverage that contribute to disparities in health. This brief examines trends in health coverage by race/ethnicity from 2010 through 2021 and discusses the implications for health disparities. All noted differences between groups and years described in the text are statistically significant at the p<0.05 level. It is based on KFF analysis of American Community Survey (ACS) data for the nonelderly population.

Following several years of rising uninsured rates during the Trump Administration, there were small gains in coverage across most racial/ethnic groups between 2019 and 2021.
The coverage gains between 2019 and 2021 were largely driven by increases in Medicaid coverage, reflecting policies to stabilize and expand access to affordable coverage that were implemented during the COVID-19 pandemic, including a requirement that states keep Medicaid enrollees continuously enrolled during the public health emergency (PHE). These coverage gains helped narrow percentage point differences in uninsured rates between people of color and White people.

Despite these coverage gains, disparities in coverage persisted as of 2021.
Nonelderly American Indian and Alaska Native (AIAN) and Hispanic people had the highest uninsured rates at 21.2% and 19.0%, respectively as of 2021. Uninsured rates for nonelderly Native Hawaiian and Other Pacific Islander (NHOPI) and Black people (10.8% and 10.9%, respectively) also were higher than the rate for their White counterparts (7.2%). Coverage

disparities have persisted over time despite these recent gains and large earlier gains in coverage under the Affordable Care Act (ACA). For example, between 2010 and 2021, the uninsured rate for AIAN people grew from 2.5 to 2.9 times higher than the uninsured rate for White people, the Hispanic uninsured rate remained over 2.5 times higher than the rate for White people, and Black people remained 1.5 times more likely to be uninsured than White people.

Uninsured rates in states that have not expanded Medicaid are nearly twice as high as rates in expansion states for nonelderly White, Black, Hispanic, and Asian people as of 2021.
Most racial/ethnic groups are more likely to be uninsured in non-expansion states compared to expansion states, and the gaps in coverage rates between Black and Hispanic people and White people are larger in non-expansion states compared with expansion states. However, the relative risk of being uninsured for people of color compared to White people is similar in expansion and non-expansion states.

The ongoing gaps in coverage for people of color and the direction that coverage moves in going forward has implications for people's access to care and overall health and well-being and broader disparities in health and health care.
Looking ahead, the end of the PHE may contribute to disproportionate coverage declines among people of color, which could further widen the coverage gaps they already face, and, in turn, exacerbate broader disparities in health and health care. As such, efforts to prevent coverage losses and further close coverage disparities are an important component of efforts to address longstanding racial disparities in health. However, to advance health equity, it also will be important to address other inequities within the health care system as well as inequities across the broad range of social and economic factors that drive health.

Trends in Uninsured Rates by Race/Ethnicity, 2010-2021

Prior to the enactment of the ACA in 2010, people of color were at much higher risk of being uninsured compared to White people, with Hispanic and AIAN people at the highest risk of lacking coverage (Figure 1).
The higher uninsured rates among people of color reflected more limited access to affordable health coverage options. Although the majority of individuals have at least one full-time worker in the family across racial and ethnic groups, people of color are more likely to live in

low-income families that do not have coverage offered by an employer or to have difficulty affording private coverage when it is available. While Medicaid helped fill some of this gap in private coverage, prior to the ACA, Medicaid eligibility for parents was limited to those with very low incomes (often below 50% of the poverty level), and adults without dependent children—regardless of how poor—were ineligible under federal rules.

Between 2010 and 2016, there were large gains in coverage across racial/ethnic groups under the ACA, but people of color remained more likely to be uninsured.

The ACA created new coverage options for low- and moderate-income individuals. These included provisions to extend dependent coverage in the private market up to age 26 and prevent insurers from denying people coverage or charging them more due to health status that went into place. Further, beginning in 2014, the ACA expanded Medicaid coverage to nearly all adults with incomes at or below 138% of poverty in states that adopted the expansion and made tax credits available to people with incomes up to 400% of poverty to purchase coverage through a health insurance Marketplace. Following the ACA's enactment in 2010 through 2016, coverage increased across all racial/ethnic groups, with the largest increases occurring after implementation of the Medicaid and Marketplace coverage expansions in 2014. Nonelderly Hispanic people had the largest percentage point increase in coverage, with their uninsured rate falling from 32.6% to 19.1%. Nonelderly Black, Asian, and AIAN people also had larger percentage point increases in coverage compared to White people over that period. Despite these larger gains, nonelderly AIAN, Hispanic, Black, and NHOPI people remained more likely than their White counterparts to be uninsured as of 2016.

Beginning in 2017, coverage gains began reversing, and the number of uninsured increased for three consecutive years.

The uninsured rate for the total nonelderly population increased from 10.0% in 2016 to 10.9% in 2019. Nonelderly Hispanic people had the largest statistically significant increase in their uninsured rate over this period (from 19.1% to 20.0%). There were also small but statistically significant increases in the uninsured rates among nonelderly White and Black people, which rose from 7.1% to 7.8% and 10.7% to 11.4%, respectively, between 2016 and 2019. Rates for nonelderly AIAN, NHOPI, and Asian people did not have a significant change. These coverage losses likely reflected policy changes made by the Trump Administration after taking office in 2017 that reduced access to and enrollment in coverage. These changes included decreased funds for outreach and enrollment assistance, guidance encouraging states to seek waivers to add new eligibility requirements for Medicaid coverage, and changes to public charge immigration policy that made some immigrant families more reluctant to participate in Medicaid and the Children's Health Insurance Program (CHIP).

After increasing for several years prior to the pandemic, uninsured rates declined between 2019 and 2021.

Nearly 1.5 million nonelderly people gained coverage between 2019 and 2021 as the uninsured rate dropped from 10.9% to 10.2%. (Because of disruptions in data collection during the first year of the pandemic, the Census Bureau did not release 1-year ACS estimates in 2020.) Hispanic people had the largest percentage point increase in coverage, with their uninsured rate falling from 20.0% in 2019 to 19.0% in 2021. There were also smaller but statistically significant declines in uninsured rates among Asian people (from 7.2% to 6.4%), Black people (from 11.4% to 10.9%), and White people (from 7.8% to 7.2%) during this period. These coverage gains were primarily driven by increases in Medicaid coverage, which offset declines in employer-sponsored coverage over the period. AIAN and NHOPI people did not have statistically significant changes in coverage over this period.

The coverage gains between 2019 and 2021 largely reflect policies adopted during the pandemic to stabilize coverage in Medicaid and enhance subsidies to purchase Marketplace coverage.

Specifically, provisions in the Families First Coronavirus Response Act (FFCRA), enacted at the start of the pandemic, prohibit states from disenrolling people from Medicaid until the month after the COVID-19 PHE ends in exchange for enhanced federal funding. Coverage gains also likely reflected enhanced ACA Marketplace subsidies made available by the American Rescue Plan Act (ARPA) and renewed for another three years in the Inflation Reduction Act of 2022 (IRA), boosted outreach and enrollment efforts, a Special Enrollment Period for the Marketplaces provided in response to the pandemic, and low Marketplace attrition, Additionally, in 2019, the Biden Administration reversed changes the Trump Administration previously made to public charge immigration policies that had increased reluctance among some immigrant families to enroll in public programs, including health coverage.

Coverage by Race and Ethnicity as of 2021

As of 2021, nonelderly AIAN, Hispanic, NHOPI, and Black people continued to face coverage disparities (Figure 2).

Nonelderly AIAN and Hispanic people had the highest uninsured rates at 21.2% and 19.0%, respectively as of 2021. Uninsured rates for nonelderly NHOPI and Black people (10.8 and

10.9%, respectively) also were higher than the rate for their White counterparts (7.2%). Coverage disparities have persisted over time even with recent gains and the large earlier gains in coverage under the ACA. For example, between 2010 and 2021, the uninsured rate for AIAN people grew from 2.5 to 2.9 times higher than the uninsured rate for White people, the Hispanic uninsured rate remained over 2.5 times higher than the rate for White people, and Black people remained 1.5 times more likely to be uninsured than White people.

Medicaid and CHIP coverage help fill gaps in private coverage and reduce coverage disparities for children, but some disparities in children's coverage remain (Figure 2). Medicaid and CHIP cover larger shares of children than adults, reflecting more expansive eligibility levels for children. This coverage helps fill gaps in private coverage, particularly for children of color, with over half of Black, Hispanic, AIAN, and NHOPI children covered by Medicaid and CHIP. However, there remain some disparities in children's coverage. For example, AIAN children are over three times as likely as their White counterparts to lack coverage, with 13.2% of AIAN children uninsured compared with 4.0% of White children. Moreover, Hispanic children are over twice as likely as White children to be uninsured (8.6% vs. 4.0%).

Among the total nonelderly population, uninsured rates in states that have not expanded Medicaid are nearly twice as high as rates in expansion states for nonelderly White, Black, Hispanic, and Asian people as of 2021 (Figure 3).
Most racial/ethnic groups are more likely to be uninsured in non-expansions states compared to expansion states. Further, the gaps in coverage rates between Black and Hispanic people and White people are larger in non-expansion states. However, the relative risk of being uninsured for people of color compared with White people is similar in expansion and non-expansion states. For example, nonelderly Hispanic people are roughly 2.5 times as likely as nonelderly White people to lack coverage in both expansion and non-expansion states. These differences in coverage by expansion status are primarily driven by differences in coverage rates among nonelderly adults. However, Hispanic, Black, Asian, and White children in non-expansion states also are more likely to be uninsured than those in expansion states. For example, 13.7% of Hispanic children in non-expansion states are uninsured, compared to 5.9% of Hispanic children in expansion states.

There are opportunities to increase coverage by enrolling eligible people in Medicaid or Marketplace coverage, but eligibility varies across racial and ethnic groups, and many remain ineligible for assistance.

Prior to the pandemic, over half of the nonelderly uninsured were eligible for financial assistance through Medicaid or the ACA Marketplaces. The ARPA, enacted in 2021, further increased access to subsidized health coverage through temporary increases and expansions in eligibility for subsidies to buy health insurance through the health insurance Marketplaces, which were extended under the IRA. While many nonelderly uninsured are eligible for health coverage assistance, some remain ineligible because their state did not expand Medicaid, they do not have access to an affordable Marketplace plan or offer of employer coverage, or due to their immigration status. Eligibility for coverage varies across racial and ethnic groups, reflecting differences in the share of people living in states that have not expanded Medicaid and sociodemographic differences. For example, uninsured nonelderly Black people are more likely than their White counterparts to fall in the Medicaid "coverage gap" because a greater share live in states that have not implemented the Medicaid expansion (Figure 4). As of November 2022, 11 states have not adopted the ACA provision to expand Medicaid to adults with incomes through 138% of poverty. In these states, adults with incomes under poverty fall in the "coverage gap" because they earn too much to qualify for Medicaid but not enough to qualify for ACA Marketplace premium subsidies.

Uninsured nonelderly Hispanic, NHOPI, and Asian people are less likely than their White counterparts to be eligible for coverage because they include larger shares of noncitizens who are subject to eligibility restrictions for Medicaid and Marketplace coverage (Figure 5). Lawfully present immigrants face eligibility restrictions for Medicaid coverage, with many having to wait five years after obtaining lawful status before they may enroll in Medicaid. Undocumented immigrants are not eligible to enroll in Medicaid and are prohibited from purchasing coverage through the Marketplaces.

Looking Ahead

Policies implemented amid the COVID-19 pandemic have helped to stabilize coverage and contributed to gains in coverage. The coverage gains experienced amid the COVID-19 pandemic were largely driven by an increase in Medicaid coverage, which offset declines in employer-sponsored coverage. As noted, temporary continuous enrollment provisions have stabilized Medicaid coverage during the PHE, contributing to rises in enrollment. Additionally, the temporary increases and expansions in eligibility for subsidies to buy health insurance through the health insurance Marketplaces provided under ARPA, which were extended through 2025 under the IRA, have likely contributed to coverage gains. Enrollment in the Marketplaces has also reached a record high, following the availability of enhanced the subsidies, boosted outreach efforts, and an extended enrollment period. Analysis suggests that Marketplace enrollment increases between 2020 and 2022 were particularly large for Hispanic, Black and AIAN people. Even with these recent actions, gaps in coverage remain. Some uninsured individuals remain ineligible for assistance through Medicaid or the Marketplace subsidies, including immigrants who face eligibility restrictions for coverage.

Opportunities remain to increase coverage and narrow disparities by enrolling eligible people in Medicaid or Marketplace coverage, and these opportunities would increase if additional states adopted Medicaid expansion. Given that most uninsured people are eligible for Medicaid or Marketplace coverage, outreach and enrollment efforts could further increase coverage and potentially narrow coverage disparities. To assist with outreach and enrollment efforts, the Biden Administration increased funding for Navigators for the 2022 Open Enrollment Period, contributing to record levels of Marketplace enrollment in 2022, and has made an additional investment of $98.9 million in Navigator funding for the 2023 Open Enrollment Period. In addition, implementation of the Medicaid expansion in the remaining 11 states that have not yet expanded would further increase eligibility for coverage among the remaining uninsured for all groups, but disproportionately for Black people. ARPA included fiscal incentives for states that have not yet adopted the ACA Medicaid expansion to do so. However, it remains unclear, which if any remaining states will implement the Medicaid expansion. Data show that, if all remaining states expanded Medicaid, six in ten uninsured adults who would become eligible would be people of color. Research further shows that Medicaid expansion is associated with reductions in racial/ethnic disparities in health coverage as well as narrowed disparities in health outcomes for Black and Hispanic individuals, particularly for measures of maternal and infant health.

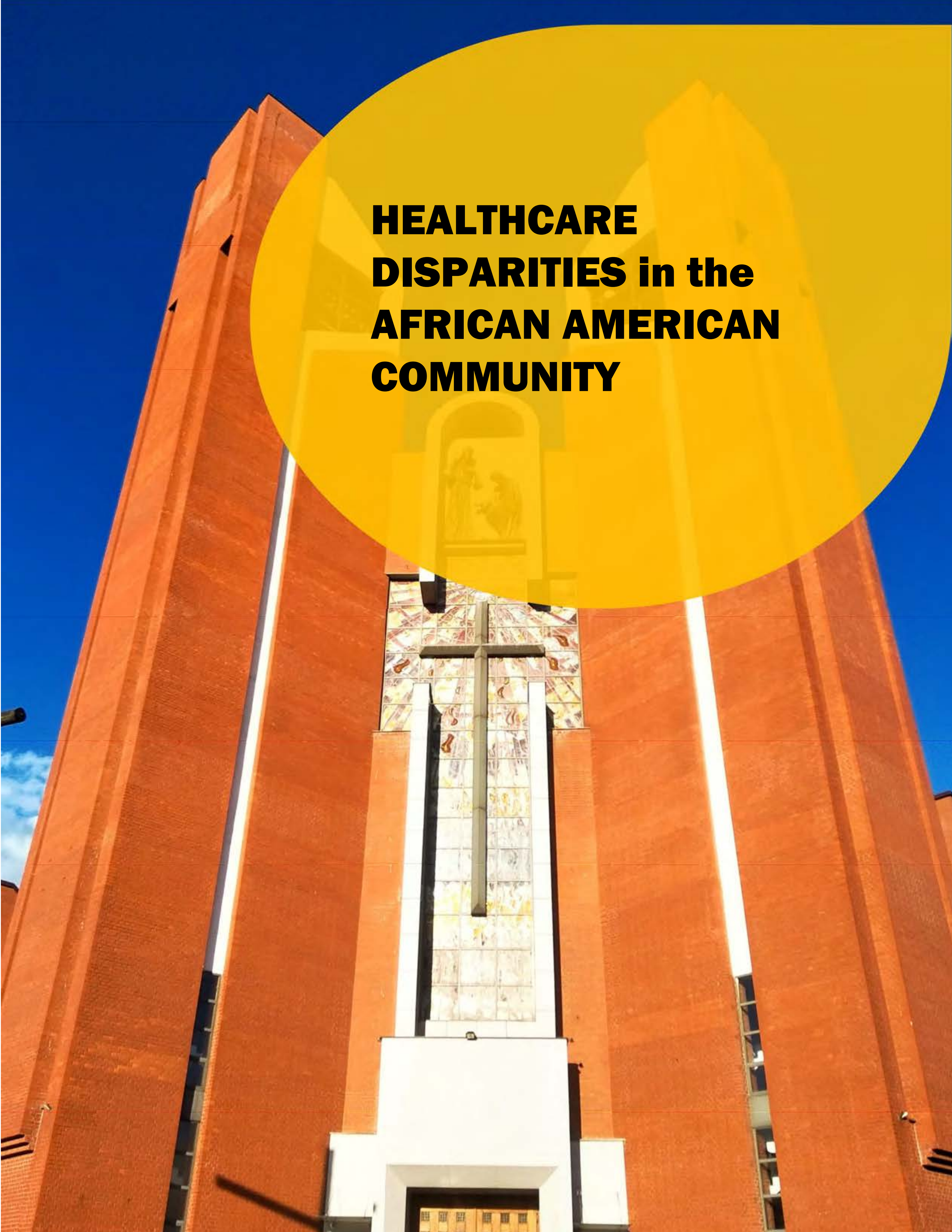
The end of the PHE may lead to coverage losses and widening disparities.

The Medicaid continuous enrollment requirement is tied to the PHE, which is in effect through mid-January 2023, although it is expected the PHE will be extended again because the Biden administration has said it will give states a 60-day notice before ending the PHE and that notice was not issued in November 2022. Once the PHE ends, states will resume Medicaid redeterminations and will disenroll people who are no longer eligible or who are unable to complete the renewal process even if they remain eligible. KFF estimates that between 5 and 14 million people could lose Medicaid coverage, including many who newly gained coverage in the past year. Other research shows that Hispanic and Black people are likely to be disproportionately impacted by the expiration of the continuous enrollment requirement. The enhanced Marketplace subsidies could act as a bridge between Medicaid and the ACA Marketplaces when the PHE ends and many people disenrolled from Medicaid could find low-cost coverage on the ACA Marketplaces, including, in some cases coverage with a zero (or near-zero) monthly premium requirement. However, because the enhanced subsidies are not permanent, future Marketplace enrollees may see steep premium increases when the subsidies eventually expire.

Preventing coverage losses and closing remaining gaps in coverage would help to address longstanding disparities in health, which have been exacerbated by the COVID-19 pandemic.

Research shows that having health insurance makes a key difference in whether, when, and where people get medical care and ultimately how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. Being uninsured can also have financial consequences, with many unable to pay their medical bills, resulting in medical debt. As such, future trends in coverage will have a significant impact on disparities in health access and use as well as health outcomes over the long-term. However, beyond coverage, it also will be important to address inequities across the broad range of other social and economic factors that drive health and to address other inequities within the health care system that lead to poorer quality of care and health outcomes for people of color as part of efforts to advance health equity.

HEALTHCARE DISPARITIES in the AFRICAN AMERICAN COMMUNITY



Health Care Disparities in the African American Community

Compared to their white counterparts, African Americans are generally at higher risk for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, and HIV/AIDS, according to the Office of Minority Health, part of the Department for Health and Human Services.

While the spotlight right now may be on the disadvantages African Americans face while fighting the novel coronavirus (COVID-19), they are also disadvantaged throughout the health care system when combating other diseases.

Compared to their white counterparts, African Americans are generally at higher risk for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, and HIV/AIDS, according to the Office of Minority Health, part of the Department for Health and Human Services.[1]

One possible contributing factor: The Centers for Disease Control and Prevention (CDC) says African Americans are more likely to die at early ages for all causes,[2] as young African Americans are living with diseases that are typically more common at older ages for other races. For example:

- High blood pressure is common in 12% vs. 10% of Black people vs. Whites aged 18-34 years, respectively. It is common in 33% vs. 22% of those aged 35-49 years, respectively.
- Diabetes is common in 10% of blacks aged 35-49 compared to 6% of whites.
- Stroke is present in 0.7% of blacks aged 18-34 compared to 0.4% of whites the same age. Stroke is common in 2% of African Americans compared to 1% of whites aged 35-49 and 7% vs. 4%, respectively, in those aged 50-64.

The CDC said that social factors compared to others in the U.S., specifically whites, affect African Americans at younger ages: unemployment, living in poverty, not owning a home, cost-prohibitive effects of trying to see an MD, smoking, inactive lifestyle, or obesity.

A white paper from Cigna went further, acknowledging mental health disparities between African Americans and white patients. They noted Black people are 20% more likely to report psychological distress and 50% less likely to receive counseling or mental health treatment due to the aforementioned underlying socioeconomic factors.[3]

Another area of health care there is a disparity is among renal disease. Blacks and African Americans can suffer from kidney failure at as much as 3 times the rate of Caucasians, according to the National Kidney Foundation.[4] Black patients represent as much of a third of all patients in the U.S. receiving dialysis for kidney failure, though they don't represent anywhere near that proportion of the U.S. population, they added. Individuals who are Black alone, the Office of Minority Health says, make up 12.7% of the U.S. population.

Cancer is another avenue for the differences in health outcomes between white and black Americans. The American Cancer Society said that for most cancers, African Americans have the highest death rate and shortest survival.[5] However, the overall cancer death rate has dropped faster in African American men and women compared to whites since 1990. They believe this has been driven by more rapid declines among black patients for lung, colorectal, and prostate cancers. This progress has narrowed the Black/White disparity for cancer mortality and they estimate almost half a million cancer deaths for black patients were avoided over the previous 25 years.

As noted, the emergence of the COVID-19 has added another spotlight on the health care disparities for Black Americans. African Americans are experiencing more serious illness and death from COVID-19 compared to white people, according to data from Johns Hopkins.[6]

Some minorities are being disproportionately affected by COVID-19, the CDC said, stemming from inequalities in health care access and poverty.[7] African Americans are experiencing 2.6 times higher cases, 4.7 times higher hospitalization rates, and 2.1 times more death from COVID-19 compared to white counterparts, the CDC said.[8] But to combat this harmful trend, Johns Hopkins suggested targeted messaging promoting social distancing and discouraging the stigma associated with COVID-19. Making testing available for those without primary care physicians or access to one is another important way to mitigate racial disparities in health care particularly in the context of COVID-19.

Notably, in 2017, 89% of African Americans had health care coverage compared to 93% of white Americans; 44% of African Americans had government health insurance that year.[9] Additionally, 12% of African Americans under the age of 65 reported having no health care coverage that year.[10]

Health care providers can also look at the race gap through the lens of mortality rates. The leading causes of deaths for African Americans have not changed from 1999 to 2015, the CDC said, but the rates have decreased. Heart disease deaths dropped 43% in that time period, cancer deaths dropped 29%, and stroke deaths were down 41%.

The American Heart Association said getting checked regularly and working with doctors to decrease risk factors can help take care of African Americans' heart health.[11] A 2017 statement from the American Heart Association said that disease management is less effective among this population which can contribute to higher mortality.[12] Clinicians and researchers from multiple disciplines can help promote equity in the cardiovascular health of African Americans, they said.

In order to help mitigate these health care disparities, a 2010 American College of Physicians position paper recommended,[13] among other things, strengthening health literacy among racial and ethnic minorities and creating cultural competency initiatives beginning in medical school for physicians and health care professionals.

Tuberculosis (TB)

In 2018, 87% of all reported TB cases occurred in racial and ethnic minorities. TB disease was reported in 1,799 non-Hispanic African Americans/Blacks in the United States, accounting for 20% of all people reported with TB disease nationally; this proportion is high considering non-Hispanic African Americans/Blacks make up approximately 13% of the U.S. population. While the rates of TB disease in non-Hispanic African Americans/Blacks have been cut in half (from 8.8 cases per 100,000 persons in 2008 compared to 4.4 in 2018) over the past decade, the rate of TB disease in non-Hispanic African Americans/Blacks is over eight times higher than the rate of TB disease in non-Hispanic whites (0.5 cases per 100,000 population). Overall, 9,025 TB cases were reported to CDC from the 50 states and the District of Columbia in 2018.

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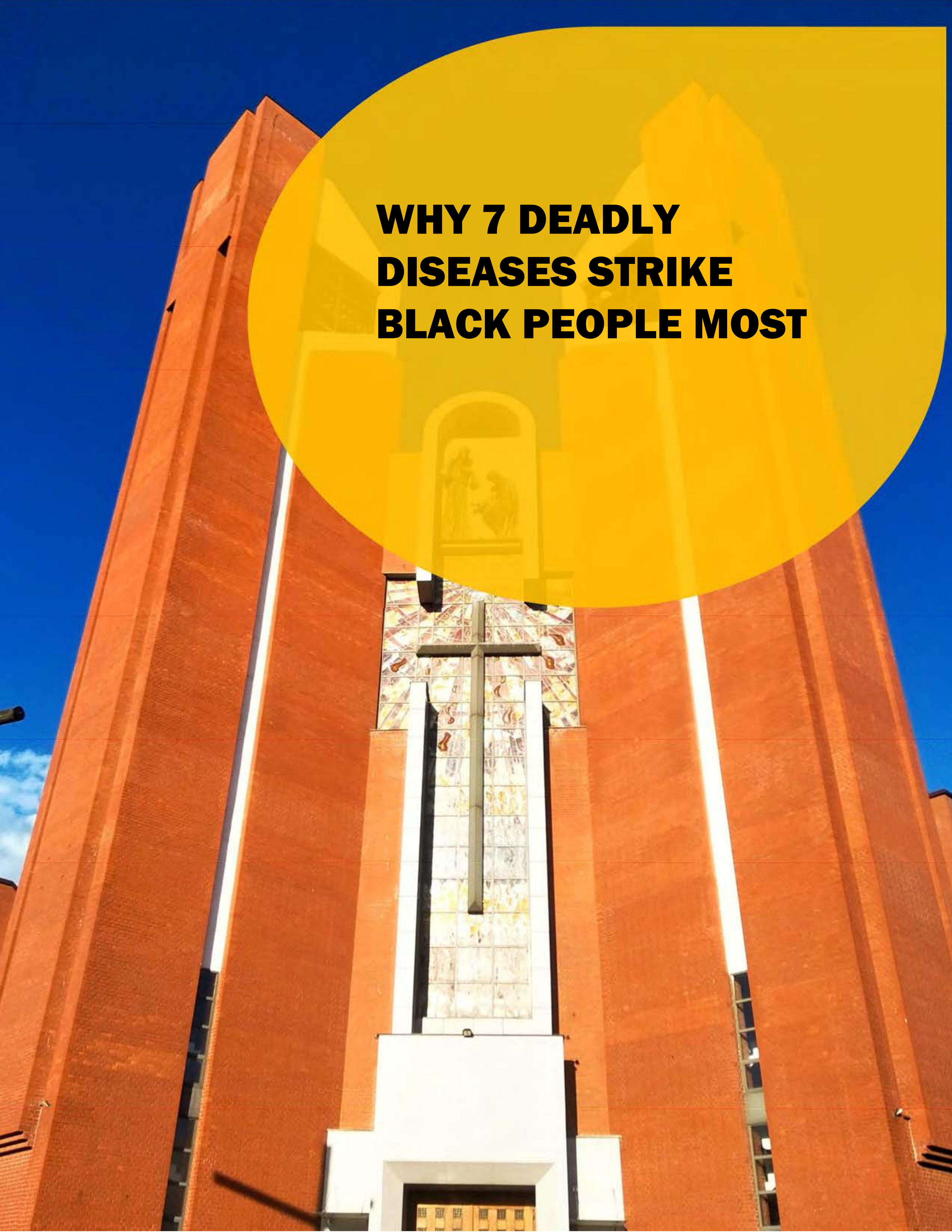


WHY 7 DEADLY DISEASES STRIKE BLACK PEOPLE MOST

Why 7 Deadly Diseases Strike Blacks Most

Health care disparities heighten disease differences between African Americans and white Americans.

Several deadly diseases strike Black Americans harder and more often than they do white Americans.

Fighting back means genetic research. It means changing the system for testing new drugs. It means improving health education. It means overcoming disparities in health care. It means investments targeted to the health of Black Americans. And the evidence so far indicates that these investments will pay health dividends not just for racial minorities, but for everyone.

Yet we're closer to the beginning of the fight than to the end. Some numbers:

- Diabetes is 60% more common in Black Americans than in White Americans. Blacks are up to 2.5 times more likely to suffer a limb amputation and up to 5.6 times more likely to suffer kidney disease than other people with diabetes.
- African Americans are three times more likely to die of asthma than white Americans.
- Deaths from lung scarring -- sarcoidosis -- are 16 times more common among blacks than among whites. The disease recently killed former NFL star Reggie White at age 43.
- Despite lower tobacco exposure, black men are 50% more likely than white men to get lung cancer.
- Strokes kill four times more 35- to 54-year-old Black Americans than white Americans. Black people have nearly twice the first-time stroke risk of whites.
- Blacks develop high blood pressure earlier in life -- and with much higher blood pressure levels -- than whites. Nearly 42% of black men and more than 45% of black women aged 20 and older have high blood pressure.
- Cancer treatment is equally successful for all races. Yet Black men have a 40% higher cancer death rate than white men. African American women have a 20% higher cancer death rate than white women.

Why?

Genes definitely play a role. So does the environment in which people live, socioeconomic status -- and, yes, racism, says Clyde W. Yancy, MD, associate dean of clinical affairs and medical director for heart failure/transplantation at the University of Texas Southwestern Medical Center.

Yancy says that all humans have the same physiology, are vulnerable to the same illnesses, and respond to the same medicines. Naturally, diseases and responses to treatment do vary from person to person. But, he says, there are unique issues that affect Black Americans.

"We must recognize there are some arbitrary issues that are present in the way we practice medicine and dole out health care," Yancy tells WebMD. "It forces us to think very carefully about the very volatile issue of race and what race means. At the end of the day, all of us acknowledge that race is an extremely poor physiological construct. Race is a placeholder for something else.

That something is less likely to be genetic. It is more likely to have to do with socioeconomics and political issues of bias as well as physiologic and genetic issues that go into that same bucket. Some racial differences are more nuances. But there are issues of disparity and there are issues relative to racism that operate in a very broad context."

Like Yancy, LeRoy M. Graham Jr., MD, says the time is ripe for Americans to come to grips with these issues. Graham, a pediatric lung expert, serves on the American Lung Association's board of directors, is associate clinical professor of pediatrics at Morehouse School of Medicine in Atlanta, and serves as staff physician for Children's Healthcare of Atlanta.

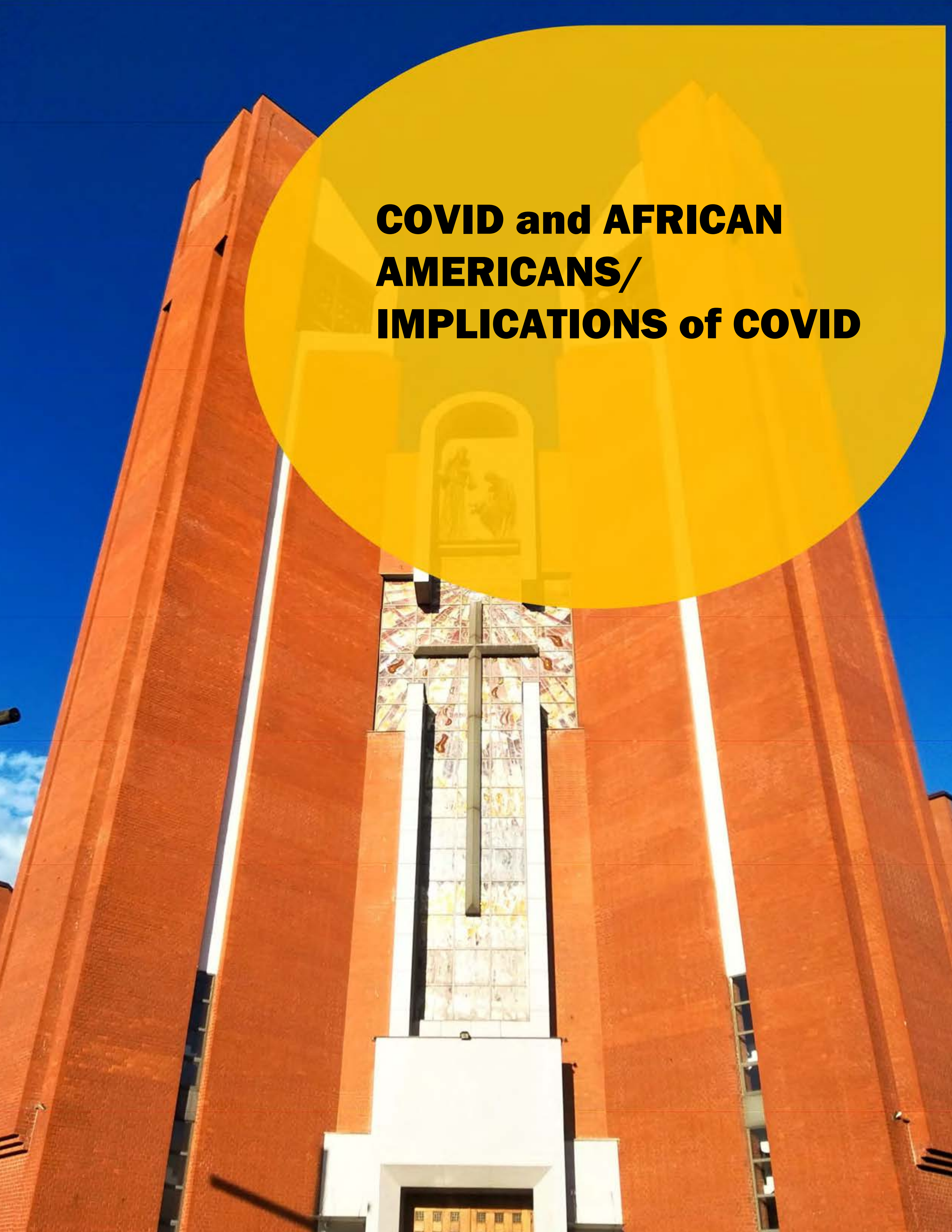
"I just think we as physicians need to get more impassioned," Graham tells WebMD. "There are health disparities. There are things that may have more sinister origins in institutionalized racism. But we as doctors need to spend more time recognizing these disparities and addressing them -- together with our patients -- on a very individual level."

Black Americans and Lung Disease

A 2005 report from the American Lung Association shows that black Americans suffer far more lung disease than white Americans do.

Some of the findings:

- Black Americans have more asthma than any racial or ethnic group in America. And blacks are 3 times more likely to die of asthma than whites.
- Black Americans are 3 times more likely to suffer sarcoidosis than white Americans. The lung-scarring disease is 16 times more deadly for blacks than for whites.
- Black American children are 3 times as likely as white American children to have sleep apnea.
- Black American babies die of sudden infant death syndrome (SIDS) 2.5 times as often as white American babies.
- Black American men are 50% more likely to get lung cancer than white American men.
- Black Americans are half as likely to get flu and pneumonia vaccinations as white Americans.



COVID and AFRICAN AMERICANS/ IMPLICATIONS of COVID

COVID and African Americans/Implications of COVID

COVID IS NOT OVER FOR THE AFRICAN AMERICAN COMMUNITY: SAYS THE CDC

COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time

Over the course of the COVID-19 pandemic, analyses of federal, state, and local data have shown that people of color have experienced a disproportionate burden of cases and deaths. This brief examines racial disparities in COVID-19 cases and deaths and how they have changed over time based on KFF analysis of data on COVID-19 infections and deaths from CDC. It updates a February 2022 analysis to reflect data through mid-2022, amid the ongoing surge associated with the Omicron variant. It finds:

- Total cumulative data show Black, Hispanic, American Indian or Alaska Native (AIAN), and Native Hawaiian or Other Pacific Islander (NHOPI) people have experienced higher rates of COVID-19 cases and deaths compared to White people when data are adjusted to account for differences in age by race and ethnicity.
- Disparities in infections and deaths have both widened and narrowed at various times over the course of the pandemic, with disparities generally widening during periods in which the virus has surged and narrowing when overall infection rates fall. In data that has not been adjusted for age, there were some periods when death rates for White people were higher than or similar to some groups of color. However, in the age-adjusted data, White people have lower death rates than AIAN, Black, and Hispanic people over most of the course of the pandemic and disparities are larger for AIAN, Black, and Hispanic people, reflecting an older White population and higher rates of death across all age groups among people of color compared to White people.

Continuing to assess COVID-19 health impacts by race/ethnicity is important for both identifying and addressing disparities and preventing against further widening of disparities in health going forward. While disparities in cases and deaths have narrowed and widened over time, the underlying structural inequities in health and health care and social and economic factors that placed people of color at increased risk at the outset of the pandemic remain. As such, they may remain at increased risk as the pandemic continues to evolve and for future health threats, such as the Monkeypox virus, for which early data show similar disparities emerging.

Disparities in Total COVID-19 Cases and Deaths

As of August 5, 2022, the Centers for Disease Control and Prevention (CDC) reported a total of over 84 million cases, for which race/ethnicity was known for 65% or over 55 million, and a total of over 880,000 deaths, for which race/ethnicity was known for 85% or over 750,000. These estimates are based on a subset of data for which case-level demographic information has been reported to CDC by state health departments, so they differ from those reported elsewhere. For example, CDC reports a total of over 1 million deaths from COVID as of August 5, 2022. Data on cases also are likely significantly underreported as they do not reflect individuals who test positive on home tests and do not report findings to their public health agency.

Total cumulative data show that Black, Hispanic, AIAN, and NHOPI people have experienced higher rates of COVID-19 cases and deaths than White people when data are adjusted to account for differences in age by race and ethnicity. Age-standardized data show that that NHOPI, Hispanic, and AIAN people are at about one and a half times greater risk of COVID-19 infection than White people, and AIAN, Hispanic, NHOPI, and Black people are about twice as likely to die from COVID-19 as their White counterparts (Figure 1). The CDC also reports large disparities in COVID-19 hospitalizations for AIAN, Black, and Hispanic people. (CDC data does not include separate reporting for NHOPI people.) Adjusting for age when comparing groups on health measures is important because risk of infection, illness, and death can vary by age, and age distribution differs by racial and ethnic group. Age adjustment allows for direct comparison between groups on health measures independent of the age distribution differences. For example, unadjusted rates underestimate racial disparities for COVID-19 deaths, since the White population is older compared to populations of color and COVID-19 death rates have been higher among older individuals. Age adjustment has limited impact on case rates by race and ethnicity, suggesting that age plays a more limited role in risk of infection.

Disparities in Cases and Deaths Over Time

Analysis of monthly data on COVID-19 infections from CDC and deaths from NCHS shows disparities in infections and deaths have both widened and narrowed over the course of the pandemic. During periods in which the virus has surged, disparities have generally widened, while they have narrowed when overall infection rates fall. However, over the course of the pandemic, specific patterns of disparities have varied by race and ethnicity and between cases and deaths.

Trends in Cases

Figure 2 shows age-adjusted monthly data on cases by race and ethnicity between April 2020 and July 2022. There were no notable differences in patterns of disparities between unadjusted and age-adjusted data for reported cases. The data show that during periods of resurgence, disparities have generally widened for people of color compared to White people, while they have narrowed when overall infection rates fall.

- Early in the pandemic Hispanic, AIAN, and Black people had higher rates of COVID-19 cases compared to their White counterparts, with a particularly high rate among Hispanic people. Asian people had the lowest monthly infection rate.
- Case rates increased through Winter 2021, spiking in December 2021, and disparities further widened for Hispanic and AIAN people. Following the spike in December 2021, monthly infection rates fell across all groups. By June 2021, gaps between groups narrowed.
- By August 2021, infection rates rose again across groups, reflecting the spread of the Delta variant, with higher rates for Black and AIAN people compared to White people during this resurgence.
- During January 2022, infections sharply rose again across all groups amidst the spread of the Omicron variant, resulting in the highest case rates recorded since the start of the pandemic. Rates were higher for all groups of color compared to White people, with AIAN people having the highest infection rate during this surge, followed closely by Hispanic people. This surge was also the first time since early in the pandemic that the infection rate for Asian people was comparable to other groups of color. By February 2022, infection rates had fallen sharply, and disparities once again narrowed.
- Between Winter 2022 and June 2022 case rates have fallen across groups. In April, Asian people had the highest infection rate and Black, AIAN and Hispanic people had the lowest infection rate, marking the first time these patterns were observed since the start of the pandemic. More research is needed to understand the factors that contributed to this recent shift in trends. However, by June 2022, this pattern began to reverse with White people having the lowest infection rate, and Hispanic people at highest risk of infection in June and July.

Trends in Deaths

Figure 3 presents age-adjusted monthly data on COVID-19 deaths by race and ethnicity between April 2020 and May 2022. Both the unadjusted and age-adjusted data show large disparities in death rates for people of color during surges in the pandemic, with the highest rates among AIAN people for most of the pandemic. In unadjusted data, there were some periods when death rates for White people were higher than or similar to some groups of color. However, in the age-adjusted data, White people have lower death rates than AIAN, Black, and Hispanic people over most of the course of the pandemic and disparities are larger for AIAN, Black, and Hispanic people, reflecting an older White population and higher rates of death across all age groups among people of color compared to White people.

- During the initial surge in summer 2020, AIAN, Hispanic, and Black people experienced higher rates of death than White people. As of July 2020, Hispanic people were five times more likely to die than White people, while AIAN and Black people were roughly four and three times as likely to die than White people, respectively. Asian people were at a similar risk of death as White people.
- Deaths peaked in December 2020 and January 2021 across groups. AIAN and Hispanic people had the highest rates of death, and all groups of color had a higher death rate than White people as of January 2021. Following that surge, death rates fell across all racial and ethnic groups and disparities narrowed by early summer 2021.
- Moving into late summer 2021, amid the rise of the Delta variant, death rates rose and were highest among AIAN people. Black and Hispanic people had higher death rates than White people, while Asian people had the lowest rate of death Following the Delta surge, monthly deaths declined slightly across groups with higher rates of death for AIAN people persisting before climbing again across groups in late 2021 with the arrival of the Omicron variant.
- As of January 2022, during the Omicron surge, Black, AIAN, and Hispanic people experienced the highest rates of death (36.5, 33.1, and 29.4 per 100,000 population, respectively). Following the spike in early 2022, monthly death rates fell across all groups and gaps between groups narrowed with similar rates of death across all groups (2.4 per 100,000 for AIAN and White people, 2.0 per 100,000 for Black people, 1.5
- per 100,000 for Hispanic people, and 1.4 per 100,000 for Asian people.)

Discussion

In sum, these data show that, overall, Black, Hispanic, and AIAN people have experienced higher rates of COVID-19 infection and death compared to White people when accounting for age differences across racial and ethnic groups. The age-adjusted data also suggest that while these disparities have narrowed at times over the course of the pandemic, people of color are disproportionately impacted by surges caused by new variants, with disparities widening during these periods.

The higher rates of infection among people of color likely reflect increased exposure risk due to working, living, and transportation situations, including being more likely to work in jobs that cannot be done remotely, to live in larger households, and to rely on public transportation. Black, Hispanic, and AIAN people have experienced the highest age-adjusted death rates amid each resurgence period, reflecting higher rates of death across all age groups among people of color compared to White people and an older White population. Overall, death rates have decreased across groups over the course of the pandemic as vaccination rates have increased and vaccination – particularly with boosters – continues to be highly effective at reducing the risk of hospitalization and death. Early disparities in vaccination rates by race and ethnicity have also narrowed over time. However, data suggest potential disparities in access to COVID-19 treatments, which will be important to monitor going forward.

Looking ahead, continuing to assess COVID-19 health impacts by race/ethnicity is important for both identifying and addressing disparities and preventing against further widening of disparities in health going forward. While disparities in cases and deaths have narrowed and widened during different periods over time, the underlying structural inequities in health and health care and social and economic factors that placed people of color at increased risk at the outset of the pandemic remain. As such, they may remain at increased risk as the pandemic continues to evolve and for future health threats, such as the Monkeypox virus, for which early data show similar disparities emerging.

Methods

This analysis uses data from multiple sources including the Centers for Disease Control and Prevention (CDC) COVID Data Tracker, the Centers for Disease Control and Prevention COVID-19 Response. COVID-19 Case Surveillance Data, the National Center for Health Statistics (NCHS) Provisional COVID-19 Deaths, and the Census Bureau Annual Estimates of the Resident Population. Unless otherwise noted, race/ethnicity was categorized by non-Hispanic White (White), non-Hispanic Black (Black), Hispanic, non-Hispanic American Indian and Alaska Native (AIAN), non-Hispanic Asian (Asian), and non-Hispanic Native Hawaiian or Other Pacific Islander (NHOPI).

Data on COVID-19 infections includes reported cases as of August 1, 2022 and data on COVID-19 deaths includes provisional deaths as of July 30, 2022 where race/ethnicity was available. Age-adjusted infection and death rates were standardized to the 2019 U.S. Census Bureau Annual Estimates of the Resident Population using the direct method of standardization. The direct method of age standardization is calculated by multiplying the age specific crude rates for each population by the appropriate weight in standard population and summing them to produce an age-standardized rate. Data for monthly age adjusted NHOPI cases and deaths not shown due to small number of observations. Age standardization allows for direct comparison of groups on health measures independent of differences in age distribution that may influence the measure being examined.

NBCI COVID Plan

National Black Church Initiative Sustainable Action Plan to Maintain the Health of the African American and Latinx Communities

The National Black Church Initiative is extremely excited to share with you an Executive Summary of our plan to encourage a hundred million of our brothers and sisters in the Black and Latino communities to get vaccinated against COVID-19. The plan is called NBCI Building a Sustainable Action Plan for the Prevention, Detection, and Treatment of COVID-19 and Eliminating Health Disparities for the African American and Latino Communities, and it calls for cooperation and collaboration between all Black and Latino civil rights and human rights organizations.

National Black Church Initiative

Health Emergency Declaration

National Black Church Initiative Sustainable Action Plan to Maintain the Health of the African American and Latinx Communities

The content on this website serves as an educational tool to link people to third-party scientific and evidenced-based information related to the vaccine development process, along with the safety, efficacy, availability, and affordability of Covid-19 vaccines.

The National Black Church Initiative (NBCI) is currently implementing critical portions of our Comprehensive Engagement Plan as we prepare the African American community to receive the coronavirus (COVID-19) vaccines.

Features of this Plan include education, outreach, the National Flu Campaign (NFC), a Mask Campaign, and a Media Campaign aimed to enhance any state-wide COVID-19 vaccination plans that are submitted to the Centers for Disease Control (CDC).

National Black Church Initiative Sustainable Action Plan to Maintain the Health of the African American and Latinx Communities

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NBCI is pleased to be part of **The Integrated Bioscience and Built Environment Consortium (IBEC)**. IBEC has created programs that educate how to successfully mitigate transmission while educating the masses on safe protocols that really make a difference in stifling the unnecessary increase of COVID-19 cases and other contagious pathogens. NBCI is proud to collaborate with IBEC as we guide our churches safely back to meeting in-person.

NBCI COVID-19 Products and Technology Listing

All-in-one platform to unify ministry, management, and mission. Grow your church with tools designed to build discipleship, increase generosity, strengthen fellowship, amplify evangelism, and optimize stewardship. This page also provides methods for cleaning and disinfecting your church and programs to potentially provide you with tens of thousands of dollars with no limitations on how you utilize them.

NBCI Launched its Comprehensive COVID-19 Plan to Vaccinate over 100 Million African Americans and Latinos

My name is Reverend Anthony Evans and I am the President and CEO of the National Black Church Initiative (NBCI). We are very excited to share with you NBCI's Comprehensive COVID-19 Plan to vaccinate over 100 Million African Americans and Latinos in the nation. We congratulate and thank all of our front-line workers who have proven their dedication and heart again and again through this devastating pandemic.

The COVID-19 pandemic has devastated and continues to negatively impact the African American church. The Black church has lost tens of thousands of our church members, active pastors, and has experienced increasing death tolls in our smaller to medium-sized churches. We want to work with the CDC very closely to determine the real data of the pandemic's impact on our church community.

VIEWPOINT

Partnering With the Faith-Based Community to Address Disparities in COVID-19 Vaccination Rates and Outcomes Among US Black and Latino Populations

Anthony Evans, MDiv
National Black Church Initiative,
Washington, DC.

Joseph Webster, MD
National Black Church Initiative,
Washington, DC.

Glenn Flores, MD
Department of Pediatrics, University of Miami Miller School of Medicine, Miami, Florida; and Holtz Children's Hospital, Jackson Health System, Miami, Florida.

Viewpoint pages 595, 597, 599, 601, 603, 605, and 607

The latest data from the Centers for Disease Control and Prevention (CDC) document that Black and Latino individuals in the US are 3 times more likely than White individuals to be hospitalized for COVID-19 and twice as likely to die from the disease.[1] Of the US population of approximately 330 million individuals, more than 100 million are Black or Latino individuals, who comprise 32%.[2] Nevertheless, Black and Latino individuals account for only 25% of the 184 million people in the US who have received at least 1 dose of the COVID-19 vaccine, whereas White individuals account for 59% of those who have received the vaccine.[3] Similarly, Black and Latino individuals comprise only 24% of the 159 million persons in the US who are fully vaccinated against COVID-19, whereas White individuals account for 60% of those fully vaccinated.[3]

The proportion of White individuals who have received a COVID-19 vaccine (47%) is about 1.4 times higher than the proportion of Black individuals (34%) and 1.2 times the proportion of Latino individuals (39%) who have received a COVID-19 vaccine.[4] A consistent pattern continues with communities of these racial and ethnic minority groups having substantially lower vaccination rates in relation to their share of the population and their overrepresentation among COVID-19 infections and deaths. In California, Latino individuals have received only 29% of COVID-19 vaccinations, although they account for 63% of those with COVID-19, 48% of deaths related to COVID-19, and 40% of the state's total population.[4] In the District of Columbia, Black individuals have received 43% of vaccinations, but comprise 56% of those with COVID-19, 71% of deaths related to COVID-19, and 46% of the total population.[4]

Several factors appear to be driving these concerning and unacceptable disparities in COVID-19 vaccination. Decades of published research has documented that Black and Latino individuals have substantially worse access to primary care and specialty care and are much more likely to lack health insurance than White individuals. As the medical literature and recent events, such as the George Floyd killing, have underscored, systemic racism continues to be a major challenge for the US health care system and for US society. In addition, Black and Latino individuals have understandably low levels of trust in the federal government and medical care due to egregious past events involving ethically unacceptable studies and programs such as the US Public Health Service and CDC 40-year Tuskegee Study of Black men with untreated syphilis, unethical development of the HeLa cell line from Henrietta Lacks without her permission, and decades of forced sterilization of Latina women in Puerto Rico and California. It is not surprising, therefore, that myth-based concerns exist among these communities that deter their willingness to receive COVID-19 vaccination, such as beliefs that these vaccines contain microchips to track Black individuals or that the vaccine registration process will be used to deport Latino individuals.

> [L]everaging a network of 150 000 churches to advance the public's health could prove to be a potent national model for eliminating Black and Latino racial and ethnic disparities in health and health care across the US.

How is it possible to overcome the triple burdens of impaired access to care, systemic racism, and distrust of the federal government and health care systems to eliminate COVID-19 vaccine disparities among Black and Latino communities? A promising and powerful strategy is to partner with the faith-based community, a highly trusted resource and frequent central gathering place for communities that are composed of racial and ethnic minority populations. The National Black Church Initiative (NBCI) is a coalition of 150 000 Black and Latino churches aiming to eradicate racial and ethnic disparities in health care, technology, education, housing, and the environment.[5] The mission of the NBCI is to provide critical wellness information to all members, congregants, churches, and the public.

In 2021, NBCI announced a 5-year plan that offers the CDC its 150 000 Black and Latino churches across the US as vaccination centers. The plan will include a national advisory committee of 9 prominent Black and Latino physicians who have evaluated the effectiveness of each COVID-19 vaccine; will leverage approximately 1000 Black and Latino US medical professionals to administer vaccines; and will mobilize several million volunteers to raise awareness among and communicate to underserved communities, provide transportation to vaccination centers, and ensure that communities of racial and ethnic minority populations obtain their second vaccinations (when indicated). The NBCI plan has been designed to seamlessly integrate with the efforts of local and state governments and health

Corresponding Author: Glenn Flores, MD, Department of Pediatrics, University of Miami Miller School of Medicine, 1601 NW 12th Ave, 9th Floor, Miami, FL 33136 (glennflores@miami.edu).

Journal of American Medical Association (JAMA) recognizes NBCI work on COVID-19 .pdf [58kb]

Leveraging a network of 150,000 churches to advance the public's health could prove to be a potent national model for eliminating Black and Latino racial and ethnic disparities in health and health care across the US.

In 2021, NBCI announced a 5-year plan that offers the CDC its 150 000 Black and Latino churches across the US as vaccination centers. The plan will include a national advisory committee of 9 prominent Black and Latino physicians who have evaluated the effectiveness of each COVID-19 vaccine; will leverage approximately 1000 Black and Latino US medical professionals to administer vaccines; and will mobilize several million volunteers to raise awareness among and communicate to underserved communities, provide transportation to vaccination centers, and ensure that communities of racial and ethnic minority populations obtain their second vaccinations (when indicated).

Rev. Evans Immunization - A Moral Challenge To NBCI's 150,000 Churches

Rev. Evans urges Black and Latino church members to get immunized and shows his card illustrating his first immunization shot.

Read "**The NBCI Building a Sustainable Action Plan for the Prevention, Detection, and Treatment of COVID-19 and Eliminating Health Disparities for the African American and Latino Communities**", which calls for cooperation and collaboration between all Black and Latino civil rights and human rights organizations.

Over 250,000 Black And Latino Churches Express Full Confidence In Dr. Fauci's Leadership And Medical Advice

Since the COVID-19 pandemic, Dr. Facui has educated the world on combating the virus

Rev. Anthony Evans, President of the National Black Church Initiative, states, "Given the devastation of COVID-19 on the African American and Latino communities, we desperately need Dr. Fauci as the chief medical leader in America. African Americans and Latinos, especially African Americans, have died disproportionately from COVID-19 and will continue to die disproportionately because of the gross misinformation that targets African American and Latino communities. NBCI is doing its part by creating **VACCNEWS**, a one-page explanation of COVID-19 that attempts to encourage every African American and Latino to get vaccinated.

NATIONAL BLACK CHURCH INITIATIVE

Please Get Vaccinated!

VACCNEWS

BLACK LIVES MATTER

Black Doctors say COVID-19 Vaccines are Good and Safe for Black People

What is COVID-19 and how did it start?

150,000 Black Churches Support What Black Doctors are saying about the COVID-19 Vaccines

How does it spread?

Why were the vaccines made so fast?

Why do we wear masks?

Why do we have to wash our hands so often?

Why do we have to stand six feet apart?

DOWNLOAD VACCNEWS TODAY!!!

Facts and Good News About COVID-19 Vaccines

150,000 Black Churches Support What Black Doctors are saying about the COVID-19 Vaccines Following a thorough safety review, including two meetings of the Advisory Committee on Immunization Practices, the U.S. Food and Drug Administration and the U.S. Centers for Disease Control and Prevention, the pause regarding the use of the Johnson & Johnson (Janssen) COVID-19 Vaccine in the U.S. was lifted on April 23, 2021 for adults aged 18 years and older in the United States.

Why Were the Vaccines Made So Fast?

The vaccines were made so fast because scientists found a new way to make vaccines that works really well called the mRNA method. Many vaccines in the future will use this method and will be made just as fast. That's very good news!

Nurse Who Received the First COVID-19 Vaccine in U.S., Gets Booster Shot

Sandra Lindsay, a New York City nurse who was the first person in the U.S. to get a COVID-19 vaccine, received her booster shot today.

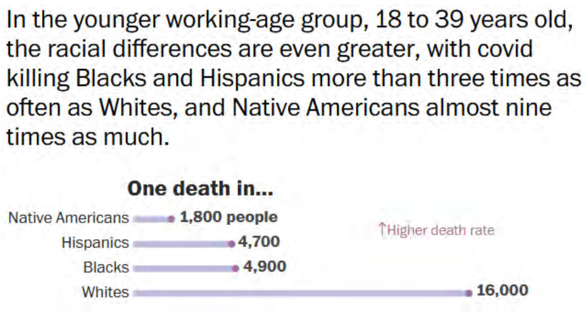
In Philadelphia, Black Doctors Bring Coronavirus Tests To Street Corners And Churches .pdf [5.63mb]

When the coronavirus arrived in Philadelphia in March of 2020, Dr. Ala Stanford hunkered down at home with her husband and kids. She's a pediatric surgeon with a private practice, and staff privileges at suburban Philadelphia hospitals.

Stanford sprang into action. Her mom rented a minivan, while Stanford started recruiting volunteers among the doctors, nurses and medical students in her network. She got testing kits from LabCorp, where she had an account through her private practice. By May, it wasn't unusual for the Black Doctors COVID-19 Consortium to test more than 350 people a day.

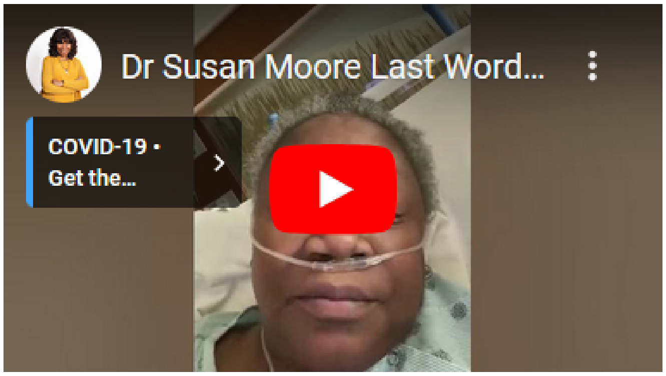
The Pandemic Marks Another Grim Milestone: 1 in 500 Americans Have Died of Covid-19 .pdf [5.63mb]

At a certain point, it was no longer a matter of if the United States would reach the gruesome milestone of 1 in 500 people dying of covid-19, but a matter of when. A year? Maybe 15 months?The answer: 19 months.


In the younger working-age group, 18 to 39 years old, the racial differences are even greater, with covid killing Blacks and Hispanics more than three times as often as Whites, and Native Americans almost nine times as much.

While covid's death toll overwhelms the imagination, even more stunning is the deadly efficiency with which it has targeted Black, Latino, and American Indian and Alaska Native people in their 30s, 40s and 50s.

The Coalition of Churches & Community U.S.A. writes a letter of support for the National Black Church Initiative (NBCI) and NBCI's Sustainable Action Plan to Maintain the Health of the African American Community 2020-2025: COVID-19: Eradicating Underlying Disparities in Healthcare to vaccinate 106 million Blacks and Latinos against COVID-19. This plan is implemented under the leadership of their President and CEO, Reverend Anthony Evans.



Dr Susan Moore Last Words Before Dying From COVID and Neglect

Dr. Susan Moore was an African American physician who developed COVID. She made a chilling and heartbreaking video before she died documenting her mistreatment. Her last words were chilling. "I have to talk to somebody. Maybe the media."


Statistical & Sociological Impact of the Coronavirus on African American and Multi-Ethnic Communities If Left Unabated

Statistical and Sociological Impact of the Coronavirus on African and Multi-Ethnic Communities If Left Unabated .pdf [3.15mb]

Please check out CDC guidelines -- Rev. Anthony Evans, M.Div

The National Black Church Initiative Data and Information Committee Independent, Non-Scientific Community-Based Statement on the Efficacy and Safety of the COVID-19 Vaccines for Pfizer, Moderna, and Johnson & Johnson .pdf[278kb]

The National Black Church Initiative (NBCI), a coalition of 150,000 Black and Latino churches, has assembled a group of nine Black and Latino physicians to assess the safety and efficacy of the Pfizer, Moderna, and Johnson & Johnson vaccines.

NBCI COVID-19 Data and Information Committee

Dr. Joseph Webster, MD – Chairman
Dr. William Strudwick, MD
Dr. Anthony Ibe, MD
Dr. Lisa Fitzpatrick
Dr. Walter Faggett, MD
Dr. Fabian Sandoval, MD
Dr. Fuentes-Affick, MD
Dr. Glenn Flores, MD, FAAP
Dr. Mario F. Pacheco, M.D

The National Black Church Initiative Launches its Comprehensive Plan to Vaccinate 100 Million African Americans and Latinos

NBCI launches its comprehensive COVID-19 plan to vaccinate over 100 Million African Americans and Latinos nationwide beginning with a press conference on February 16, 2021 at Mount Zion Baptist Church, Washington D.C., 20011, and broadcast over Zoom and Facebook Live.

Text of opening remarks at the February 16, 2021 news conference held at Mt. Zion Baptist Church, Washington, DC




Religious Leaders Unveil $150M Plan to Vaccinate Black, Latino Churchgoers Across US

Matt Small, WTOP News (February 16, 2021)

Stop The Madness Poster

Lessons Learned in the Pandemic: How Can the Black Church Work Effectively w/Public Health Experts (Online event)

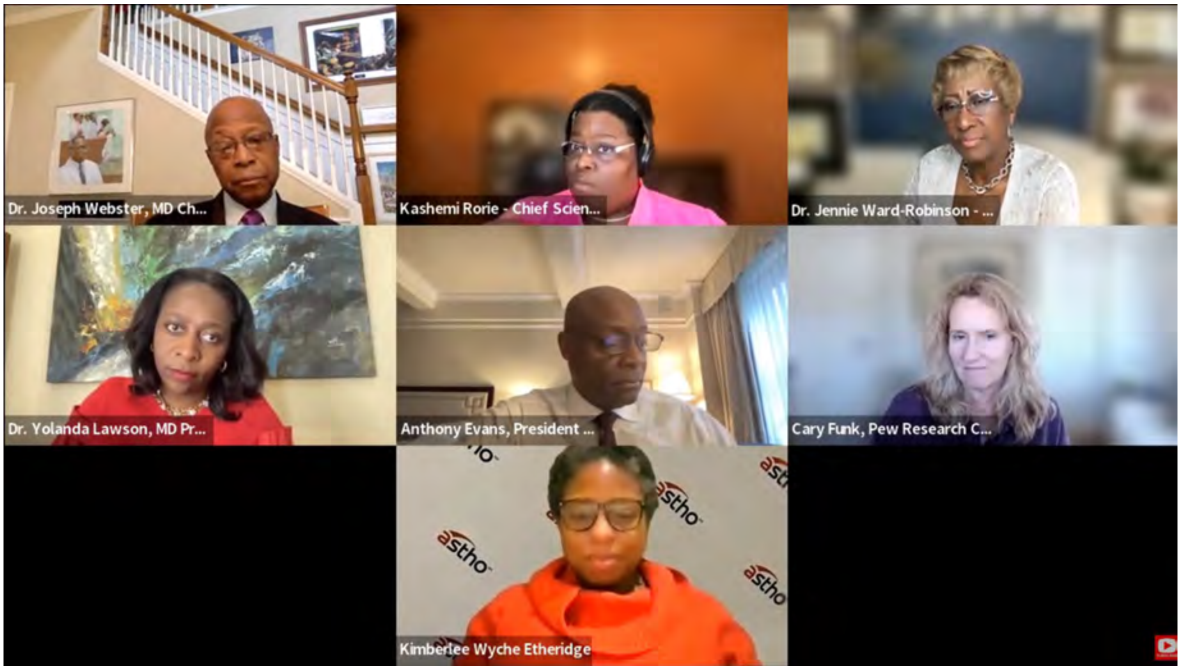
This webinar was held March 4, 2023 and live cast on NBCI's Facebook and YouTube platforms. We desired to find what could have been done differently to strengthen community and faith-based relationships to avoid the 1.8 million fatalities of the pandemic.

NBCI hopes this meeting will facilitate a rich discussion that will lead to practical steps and become a part of the overall pandemic protocol playbook now and in the near future.

Participants included;

- Rev. Anthony Evans, NBCI's president (event host/sponsor)
- Dr. Joseph Webster. Internist, gastroenterologist, Chair; NBCI's COVID-19 Data and Information Committee
- Dr. Cary Funk; Director of Science and Society Research at Pew Research Center
- Dr. Kimberlee Wyche Etheridge; Adolescent provider for the Meharry Pediatric Practice
- Dr. Ward-Robinson; Chief Executive Officer for the Society to Improve Diagnosis in Medicine (SIDM)
- Dr. Yolanda Lawson; Board-certified OB/GYN, founder of MadeWell OBGYN in Dallas, Texas, President-Elect of the National Medical Association.

Watch the video on YouTube at https://youtu.be/Bdifma9_whA.



NATIONAL
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"Bringing people together to serve humanity"

ATTN: Dr. Rochelle P. Walensky
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329

Dear Dr. Rochelle P. Walensky:

My name is Reverend Anthony Evans and I serve as the President of the National Black Church Initiative (NBCI), one of our nation's largest faith-based organization comprised of 150,000 Black and Latino churches with 27.7 million members.

NBCI is pleased that you have assumed the leadership helm of the Center for Disease Control (CDC) and commend you on shepherding comprehensive efforts through the COVID pandemic. While initial responses to COVID resulted in CDC apologies to domestic and global communities, NBCI recognizes the enormity and complexity of the role assumed and perceived the CDC as operating in good faith and with the interest of the people served.

To that end, the nature of this correspondence is two-fold: 1) To provide background information about the NBCI programmatic endeavors unique to COVID and steps taken against misinformation campaigns; and 2) To request data about African American, Latino and related ethnic communities unique to COVID to inform the delivery of messaging of our VACCNEWS, an information sheet on COVID-19 vaccinations that also dispels vaccine myths, and for purposes of other NBCI dissemination efforts.

The nature of the correspondence is situated within the broader interest of NBCI as fostering a meaningful and strategic partnership with the CDC. Through funded and informational data support, such level of engagement furthers efforts of both CDC and NBCI to ensure the dissemination of quality and accurate COVID information to constituencies served.

BACKGROUND INFORMATION AND PROGRAMMATIC ENDEAVORS

The mission of NBCI is to eradicate racial disparities in healthcare, technology, education, housing, and the environment. We provide critical wellness information to all of our members and the public, and partner with all other organizations and officials with similar goals. NBCI offers faith-based, out-of-the-box, cutting-edge solutions to stubborn economic and social issues based on statistical analyses, science-based strategies, and methods that work. NBCI is comprised of an advisory committee of African American and Latinx medical professionals to guide and ensure that the information we distribute is scientifically accurate. The composition of the advisory committee along with our strategic partnerships has established internal and external credibility toward ensuring appropriate development and implementation of programmatic endeavors.

- **NBCI AND THE IMPLEMENTATION OF TARGETED COVID INITIATIVES**

What We Have Done as NBCI with Current Collaborative Partners: Since the start of the COVID pandemic, NBCI has engaged in diverse efforts to address the holistic needs of our 27.7 million members. Our programmatic initiatives have generated critical efforts toward educating African Americans and Latinos about COVID. Here is the link highlighting one approach NBCI has addressed COVID: https://www.naltblackchurch.com/healthcovid-19.html. Such user-friendly site offers concise responses to pertinent questions. Following are other videos to highlight efforts pursued by NBCI to address COVID:

1. COVID Success Story with Shannon
   https://www.youtube.com/watch?v=5MNxH4Kh4C8&list=PL3TJQ8W0kdiDMASF7gNRV7NCEdQTDxNrG&index=4

2. Promotion of Vaccine with the Mayor of Charlotte, North Carolina
   https://www.youtube.com/watch?v=oL9_qwaJl-w&list=PL3TJQ8W0kdiBtOn5rMI7CB39hJUWbwqlQ

3. Black Churches Work to Boost Baltimore Vaccination Rates
   https://www.wypr.org/wypr-news/2021-09-06/black-churches-work-to-boost-baltimore-vaccination-rates

4. Baltimore Vaccination Campaign
   https://www.youtube.com/watch?v=3PzBYIZCOrg&t=34s

5. NBCI's Publication of VACCNEWS
   https://www.naltblackchurch.com/health/pdf/vacc-news0612221.pdf

6. NBCI Launched Children's' Vaccination Program in Savannah, Georgia
   https://www.facebook.com/NBCIonline/videos/970551947158686/

***What We Will Do with CDC as a New Collaborative Partnership*:** NBCI has been on the forefront of the fight against COVID-19 since December 2019. To that end, we will leverage work with our 150,000 African American and Latino Churches and 27.7 million partners to engage with CDC to further current programming of COVID safety measures and related innovative and emerging programming endeavors. Black and Latino churches are powerful forces within our communities and we will be good allies with the CDC given the capacity of our internal constituencies served.

- **NBCI SPEAKS OUT AGAINST COVID MISINFORMATION**

<u>What We Have Done as NBCI with Current Collaborative Partners</u>: African Americans are still dying at very high rates from COVID given the level of pre-existing medical conditions existing among this group. Consequently, anything that discourages them from getting vaccinated is not helpful and does not advance the need for achieving overall health and wellness within our community. To that end, NBCI is sorely disappointed in the Nation of Islam and their documented spread of misinformation in the Black community regarding the effectiveness and safety of COVID-19 vaccinations. While many of our NBCI members love and respect the work of the Nation of Islam and its focus on socioeconomic programs in our community, we strongly believe the COVID misinformation about COVID, the vaccines, the vaccines' effectiveness, and whether or not the vaccines harm African American people is completely and fundamentally wrong. The conscientious nature of this ill-willed and ill-intent phenomenon is unnecessary and a blatant attempt to confuse our people within our own community. Additionally, NBCI recognizes the Nation of Islam as a religious organization and thereby is neither scientifically competently nor medically qualified to make such unwarranted claims. Our 150,000 African American churches including 37 major Black Protestant denominations have stood in agreement with the National Medical Association as well as the National Black Nurses Association regarding the safety and effectiveness of the COVID vaccine.

<u>What We Will Do with CDC as a New Collaborative Partner</u>: NBCI, along with our NBCI Scientific Team, remains willing to engage with the CDC regarding the spread of COVID misinformation and the seriousness of this matter. NBCI remains committed toward eliminating any misconceptions about COVID, the vaccine, the effectiveness, and adverse implications associated with COVID misinformation for African Americans. Thus, given our platform of churches and the congregants served, we would continue to work with the CDC in developing targeted communication plans for addressing the concerns of similarly-situated organizations that spread COVID misinformation.

REQUESTED DATA AND FUNDING SUPPORT

- **<u>NATIONAL DATA</u>**: As you are acutely aware, within our society, we are encountering a catastrophic wholesale failure of the entire healthcare system from municipal, state, and federal levels. In some ways, trying to determine who and where we can retrieve accurate and current data becomes challenging. Reversing the racism and discriminatory practices from the American healthcare and integrating cultural competency for all groups into it are important goals that will reduce the health disparity gaps between White communities and communities of color.

  To that end, we are asking the CDC to provide us with COVID-19 data involving African Americans and Latinos and their mortality and morbidity from the across the country to address and/or clear up any misconceptions therein. We would be interested in having the data disaggregated by race, gender, and age.

  Following are the requested data:

    - The number of COVID deaths to date in the USA broken down by age, gender, race, and location;
    - The number of COVID deaths to date in each state broken down by age, gender, race, and location;
    - The number of these deaths to date that were in African American, Latin American, and Asian communities;
    - The pre-existing medical conditions of those who died;
    - The marital status of those who died;
    - The educational levels of those who died; and
    - The results of contact tracing within each community, state, and the nation as a whole that show the pattern of spread.

- **DATA PUBLICATION AND FUNDING SUPPORT**: As we prepare to publish our second edition of VACCNEWS, an information sheet on COVID that also dispels vaccine myths, the data will be helpful toward ensuring that NBCI is able to create effective vaccination and lifestyle change programs. Such data will contribute to the overall efforts of NBCI to actually reduce the incidence of COVID as well to deliver and disseminate appropriate information to rural and urban communities that might be underserved among our NBCI constituencies.

  It is important to note that a half million copies of the first edition of VACCNEWS were distributed in African American and Latinx communities. The distribution of VACCNEWS was a huge success and we could have distributed a million more. Unfortunately, we applied for funding from the CDC and CDC Foundation and was denied the requested funding. The funds to support this dissemination effort came from a small grant from a healthcare agency.

  While we were denied initial funding, NBCI is still interested in receiving the aforementioned data request to be used in the publication of our second edition VACCNEWS. We would also be interested in seeking your approval or support of the second edition VACCNEWS on social media prior to the publication. NBCI is aware of review processes that might have to occur for this type of approval, support, or some type of endorsement. Nonetheless we welcome the opportunity to engage in this type of dialogue.

  Additionally, it is important to note that one of the biggest issues facing NBCI related to COVID, the vaccine, and therapies is the misinformation campaigns that occurring from organizations whom we share similar values. As indicated in the above section, we have spoken out against religious organizations like The National of Islam for disseminating misinformation about COVID vaccinations. Having funding to support the publication of VACCNEWS would serve as important resource to ensure accurate and current COVID information is disseminated to our 150,000 African American and Latino churches with its 27.7 million members.

- **DATA CLARIFICATION AND INFORMATION DISSEMINATION:** Through data searches conducted by our researchers, NBCI recently found preliminary information that African American and Latino women of childbearing age are refusing to get COVID-19 vaccinations. The reports suggest these women believe that COVID vaccines will cause infertility. When we checked the CDC website and other health-related websites to see if there was any data on this phenomenon, we could not find any substantiating data. More specifically, an article published by Mariel Padilla in the Journal of General Internal Medicine by Harvard GenderSci Lab, found that Black women are dying of coronavirus at three times the rate of both White and Asian men in Georgia and Michigan. Black men had far higher mortality rates than any other race or gender group. When we checked the CDC website and other health-related websites to see if there was any data on this phenomenon, again, we could not find any substantiating data. The aforementioned examples regarding data [or misapplied data] impacting the NBCI constituencies could be clarified through informational communication and dissemination within a NBCI-CBC partnership. Such partnership would be a viable source for all of the constituencies involved.

- **ETHNIC GROUP COMPARISON**: Although we have plenty of anecdotal evidence about COVID mortality and morbidity of worldwide people of African, Asian, European, and related ethnic groups, NBCI would be interested in having data unique to broader ethnic groups. Following is the request for data to conduct ethnic group comparisons:

    - What is the percentage of people of African, Latin, European, Asian, and related ethnic groups who contracted COVID-19 worldwide?

  If the CDC does not collect and/or maintain this type of data, does the World Health Organization maintain this type of data? If CDC does not maintain this type of data, NBCI would seek to engage with the CDC collaboratively in legislative efforts to require more detailed records and/or demographical information regarding the collected data. NBCI certainly recognizes how onerous a task that is and understand the need for such records and/or information will be needed, not just for COVID-19, but for any pandemics or health emergency situations in the future.

Being able to engage in a meaningful and strategic partnership between the NBCI and CDC would serve impactfully for all of our millions of constituencies involved domestically and globally. Accessing critical data from the CDC for publication, clarification, and/or related dissemination purposes are important toward keeping our constituencies informed as well as the need for funding toward ensuring sustainability of this COVID-focused effort. I would welcome the opportunity to speak with you to engage further in dialogue around the possibilities of this NBCI-CDC collaborative opportunity.

Thank you for your time and consideration of this important proposed collaborative.

Sincerely,
Reverend Anthony Evans, *President*
The National Black Church Initiative

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

December 12, 2022

The Right Most Rev. Anthony Evans
President
National Black Church Initiative
Washington, DC 20035

Dear Reverend Evans:

Thank you for your letter to Centers for Disease Control and Prevention (CDC) Director Rochelle P. Walensky, MD, MPH, regarding coronavirus disease 2019 (COVID-19) data. I am responding on behalf of Dr. Walensky.

Data-driven, evidence-based approaches, including sharing data on COVID-19 outcomes among African American, Latino, and other racial and ethnic minority populations, is central to CDC's COVID-19 Health Equity Response Strategy.[1] COVID-19 mortality and related data are collected through multiple data sources and systems, as well as special studies, and shared on the CDC's website through data tools, reports, and in peer-reviewed publications. As these data and tools are regularly updated, some recent data on COVID-19 mortality and related outcomes and disparities are provided below.

A new CDC report[2] provides a comprehensive look into recent and overall trends in COVID-19–related mortality among adults in the United States. The data show that the risk of severe illness and death has significantly decreased for most people; however, thousands of people continue to die each week. The people most at risk of COVID-19–related death continue to be older adults, people with underlying medical conditions, people with disabilities, and people who are not up to date with COVID-19 vaccinations. In a recent study, CDC found that racial and ethnic disparities persisted in outpatient COVID-19 treatment through July 2022. More specifically, the study found that during April–July 2022, the percentage of COVID-19 patients aged 20 years and older treated with Paxlovid was 36% and 30% lower among Black and Hispanic patients than among White and non-Hispanic patients, respectively.[3] These disparities existed among all age groups and patients with immunocompromise.

CDC has also examined excess mortality, including an analysis of 2020 data, "Disparities in Excess Mortality Associated with COVID-19,"[4] which found that excess mortality incidence rates were higher for people aged 65 years or older, with notable racial and ethnic disparities

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[1] https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/cdc-strategy.html

[2] https://www.cdc.gov/coronavirus/2019-ncov/science/data-review/index.html

[3] Boehmer TK, Koumans EH, Skillen EL, et al. Racial and Ethnic Disparities in Outpatient Treatment of COVID-19 — United States, January–July 2022. MMWR Morb Mortal Wkly Rep 2022;71:1359–1365. DOI: http://dx.doi.org/10.15585/mmwr.mm7143a2

[4] Rossen LM, Ahmad FB, Anderson RN, et al. Disparities in Excess Mortality Associated with COVID-19 — United States, 2020. MMWR Morb Mortal Wkly Rep 2021;70:1114–1119. DOI: http://dx.doi.org/10.15585/mmwr.mm7033a2

across all age groups. In 2020, among Black and Hispanic people aged 65 years or older, more than 1,000 excess deaths per 100,000 person-years occurred compared with the number of deaths expected to occur.[4] Another study "COVID-19–Associated Hospitalizations Among Adults During SARS-CoV-2 Delta and Omicron Variant Predominance, by Race/Ethnicity and Vaccination Status — COVID-NET, 14 States, July 2021–January 2022"[5] showed that during the period of Omicron predominance, hospitalization rates increased most sharply among Black adults in the United States relative to all other racial and ethnic groups examined and reached the highest rate observed among all racial and ethnic groups since the beginning of the pandemic.

CDC's COVID Data Tracker provides a range of publicly available data on COVID-19 vaccinations, cases, and deaths and how they differ by age, race and ethnicity, sex, and other demographic characteristics.[6] Data includes COVID-19 weekly cases per 100,000 population by age group and race and ethnicity,[7] which is important to track changes in trends over time. CDC provides data on several aspects of COVID-19 deaths, including race and ethnicity, education, state and county location, and other contributing causes of death, via the National Center for Health Statistics' National Vital Statistics System (NVSS). Data from NVSS indicate that between 2020 and 2022 so far, 148,972 COVID-19 deaths have been recorded among the non-Hispanic Black population; 165,645 deaths recorded among the Hispanic population; and 33,090 deaths among the non-Hispanic Asian population. COVID-19 mortality data from NVSS are available publicly from CDC's National Center for Health Statistics COVID-19 mortality data website,[8] including a site focused on health disparities[9] in COVID-19 mortality, and through CDC WONDER,[10] which allows users to tabulate their own data.

In addition, CDC shares data on the "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity,"[11] which is updated monthly. Data updated through September 2022 show that compared to White, non-Hispanic persons, Black, non-Hispanic persons are 1.1 times more likely to be infected, 2.3 times more likely to be hospitalized, and 1.7 times more likely to have died from COVID-19. These data are age-adjusted, which is important because risk of infection, hospitalization, and death is different by age, and age distribution differs by racial and ethnic group.

Further, CDC collects information on long COVID from the Household Pulse Survey,[12] conducted by CDC's National Center for Health Statistics in partnership with the U.S. Census Bureau. From the most recent survey, among adults who had COVID-19, the percent currently reporting long COVID was highest for Hispanics (16.2%), followed by non-Hispanic Whites (15.4%), non-Hispanic others (14.5%), non-Hispanic Blacks (12.2%), and lowest among non-Hispanic Asians (6.1%).

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[5] Taylor CA, Whitaker M, Anglin O, et al. COVID-19–Associated Hospitalizations Among Adults During SARS-CoV-2 Delta and Omicron Variant Predominance, by Race/Ethnicity and Vaccination Status — COVID-NET, 14 States, July 2021–January 2022. MMWR Morb Mortal Wkly Rep 2022;71:466–473. DOI: http://dx.doi.org/10.15585/mmwr.mm7112e2

[6] https://covid.cdc.gov/covid-data-tracker/#health-equity-data

[7] https://covid.cdc.gov/covid-data-tracker/#demographicsovertime

[8] https://www.cdc.gov/nchs/nvss/covid-19.htm

[9] https://www.cdc.gov/nchs/nvss/vsrr/covid19/health_disparities.htm

[10] https://wonder.cdc.gov/

[11] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html#footnote02

[12] https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm

As you noted, non-Hispanic Black and Hispanic persons experience higher COVID-19–associated morbidity and mortality, yet COVID-19 vaccination coverage is lower in these groups. A previous CDC study among 9.6 million people in the eight integrated healthcare organizations from six states included in CDC's Vaccine Safety Datalink found that COVID-19 vaccination coverage continued to increase for all racial and ethnic groups, especially among people with medical conditions that place them at higher risk for severe COVID-19.[13] However, racial and ethnic minority groups, including Black and Hispanic persons, continue to have lower vaccination coverage, and these gaps may have even widened over time. CDC agrees that efforts to address vaccine misinformation, barriers to access, and insufficient vaccine confidence, coupled with strategies to prioritize equity, could help increase coverage and reduce COVID-19 incidence, especially among populations disproportionately affected by the pandemic.

CDC appreciates the efforts that the National Black Church Initiative (NBCI) has taken to disseminate accurate information regarding COVID-19. Most misinformation and disinformation that has circulated about COVID-19 vaccines has focused on vaccine development, safety, and effectiveness, as well as COVID-19 denialism.[14]

A community of trusted messengers is integral in addressing this misinformation and disinformation. Faith and community leaders, like those involved in NBCI, are uniquely positioned as trusted messengers to engage with the members of their communities to both hear concerns that have arisen surrounding vaccination and address those concerns. Faith-based and community-based organizations foster community and provide healthcare every day during a time rife with feelings of confusion and isolation. CDC strongly values partnerships that help inform, implement, and assess activities focused on vaccine awareness, access, availability, and confidence in their communities. NBCI's continuing efforts to address misinformation and disinformation within the African American, Latino, and related ethnic communities are appreciated.

The best way to apply for CDC funding is through Grants.gov.[15] Two programs that may be of interest for NBCI to apply to during future funding opportunities are the Racial and Ethnic Approaches to Community Health (REACH) program and the Partnering for Vaccine Equity (P4VE) program.

- The REACH program is at the forefront of CDC's efforts to reduce health disparities and achieve health equity. Since 1999, REACH has worked to reduce health disparities among specific racial and ethnic groups in communities with the highest risk or rates of chronic disease.[16] It is especially important for patients with chronic health conditions to be up to date on recommended vaccinations as they are at increased risk for complications from certain vaccine-preventable diseases.[17]

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[13] Pingali C, Meghani M, Razzaghi H, et al. COVID-19 Vaccination Coverage Among Insured Persons Aged ≥16 Years, by Race/Ethnicity and Other Selected Characteristics — Eight Integrated Health Care Organizations, United States, December 14, 2020–May 15, 2021. MMWR Morb Mortal Wkly Rep 2021;70:985–990. DOI: http://dx.doi.org/10.15585/mmwr.mm7028a1

[14] https://www.cdc.gov/vaccines/covid-19/health-departments/addressing-vaccine-misinformation.html

[15] https://www.grants.gov/

[16] https://www.cdc.gov/chronicdisease/resources/publications/factsheets/reach.htm

[17] https://www.cdc.gov/vaccines/hcp/adults/for-patients/health-conditions.html

- The P4VE program was launched in 2020 and focuses on increasing equity in adult immunization. Through the P4VE program and broader adult immunization efforts, CDC aims to improve equity in adult immunization across disproportionately affected populations, including racial and ethnic minority groups, through partnerships that drive community-level action.[18] As part of this effort, the Vaccine Resource Hub offers resources to help increase adult vaccination in the community.[19] Funding for the P4VE program is made possible through a sub-award from the CDC Foundation.

Thank you again for your letter. CDC continues to improve our messaging on vaccine effectiveness and safety, and feedback is welcome.

Sincerely,

Brendan R. Jackson

Brendan R. Jackson, MD, MPH
Incident Manager
COVID-19 Emergency Response
CDC

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[18] https://www.cdc.gov/vaccines/health-equity/index.html

[19] https://vaccineresourcehub.org/

VIEWPOINT

Partnering With the Faith-Based Community to Address Disparities in COVID-19 Vaccination Rates and Outcomes Among US Black and Latino Populations

Anthony Evans, MDiv
National Black Church Initiative,
Washington, DC.

Joseph Webster, MD
National Black Church Initiative,
Washington, DC.

Glenn Flores, MD
Department of Pediatrics, University of Miami Miller School of Medicine, Miami, Florida; and Holtz Children's Hospital, Jackson Health System, Miami, Florida.

Viewpoint pages 595, 597, 599, 601, 603, 605, and 607

The latest data from the Centers for Disease Control and Prevention (CDC) document that Black and Latino individuals in the US are 3 times more likely than White individuals to be hospitalized for COVID-19 and twice as likely to die from the disease.[1] Of the US population of approximately 330 million individuals, more than 100 million are Black or Latino individuals, who comprise 32%.[2] Nevertheless, Black and Latino individuals account for only 25% of the 184 million people in the US who have received at least 1 dose of the COVID-19 vaccine, whereas White individuals account for 59% of those who have received the vaccine.[3] Similarly, Black and Latino individuals comprise only 24% of the 159 million persons in the US who are fully vaccinated against COVID-19, whereas White individuals account for 60% of those fully vaccinated.[3]

The proportion of White individuals who have received a COVID-19 vaccine (47%) is about 1.4 times higher than the proportion of Black individuals (34%) and 1.2 times the proportion of Latino individuals (39%) who have received a COVID-19 vaccine.[4] A consistent pattern continues with communities of these racial and ethnic minority groups having substantially lower vaccination rates in relation to their share of the population and their overrepresentation among COVID-19 infections and deaths. In California, Latino individuals have received only 29% of COVID-19 vaccinations, although they account for 63% of those with COVID-19, 48% of deaths related to COVID-19, and 40% of the state's total population.[4] In the District of Columbia, Black individuals have received 43% of vaccinations, but comprise 56% of those with COVID-19, 71% of deaths related to COVID-19, and 46% of the total population.[4]

> [L]everaging a network of 150 000 churches to advance the public's health could prove to be a potent national model for eliminating Black and Latino racial and ethnic disparities in health and health care across the US.

Several factors appear to be driving these concerning and unacceptable disparities in COVID-19 vaccination. Decades of published research has documented that Black and Latino individuals have substantially worse access to primary care and specialty care and are much more likely to lack health insurance than White individuals. As the medical literature and recent events, such as the George Floyd killing, have underscored, systemic racism continues to be a major challenge for the US health care system and for US society. In addition, Black and Latino individuals have understandably low levels of trust in the federal government and medical care due to egregious past events involving ethically unacceptable studies and programs such as the US Public Health Service and CDC 40-year Tuskegee Study of Black men with untreated syphilis, unethical development of the HeLa cell line from Henrietta Lacks without her permission, and decades of forced sterilization of Latina women in Puerto Rico and California. It is not surprising, therefore, that myth-based concerns exist among these communities that deter their willingness to receive COVID-19 vaccination, such as beliefs that these vaccines contain microchips to track Black individuals or that the vaccine registration process will be used to deport Latino individuals.

How is it possible to overcome the triple burdens of impaired access to care, systemic racism, and distrust of the federal government and health care systems to eliminate COVID-19 vaccine disparities among Black and Latino communities? A promising and powerful strategy is to partner with the faith-based community, a highly trusted resource and frequent central gathering place for communities that are composed of racial and ethnic minority populations. The National Black Church Initiative (NBCI) is a coalition of 150 000 Black and Latino churches aiming to eradicate racial and ethnic disparities in health care, technology, education, housing, and the environment.[5] The mission of the NBCI is to provide critical wellness information to all members, congregants, churches, and the public.

In 2021, NBCI announced a 5-year plan that offers the CDC its 150 000 Black and Latino churches across the US as vaccination centers. The plan will include a national advisory committee of 9 prominent Black and Latino physicians who have evaluated the effectiveness of each COVID-19 vaccine; will leverage approximately 1000 Black and Latino US medical professionals to administer vaccines; and will mobilize several million volunteers to raise awareness among and communicate to underserved communities, provide transportation to vaccination centers, and ensure that communities of racial and ethnic minority populations obtain their second vaccinations (when indicated). The NBCI plan has been designed to seamlessly integrate with the efforts of local and state governments and health

Corresponding Author: Glenn Flores, MD, Department of Pediatrics, University of Miami Miller School of Medicine, 1601 NW 12th Ave, 9th Floor, Miami, FL 33136 (glennflores@miami.edu).

departments and build communities and networks of cooperation and trust.

To date, NBCI has engaged 2.5 million volunteers and held more than 157 vaccination events. In addition, NBCI will soon distribute a half million copies of *VACCNEWS*, a newspaper-style single sheet in simple language (at an eighth-grade literacy level) that describes COVID-19, COVID-19 vaccines, and the importance of getting vaccinated. The information will be distributed in NBCI's 150 000 churches, focusing on low-income Black and Latino communities throughout the country. *VACCNEWS* additionally will be posted on social media and disseminated nationally as a supplement to 274 Black newspapers and regional dailies targeting Black and Latino communities.

The NBCI plan also will provide assistance and navigation for Black and Latino individuals to ensure that they obtain patient-centered medical homes for primary care, enhance access to care by collaborating with clinics and hospitals in both urban and rural areas, launch African American National Health Week during the last week of July every year, aim to increase childhood and adult vaccination rates for all diseases by 60% over the next 10 years, and create special emphasis programs for patients with diabetes, obesity, or cancer. In addition, NBCI's approximately 2.5 million nationwide volunteers will ensure that Black and Latino individuals receive culturally appropriate guidance and education in language they can understand and trust. It will also ensure that vaccine administration at churches is an optimal fit with their beliefs, lifestyles, communities, and cultural values.

The NBCI's national advisory committee of 5 Black and 4 Latino physicians (the NBCI COVID-19 Data and Information Committee) is doing more than just evaluating and reporting on vaccine effectiveness and safety. NBCI national advisory committee members will publicize the plan via Black and Latino radio stations, write articles targeting Black and Latino newspapers and magazines, leverage social media to eliminate vaccine myths and correct misinformation, directly address the concerns of Black and Latino populations, and mobilize neighborhood influencers, civic groups, and local public health officials to advocate for vaccination.

Additionally, the NBCI plan will involve sending critical response teams to zip code–based locations with the highest proportions of impoverished residents, those living in public housing, or both. Critical response teams will consist of a local team leader, Latino and Black health professionals, a community representative, 5 to 10 outreach workers/volunteers, and mental health specialists. Critical response teams will develop and disseminate culturally and linguistically diverse multimedia outreach programs about COVID-19 vaccinations; promote use of best practices for disease prevention, detection, and treatment; and identify future COVID-19 health care priorities for Black and Latino communities.

NBCI estimates indicate that the total cost of implementing this plan is $100 million, equivalent to less than $1 per person to ensure that all 100 million Black and Latino individuals in the US are fully immunized against COVID-19. Although the NBCI plan is ambitious, it would be money well spent. If successful, the NBCI initiative could help ensure progress in the following ways: dispel COVID-19 vaccine myths, reduce vaccine hesitancy by having culturally relevant information delivered by trusted health care professionals and volunteers of racial and ethnic minority groups, administer COVID-19 vaccines equitably to those at greatest risk and with the least access, eliminate COVID-19 hospitalization and mortality disparities for Black and Latino individuals, and empower communities of racial and ethnic minority populations to help themselves. Indeed, the NBCI plan of leveraging a network of 150 000 churches to advance the public's health could prove to be a potent national model for eliminating Black and Latino racial and ethnic disparities in health and health care across the US.

ARTICLE INFORMATION

Conflict of Interest Disclosures: None reported.

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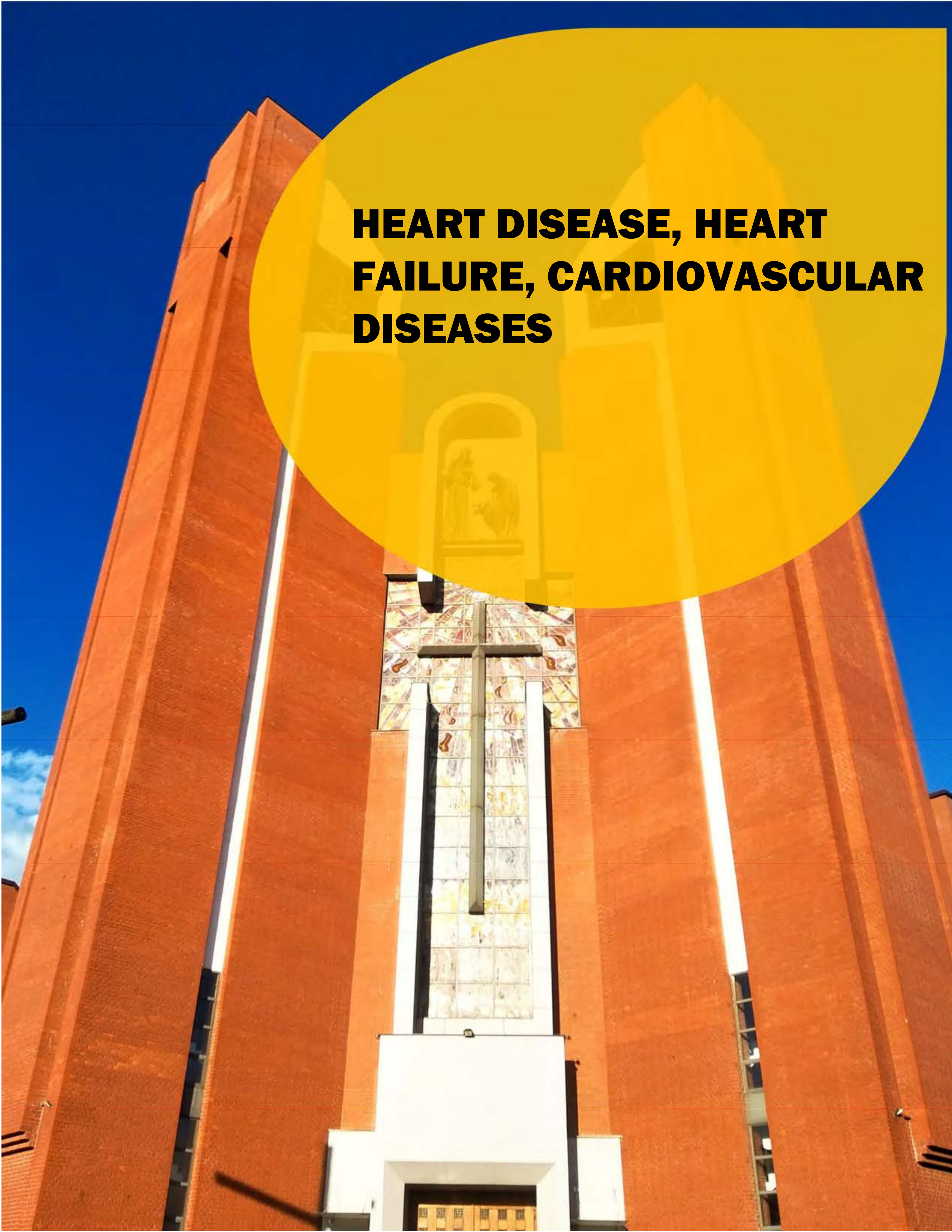


HEART DISEASE, HEART FAILURE, CARDIOVASCULAR DISEASES

Heart Disease, Heart Failure, Cardiovascular Diseases

Heart Disease and African Americans

What is Heart Disease?
According to the Centers for Disease Control and Prevention (CDC), heart disease is the leading cause of death in the United States. The term "heart disease" refers to several types of heart conditions. In the United States, the most common type of heart disease is coronary artery disease (CAD), which can lead to heart attack. You can reduce your risk for heart disease through lifestyle changes and, in some cases, medicine.

How Does Heart Disease Affect African American Populations?

- In 2019, African Americans were 24 percent less likely to die from heart disease than non-Hispanic whites.
- Although African American adults are 20 percent more likely to have high blood pressure, they are less likely than non-Hispanic whites to have their blood pressure under control.
- African American women are nearly 60 percent more likely to have high blood pressure, as compared to non-Hispanic white women.

Diagnosed Cases of Coronary Heart Disease:

Age-adjusted percentage of coronary heart disease among persons 18 years of age and over, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
5.2	5.6	0.93

Source: CDC 2022. National Center for Health Statistics. Percentage of coronary heart disease for adults aged 18 and over, United States, 2019—2021. National Health Interview Survey. Generated interactively: Jan 04, 2023. https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html

Death Rate:

Age-adjusted heart disease death rates per 100,000 (2019)			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Men	221.2	284.9	0.78
Women	176.0	235.3	0.75
Total	197.6	259.8	0.76

Source: CDC 2022. National Vital Statistics Report, Vol. 70, No. 8. Table 10. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-08-508.pdf.

Hypertension/High Blood Pressure

Age-adjusted percentage of persons 18 years of age and over who have high blood pressure, 2017-2018			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Men	57.2	50.2	1.1
Women	56.7	36.7	1.5
Total	57.1	43.6	1.3

Source: CDC 2022. Hypertension Prevalence and Control Among Adults: United States, 2017–2018. NCHS Data Brief, No. 364. Figure 4.
https://www.cdc.gov/nchs/data/databriefs/db364-h.pdf [PDF | 398.15 KB]

Percentage of persons 18 years of age and over who have high blood pressure, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
35.2	28.3	1.2

Source: CDC 2022. National Center for Health Statistics. Percentage of hypertension for adults aged 18 and over, United States, 2019—2021. National Health Interview Survey. Generated interactively: Jan 04, 2023. https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html

Percentage of adults aged 18 and over with hypertension whose blood pressure is under control, 2015-2016			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Men	40.1	47.7	0.8
Women	48.5	57.1	0.8
Total	44.6	50.8	0.9

Source: CDC 2022. Hypertension Prevalence and Control Among Adults: United States, 2015–2016. NCHS Data Brief, No. 289. Figure 4.
https://www.cdc.gov/nchs/data/databriefs/db289.pdf [PDF | 361 KB]

Source: CDC 2022. Prevent High Blood Pressure. https://www.cdc.gov/bloodpressure/prevent.htm

High Cholesterol

Age-adjusted percentage of persons 20 years of age and over who have high cholesterol, 2015-2018			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Men	22.4	27.0	0.8
Women	21.8	23.1	0.9
Total	22.2	25.0	0.9

Source: CDC 2022. Health United States, 2019. Table 23. https://www.cdc.gov/nchs/data/hus/hus19-508.pdf

Percentage of adults who received a blood cholesterol measurement in the last 5 years, 2017		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
90.1	87.3	1.0

Source: National Healthcare Quality and Disparities Reports. Data Query. http://nhqrnet.ahrq.gov/inhqrdr/data/query [Accessed 11/10/2022]

Cigarette Smoking

Percentage of persons 18 years of age and over who are current cigarette smoker, 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
14.4	13.3	1.1

Source: CDC 2022. Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion , Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm

Percentage of current smokers age 18 and over who reported receiving advice from a health professional to quit smoking, 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
51.3	49.8	1.03

Source: National Healthcare Quality Report. http://nhqrnet.ahrq.gov/inhqrdr/data/query

Risk Factors:

There are several risk factors related to heart disease. Some of these risk factors are:

Diabetes - See Obesity and African Americans
Obesity and Overweight - See Obesity and African Americans
Hypertension - See Heart Disease and African Americans
High Cholesterol - See Heart Disease and African Americans
Cigarette Smoking - See Heart Disease and African Americans

Source: CDC 2022. Know Your Risk for Heart Disease. https://www.cdc.gov/heartdisease/risk_factors.htm

Prevent Heart Disease:

There are things that you can do to prevent heart disease:

Nutrition: Eat healthy diet (increase fresh fruits and vegetables and lower salt intake)
Weight: Maintain a healthy weight
Exercise: Be physically active (seek advice from your doctor)
Smoking: Do not smoke
Alcohol: Limit alcohol intake

Source: CDC 2022. Prevent Heart Disease. https://www.cdc.gov/heartdisease/prevention.htm

Cytokinetics

Worsening Heart Failure: A Growing Public Health Epidemic

the facts

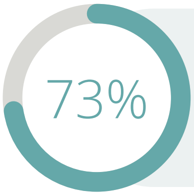
Heart failure is a chronic, progressive condition that occurs when the heart muscle is unable to pump enough oxygen-rich blood to the body's cells and organs.[1] The definition of **"worsening heart failure"** (WHF) is evolving. Instead of an in-hospital and clinical trial-based definition, it's now based on deterioration of HF signs and symptoms after a period of stability that requires escalation of therapy or development of breakthrough symptoms despite maximally tolerated guideline-directed therapy (GDMT).[2, 3]

Over time, the heart tries to compensate by stretching, enlarging and pumping faster to keep up with the body's demands, and becomes weakened as a result. Because this can occur without the patient recognizing any symptoms, people with heart failure may go undiagnosed for years.[1]

HEART FAILURE WITH REDUCED EJECTION FRACTION (HFrEF)

Ejection fraction (EF) is a percentage measurement of how much blood the left ventricle pumps out of the heart with each contraction. A healthy heart has an ejection fraction between 50–70%, but someone with HFrEF has an ejection fraction of 40% or less.[4]

On average, ~50% of overall HF cases are classified as HFrEF.[5] There is a large and growing heart failure patient population, with the HFrEF population expected to go from 3.1M in 2020, to 4.0M in 2032.[6, 7]



of patients with HFrEF experience worsening heart failure, while receiving GDMT.[8]

COMMON SYMPTOMS OF WHF[9]

- Shortness of breath and/or difficulty breathing during daily activities or even when lying down
- Weight gain
- "Edema" or swelling, usually in the feet, legs, ankles, or stomach
- Fatigue

ALARMING STATISTICS

Prevalence in Adults (18+, USA)
2020 Estimates

6.2M[10]
Heart Failure

3.1M[6]
HFrEF Population

2.0M[6]
HFrEF & EF ≤30%

Between 2025 and 2060, prevalence of HF is expected to reach

13 million[11]

Heart failure complications hospitalize **more Americans per year than all cancers combined[12, 13, 14]**

Hospitalizations and rehospitalizations for heart failure patients remain high, with each additional hospitalization associated with an **increased risk of death[15, 16, 17]**

of heart failure patients die within 5 years of diagnosis[18]

BURDEN OF HEART FAILURE

Financial

- The average cost for each heart failure-related hospital stay in the US is $17k.[19]
- 56% of patients are re-hospitalized within 30 days of a WHF event.[20]
- The total cost of care is expected to increase to $69.7 billion by 2030.[19]
- Patients and caregivers alike experience added financial hardship due to early retirement or reduced employment hours.[21]

Physical

- Everyday activities, like walking to the mailbox, cleaning one's home, climbing stairs and participating in social activities are difficult — often leading to a poorer quality of life.[22]

Mental

- WHF patients often feel depression and sadness, isolation, fear of dying and anxiety related to their condition.[22]
- In some patients, mental health challenges can lead to further isolation from family and loved ones, missed doctor's appointments and undertreatment.[23]

Comorbidities

- More than half of patients with HF have coexisting conditions such as obesity, chronic kidney disease, diabetes mellitus, hypertension and atrial fibrillation.[24, 25]
  - 85% of HFrEF patients may be prescribed 5-14 medications.

Caregiver

Living with HF is a "shared experience" for patients, caregivers and loved ones. Many caregivers report social isolation, anxiety, exhaustion, and fearfulness.[23]

TREATMENT OPTIONS

Heart failure patients may need multiple medications to treat different symptoms or contributing factors.[26]

Recent research suggests that most patients with newly diagnosed HFrEF are treated with GDMT which includes angiotensin receptor neprilysin inhibitors (ARNIs), angiotensin receptor blockers (ARBs), mineralocorticoid receptor antagonists (MRAs) and sodium-glucose contransporter-2 inhibitors (SGLT2).[27]

Many HFrEF patients continue to worsen despite GDMT, and add-ons often result in tolerability issues.[28]

OUTLOOK

While the term "heart *failure*" makes it sound like the heart is no longer working at all and there's nothing that can be done, what it actually means is that the heart isn't functioning as well as it should.

New and effective treatments are needed to get to the heart of the problem: enhancing cardiac performance, reducing clinical events, and improving the quality of life for this growing patient population and their families.

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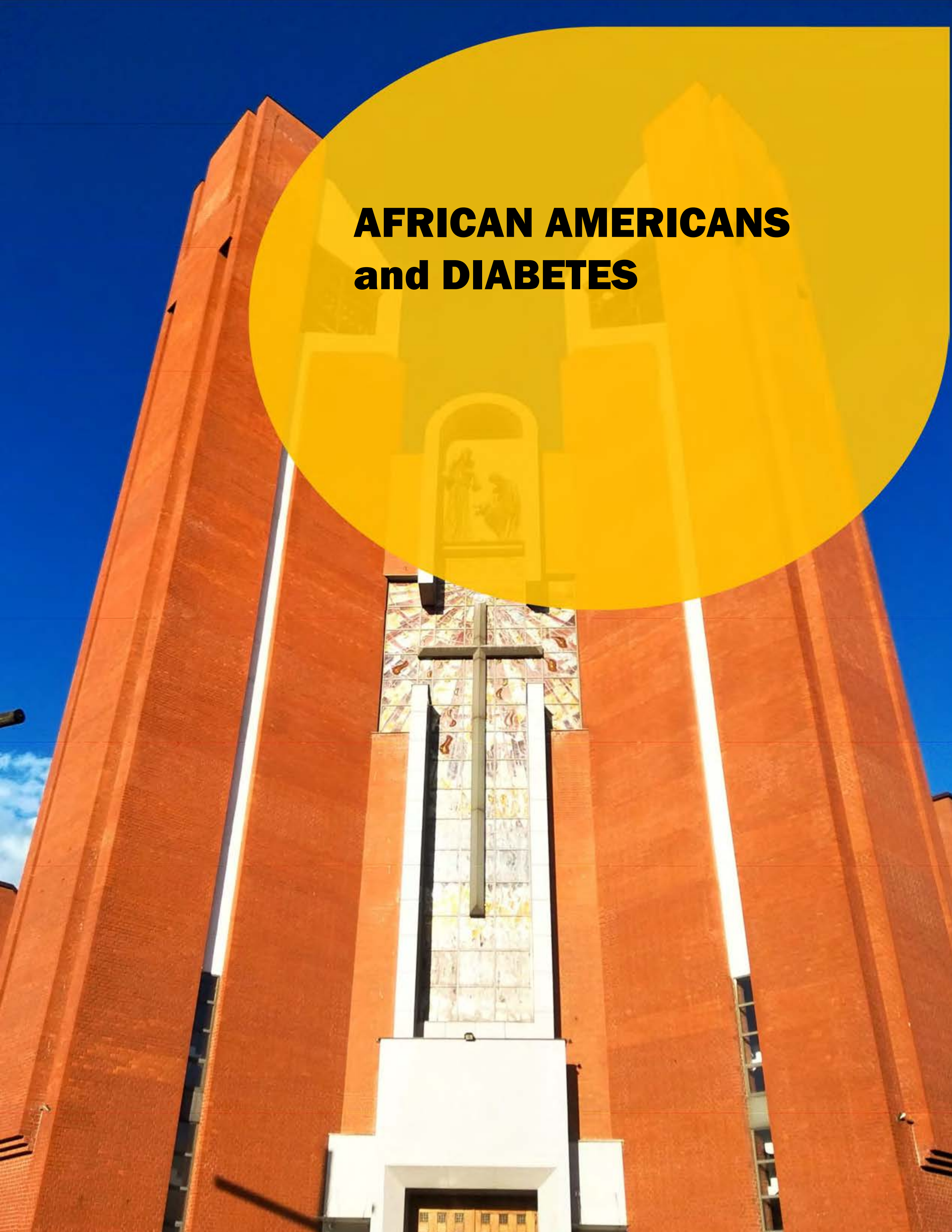

AFRICAN AMERICANS and DIABETES

African Americans and Diabetes

What is Diabetes?

According to the Centers for Disease Control and Prevention (CDC), diabetes is a chronic (long-lasting) health condition that affects how your body turns food into energy. Your body breaks down most of the food you eat into sugar (glucose) and releases it into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy.

With diabetes, your body does not make enough insulin or cannot use it as well as it should. When there is not enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, diabetes can cause serious health problems, such as heart disease, vision loss, and kidney disease. There is not a cure yet for diabetes, but losing weight, eating healthy food, and being active can really help. Other things you can do to help your diabetes include taking medication as prescribed; receiving diabetes self-management education and support; and being consistent with your medical appointments.

How Does Diabetes Affect African American Populations?

- In 2019, non-Hispanic blacks were twice as likely as non-Hispanic whites to die from diabetes.
- In 2018, African American adults were 60 percent more likely than non-Hispanic white adults to be diagnosed with diabetes by a physician.
- In 2019, non-Hispanic blacks were 2.5 times likely to be hospitalized with diabetes and associated long-term complications than non-Hispanic whites.
- In 2019, non-Hispanic blacks were 3.2 times more likely to be diagnosed with end stage renal disease as compared to non-Hispanic whites.

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Feb 17, 2023

Diagnosed Cases of Diabetes

Age-adjusted percentage of adults aged 18 and over diagnosed with diabetes, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
12.7	7.0	1.8

Source: CDC 2022. National Diabetes Surveillance System. https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html

Age-adjusted percentage of diagnosed diabetes for adults aged 18 and over, 2018-2019

	Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
Men	12.2	8.0	1.5
Women	12.1	6.9	1.7
Total	12.1	7.4	1.6

Source: CDC 2022. National Diabetes Statistics Report, 2021. Appendix Table 3. https://www.cdc.gov/diabetes/data/statistics-report/appendix.html

Death Rates

Age-adjusted diabetes death rates per 100,000 (2019)

	Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
Male	47.1	24.9	1.9
Female	32.6	14.3	2.3
Total	38.8	19.1	2.0

Source: CDC 2022. National Vital Statistics Report, Vol. 70, No. 8. Table 10. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-08-508.pdf [PDF | 2.05MB]

Related Conditions

Age-adjusted percentage of visual impairment for adults with diabetes (2021)

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
18.4	16.0	1.2

Source: CDC 2022. National Diabetes Surveillance System. https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html [Accessed 12/16/2022]

Hospital admissions per 100,000 for uncontrolled diabetes without complications, age 18 and over, 2019

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
115.9	30.6	3.8

Source: National Healthcare Quality and Disparities Reports. Data Query: Table 5_4_1_1_1_.2a. http://nhqrnet.ahrq.gov/inhqrdr/data/query [Accessed 12/16/2022]

Hospital admissions with diabetes with long-term complications per 100,000, age 18 and over, 2019

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
231.5	94.3	2.5

Source: National Healthcare Quality and Disparities Reports. Data Query. https://datatools.ahrq.gov/nhqdr [Accessed 12/16/2022]

Age-adjusted incidence rate per million of end stage renal disease (ESRD) due to diabetes, 2019

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
437.5	138.2	3.2

Source: National Healthcare Quality and Disparities Reports. Data Query. http://nhqrnet.ahrq.gov/inhqrdr/data/query [Accessed 11/10/2022]

Age-adjusted incidence rate per million of end stage renal disease (ESRD) related to diabetes, 2018

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
326.5	111.8	2.9

Source: CDC 2022. National Diabetes Surveillance System. https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html

Treatment

Age-adjusted percentage of persons 40 years of age and over with diabetes who had received an influenza immunization, 2019

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
55.3	65.2	0.8

Source: National Healthcare Quality and Disparities Reports. Data Query: [Accessed 11/10/2022]
http://nhqrnet.ahrq.gov/inhqrdr/data/query

Age-adjusted percentage of persons 40 years of age and over with diabetes who had a foot examination, 2019

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
67.3	66.3	1.0

Source: National Healthcare Quality and Disparities Reports. Data Query: [Accessed 11/10/2022]
http://nhqrnet.ahrq.gov/inhqrdr/data/query

Age-adjusted percentage of adults 40 years of age and over with diabetes who had a dilated eye examination, 2019

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
57.5	63.9	0.9

Source: National Healthcare Quality and Disparities Reports. Data Query: [Accessed 11/10/2022]
http://nhqrnet.ahrq.gov/inhqrdr/data/query

Age-adjusted percentage of adults aged 40 and over with diagnosed diabetes who received 2 or more hemoglobin A1c measurements in the calendar year, 2019

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
75.1	79.2	0.9

Source: National Healthcare Quality and Disparities Reports. Data Query: [Accessed 11/10/2022]
http://nhqrnet.ahrq.gov/inhqrdr/data/query

Risk Factors

There are several risk factors related to diabetes. Some of these risk factors are:
Obesity and Overweight - See Obesity and African Americans
Hypertension - See Heart Disease and African Americans
High Cholesterol - See Heart Disease and African Americans
Cigarette Smoking - See Heart Disease and African Americans

What Percentage of Black Americans Have Diabetes?

The rates of diagnosed diabetes in adults by race/ethnic background are: 14.5% of American Indians/Alaskan Natives. 12.1% of non-Hispanic Blacks. Jul 28, 2022

Diabetes and African Americans

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Diabetes: Issues of Insulin
NBCI’s Position on Insulin

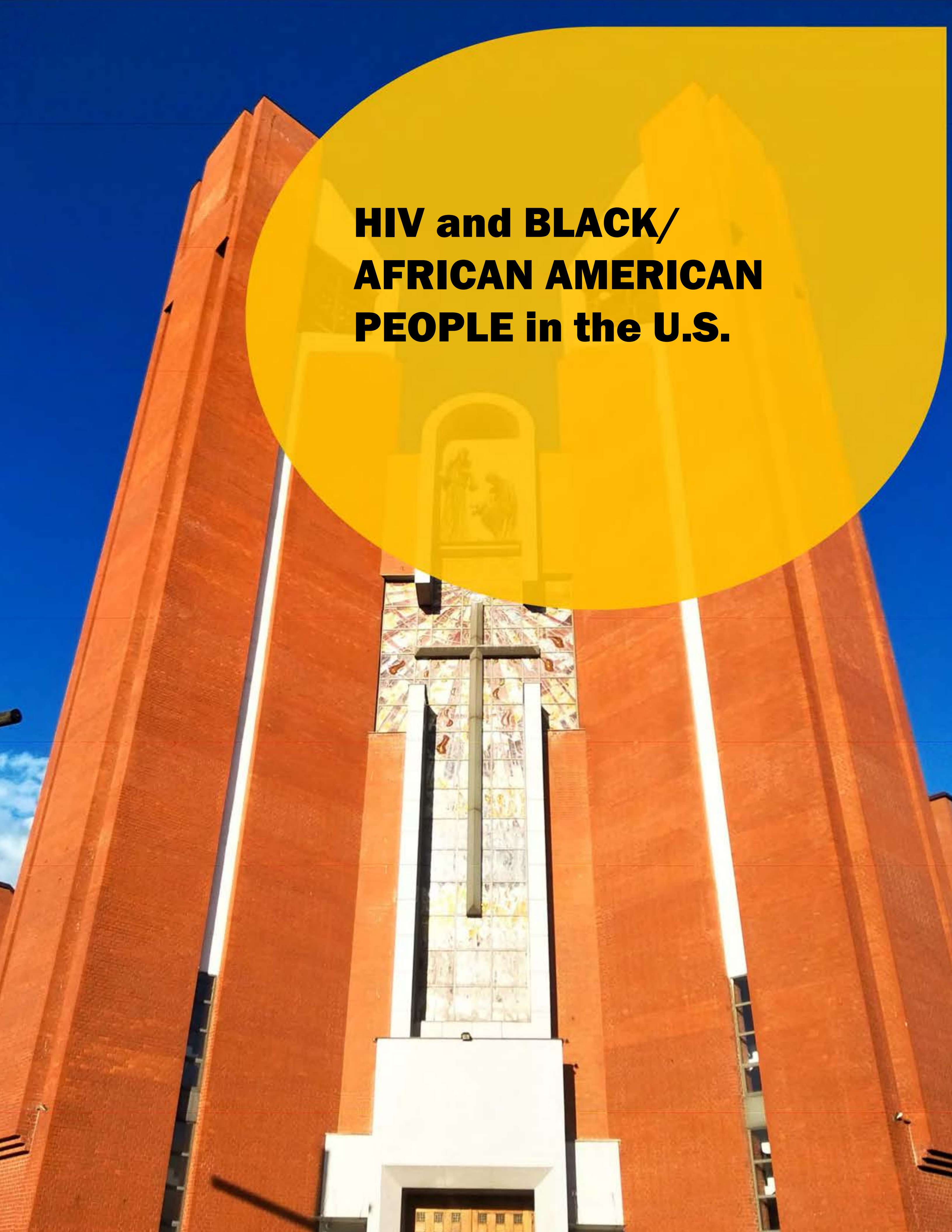
The industry has been working nonstop on issues associated with the costs patients pay for insulin. It’s important to note that in the case of insulin, more so that almost any other drug, the price a patient pays bears no relationship to the price a manufacturer receives for that dose. The market for insulin itself shows the pernicious problem of insurance company and pharmacy benefit managers in the value chain between manufacturers and patients.

A recent study by Milliman highlights this issue. It shows that from 2007 to 2021 the rebates collected by insurers and PBMs on insulin - and not passed along as savings to patients - grew exponentially. While the net price received by the manufacturer decreased each year. In 2021 the value of rebates and discounts captured by insurers for insulin was $448 per prescription. This is the issue in the system that must be changed in order to fundamentally address what patients actually pay.

Certain improvements have been made. For instance, the inflation reduction act passed last year will cap the cost of insulin for Medicare patients at $35 per month. Additionally, Congress recently introduced the Pharmacy Benefit Manager Transparency Act, which would require insurers disclose those significant rebates they are taking on insulin prescriptions and show where they are going in the system. Additionally, there was a rule proposed during the last Presidential administration that would have required all these rebates collected by insurers be passed along to patients as savings at the pharmacy counter (the Rebate Rule), but unfortunately the insurance industry convinced Congress to kill this rule.

In short, advocating for the passage of the PBM Transparency Act and the reintroduction of the Rebate Rule would have a profound impact on actually lowering costs for patients who need insulin. It would also allow for more generic competition for insulin, which right now is hampered due to PBMs preference for higher cost insulin due to their ability to extract significant rebates to help their own bottom line, and not those of their patients.

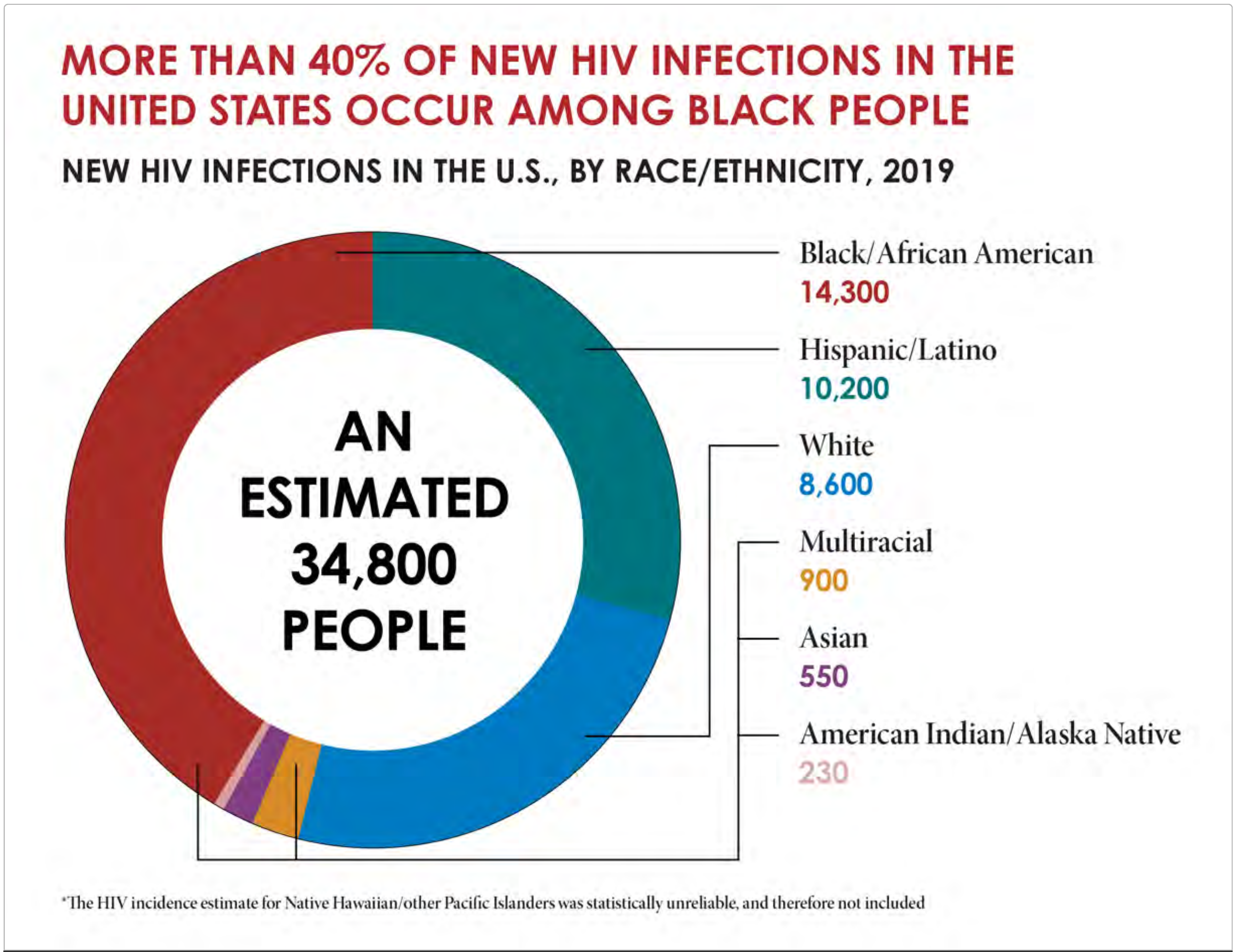
Analysis of insulin competition and costs in the United States (milliman.com)



HIV and BLACK/ AFRICAN AMERICAN PEOPLE in the U.S.

HIV and Black/African American People in the U.S.

Racism, systemic inequities, social and economic marginalization, residential segregation, and other longstanding barriers are key drivers of the disproportionate impact of HIV among Black or African American (hereafter referred to as Black) communities in the U.S.



The donut graph shows the estimated 34,800 people with new HIV infections in the U.S., by race and ethnicity, in 2019

View Larger

A growing body of research shows that centuries of racism and discrimination in this country have had a profound negative impact on communities of color. The impact is pervasive and deeply embedded in society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to housing, quality education, wealth, employment, and a range of other social and economic benefits. These conditions—often referred to as social determinants of health—are key drivers of health inequities, causing people within some populations to experience greater risk for poor health outcomes.

With effective prevention and treatment tools at our disposal, the nation has a decades-in-the-making opportunity to end the domestic HIV epidemic and eliminate disparities in HIV prevention and care. CDC is working with partners on many fronts—including the federal *Ending the HIV Epidemic in the U.S.* (EHE) initiative—to deliver and scale up key, science-based HIV treatment and prevention strategies in innovative ways that reach populations equitably.

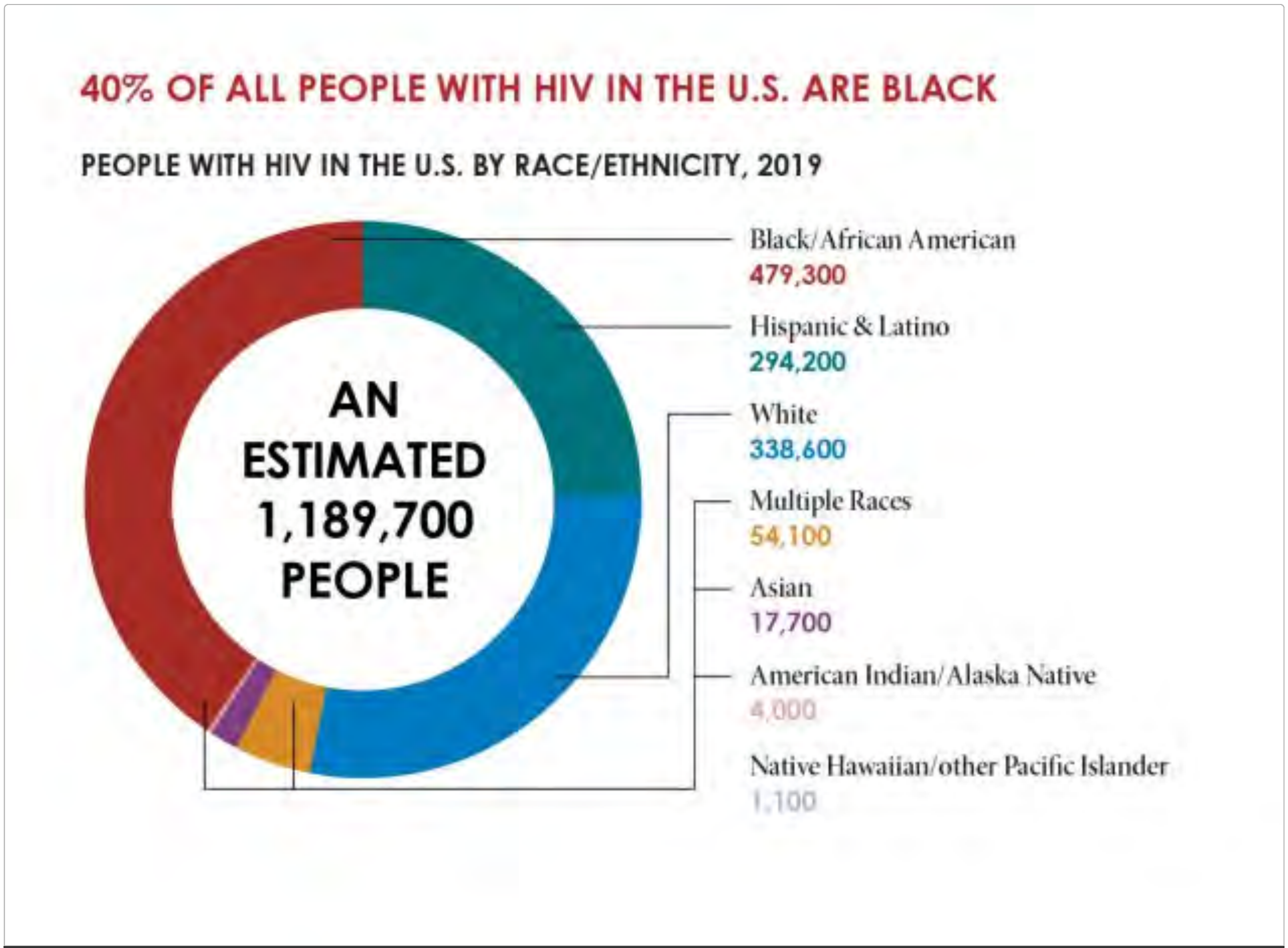
COVID-19 and HIV

The COVID-19 pandemic in the U.S. led to disruptions in HIV testing and access to clinical services throughout 2020. Although the full impact of the COVID-19 pandemic on HIV in the U.S. will not be known for some time, recent CDC data have shown concerning setbacks to HIV prevention, including sharp declines in HIV testing and diagnosis, as well as slowed pre-exposure prophylaxis (PrEP) prescriptions. In 2020, 44% fewer HIV tests were administered among Black people in non-healthcare settings than in 2019.

Due to the disruptions in testing and clinical care services, CDC is not able to estimate new HIV infections ("HIV incidence") for 2020 or to provide HIV trends through 2020. CDC is also unable to estimate the total number of diagnosed and undiagnosed HIV infections ("HIV prevalence"); or knowledge of HIV status.

SECTION 1: DESPITE PROGRESS, HIV CONTINUES TO DISPROPORTIONATELY AFFECT BLACK PEOPLE IN THE U.S.

CDC estimates that, as of 2019, about 1.2 million people in the U.S. have HIV. In 2019, Black people accounted for 13% of the U.S. population but 40% (479,300) of people with HIV.

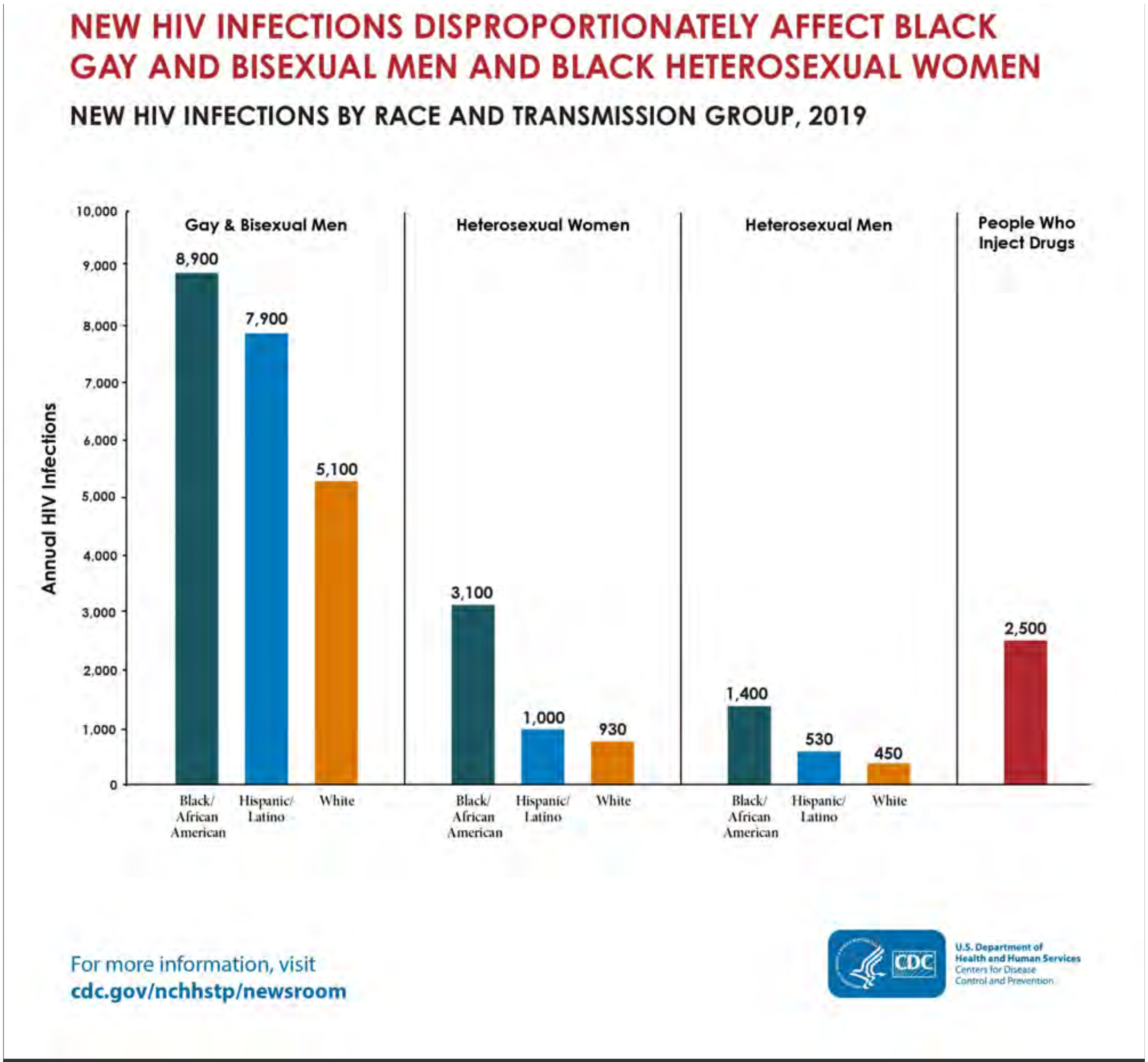


The donut chart shows people with HIV in the U.S. by race and ethnicity

View Larger

While new HIV infections declined 8% overall from 2015 to 2019, they remained stable among Black people during that timeframe.

New HIV Infections Disproportionately Affect Black Gay and Bisexual Men and Black Heterosexual Women



The bar chart shows the number of new HIV infections by race and ethnicity and transmission category

View Larger

BLACK MEN accounted for three-quarters of new HIV infections among all Black people in the United States in 2019, with 82% of infections attributed to male-to-male sexual contact. Furthermore, a CDC analysis found that Black gay and bisexual men were less likely to receive an HIV diagnosis, use PrEP to prevent HIV, and be virally suppressed compared to White gay and bisexual men.

FOR BLACK WOMEN, 91% of new HIV infections were attributed to heterosexual contact while the HIV infection rate among Black women was the highest compared to women of all other races and ethnicities.

Additionally, a recent CDC study found that **BLACK TRANSGENDER WOMEN** accounted for **62%** of HIV infections among transgender women with HIV living in seven major U.S. cities.

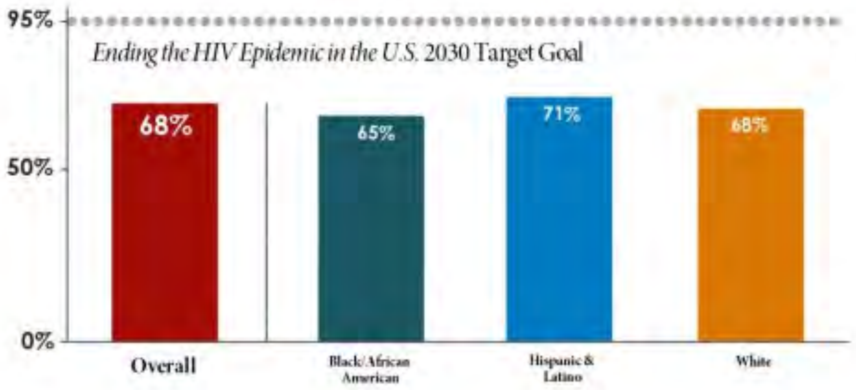
SECTION 2: HIV PREVENTION AND TREATMENT ARE NOT REACHING PEOPLE WHO NEED IT MOST

To end the HIV epidemic, **the nation must scale up HIV testing; link people with HIV to care and treatment; and ensure equitable access to HIV prevention—including PrEP**—for everyone who could benefit.

Approximately 13% of Black people with HIV in the U.S. still do not know their status, and few are receiving adequate HIV care and treatment that will help them get and keep viral suppression, and live longer, healthier lives. Further, PrEP use is lowest among Black people relative to White and Hispanic and Latino people.

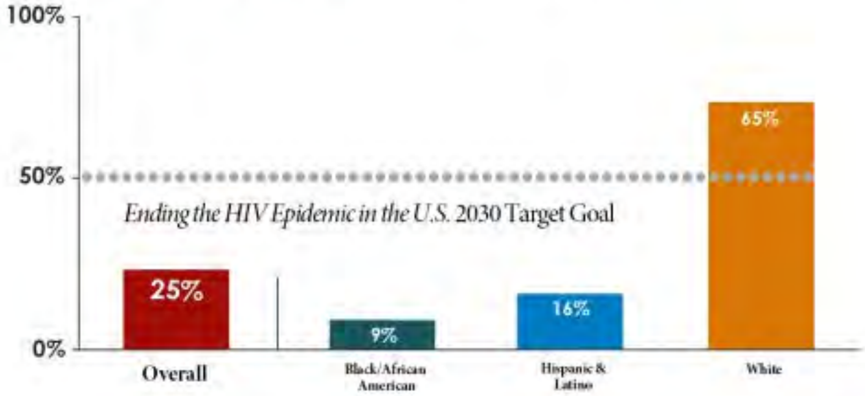
IN 2020, JUST 65% OF BLACK PEOPLE IN THE U.S. WERE VIRALLY SUPPRESSED WITHIN SIX MONTHS OF DIAGNOSIS

VIRAL SUPPRESSION IN THE U.S. BY RACE/ETHNICITY, 2020 (46 JURISDICTIONS)



ONLY 9% OF BLACK PEOPLE IN THE U.S. WHO WERE ELIGIBLE FOR PREP IN 2020 WERE PRESCRIBED IT, SHOWING THAT UNEQUAL COVERAGE PERSISTS

PREP COVERAGE IN THE U.S. BY RACE/ETHNICITY, 2020



SECTION 3: WE MUST EQUITABLY DELIVER EFFECTIVE HIV PREVENTION AND TREATMENT

To achieve health equity and end the HIV epidemic, the nation must overcome systemic racism, homophobia, transphobia, HIV-related stigma, and other ingrained barriers that have contributed to disparities for far too long.

Innovation is also key. For example, a total-person approach to care integrates HIV prevention and treatment into health services that people are already seeking. This approach also addresses interconnected epidemics, such as sexually transmitted infections and hepatitis. HIV self-testing and mobile services should be maximized to reach people where they are—which, for many, is outside of traditional health care settings. And because not all areas can implement the most recent advances in HIV prevention and care, health care providers and prevention partners must deliver resources to the communities most in need.

CDC's key efforts include:

- CDC monitors and reports HIV data, including diagnoses, linkage to care, viral suppression, and PrEP prescriptions.

CDC shares these data publicly through various channels—including annual data reports and America's HIV Epidemic Dashboard (AHEAD) —so that federal, state, and local health authorities can use this information to equitably address HIV.

- CDC analyzes data to call urgent attention to concerning trends in disparities. For example, recent CDC analyses have identified that despite overall progress, new HIV infections remained flat among Black gay and bisexual men in the decade leading up to the federal EHE; and that nearly two in three Black transgender women surveyed in seven major U.S. cities have HIV.
- CDC awards $400 million per year to health departments for integrated HIV data collection and prevention efforts. Through these awards, health departments work to reach the populations and geographic areas with the greatest need.
- The federal EHE initiative is also working to address disparities. In July 2020, CDC awarded approximately $109 million to state and local health departments within the 57 EHE jurisdictions to begin the first year of a five-year funding program. In July 2021, CDC awarded $117 million to those areas to help rebuild and begin to expand HIV prevention and treatment efforts as the U.S. continues to respond to COVID-19.
- CDC funds community-based organizations (CBOs), which are positioned to complement the HIV prevention work of health departments, in two ways: CDC provides direct funding to CBOs, as well as indirect funding to CBOs through health departments. CDC is providing up to $210 million in direct funding over five years, through 2026, to nearly 100 CBOs to implement comprehensive HIV prevention programs. These resources are focused on Black gay and bisexual men, transgender people, cisgender women and people who inject drugs.
- In April 2022, CDC awarded funds to 36 CBOs to develop and implement high-impact prevention programs for young gay and bisexual men of color and transgender youth of color. These programs will be guided by a status-neutral approach to care; continually engage people who could benefit from HIV care, prevention, and essential support services; and address the social determinants of health that adversely affect HIV outcomes in young gay and bisexual men and transgender people of color.
- To help reduce stigma and encourage people who experience risk for and with HIV to seek out vital testing, treatment, and prevention services, CDC works with community partners to design and deliver education and awareness campaigns such as *Let's Stop HIV Together*. *Let's Stop HIV Together* reaches Black people with culturally appropriate messages about HIV testing, prevention, and treatment.
- CDC identifies evidence-based interventions and best practices through CDC's HIV Prevention Research Synthesis (PRS) Project. The PRS Project has identified several interventions for Black people, including *Centralized HIV Services*, the *PrEP Counseling Center*, and *Project IMAGE*.
- CDC centers its work on health equity by developing and implementing strategies and programs to address health disparities through the Office of Health Equity.
- CDC builds capacity for HIV epidemiologic and prevention research in Black communities through the Minority HIV/AIDS Research Initiative program.

To end the HIV epidemic once and for all, the nation must work together to increase the accessibility and uptake of powerful HIV prevention and treatment tools by everyone.

HIV/AIDS and the African-American Community 2018: A Decade Long Call to Action

HIV/AIDS disproportionately affects African Americans more than any other racial or ethnic group in the USA. Currently representing only 12% of the US population, African Americans now comprise close to half of the total reported HIV/AIDS cases in the USA according to the Centers for Disease Control and Prevention since the initial reporting of HIV/AIDS. In this paper, we examined the prevalence and current direction of the HIV/AIDS epidemic in the African-American community especially in comparison to our first call to action in 2008. The situation remains dire and broader attention is necessary from the public health and medical sectors who serve the majority of African-American populations and the community at-large to work towards closing this health disparity gap. This paper thus recommends an action plan for community leaders (i.e., the public health sector, policy makers, public health practitioners, and other stakeholders) to reduce the disparity.

Figures

Figure 1.

New HIV Diagnoses (including children) by Race 2005
Adapted from 2005 CDC Fact Sheet: HIV/AIDS among African-Americans

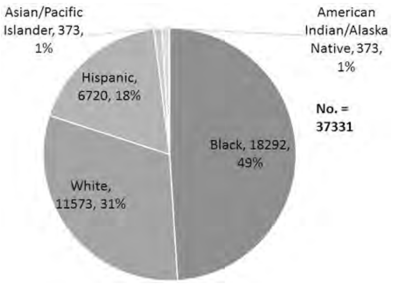


Figure 2.

New HIV Diagnoses (including children) by Race 2016
Adapted from 2016 HIV Surveillance Report by the CDC

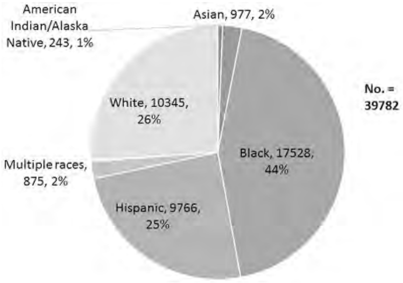


Figure 3.

HIV Diagnoses Among Men Who Have Sex with Men, by Race/Ethnicity and Age at Diagnosis, 2016. Adapted from CDC. Adapted from the CDC

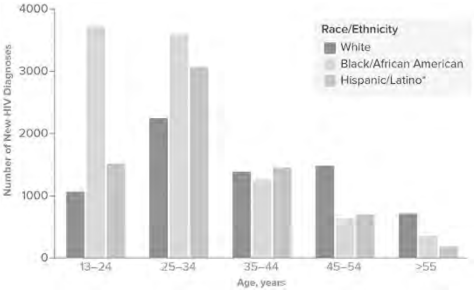


Figure 4.

Largest Categories for Affected Individuals by race and transmission influence.

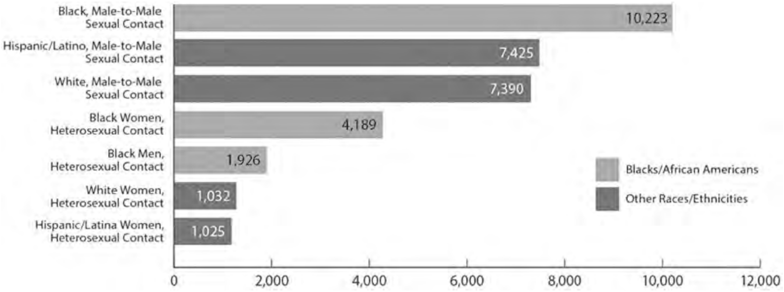


Figure 5.

Largest Categories for Affected Individuals by Sex and Transmission Influence in 2005.

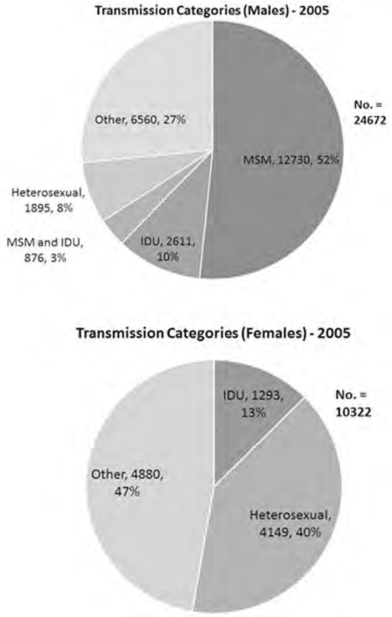
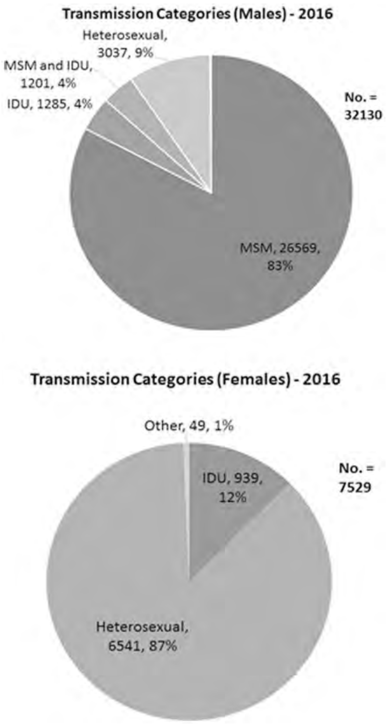
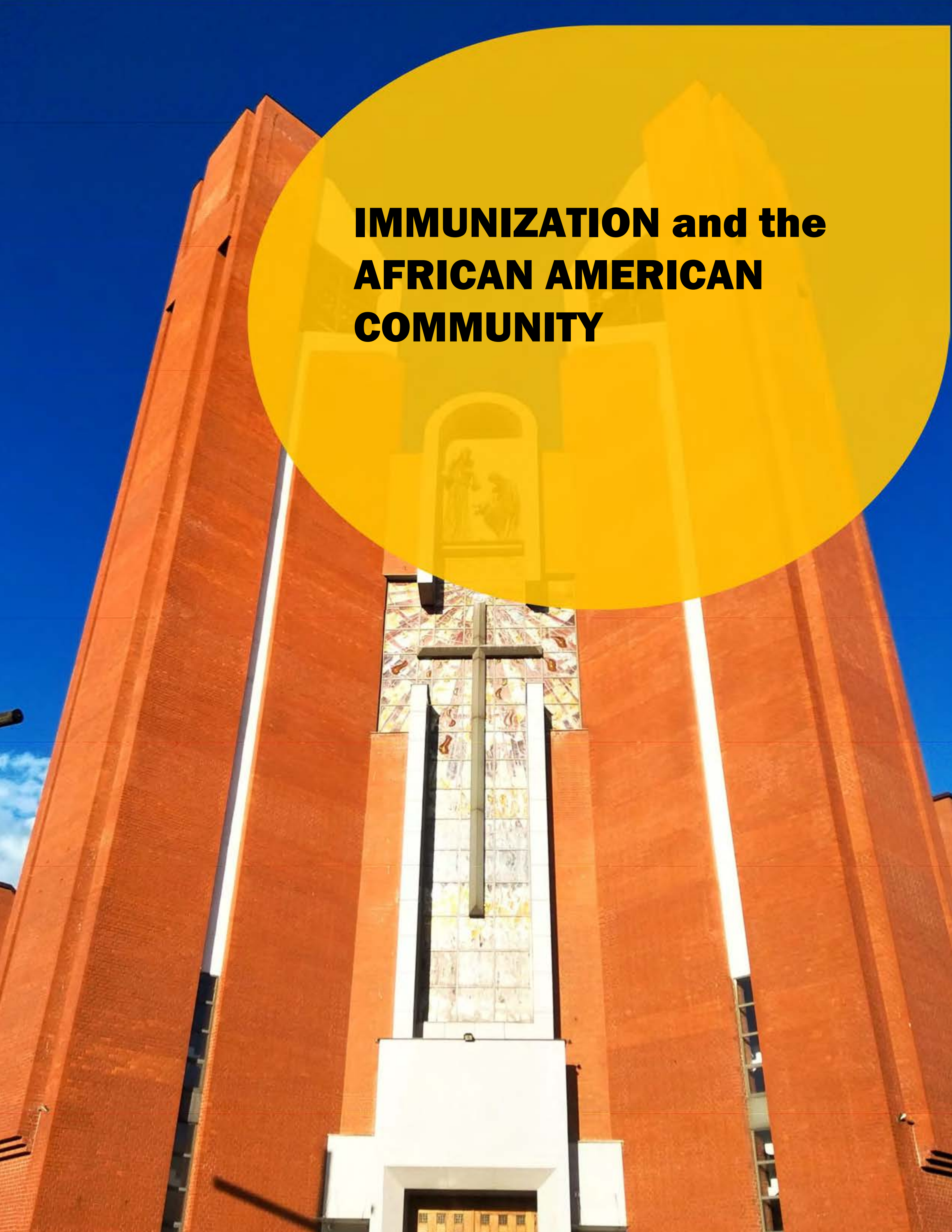


Figure 6.

Largest Categories for Affected Individuals by Sex and Transmission Influence in 2016.





IMMUNIZATION and the AFRICAN AMERICAN COMMUNITY

Immunization and the African American Community

Immunizations and African Americans - The Office of Minority Health (hhs.gov)

What is Immunization?

According to the Centers for Disease Control and Prevention (CDC), immunization is a process by which a person becomes protected against a disease through vaccination. This term is often used interchangeably with vaccination or inoculation. Vaccination is the act of introducing a vaccine into the body to produce protection from a specific disease.

What are the Rates of Immunizations among African American Populations?

African American adults are less likely than non-Hispanic white adults to have received a flu vaccine in the past year or to have ever received the pneumonia vaccine.

- In 2018, Non-Hispanic Blacks aged 65 and older were 10 percent less likely to have received the influenza (flu) shot in the past 12 months, as compared to non-Hispanic whites of the same age group.
- African American children aged 19 to 35 months had comparable rates of immunization in 2017.
- African Americans are 10 percent less likely to have received a human papillomavirus (HPV) vaccine as white populations.

National Black Church Initiative Launches Immunization Program

Introduction

On December 17th in Harlem, New York, the National Black Church Initiative along with two local clinics staged an immunization rally in front of the CVS on 125th Street and Fedrick Douglas. The purpose of the rally was to encourage all New Yorkers to get their flu shots and COVID boosters and to restart their immunization schedule to prevent common disease states. The rally consisted of music, news conference, literature, and the rendering of flu shots. The campaign particularly focused on the Black, Latino, and related vulnerable populations.

https://www.youtube.com/watch?v=E9N-xal2BM0&t=1128s

As you know, COVID interrupted the lives of families and individuals as well their immunization schedules. Thus, this new effort by The National Black Church Initiative, working with state, city, health officials, clinics, and churches, will provide critical information and education about immunization. The new effort further involves building vaccine confidence during the COVID pandemic. Additionally. It is important to note that two weeks before this rally, Cornerstone Baptist Church, one of our most historic churches, launched NBCI's first vaccine event for the season.

To that end, these two events served as our soft opening to a national campaign which, in return, would consist of, but are not limited to, news conferences, immunization rallies, educational sessions, literature, and the launch of our immunization online tracker.

Following below are various approaches taken by NBCI to address immunization efforts:

1) NBCI immunization Online Tracker

NBCI has developed and launched an online immunization tracker as an online information hub and portal. The purpose of the tracker is for the explicitly purpose of documenting the 15-city immunization tour, providing real-time information on where and how you can get flu and COVID shots, and how to start tracking every vaccination that families might need.

The immunization tracker also involves the following areas:
-Schedule of NBCI immunization rallies and events;
-A how-to guide to evaluating what vaccinations your family needs and where to get them;
-Location of NBCI churches that will be offering flu, COVID, and other immunization vaccinations for individuals and their families; and
-Education literature on how to build vaccine confidence;

2) Methodological Plan

A. Immunization Rallies

We will hold a public rally in front of Walgreens of CVS consisting of music, literature hand-outs, and motivational approaches to help build vaccine confidence.

B. Partner with City and state health officials

NBCI has contacted all the city and state health officials in fifteen cities. We will partner with them to provide immunization clinics in our churches. The partnership is critical for the purpose of messaging and with the local and social media to the public. The purpose is to dispel any midst around immunization and to help build vaccine confidence with ministers, key stakeholders, and public health experts saying the same message.

C. Clinics

NBCI currently has strong relationships with public, private, faith-based and federal clinics to create a vaccine immunization health web utilizing NBCI churches as vaccine centers.

D. Utilizing NBCI Churches as Vaccination Centers

NBCI has designated 50 churches in every city as a part of the immunization city tour. Twenty-five (25) of the churches are committed to offering immunizations/flu events at their churches partnering with the city health department and their partner neighborhood health clinics. The other 25 churches will distribute immunization information driving their people to the other 25 immunization churches to receive their vaccine immunization shots.

The churches that serve as immunization centers are closely aligned with the churches. These churches offer literature based on their city or state zip code clusters and NBCI key and non-key church locations.

The immunization churches as well as the literature churches will report in real-time. The numbers of the following categories involve the NBCI immunization tracker with consideration of the following information:

- How many people were vaccinated?
- How many seniors were vaccinated?
- How many people were given literature?
- How many immunization health sermons were given?
- How many families were vaccinated?
- How many individuals were vaccinated?
- How many disabled individuals were vaccinated (vulnerable populations)

All of this data will be reviewed on the NBCI immunization tracker within 12 hours of the event.

3) 15 Participating Cities

- Washington, DC
- Baltimore, MD
- Richmond, VA
- Harlem, New York *(done December 17, 2022)*
- Co-op City Bronx, NY
- Chicago, IL
- Detroit, MI
- Houston, TX
- Dallas, TX
- Los Angeles, CA
- Oakland, CA
- Miami, FL
- Orlando, FL
- Jackson, MS
- Charlotte, NC
- Columbia, SC
- Savannah, GA
- Atlanta, GA

4) Immunization Newspaper

NBCI is working on “Vaccnews”, a one-page newspaper that focuses m on the issues of building vaccine confidence around the issue of roadblocks in the Black and Latino communities.

NATIONAL BLACK CHURCH INITIATIVE

Please Get Vaccinated!

VACCNEWS

BLACK LIVES MATTER

COVID IS NOT OVER!

BLACK AND LATINO DOCTORS AND THE BLACK CHURCH CONTINUE TO URGE AND EDUCATE THE COMMUNITY THAT COVID-19 IS STILL A MAJOR THREAT TO THE HEALTH OF BOTH COMMUNITIES

EVERYONE SHOULD BE VACCINATED AND BOOSTED AT ALL TIMES

COVID Deaths as of 29 September

Worldwide = 616,747,328 confirmed cases; 6,542,409 deaths, reported to WHO

USA = 95,972,697 confirmed cases; 1,052,949 deaths, reported to CDC

As of 29 September 2022, a total of 9,052,820,536 vaccine doses were administered around the world.

The trend of both confirmed cases and deaths is downward around the world.

Novavax Launches New Vaccine and Why This is Important!

The NEW BOOSTER Vaccines are Ready

How Does COVID-19 Spread?

How Do I know If I Have COVID-19?

COVID POSITIVE TEST

COVID NEGATIVE TEST

Stephen A. Smith of ESPN Off-Air With COVID-19 Again Just 10 Months After Near-Death Experience With the Virus

“COVID IS NO JOKE - GET VACCINATED!”
- Stephen A.

We will tackle the issues of hesitancy and misinformation, given the skepticism that continues to exist among a skeptical minority population about vaccines in general during this pandemic.

The newspaper will be presented at a third to fifth-grade reading level tackling some of the most difficult issues surrounding vaccine hesitancy and confidence.

Lastly, in everyday language, the paper will explain what the research is revealing concerning immunization and vaccination particularly focusing on the Black and Latino communities.

Projected Impact

This is a year-long project and it's with involves the following:

50,000 NBCI churches
200 City, State, and Federal agencies
5467 Public, federal, and Private Community-Based Clinics
3.7 million social media posts and email blast
245 Black and Latino newspaper and media outlets
Seven percent to 15% increase in immunization.
10-15 million of Black and Latino members would be positively impacted by a vaccine confidence message.

Immunizations and African Americans

What is Immunization?

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- African American children aged 19 to 35 months had comparable rates of immunization in 2017.
- African Americans are 10 percent less likely to have received a human papillomavirus (HPV) vaccine as white populations.

Adults (Hepatitis)

Percentage of adults ages 19-49 years, high risk groups, who received 3 doses of the hepatitis B vaccination, 2018

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
35.4	43.6	0.8

Source: CDC 2022. Vaccination Coverage among Adults in the United States, National Health Interview Survey, 2018. Box 3, Table 2.
https://www.cdc.gov/mmwr/volumes/70/ss/ss7003a1.htm

https://stacks.cdc.gov/view/cdc/105322

Adults (Influenza)

Age-adjusted percentage of adults age 65 years and older who received the influenza (flu) shot, 2021-2022 season		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
67.8	75.7	0.9

Source: CDC 2022. Flu Vaccination Coverage, United States, 2021–22 Influenza Season. https://www.cdc.gov/flu/fluvaxview/coverage-2022estimates.htm

Age-adjusted percentage of adults age 18 and over who received the influenza (flu) shot, 2021-2022 season		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
42.0	53.9	0.8

Source: CDC 2022. Flu Vaccination Coverage, United States, 2021–22 Influenza Season. https://www.cdc.gov/flu/fluvaxview/coverage-2022estimates.htm

Adults (Pneumonia)

Age-adjusted percentage of adults age 65 years and older who ever received the pneumococcal vaccine (pneumonia shot), 2018		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
59.8	72.6	0.8

Source: CDC 2022. Vaccination Coverage among Adults in the United States, National Health Interview Survey, 2018; Table 2.
https://www.cdc.gov/mmwr/volumes/70/ss/ss7003a1.htm

Age-adjusted percentage of high-risk adults age 19 to 64 years who ever received the pneumococcal vaccine (pneumonia shot), 2018		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
25.7	23.6	1.1

Source: CDC 2022. Vaccination Coverage among Adults in the United States, National Health Interview Survey, 2018; Table 2.
https://www.cdc.gov/mmwr/volumes/70/ss/ss7003a1.htm

Adults (HPV)

Percentage of women ages 19 to 26, who ever received at least 1 dose of the human papillomavirus (HPV) vaccination, 2018		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
45.2	56.5	0.8

Source: CDC 2022. Vaccination Coverage among Adults in the United States. Estimated proportion of adults aged 19–26years who received at least one dose of human papillomavirus (HPV) vaccine, by age group, sex, and race/ethnicity —National Health Interview Survey, United States, 2018. Suppl. Box 4. https://stacks.cdc.gov/view/cdc/105323

Adolescents (Hepatitis)

Percentage of adolescents aged 13 to 17 years who received 3 doses of the hepatitis B vaccination, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
92.2	92.9	1.0

Adolescents (Measles, Mumps, Rubella (MMR))

Percentage of adolescents aged 13 to 17 years who received 2 doses of measles, mumps, rubella vaccination, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
92.1	93.5	1.0

Adolescents (Tdap)

Percentage of adolescents aged 13 to 17 years who received the tetanus- diphtheria booster or Tdap, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
90.6	90.1	1.0

Adolescents (HPV)

Percentage of adolescents aged 13 to 17 years who ever received the human papillomavirus (HPV) vaccination, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
81.7	74.4	1.1

Source: CDC 2022. Vaccination Coverage with Selected Vaccines and Doses Among Adolescents Aged 13–17 Years, National Immunization Survey–Teen, United States, 2021. Suppl Table 1. https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/pubs-presentations/nis-teen-vac-coverage-estimates-2021-tables.html

Children (DTaP)

Percentage of children aged 19 to 35 months who received the universally recommended vaccination – 4 doses of diphtheria-tetanus-acellular pertussis (DTaP), 2017		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
79.7	83.0	1.0

Children (Hib)

Percentage of children aged 19 to 35 months who received the universally recommended vaccination – full series Haemophilus influenzae type b (Hib), 2017		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
77.4	81.0	1.0

Children (Hepatitis B)

Percentage of children aged 19 to 35 months who received the universally recommended vaccination – 3 doses hepatitis B (hep B) vaccine, 2017		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
91.8	91.1	1.0

Children (MMR)

Percentage of children aged 19 to 35 months who received the universally recommended vaccination – 1 dose of measles-mumps-rubella (MMR), 2017		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
89.5	91.2	1.0

Children (Polio)

Percentage of children aged 19 to 35 months who received the universally recommended vaccination – 3 doses of polio, 2017		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
91.5	92.3	1.0

Children (Chicken Pox)

Percentage of children aged 19 to 35 months who received the universally recommended vaccination – 1 dose varicella vaccine (chicken pox), 2017		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
89.3	90.3	1.0

Children (Fully Immunized)

Percentage of children aged 19 to 35 months who are fully immunized, 2017 (4:3:1:3)		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
66.5	71.5	0.9

Source: CDC 2018. Vaccination Coverage Among Children Aged 19–35 Months — United States, 2017. Supplementary Table 1.
https://stacks.cdc.gov/view/cdc/59414

VACCINE DEVELOPMENT, LICENSURE & SAFETY

The creation of a vaccine involves scientists and medical experts from around the world, and it usually requires **10 to 15 years of research** before the vaccine is made available to the general public.[1]

Safety is a priority at every stage of vaccine development.[2]

Vaccine Development

Clinical Development	Regulatory Review and Approval	Manufacturing
Clinical trials generally involve three phases of research studies in humans to evaluate the safety and efficacy of a vaccine, with each phase growing by more and more volunteers. By the time a vaccine is up for approval, tens of thousands of people have participated and definitive safety information has been established.	Through a rigorous data review process, experts at the Food & Drug Administration (FDA) determine whether a vaccine is safe, effective, and can be manufactured at a high quality and on a consistent basis. Only after these criteria are met, FDA will provide its stamp of approval.	Manufacturers work to ensure they adhere to the highest quality manufacturing standards and routinely verify the quality of the vaccine being produced. This quality is then verified separately by the FDA for each lot produced.

Vaccine Licensing

FDA licenses a vaccine only if it is safe and effective and its benefits outweigh any risks.[3] In some cases, FDA seeks advice from an external advisory committee to assist in assessing benefits and risks. The Vaccines and Related Biological Products Advisory Committee (VRBPAC) is a panel of outside, independent, technical experts from various scientific and public health disciplines that provide input on scientific data and its public health significance in a public forum. Its input is considered by FDA, but is not binding when determining whether to approve a vaccine.

Recommendations for Use of Vaccines

A vaccine receives a recommendation from the Centers for Disease Control & Prevention (CDC) only after FDA approves and licenses it. Healthcare professionals seek guidance from the Advisory Committee on Immunization Practices (ACIP), a group of independent medical and public health experts who develop vaccine use recommendations and schedules. An ACIP recommendation does not mean that a vaccine is required for use. State legislatures and health departments determine whether a vaccine is required.

Vaccine Safety Monitoring

After a vaccine is licensed, its safety continues to be monitored. CDC, FDA and numerous US university medical centers and health organizations have systems and approaches to watch for adverse events (or side effects) and assure that possible risks associated with use of the vaccine by the public are identified.

- **Vaccine Adverse Event Reporting System (VAERS)**
  - *Analyzes reports of adverse events that happen after vaccination. Anyone can submit a report to VAERS, and submissions do not mean that a vaccine definitely caused the event.*
- **Vaccine Safety Datalink (VSD)**
  - *Analyzes healthcare information from more than 24 million people in group form (protects an individual's confidentiality)*
- **Post-Licensure Rapid Immunization Safety Monitoring (PRISM)**
  - *Analyzes healthcare information from more than 190 million people in group form (protects an individual's confidentiality)*
- **Clinical Immunization Safety Assess (CISA) Project**
  - *CDC collaborates with 7 medical research centers that provide expert technical advice and research focused on vaccine safety and decreasing side effects*
- **Emergency Preparedness for Vaccine Safety**
  - *Activated by CDC in event of disease outbreak in which mass vaccination programs are needed*

Making a Vaccine

Vaccines against various viruses and bacteria are designed and manufactured in different ways.[4]

Approaches for different types of vaccines include:

Weakening the virus or bacteria in a laboratory, usually by repeated culturing[5], and then given to a human to provoke an immune response[6]

Examples
Chickenpox,
Measles

Completely **inactivating (killing) the virus** with a chemical

Examples:
Polio,
Influenza

Using part of the **virus or bacteria (the pathogen)** as the vaccine

Examples:
Shingles,
Hepatitis B

Inactivating (killing) a harmful protein made by bacteria (a toxin) with a chemical

Examples:
Tetanus,
Diphtheria

Using part of the **genetic material for a specific protein** that directs the body to produce a small amount of that protein, to which the immune system reacts defensively once detected.[7] These are not gene therapies.[8]

Examples:
COVID-19

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[1] New York State, Department of Health. The Science Behind Vaccine Research and Testing. https://www.health.ny.gov/prevention/immunization/vaccine_safety/science.htm

[2] CDC: Overview, History, and How the Safety Process Works. https://www.cdc.gov/vaccinesafety/ensuringsafety/history/index.html

[3] Journey of Your Child's Vaccine. Centers for Disease Control. https://www.cdc.gov/vaccines/parents/infographics/journey-of-child-vaccine-h.pdf

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[6] History of Vaccines. Different Types of Vaccines. https://historyofvaccines.org/vaccines-101/what-do-vaccines-do/different-types-vaccines

[7] CBER. Vaccine Development 101. https://www.fda.gov/vaccines-blood-biologics/development-approval-process-cber/vaccine-development-101

[8] https://www.genomicseducation.hee.nhs.uk/blog/why-mrna-vaccines-arent-gene-therapies/

VALUE OF VACCINES: A LANDMARK ACHIEVEMENT

Vaccination is often cited among the 10 greatest public health achievements of the 20th century.[1] Only access to safe and clean water has had a larger effect on human health by preventing disease and extending lifespans.[2]

In addition to their societal benefit, vaccines deliver significant benefits to individuals across their lifespan:

- **Children and adolescents are less threatened by diseases** that once damaged or cut short young lives.
- **Older adults are protected from diseases,** allowing them to remain productive and enjoy healthier years later in life.
- **Individuals are able to work, learn, and participate** in community life and travel in the US and abroad in safer, healthier environments.

Vaccines help children grow and develop free from preventable diseases.

- Over the course of their lifetimes, U.S. children born between 1994 and 2018 who are vaccinated according to the recommended immunization schedule **will prevent:**[3]
  - **419 million illnesses,**
  - **26.8 million hospitalizations,**
  - **936,000 deaths.**

Vaccines benefit the individuals who receive them, their families, *and* their communities.

- For the U.S. population in 2019 (328 million people), childhood vaccines were universally recommended.[4] These vaccines have:
  - **Prevented more than 24 million illnesses spanning all ages**
  - **Decreased hospitalizations**
    - » **91%** for rotavirus hospitalizations and pertussis
    - » **84%** for pneumococcal pneumonia
- Antibiotic resistance, a persistent and challenging problem for healthcare providers and hospitals in the community, may be reduced because of vaccines.[5]

Vaccines save money.

- CDC estimates that vaccination of children born between 1994 and 2018 will saved **$406 billion** in direct costs and nearly **$1.9 trillion** in total society costs.[9]
- Flu, pneumococcal disease, shingles, and whooping cough cost **$27 billion** to treat annually in adults over age 50.[10]

Vaccination helps protect vulnerable people.

- Young children, minorities, and the elderly bear the most significant burden of infections from vaccine preventable diseases.
- Vaccination helps reduce the risk of acquiring a disease spread from person to person,[6] especially among vulnerable groups, which include:
  - Young babies and children too young to be vaccinated
  - People undergoing chemotherapy for cancer or who have HIV
  - Children on steroids for asthma
  - The elderly who may not have an adequate immune response
  - Those without adequate access to vaccines
  - Those who choose to remain unvaccinated[7]
- For example, vaccination against chickenpox over the last 25 years has practically eliminated U.S. deaths[8] and annually prevents more than:
  - 3.8 million cases
  - 10,500 hospitalizations
  - 100 deatths

OUTBREAKS OF VACCINE PREVENTABLE DISEASE CONTINUE TO OCCUR IN MANY U.S. STATES, HIGHLIGHTING THE NEED FOR CONTINUED VACCINATION EFFORTS.

Measles

1,282 measles cases were reported in the U.S. in **2019** across **31** states and **94** counties.

Mumps

In 2019, CDC reported that there were **3,486** people infected with mumps in **48** states and DC.[9]

Hepatitis A

Since the hepatitis A outbreaks were first identified in 2016, **30 states** have reported:[13]

- **42,049** cases
- **25,524** hospitalizations
- **383** deaths[10]

Influenza

CDC estimates that flu leads to between:

- **9 million** and **41 million** illnesses every year
- **140,000** and **710,000** hospitalizations every year
- **12,000** and **52,000** deaths every year

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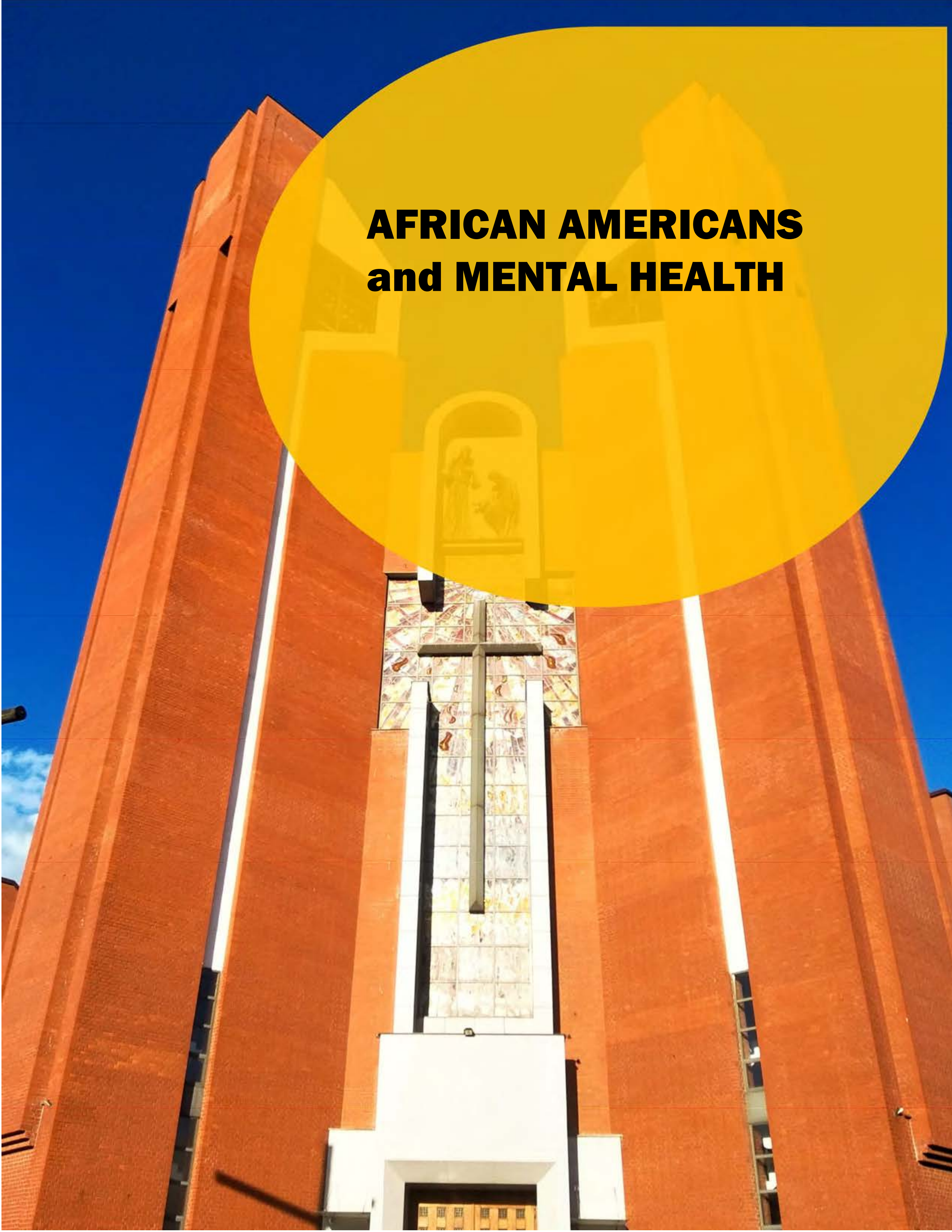

AFRICAN AMERICANS and MENTAL HEALTH

African Americans and Mental Health

According to the National Institute of Mental Health, nearly one in five U.S. adults live with a mental illness (52.9 million people in 2020). While People of Color (POC) have rates of mental health disorders similar to Whites, these disorders are more likely to last longer and result in more significant disability for POC. Most mental illness goes untreated, especially in communities of color. Fifty-two percent of Whites with AMI received mental health services in 2020, compared to 37.1% of Blacks and 35% of Hispanics.

According to SAMHSA, “service cost or lack of insurance coverage was the most frequently cited reason for not using mental health services across all racial/ethnic groups.” A 2021 report by HHS cites “persistent systemic social inequities and discrimination” that worsen stress and associated mental health concerns for POC during the COVID-19 pandemic when 40.3% of Hispanics experienced current depression, and 36.9% had an increase or initiation of substance use, compared to 25.3% depression and 14.3% substance use in Whites.

The statistics in this Fact Sheet point to significant health inequities in the United States. These inequities are reflected in differences in the average length of life, quality of life, rates of disability, severity of illness, and access to treatment. Mental health equity will be achieved when all people have the opportunity to attain their full health potential, and no one is impeded from doing so because of socially determined circumstances.

CHILDREN & TEENS

In the BIPOC community, childhood depression has been associated with increased welfare dependence and unemployment. (3)

Psychiatric and behavioral problems among BIPOC youth often result in school punishment or incarceration, but rarely mental health care. (15)

INCARCERATION & MENTAL HEALTH

Students of color, students with disabilities and students that are impacted by trauma are disproportionately disciplined and arrested rather than receiving the support and services that allow them to remain in the classroom and continue to make educational progress. (17)

Students of color who drop out of school prematurely are more than right times more likely to end up in the criminal justice system. (17)

One in 10 US Black men are put in solitary confinement before the age of 32. (12)

According to the United Nations, solitary confinement is defined as torture as it can lead to PTSD and suicide. Black men in the US are sent to solitary confinement for a longer period compared to their counterparts. (17)

People who are incarcerated with mental health illness of all races suffer mistreatment and medical neglect and have high rates of suicide and self-harm. But people of color with mental health illness are even less likely to receive proper mental health services. (9)

Inmates of color are disproportionately punished and placed in solitary confinement, which has been shown to exacerbate mental illness. Many individuals experience their first psychotic episode in these conditions. (9)

Racial bias often prevents people of color from qualifying for diversion programs that could keep them out of jail and receiving mental health treatment in jail. (9)

RACISM, MISTRUST, AND BARRIERS IN ACCESS TO CARE

Mistrust of medical and mental institutions is rooted deeply inside the Black community as a result of generations of racism, discrimination and trauma. (11)

As a result of racism, Black people are at an increased risk of developing psychosis, in part due to high amounts of chronic stress and trauma.(11)

Racial trauma can increase the risk of people of color meeting the criteria for Post-traumatic Stress Disorder. Stress plays a crucial role in how racism impacts both mental and physical health. (15)

Microaggressions are a form of racial trauma which can harm a person of color’s identity and sense of self-worth potentially impacting their mental health. (10)

Black children are more likely than White children to be put in a restraint during ED visits. According to research, systemic bias, racism, and “adultification” of Black youth specifically Black boys, may impact the way they are perceived by nurses, doctors, and other specialists.(19)

Although Black families have more contact with mental health providers, fewer Black individuals seek out family psychoeducation and other essential aspects of the treatment process due to historic mistrust in the system. (11)

People from racial and ethnic minority groups are disproportionately affected by lack of access to quality health care, health insurance, and/or linguistically and culturally responsive health care. (20)

More than 80% of Black Americans are very concerned about the stigma associated with mental illness, which discourages them from seeking treatment. (21)

Lack of cultural understanding by health care providers may contribute to underdiagnosis and/or misdiagnosis of mental illness in people from racially/ethnically diverse populations. (7)

Language differences between patients and providers, stigma of mental illness in communities of color, and cultural presentation of symptoms can contribute to misdiagnoses. (7)

According to research from the Satcher Health Leadership Institute at Morehouse School of Medicine, racial mental health disparities cost the United States around $278 billion between 2016 and 2020 as a result of premature deaths that has been linked back to mental health, substance use disorder and suicide.(11)

OTHER BIPOC HEALTH FACTS

COVID-19 has disproportionately affected Black individuals in the U.S., and vaccination rates among Black individuals trail those of other racial groups. (18)

These results suggest that this might be less likely the result of vaccine hesitancy than other factors such as access, distant vaccine sites, lack of transportation and inflexible work hours. (18)

By December 2020, only 36% to 49% of Blacks and African Americans (compared with 44%-59% of White individuals) intended to be vaccinated when they became eligible. (18)

Non-Hispanic Black women are overrepresented in the number of deaths reported among women with confirmed COVID-19 regardless of pregnancy status, and Non-Hispanic Black pregnant women are at increased risk for developing severe COVID-19 symptoms compared with non-Hispanic White women. (8)

Black women are 3x more likely to die from a pregnancy-related cause than White women. (8)

Multiple factors contribute to these disparities, such as variation in quality healthcare, underlying chronic conditions, structural racism, and implicit bias. (8)

BIPOC are more at risk for complications from heart disease than white Americans. This includes a higher death rate and is partly due to the barriers to healthcare BIPOC groups face.

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"Bringing people together to serve humanity"

Highlighting the State of Mental Health for African American and Latino Communities: Insights, Intersectionality, and Initiative of What We Know and Need to Be Able to Do

Disparate access to mental health services for African American and Latino communities requires intentional efforts to address holistically the well-being needs for these traditionally underserved groups. While decades of research document these disparities, researchers share varying views on the degree to which various variables influence these inequities (Snowden, 2001; Whaley, 2001; Dana, 2002; Mama, Li, Basen-Engquist, Lee, Thompson, Wetter, & McNeill, 2016; Reynolds & Gonzales-Backen, 2017; Holden & Xanthos 2009). Nonetheless religion is identified as a conduit for being able to cope with challenges associated with mental health, particularly as it relates to cultural background (Hechanova and Waelde, 2017; Lukachko, Myer, Hankerson, 2015). Researchers call for actively involving clergy and the church in the delivery of health services to offset the effects of racial discrimination and increase access to professional mental health services (Lukachko & Hankerson. 2015; Ellison, DeAngelis, & Güven, 2017). The way religious communities are considered as a viable constituency to address structural and societal issues unique to mental health for African American and Latino communities is important toward minimizing the overall and devastating impact for these traditionally underserved groups.

Lukacho, Myer, and Hankerson (2015) particularly address the clashes that exist within cultures related to mental health as they indicate that "professional mental health care may clash with sociocultural religious norms" (p. 578). Hechanova and Waelde (2017) identify five areas for which mental health professionals need to be concerned: 1) emotional expression; 2) shame; 3) power distance; 4) collectivism; and 5) spirituality and religion. The focus on spirituality and religion particularly highlights how individuals access spirituality and religion in such a manner that is transferable into coping skills of mental health and the challenges therein (i.e.,depression, anxiety). More specifically, within the Nashville Stress and Health Study (2017), as it relates to the Black Church, assert the following:

> Church-based social support may be particularly important for African Americans. On average, they tend to exchange instrumental and socioemotional aid informally with fellow church members more often than Whites from comparable backgrounds (Krause 2002, 2008). Several studies report that such congregational support, particularly socioemotional assistance, is linked with health and well-being among African Americans (Chatters et al. 2011, 2015; Ellison, Musick, and Henderson 2008; Head and Thompson 2017; Hope et al. 2017), perhaps more so than among Whites (Krause 2003, 2008a). Among African Americans, church-based support often augments and complements – rather than replicates the support that is available from family members and other non-kin ties (Nguyen, Chatters, and Taylor 2016).

The aforementioned perspectives indicate the intricate role of the church within the mental health affairs. African Americans tend to gravitate toward the church as a source of inspiration and comfort to respond to the varying pressures. More specifically, with Latinos, Caplan (2019) reports the following:

> Among the Hispanic/Latino faith-based communities in this study, mental illness and depression were culturally defined and often perceived to be a spiritual problem rather than a "sickness." This non-biomedical interpretation of illness is consistent with the findings of Breslau et al. (2017), indicating that Hispanics/Latinos (particularly Spanish-speaking individuals) have very low perceived need for mental health services irrespective of severity of illness. The importance of religion and religious coping as a means of treating of depression, as well as *Familismo*, or the necessity of family and community support, illustrate the cultural and religious values of many Latinos in the United States (Dalencour et al., 2017; Moreno, & Cardemil, 2013).

Findings from Caplan (2019) show how Latinos rely upon churches as a critical reliance of support for social, educational, and spiritual resources. Cultural values among Latinos are identified as a source of strength, but also serves as a contributor as a stigma. Within the faith-based community for Latinos, there is need for mental health literacy and anti-stigma interventions. Understanding what we know broadly from what broader and specific trends on mental health becomes critically important for contextualizing the role of the religious community to respond in intentional and relevant ways.

WHAT WE KNOW: INSIGHTS AND INTERSESCTIONALITY

Issues surrounding mental health are often plagued by misinformation and incomplete information which impact the perception of those who need these services as well as the likelihood of those persons to pursue the services they need. As extracted directly, following below is a table which identifies five commonly held fictitious views and clarifying facts regarding mental health (MentalHealth.Gov, 2022):

Table 1: Fact and Fiction Perspectives on Mental Health

FACT	**FICTION**
One in five American adults experienced a mental health issue One in 6 young people experienced a major depressive episode One in 20 Americans lived with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression	Mental Health problems do not affect me.
Even very young children may show early warning signs of mental health concerns. These mental health problems are often clinically diagnosable, and can be a product of the interaction of biological, psychological, and social factors. Half of all mental health disorders show first signs before a person turns 14 years old, and three-quarters of mental health disorders begin before age 24. Unfortunately, only half of children and adolescents with diagnosable mental health problems receive the treatment they need. Early mental health support can help a child before problems interfere with other developmental needs.	Children do not experience mental health problems.
The vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3%–5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population. You probably know someone with a mental health problem and don't even realize it, because many people with mental health problems are highly active and productive members of our communities.	People with mental health problems are violent and unpredictable.

People with mental health problems are just as productive as other employees. Employers who hire people with mental health problems report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees. When employees with mental health problems receive effective treatment, it can result in: • Lower total medical costs • Increased productivity • Lower absenteeism • Decreased disability costs	People with mental health needs, even those who are managing their mental illness, cannot tolerate the stress of holding down a job.
Mental health problems have nothing to do with being lazy or weak and many people need help to get better. Many factors contribute to mental health problems, including: • Biological factors, such as genes, physical illness, injury, or brain chemistry • Life experiences, such as trauma or a history of abuse • Family history of mental health problems People with mental health problems can get better and many recover completely.	Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough.

MentalHealth.Gov (2022) clearly articulates the plethora of perspectives for which those who need mental health and the internal and external challenges they encounter. Internally, individuals are faced with their own understanding, real or imagined, of what might be occurring with their mental health state. Externally, individuals are faced with a society and subsequent conditions that maintains or demonstrates an understanding, real or imagined, of who and/or what constitutes as a state of mental healthiness. MentalHealth.Gov (2022) also shows how mental health is a multi-layered phenomenon that cannot be solved with a one-size fits all approach. Individualized and personalized, yet intentional, perspectives need to be considered when generating a solution. MentalHealth.Gov (2022) further highlights the need to be deliberate in how children are responded to and how adults are responded to involving mental health.

One of the more comprehensive reports, *The State of Mental Health in America* (2022), as published by Mental Health America (MHA), highlights the diversified measures used to understand mental health in holistic ways:

> 1) Adults With Any Mental Illness (AMI); 2) Adults With Substance Use Disorder in the Past Year; 3) Adults With Serious Thoughts of Suicide; 4) Youth With At Least One Major Depressive Episode (MDE) in the Past Year; 5) Youth With Substance Use Disorder in the Past Year; 6) Youth With Severe MDE; 7) Adults With AMI Who Did Not Receive Treatment; 8) Adults With AMI Reporting Unmet Need; 9) Adults With AMI Who Are Uninsured; 10) Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs; 11) Youth With MDE Who Did Not Receive Mental Health Services; 12) Youth With Severe MDE Who Received Some Consistent Treatment; 13) Children With Private Insurance That Did Not Cover Mental or Emotional Problems; 14) Students Identified With Emotional Disturbance for an Individualized Education Program; and 15) Mental Health Workforce Availability.

Such measures become important toward generating a picture of mental health in expanded ways. Thus, identifying as the nation’s leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health, the overall focus of MHA is as follows: 1) To provide a snapshot of mental health status among youth and adults for policy and program planning, analysis, and evaluation; 2) To track changes in the prevalence of mental health issues and access to mental health care; 3) To understand how changes in national data reflect the impact of legislation and policies; and 4) To increase dialogue with and improve outcomes for individuals and families with mental health needs.

To that end, MHA offers useful insights regarding the state of mental health within America and how those areas can be used to advance strategic efforts toward improving the overall health and well-being of the population served. Following are critical findings from this report (MHA, 2022):

- 4.58% of adults report having serious thoughts of suicide;
- 8.1% of children had private insurance that did not cover mental health services;
- 10.6% of American youth have severe major depression;
- 15.8% of youth experienced a major depressive episode in the past year;
- 19.86% of American adults experienced some type of mental illness;
- 24.7% of adults with a mental illness report an unmet need for treat;
- 27% of youth with severe depression receive consistent care and in states with the least access, only 12% receive consistent care;
- Over 60% of youth with major depression do not receive any mental health treatment; and
- More than half of adults with mental illness do not receive treatment.

Findings from the MHA report highlight how Americans are facing mere thoughts of suicide and while it is near 5%, that percentage is significant given the implications of how thoughts lead to action, which, in this case, would be suicide. Findings from the MHA report also indicate how youth are dealing with depression and they are not receiving the appropriate treatment. This becomes critical given the need to intervene early. If early intervention does not occur, then, in many ways, the absence or lack of intervention for depression becomes the precursor for suicide.

Findings from the MHA report further show the gapping need of insurance companies to address the mental health services. Insurance companies are not providing funding for these needs in the manner needed by the constituencies served. Again, if the types of mental health services are not provided to address underlining needs, then unfortunately, suicide may become the preferred approach by those who are affected by these conditions.

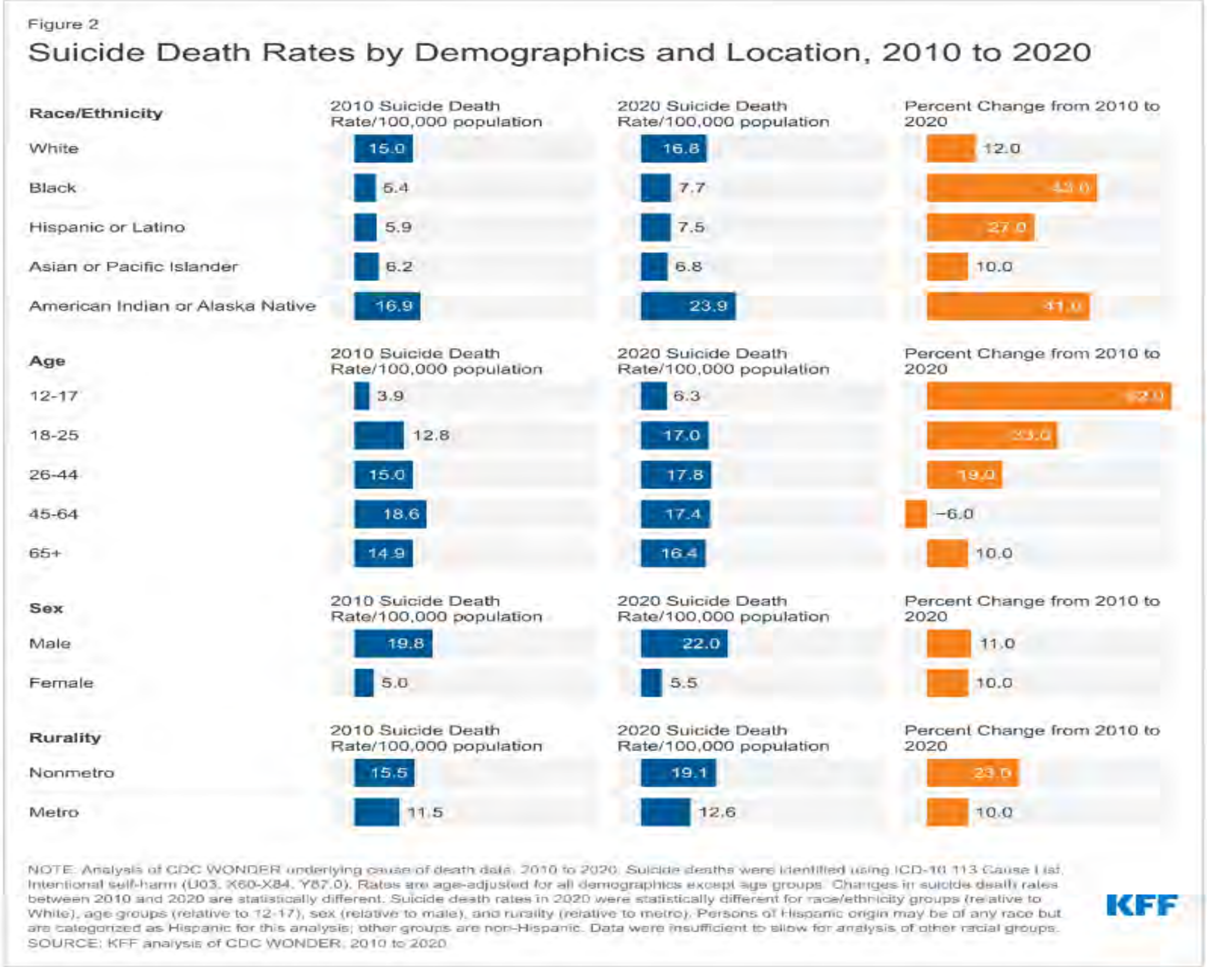
Figure 2

Suicide Death Rates by Demographics and Location, 2010 to 2020

NOTE: Analysis of CDC WONDER underlying cause of death data, 2010 to 2020. Suicide deaths were identified using ICD-10 113 Cause List: Intentional self-harm (U03, X60-X84, Y87.0). Rates are age-adjusted for all demographics except age groups. Changes in suicide death rates between 2010 and 2020 are statistically different. Suicide death rates in 2020 were statistically different for race/ethnicity groups (relative to White), age groups (relative to 12-17), sex (relative to male), and rurality (relative to metro). Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Data were insufficient to allow for analysis of other racial groups.
SOURCE: KFF analysis of CDC WONDER, 2010 to 2020

The Kaiser Family Foundation (2022) from 2010 to 2020, as shown in the extracted map of Figure 2 from the report, shows how suicide death rates increased substantially among people of color, with the highest increase among Black people (43% increase, from 5.4 to 7.7 per 100,000), followed by American Indian or Alaska Native (41% increase, from 16.9 to 23.9 per 100,000), and Hispanic (27% increase, 5.9 to 7.5 per 100,000).

The Kaiser Family Foundation (2022) offered an analysis of suicide death rate by state, as shown in the extracted map in Figure 3. What the report indicates is that of the states reporting the highest suicide deathrates (21 to 30 suicides per 100,000 in the population), only three (3) of the seven (7) reported state health agencies providing treatment or prevention activities, the states with the second highest suicide rate (16 to 20 per 100,000 in population) reported just six (6) of 17 agencies providing treatment or prevention activities. Likewise of the states with the third highest suicide rate, 13 to 15.9 suicides per 100,000, a mere three (3) of 14 had state agencies providing activities related to treatment or prevention.

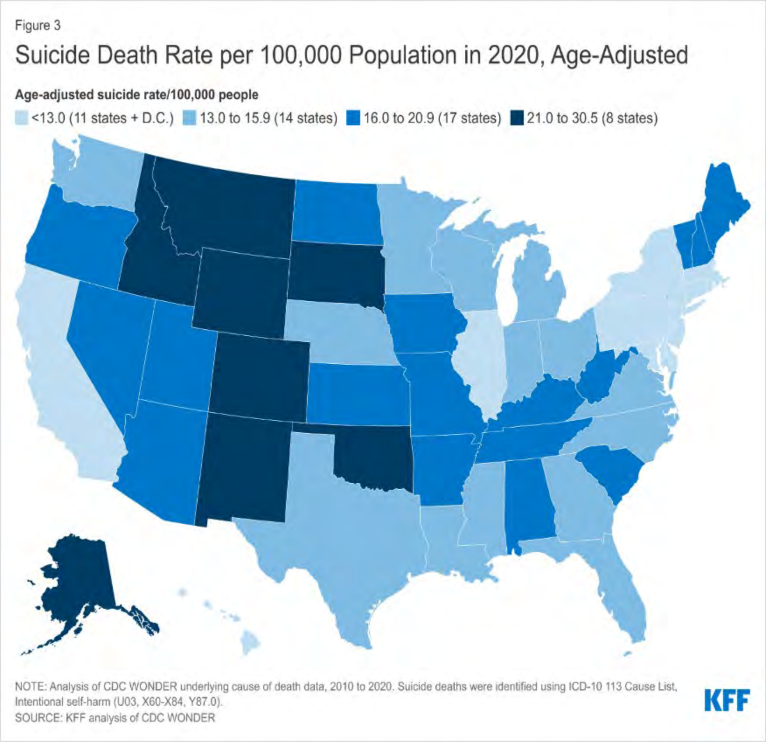
Figure 3

Suicide Death Rate per 100,000 Population in 2020, Age-Adjusted

NOTE: Analysis of CDC WONDER underlying cause of death data, 2010 to 2020. Suicide deaths were identified using ICD-10 113 Cause List, Intentional self-harm (U03, X60-X84, Y87.0).
SOURCE: KFF analysis of CDC WONDER

More specifically, as indicated in Figure 5 of the extracted map, the Kaiser Family Foundation and the analysis of the 2019 National Health Interview Survey, reveals how Black and Latinos did not receive treatment for anxiety or depression compared to other racial or ethnic groups. The findings revealed similar reporting of moderate to severe symptoms of anxiety

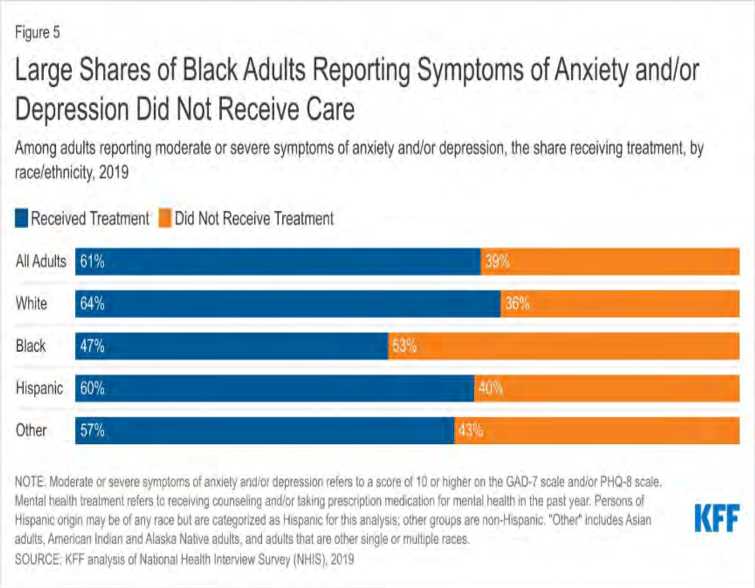
Figure 5

Large Shares of Black Adults Reporting Symptoms of Anxiety and/or Depression Did Not Receive Care

Among adults reporting moderate or severe symptoms of anxiety and/or depression, the share receiving treatment, by race/ethnicity, 2019

NOTE: Moderate or severe symptoms of anxiety and/or depression refers to a score of 10 or higher on the GAD-7 scale and/or PHQ-8 scale. Mental health treatment refers to receiving counseling and/or taking prescription medication for mental health in the past year. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. "Other" includes Asian adults, American Indian and Alaska Native adults, and adults that are other single or multiple races.
SOURCE: KFF analysis of National Health Interview Survey (NHIS), 2019

and depression symptoms across all racial groups however, "…receipt of treatment varied considerably – compared to White adults (36%).

The Mental Health Alliance (2022) suggests that "a comprehensive 988 crisis system necessitates: training call staff to provide empowering, linguistically, and culturally appropriate supports to callers, ensuring the inclusion of appropriate care for subpopulations…" (p. 23). MHA acknowledges that successful 988 implementation will require state legislation to fund an adequate 988 infrastructure. Sadly, according to MHA's analysis of the 13 bottom ranked states with the highest rates of suicidal thoughts, "only four states passed laws for 988 implementation: Utah, Oregon, Indiana, and Colorado with only Utah including fees." MHA also designates Youth Mental Health as a priority and reports "While rates of mental health treatment are low for all youth with major depression, youth of color are significantly less likely to receive depression treatment than white youth." (p. 36). Because youth of color typically receive mental health services in schools, MHA recommends a series of policies to improve access to metal health services through education legislation.

Additionally, from a state-based perspective, the Association of States and Territories Health Officials (ASTHO, 2022) presents data on every state health agency in the United States. ASTHO provides an interactive online dashboard which shows the states' health agencies and how they are responding to mental illness treatment or mental illness prevention related activities. Findings indicate the number of state health agencies providing treatment activities decreased from eleven (11) states in 2016 to only six (6) states in 2019. Those six states included Nevada, Texas, Oklahoma, Iowa, Michigan, and Ohio. ASTHO (2022) also reports the number of state health agencies providing prevention activities decreased from twelve (12) in 2016 to eight (8) in 2019. Those states included Montana, Nevada, Utah, Colorado. Oklahoma, Michigan, New Hampshire, and Maine. The small number of state health agencies addressing mental health needs compared to the high need for mental health services, illustrates broadly the present mental health crisis in the United States.

The National Alliance on Mental Illness (2022) report that only one in three Black adults with mental illness receive treatment. According to the American Psychiatric Association's *Mental Health Facts for African Americans Guide*, as identified by the National Alliance on Mental Health (2022), African Americans are: 1) Less likely to receive guideline-consistent care; 2) Less frequently included in research; and 3) More likely to use emergency rooms or primary care (rather than mental health specialists). For Latinos, The National Alliance on Mental Illness (2022) report that only more than half of Hispanic young adults ages 18-25 with serious mental illness may not receive treatment. This inequality puts these communities at a higher risk for more severe and persistent forms of mental health conditions, because without treatment, mental health conditions often worsen. More specifically, a total of 35.1% of Hispanic/Latinx adults with mental illness receive treatment each year compared to the U.S. average of 46.2%. Such findings indicate the lacking availability of mental health treatment for African Americans and Latinos.

WHAT WE NEED TO DO: INITIATIVE

What we need to do requires an initiative-oriented response given the perspectives that not only have demonstrated the importance of having informed perspectives, but also the need to have practical approaches to address mental health matters within African American and Latino communities. Such approaches need to be responsive to *inter*- and *intra-contextual needs*. In effect, both the *inter*- and *intra*-contextual needs focus on addressing the issues of perceptions and impact of mental health in African Americans and Latinos and faith-based and broader communities. Thus, the National Black Mental Health Program consists of three fundamental elements: Education (*knowledge*), Intervention (*mediators*) and Support (*practices*). Following below are approaches that comprise the NBCI program given what we know and what we need to do *inter*- and *intra*-contextually:

Table 2: What We Know and What We Need to Do for Mental Health Awareness

What We Know	**What We Need To Do**
The Importance of Education	Utilize mental health literature and video materials to prepare professional clinicians with the appropriate leadership knowledge to prepare clinicians with relevant administrative skills; Integrate of a Mental Health Dashboard where constituencies can determine their quality of mental health; Disseminate resource materials for educating church clergy and lay persons about mental health to ensure their knowledge of referral processes for intervention; and Implement the 'train the trainer' approach to ensure the sustainability of learning.
The Impact of Intervention	Provide early intervention to prevent escalation to crisis level issues; Offer comprehensive intervention approaches utilizing professionals with the following expertise: ➢ Life Coaching Sessions ➢ Individual and Group Counseling Sessions ➢ Individual and Group Therapy Sessions ➢ Talk Therapy ➢ Family Therapy ➢ Couples Therapy ➢ Teletherapy access when needed Implement emergency intervention protocols (i.e., referral for emergency or long-term treatment).

The Intricacies of Support	Demonstration and integration of prayer and other faith practices (i.e., meditation) as a resource for supporting mental health needs; Include resource listing of mental health professionals for social and related medical needs; and Promote *Mental Health Sundays* as a mechanism to prioritize the importance of mental health and well-being for congregations.

Table 2 outlines the education, implementation, and support necessary to address the needs of African Americans and Latinos regarding mental health.

To that end, given the level of commitment toward mental health within African American and Latino communities, what we need to do emerges in how NBCI anticipates spending $3 to $5 million dollars over the next two years to launch the aforementioned NBCI Mental Program in 1,000 churches. Depending on their size and resources, a total of 500 churches will be designated as primary program locations and 500 churches will be designated as secondary. The expected impact of access to quality mental health services is improved mental health outcomes for 200,000 to 350,000 African Americans and Latinos living in communities within NBCI's sphere of influence. More specifically, to achieve such outcomes in what it needs to do, NBCI seeks to implement the Mental Health Program by fostering buy-in from African American and Latino Mental Health Professionals who will provide research-based, data driven, mental health interventions to its congregants with the utmost confidentiality. Thus, NBCI's Mental Health Program will provide a top to bottom collection of organizational and individual professional resources, including training to develop culturally competent mental health clinicians as well as provide ongoing mental health education to its members and the public.

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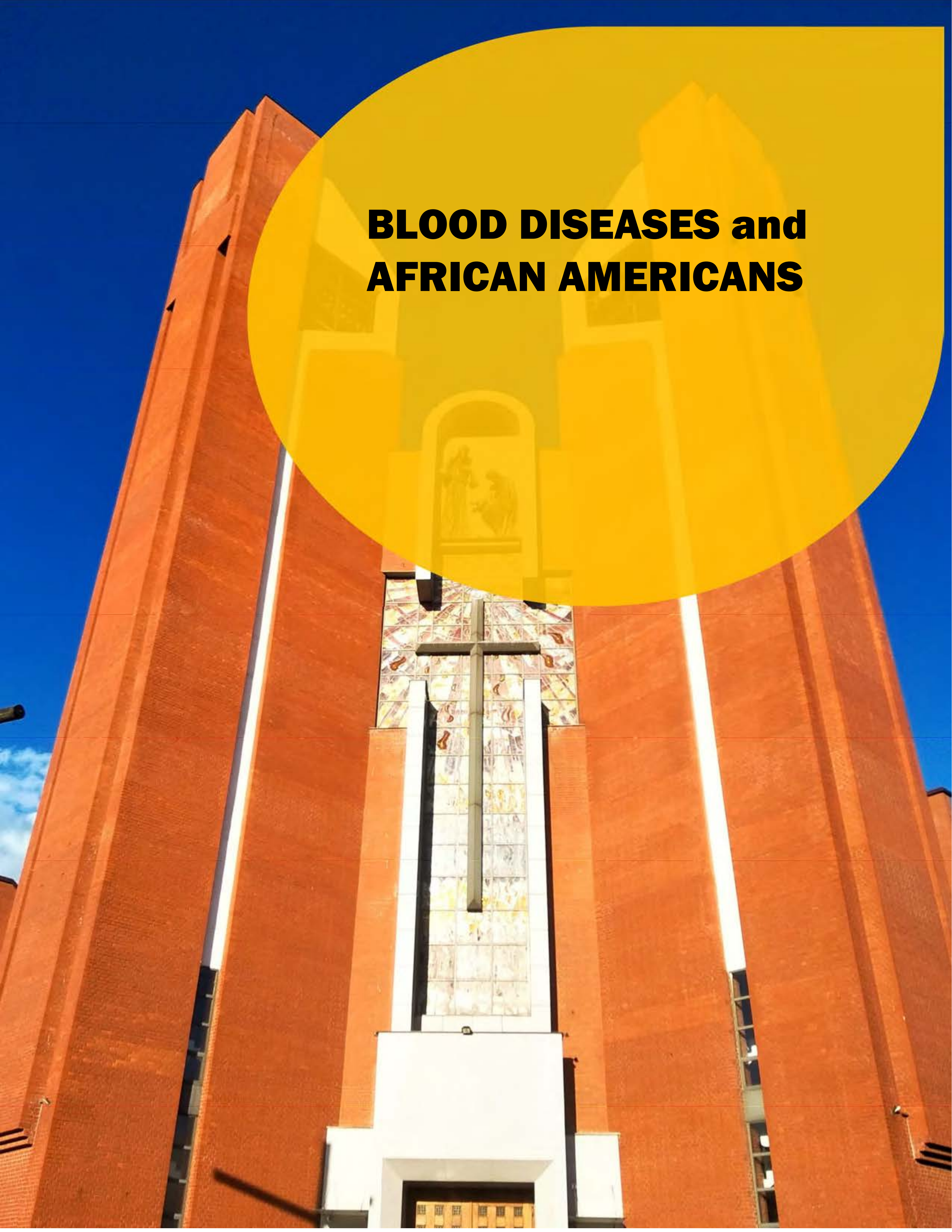
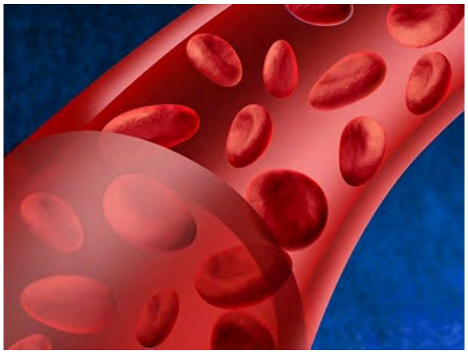
BLOOD DISEASES and AFRICAN AMERICANS



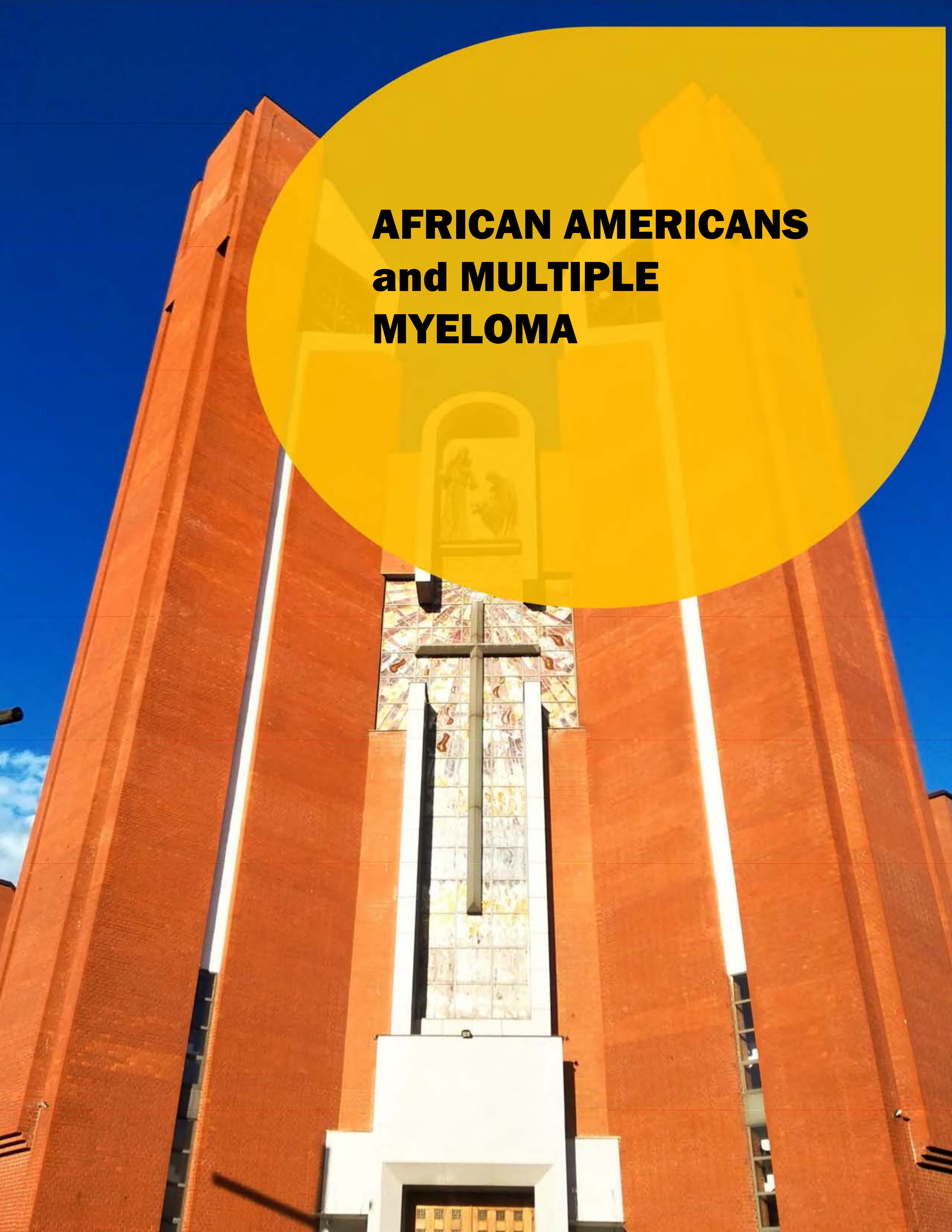
Blood Diseases and African Americans

Your blood is living tissue made up of liquid and solids. The liquid part, called plasma, is made of water, salts and protein. Over half of your blood is plasma. The solid part of your blood contains red blood cells, white blood cells, and platelets.

Blood diseases and disorders affect one or more parts of the blood and prevent your blood from doing its job. Many blood diseases and disorders are caused by genes. Other causes include other diseases, side effects of medicines, and a lack of certain nutrients in your diet. Common blood disorders include anemia and bleeding disorders such as hemophilia.



AFRICAN AMERICANS and MULTIPLE MYELOMA



African Americans and Multiple Myeloma

Approximately 32,000 people are diagnosed with multiple myeloma annually in the US – 20% of that population are Black patients. Black patients are typically diagnosed at an earlier age and have a higher rate of precursor conditions such as MGUS. It is the leading blood cancer in the Black community.
Multiple Myeloma Awareness and African American Disparities - NCI (cancer.gov)

Multiple Myeloma Awareness and African American Disparities

As part of Minority Cancer Awareness Week, we want to discuss cancers that disproportionately affect minorities. One such cancer is multiple myeloma.

So, what is multiple myeloma? It is a rare and incurable cancer of a person's white plasma cells, the cells that fight infection and disease, and it can permanently weaken bones and damage organs.

African Americans are not only at twice the risk of developing multiple myeloma when compared to White Americans, they are also more likely to be diagnosed at a younger age. African Americans, on average, are diagnosed around 66 years old, while white Americans are around age 70.

There are many reasons why these disparities exist, and one reason is low levels of awareness. In African American communities, even among primary care physicians, there simply isn't enough awareness about the disease itself and how it effects the community. Without proper awareness, those who are at the highest risk cannot take the necessary precautions needed to find the disease and treat it.

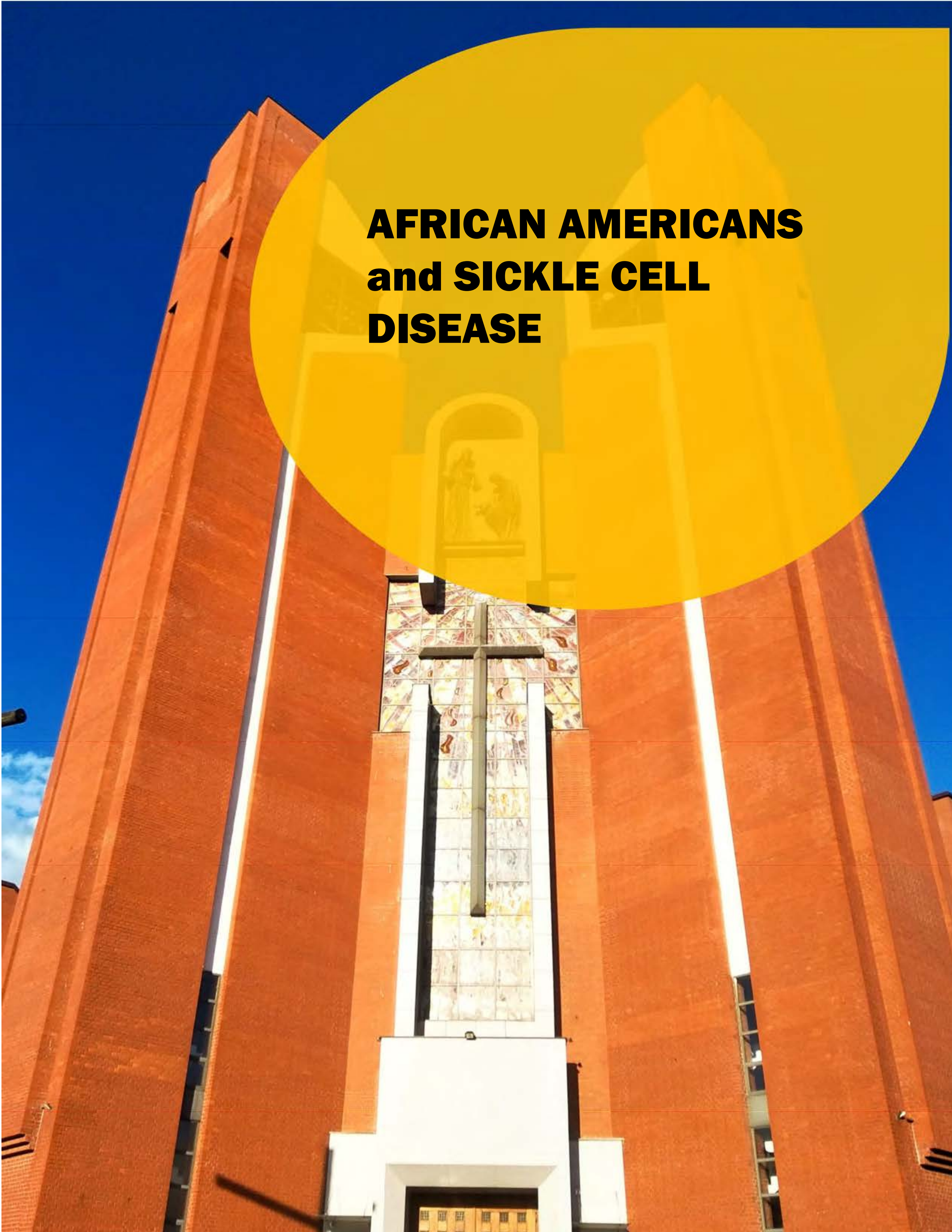
If a patient presents with signs or symptoms of the disease, the patient and their doctor may not know they should be tested for multiple myeloma. Often the common symptoms of multiple myeloma—unrelenting back pain, weakness, tiredness, frequent urination and constipation—get confused with symptoms of "just-getting older." Primary care physicians who are aware that their patients are at higher risk for multiple myeloma may run additional blood and urine tests.

Another important factor that contributes to these disparities is access to health care and services. About 51% of African Americans under the age of 65 and 28% over 65 have private insurance, in comparison to 67% of White Americans under 65 and 44% over 65. (CDC, 2015). These differences in insurance coverage may result in different experiences in treatment.

A study by Warren and colleagues (2013) among patients with newly diagnosed multiple myeloma found that non-white recipients of Medicaid or Medicare were significantly less likely to be treated with novel agents or transplant when compared to non-white patients with private insurance. African Americans make up a quarter of Medicare patients and a quarter of Medicare Advantage patients.

Finally, researchers must continue to work to understand multiple myeloma in African American populations. There is some debate about why African Americans are at greater risk. Some research suggests the cause may be environmental factors such as exposure to radiation, but other research points to genetic factors playing a role. One way to better understand the effect of multiple myeloma in African Americans is by increasing their participation in clinical trials.

NCI's Cancer Therapy Evaluation Program has several trials including the Endurance E1A11 Study, which seeks to better understand the best treatment for multiple myeloma. Clinical trials like the Endurance Study benefit when African Americans diagnosed with multiple myeloma understand the treatments available and make an informed decision to participate in clinical trials.



AFRICAN AMERICANS and SICKLE CELL DISEASE

African Americans and Sickle Cell Disease

Sickle cell disease can affect people of ANY race or ethnicity. Sickle cell disease, an inherited disorder of the red blood cells, is more common in African Americans in the U.S. compared to other ethnicities—occurring in approximately 1 in 365 African Americans.

150,000 Black Churches Ask President Biden for Support of the Sickle Cell Disease Comprehensive Care Act

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NEWS PROVIDED BY
National Black Church Initiative
November 03, 2022

Rev. Anthony Evans,
President, National Black Initiative

US President Joe Biden

WASHINGTON, DC, UNITED STATES, November 3, 2022 -- 150,000 Black and Latino Churches of the National Black Church Initiative and The Sickle Cell Disease Partnership Send President Biden and the Congressional Leadership A Letter Seeking Their Support for the Sickle Cell Disease Comprehensive Care Act (H.R. 6216/S.3389)

The National Black Church Initiative (NBCI), a coalition of 150,000 African American and Latino churches which constitute 27.7 million churchgoers and voters, sends President Biden and the congressional leadership a letter seeking their support for the Sickle Cell Disease Comprehensive Care Act (H.R. 6216/S.3389). The Black Church leadership cites this bill as one of its top priorities on its legislative agenda for 2022 and 2023.

Dear President Biden, Senator Schumer, Rep. Joyce Beatty, and Speaker Pelosi:

We, the National Black Church Initiative, are writing in support of the Sickle Cell Disease Comprehensive Care Act (H.R. 6216/S.3389), the Sickle Cell Care Expansion Act (H.R. 7177/S.4425), and the Sickle Cell Disease Treatment Centers Act of 2022, and humbly request that every member of the House of Representatives and the United States Senate support, pass and fund these critical pieces of legislation.

The Biden administration has done an excellent job in safeguarding Americans. We ask that you include those living with sickle cell disease-- sickle cell Warriors--and their families by supporting these three bills.

The National Black Church Initiative (NBCI) is a coalition of 150,000 African American and Latino churches working to eradicate racial disparities in healthcare, technology, education, housing, and the environment. NBCI's mission is to provide critical wellness information to all its members, congregants, churches, and the public through faith-based, out-of the-box innovative solutions and sound health science, to address critical economic and social issues.

Our purpose is to partner with major organizations and officials to reduce racial disparities in the variety of areas cited above. NBCI's programs are governed by credible statistical analysis, science-based strategies and techniques, and methods that work. Our 27.7 million members are looking forward to collaborating with you and your respective staff members to propel these pieces of legislation toward a successful outcome.

NBCI has joined forces with the Sickle Cell Disease Partnership, a group of over 15 organizations committed to improving the lives and outcomes of individuals living with sickle cell disease. We are calling on Congress to pass the three pieces of legislation that will increase access to treatment and improve the lives of the 100,000 plus Americans living with the disease.

Together, the Sickle Cell Disease Comprehensive Care Act (H.R. 6216/S.3389), Sickle Cell Care Expansion Act (H.R. 7177/S.4425), Sickle Cell Care Expansion Act (H.R. 7177/S.4425) and the newly introduced The Sickle Cell Disease Treatment Centers Act of 2022 (H.R.8855/S.4866) will boost funding for research and increase access to life-changing treatment. We are seeking 250 members of the House of Representatives and thirty-five members of the United States Senate from both sides of the aisle, to be co-sponsors of these pieces of legislation
"The time for Congress to act is now," said Brett Giroir, M.D., Senior Advisor, Sickle Cell Disease Partnership. "For too long, our nation's efforts to address this painful, debilitating disease have been woefully inadequate, leaving patients and families behind – without access to high-quality care and without sufficient progress toward new treatments and cures. Sickle Cell Disease affects African Americans at a disproportionate rate, and frighteningly, 1 in 12 are diagnosed as genetic carriers. For far too long, policymakers have stood on the sidelines. Congress can take a giant first step to addressing this significant health inequity by passing legislation this session and ensuring Sickle Cell warriors get the care and the support they need now."

The Sickle Cell Disease Comprehensive Care Act (H.R. 6216/S. 3389) is bipartisan House and Senate legislation that authorizes the federal government to establish a demonstration program in up to 10 states to provide comprehensive care to Americans with Sickle Cell Disease who are low-income or disabled and receive health coverage through a state Medicaid program. The legislation would ensure such individuals in participating states have coordination of, and access to, clinical, mental health, and ancillary and support services they need because of their disease. The legislation would also require reporting and evaluation to study the results of the demonstration project.

The Sickle Cell Care Expansion Act (H.R.7177/ S.4425) is legislation in the House and Senate that would authorize a scholarship and loan repayment program to incentivize medical physicians to enter into the field of Sickle Cell Disease research and treatment.

The bill would also award grants to health clinics, community organizations, and other local nonprofit organizations that collaborate with individuals who have Sickle Cell Disease, to help improve health literacy, equip them with information on health and community services related to Sickle Cell Disease, and improve the care and treatment decision-making process related to the disease.

The Sickle Cell Disease Treatment Centers Act of 2022 (H.R.8855/S.4866) establishes a nationwide network of more than 120 Sickle Cell Disease Treatment Centers based on a hub-and-spoke framework and provides support for 100 community-based organizations. The legislation also creates a National/Regional Coordinating Center to coordinate the National Sickle Cell Disease Treatment Center Program and authorizes appropriations of $535,000,000 annually to address the issue.

About Sickle Cell Disease

Sickle Cell Disease is a rare, genetic blood disorder that primarily affects African American individuals. Sickle Cell Disease is inherited when a child receives two sickle cell genes—one from each parent. A person with Sickle Cell Disease is born with it.

Healthy red blood cells are round, and they move through small blood vessels to carry oxygen to all parts of the body. In someone who has SCD, the red blood cells become hard and sticky and look like a C-shaped farm tool called a “sickle.” The sickle cells die early, which causes a constant shortage of red blood cells. Also, when they travel through small blood vessels, they get stuck and clog the blood flow. This can cause pain and other serious problems such infection, acute chest syndrome, lung problems, severe pain, and stroke.

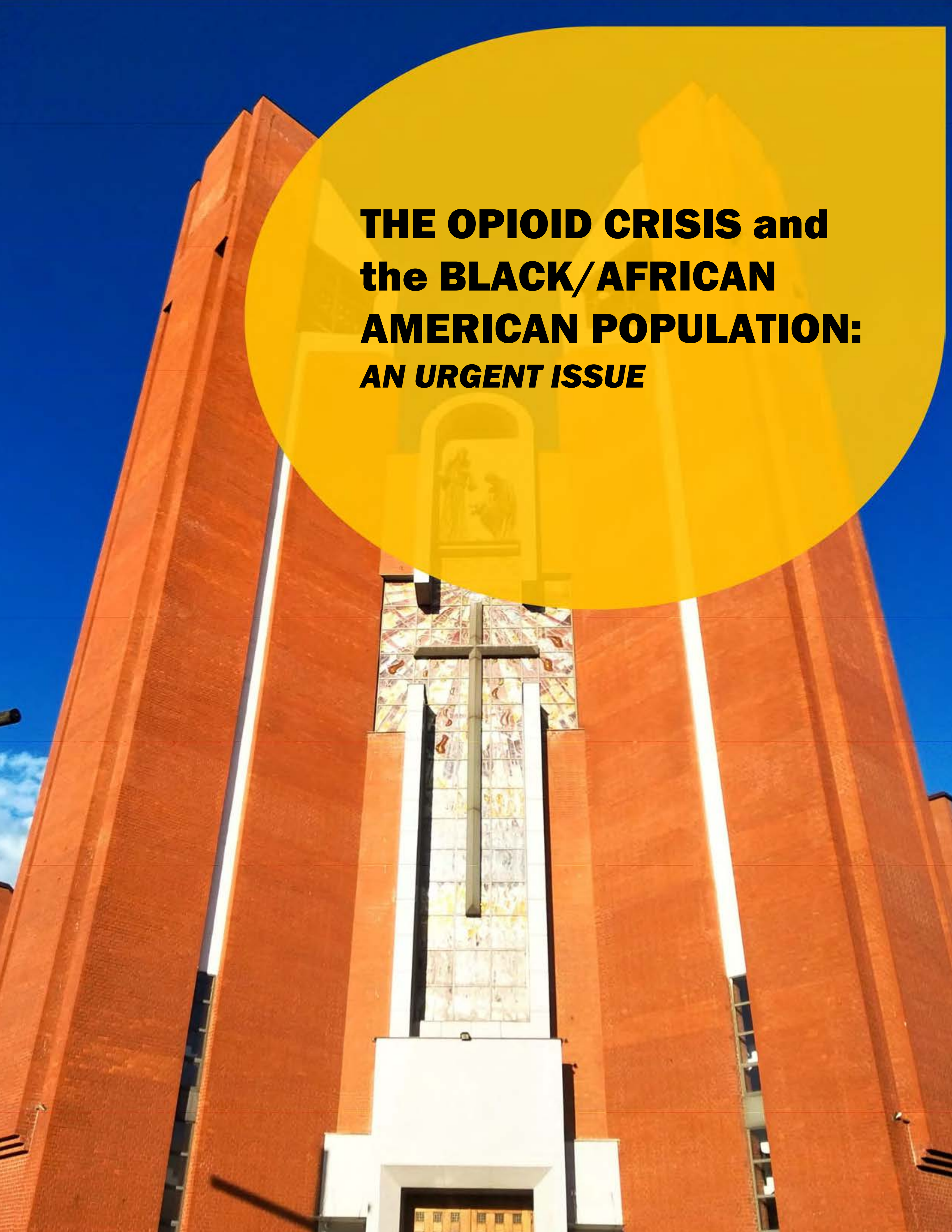
We thank you for taking the time to read our letter and encourage the Biden Administration, the House of Representatives and Congress to come together to pass and fully fund these critical bills. Doing so will vastly improve the quality of life, health and access to all those living with sickle cell disease.

ABOUT NBCI

The National Black Church Initiative (NBCI) is a coalition of 150,000 African American and Latino churches working to eradicate racial disparities in healthcare, technology, education, housing, and the environment. The mission of NBCI is to provide critical wellness information to all of its members, congregants, churches and the public. NBCI utilizing faith and sound health science and partners with major organizations and officials reduce racial disparities in the variety of areas cited above. NBCI's programs are governed by credible statistical analysis, science based strategies and techniques, and methods that work and offers faith-based, out-of-the-box and cutting-edge solutions to stubborn economic and social issues.

THE OPIOID CRISIS and the BLACK/AFRICAN AMERICAN POPULATION:

AN URGENT ISSUE



THE OPIOID CRISIS AND THE BLACK/AFRICAN AMERICAN POPULATION: AN URGENT ISSUE

SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Introduction

i. Purpose of the Issue Brief

ii. Sources of Information

Opioids in Black/African American Communities: Context

i. What Do the National Data Show?
ii. Routes to Opioid Misuse and Overdose Deaths: Pain Management, Illicit Drug Use, and Opioid Comorbidities in Black/African American Communities

iii. Challenges to Prevention, Treatment, and Recovery

Strategies to Address Opioid Misuse and OUD in Black/African American Communities

i. Standard Treatment
ii. Community-Informed Strategies to Address Opioid Misuse and OUD in Black/African American Communities

Moving Forward

Glossary

Resources

References

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Office of Behavioral Health Equity

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Introduction

The current opioid epidemic is one of the largest drug epidemics recorded in U.S. history for all racial and ethnic groups. From 1999 to 2017, there were nearly 400,000 overdose deaths involving opioids in the U.S.[1] In 2018, 10.3 million people misused opioids, including prescription opioids and heroin, and two million had an opioid use disorder (OUD).[2] In 2017, the opioid epidemic in the U.S. was declared a national public health emergency with 47,600 reported deaths from opioid-related overdoses, which accounted for the majority of overdose drug deaths.[3] With approximately 130 people dying each day due to an opioid-related overdose,[4] this epidemic has garnered nation-wide attention, generated significant federal and state funding for prevention, treatment, and recovery and shaped the priorities of many local communities.

Attention to this epidemic has focused primarily on White suburban and rural communities. Less attention has focused on Black/African American* communities which are similarly experiencing dramatic increases in opioid misuse and overdose deaths. The rate of increase of Black/African American drug overdose deaths between 2015-2016 was 40 percent compared to the overall population increase at 21 percent. This exceeded all other racial and ethnic population groups in the U.S.[5] From 2011-2016, compared to all other populations, Black/African Americans had the highest increase in overdose death rate for opioid deaths involving synthetic opioids like fentanyl and fentanyl analogs.[6]

Three decades ago, when opioids and crack cocaine were devastating Black/African American communities, the national response was "The War on Drugs." This resulted in widespread incarceration of drug users and disruption of primarily Black/African American families and communities. This population was criminalized for drug-related offenses at much higher rates than White Americans and this has had lasting effects through the present day.[7] In 2017, though Black/African Americans represented 12 percent of the U.S. adult population they made up a third of the sentenced prison population.[8] In 2012, they accounted for 38 percent of the sentenced prison population in the U.S. and 39 percent of the population incarcerated for drug-related offenses.[9]

***In this issue brief, Black/African American is used as an umbrella term to include those who identify as "African American" and/or "Black" in the U.S. When data are reported, if describing specifically the non-Hispanic Black population, "non-Hispanic Black" is used.**

Today, the response to the drug epidemic is framed as an urgent public health issue. Substance use disorders (SUDs) and addiction are now viewed as a health condition, a disease that needs to be prevented and treated, and where recovery is possible with appropriate services and supports.

PURPOSE OF THE ISSUE BRIEF

As Congress, federal agencies, state health departments, and other stakeholders mobilize to address the opioid epidemic, what is happening within the Black/African American communities? This issue brief aims to convey snapshots of how this population is impacted. Specifically, it aims to do the following:

a) Provide recent data on prevalence of opioid misuse and opioid overdose death rates in the Black/African American population in the U.S.;

b) Discuss contextual factors that impact the opioid epidemic in these communities, including challenges to accessing early intervention and treatment;

c) Highlight innovative outreach and engagement strategies that have the potential to connect individuals with evidence-based prevention, treatment, and recovery and;

d) Emphasize the importance of ongoing community voice and leadership in the development and implementation of solutions to this public health crisis.

SOURCES OF INFORMATION

This issue brief includes information compiled from a variety of sources, including interviews with key informants, federal data, and the peer-reviewed research and policy literature. Key informants were selected for their expertise and current work to reduce opioid misuse and provide treatment and other services in Black/African American communities. They represented a range of roles—including community leader, person with lived experience, peer recovery coach, peer recovery supervisor, executive director and staff of community-based programs, evaluator, researcher, addiction psychiatrist, clinical psychologist, physician, social worker, nurse, and city representative. The information they shared represents a snapshot of what is happening in selected Black/African American communities struggling with opioid misuse and is not a full comprehensive picture of this population across the country. Their direct statements, indicated by italics and quotation marks, are interspersed throughout the document.

Opioids In Black/African American Communities: Context

WHAT DO THE NATIONAL DATA SHOW?

National and state opioid estimates are from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health,[10] and the Centers for Disease Control and Prevention (CDC) National Vital Statistics System.[11] In the figures and tables below, the most recent available data are shown.

Opioid misuse. The opioid misuse rate among non-Hispanic Blacks is similar to the national population rate, about 4 percent.[2] In 2018, 1.2 million non-Hispanic Blacks and 10.3 million people nationally, aged 12 and older, were estimated to have had opioid misuse in the past year.[2]

Opioid-related overdose deaths and deaths involving selected drugs by race/ethnicity. The opioid-related overdose death rate for the national population increased from 2.9 deaths per 100,000 people in 1999[12] to 14.9 per 100,000 in 2017[3]—with a large increase in overdose deaths involving synthetic opioids other than methadone (synthetic opioids, i.e., fentanyl, fentanyl analogs, and tramadol) from 2013 to 2017.[3] In 2017, among non-Hispanic Blacks the opioid-related overdose death rate was 12.9 deaths per 100,000 people (Table 1). It was the third highest opioid-related overdose death rate compared to other race/ethnicities.[13]

Synthetic opioids (other than methadone). Data suggest that illicitly manufactured synthetic opioids are heavily contributing to current drug overdose deaths in the U.S.[3,14] The fast rise in overdose deaths involving synthetic opioids in recent years is alarming and data show that the mixing of synthetic opioids with other drugs occur across populations.[15]

Synthetic opioids are affecting opioid death rates among non-Hispanic Blacks more severely than other populations.[3,12-13] In 2017, non-Hispanic Blacks had the highest percentages of opioid-related overdose deaths and total drug deaths attributed to synthetic opioids when compared to other race/ethnicities and the national population (Table 1).[13] *Synthetic opioids accounted for nearly 70 percent of the opioid-related*

Table 1. Number and age-adjusted rates[a] of drug overdose deaths[b] involving selected drugs by race/ethnicity—United States, 2017

	Drug overdose deaths,[b] overall		Drug overdose deaths involving: Any opioid[c]		Natural and semi-synthetic opioids[d]		Synthetic opioids other than methadone[e]		Prescription opioids[f]		Heroin[g]	
Race/Ethnicity	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**
Total	70,237	21.7	47,600	14.9	14,495	4.4	28,466	9.0	17,029	5.2	15,482	4.9
non-Hispanic White	53,516	27.5	37,113	19.4	11,921	5.9	21,956	11.9	13,900	6.9	11,293	6.1
non-Hispanic Black	**8,832**	**20.6**	**5,513**	**12.9**	**1,247**	**2.9**	**3,832**	**9.0**	**1,508**	**3.5**	**2,140**	**4.9**
non-Hispanic Asian/Pacific Islander	756	3.5	348	1.6	117	0.5	189	0.8	130	0.6	119	0.5
non-Hispanic American Indian/Alaska Native	672	25.7	408	15.7	147	5.7	171	6.5	187	7.2	136	5.2
Hispanic	5,988	10.6	3,932	6.8	994	1.8	2,152	3.7	1,211	2.2	1,669	2.9

Source: National Vital Statistics System, Mortality File

[a] Rate per 100,000 population age-adjusted to the 2000 U.S. standard population using the vintage year population of the data year. Rates are suppressed when based on <20 deaths.

[b] Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD–10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined). Because deaths might involve more than one drug, some deaths are included in more than one category. On death certificates, the specificity of drugs involved with deaths varies over time. In 2016, approximately 15% of drug overdose deaths did not include information on the specific type of drug(s) involved.

[c] Drug overdose deaths, as defined using ICD-10 codes, that involve opium (T40.0), heroin (T40.1), natural and semi-synthetic opioids (T40.2), methadone (T40.3), synthetic opioids other than methadone (T40.4) and other and unspecified narcotics (T40.6).

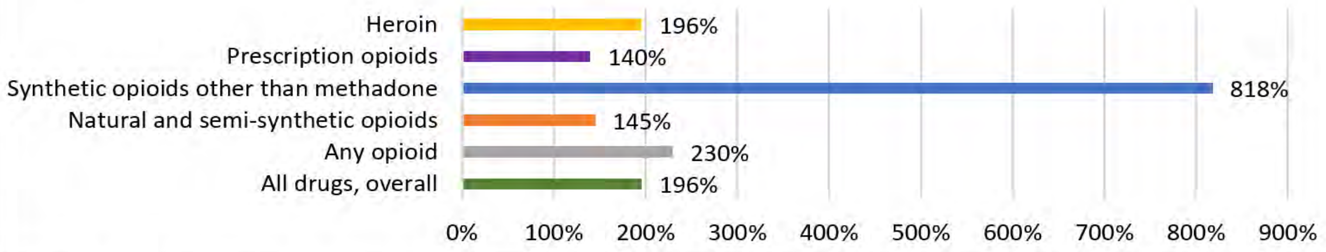
[d] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2).

[e] Drug overdose deaths, as defined, that involve synthetic opioids other than methadone (T40.4).

[f] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2) and methadone (T40.3).

[g] Drug overdose deaths, as defined, that involve heroin (T40.1).

Figure 1. Percent Increase from 2014 to 2017 in overdose death rates by drug among the non-Hispanic Black population in the United States,
data from CDC National Vital Statistics System



See notes from Table 1 for details about drug definitions

overdose deaths and 43 percent of the total drug overdose deaths for non-Hispanic Blacks in 2017.[13] Synthetic opioids are especially affecting the overdose death rates among older non-Hispanic Blacks.[16] From 2015-2017, non-Hispanic Blacks aged 45-54 and 55-64 had synthetic opioid-related overdose death rates double in large urban areas.[16]

Percent increase in overdose death rates by drug among the non-Hispanic Black population. From 2014-2017, among the non-Hispanic Black population drug overdose death rates involving all types of opioids increased, with the sharpest rise from synthetic opioids (Figure 1).[13,17] Death rates involving synthetic opioids increased by 818 percent, and was the highest for non-Hispanic Blacks compared to all other race/ethnicities (data not shown).[13,17]

Table 2. Opioid Overdose Death Rates (age-adjusted per 100,000), Top 5 States and District of Columbia, by Total and non-Hispanic Black Populations, 2018

Total			non-Hispanic Black		
1.	WV	42.4	1.	WV	58.2
2.	DE	39.3	2.	DC	47.7
3.	MD	33.7	3.	MO	40.5
4.	NH	33.1	4.	MD	34.3
5.	NJ	29.7	5.	IL	31.3

Table 3. Number of Opioid Overdose Deaths, Top 5 States, by Total and non-Hispanic Black Populations, 2018

Total			non-Hispanic Black		
1.	OH	3237	1.	MD	709
2.	FL	3189	2.	IL	598
3.	NY	2991	3.	NJ	459
4.	PA	2866	4.	MI	426
5.	NJ	2583	5.	OH	402

Opioid-related overdose death rates by state.[18] The picture of opioid-related overdose by state population varies depending on whether death rate or absolute number of deaths are being considered. When looking at the 2018 data using death *rates*, the opioid-related overdose death rates among non-Hispanic Blacks were the same or worse when compared to rates by total (all race/ethnicities combined) state population (Table 2). In 2018, the highest opioid-related overdose death rates by state were primarily in the Mid-Atlantic and Midwest regions. West Virginia (WV), and Maryland (MD) appear in the top five states with the highest opioid-related overdose death rate by both total state and non-Hispanic Black populations. Among non-Hispanic Blacks, the District of Columbia (DC) had the second highest opioid-related overdose death rate, 47.7 per 100,000 compared to all states. This death rate was higher than any total state opioid-related overdose death rate. Of DC's opioid-related overdose deaths, 89 percent were among non-Hispanic Blacks (data not shown). However, when looking at the state data by *number* of opioid-related overdose deaths instead of rates, DC does not appear in the top five states with opioid-related overdose deaths among non-Hispanic Blacks (Table 3) since DC's overall non-Hispanic Black population is smaller than many other states. Only two states appear in the top five for both total state population and non-Hispanic Black population when looking at the data by the number of deaths (OH and NJ). Maryland has the highest number of opioid-related overdose deaths among non-Hispanic Blacks and outpaces the second highest state (IL) by over 100 deaths. Some states had insufficient data or did not report data specific to non-Hispanic Blacks and were excluded. Regardless of how the data are represented, it is clear that Black/African Americans across the U.S. are substantially affected by the opioid crisis.

ROUTES TO OPIOID MISUSE AND OVERDOSE DEATHS: PAIN MANAGEMENT, ILLICIT DRUG USE, AND OPIOID COMORBIDITIES IN BLACK/AFRICAN AMERICAN COMMUNITIES

For Black/African Americans, the current rise in opioid misuse and overdose deaths involves multiple pathways. One route to opioid misuse and overdose death is initiated through excessive prescribing and use of prescription opioids leading to OUD. For some individuals, as dependency grows on these pain medications, this evolves into the use of heroin, a cheaper and more readily accessible illicit opioid. Yet another pathway is initiated through the use of illicit drugs, i.e. heroin and cocaine, which has a history in low-income Black/African American communities dating back to the drug epidemics of the 1960s and 1970s. What is particularly dangerous now, is that these street drugs are increasingly laced with fentanyl and fentanyl analogues leading to more opioid-related overdose deaths.[7]

In terms of prescription opioids, it has been proposed that Black/African Americans may be insulated from fast-rising rates of opioid misuse and overdose deaths due to lack of access to these medications. The lack of access to prescription opioids is rooted in misperceptions and biases in the health care system including the undervaluing of Black/African Americans' self-reports of pain and stereotyping by providers.[19] A study of emergency departments found that Black/African Americans are significantly less likely to be prescribed opioid prescriptions for pain from medical providers than White patients.[20-21] A recent meta-analysis found that compared to Whites, Black/African Americans were 29 percent less likely to be prescribed opioids for pain.[21] Racial and ethnic minorities are more likely to experience miscommunication or misinterpretation about their pain with their medical providers.[22] For example, Black/African Americans have higher self-reported pain scores when compared to Whites,[23] yet some doctors choose to believe that pain levels are lower for Black/African Americans compared to Whites[24] or that Black/African Americans are drug seekers.

This lower access to prescription opioids for Black/African Americans contributes to at least two adverse outcomes: a myth of Black/African Americans being "perversely protected" from the opioid crisis is spread[7,25] and the potential for severe under-treatment or mistreatment of pain for Black/African Americans with severely painful medical conditions such as sickle cell disease, certain cancers, HIV/AIDS and other autoimmune diseases.[22] The data show that Black/African Americans are not "protected" from this epidemic. And, under-prescribing in some cases may have life-threatening consequences for people affected with pain disorders.

CHALLENGES TO PREVENTION, TREATMENT AND RECOVERY

The social determinants of health and other community and system level factors cannot be ignored when discussing the contextual factors associated with any major public health issue. Described below are some of the key challenges associated with opioid misuse and OUD within the Black/African American population.

Negative representations, stereotyping and stigma. Black/African Americans with SUDs are doubly stigmatized by their minority status and their SUD. Negative images of Black/African Americans with SUD contribute to mistreatment, discrimination and harsh punishment instead of treatment and recovery services. Even today, some Black/African American community leaders indicate that using words such as an "opioid epidemic" or "crisis" may be inflammatory in their communities, putting residents on high alert and triggering fears of incarceration. Mostly absent from this narrative are opportunities for compassion, understanding, treatment and recovery.

Intergenerational substance use and polysubstance use. For many families in the U.S., substance misuse is passed on from generation to generation and opioids are not the first or only drug being used. In some cases, multi-generational households are misusing opioids and other substances together. In communities with high poverty and economic disinvestment, intergenerational and polysubstance use are not uncommon nor unique to Black/African American communities. For many in these poor and low-income communities, using and/or selling drugs is a means of survival. Opioids are not the only substances of concern and are likely not being misused in isolation. An understanding that intergenerational and polysubstance use are common among some impoverished communities, and that disentangling the behaviors of a person's social network, including their family, are challenging yet critically necessary.

Fear of legal consequences. Only 10 percent of people with a SUD in the general population seek treatment.[2] This is magnified in the Black/African American community where there is significant historical mistrust of the health care, social services, and the justice system. For men, there is the looming fear that seeking treatment will result in severe sentencing and incarceration reminiscent of the harsh policies of the past.[7, 26] Stricter drug policies for possession or sale of heroin in New York known as the Rockefeller Laws were put into place in 1973, and the Anti-Drug Abuse Act of 1986 enforced across the country resulted in mandatory and severe sentencing for low-level, non-violent drug offenses, particularly related to cocaine, for a disproportionately high number of people of color compared to Whites.[7] These severe penalties have had lasting impacts on the current criminal justice system, where Black/African Americans represent a substantial percentage of drug offenders in federal prison[9] despite Whites representing the majority of illicit drug users in the U.S.[2] Black/African American women fear losing their children to the foster care system if they acknowledge a substance use problem and seek treatment.[27] These fears are a major barrier to timely treatment and support for recovery.

Misperceptions and faulty explanations about addiction and opioids. Similar to society in general, in Black/African American communities there is a lack of understanding of SUD as a disease and the high risk for OUD from prescription opioid misuse. Within all communities, and especially Black/African American communities, as one key informant stated, people are hiding their SUD because "*addiction is seen as a weakness not a disease*" and another noted that solutions must discuss "*how addiction is a disease, not a moral failing.*" Misperceptions of current treatment options also exist among Black/African Americans and their families. According to key informants, many from this population are not informed about the standard treatment options for OUD, reducing the chance that evidence-based treatments will be sought.

Lack of culturally responsive and respectful care. While it can be challenging to take a holistic view of an individual and see more than the SUD, this may be even more so for the Black/African American who is subjected to the implicit biases of the health care system. Failing to bridge a racial cultural divide often contributes to premature termination of treatment among people of color. A shortage of Black/African American and Hispanic/Latino physicians, in general, and also clinicians who are waivered to prescribe buprenorphine exists.[28-30] Engaging in treatment is a difficult task for all populations. When the cultural context is ignored or misunderstood, respect for the patient is lacking, little hope is provided, and a lack of Black/African American practitioners who treat OUD exists, it becomes very difficult for a Black/African American with OUD to engage in treatment.

Separate and unequal prevention and treatment. Universal, broad, substance prevention campaigns have limited impact in diverse communities, including Black/African communities. The expectation that general prevention efforts and messaging will be equally relevant to Black/African Americans is unrealistic. Messages about SUD as described by a key informant cannot be *"easily uncoupled from disinvestment in our communities, mass incarceration, over-policing, over-traumatizing…when the messages are devoid of the context, [they are] not effective and it feels naïve for the folks that are living it."* The framing of a prevention message must be tailored to resonate with the community culture and be conveyed by a trusted messenger.

Unequal treatment is common in many Black/African American communities, where access to treatment options is more dependent on race, income, geography, and insurance status, rather than individual preferences, or medical or psychiatric indicators.[31-33] Research suggests that Black/African Americans with OUD have experienced limited access to the full range of medication-assisted treatment (MAT) when compared to Whites.[7,34-38] One study based in New York City found that the residential area with the highest proportion of Black/African American and Latino low-income individuals also had the highest methadone treatment rate, while buprenorphine and naloxone were most accessible in residential areas with the greatest proportion of White high-income patients.[36] Another study showed that in recent years buprenorphine treatment has increased in higher-income areas that have lower percentages of Black/African American, Hispanic/Latino and low-income residents while methadone rates have remained stable over time and continue to cluster in urban low-income areas.[34] Among individuals with OUD, Black/African Americans in the U.S. were less likely to receive buprenorphine compared to Whites, and those who self-pay or had private insurance represented nearly 74 percent of those who received buprenorphine from 2012-2015.[38]

This disparity in access to buprenorphine by race/ethnicity, geography, income, and insurance status, may be related to barriers for both the patient and clinician. Buprenorphine is generally a less stigmatizing treatment for people with SUD compared to methadone. It is an office-based treatment available for general/primary care practitioners to prescribe and administer. Office-based treatment programs only work for patients with access to primary care, something that may be inaccessible to many low-income or uninsured people of color. While in general it may be difficult to get physicians waivered, incentives to obtain a buprenorphine waiver are often lacking for providers serving the publicly insured or uninsured population due to limited or low reimbursement rates and lack of time and resources to pursue the training and acquire the mentorship to properly administer and care for buprenorphine patients.[34,36] In contrast, methadone must be administered in a federally regulated opioid treatment program, which has strict regulations and is often located in low-income areas. Methadone, while an effective treatment, places more burdens on the patient such as daily clinic visits, regular and random drug testing, employment disruptions, required counseling, etc. Thus, methadone —stigmatized in many Black/African American communities and as one key informant noted, "*just doing one drug for another drug*"—is often viewed as the default treatment for Black/African Americans and often the only treatment option. Essentially, a two-tiered treatment system exists where buprenorphine is accessed by Whites, high-income, and privately insured, while methadone is accessed by people of color, low-income, and publicly insured.

Strategies to Address Opioid Misuse and OUD in Black/African American Communities

Effective treatments for OUD have been developed and generally work across all adult populations.[39] However, access to these treatments is uneven,[34-38] with particular obstacles for minority populations. This section begins with a description of standard treatment for OUD and overdose. This is followed by innovative outreach and engagement strategies that have been used in Black/African American communities. These strategies, illustrated by snapshots from Black/African American communities, focus on outreach and engagement efforts that facilitate prevention, treatment and recovery. Supported by community-based participatory research efforts, these strategies are implemented by case managers, partnerships with community leaders and advocates, treatment providers, and peers/people with lived experience of a SUD.

STANDARD TREATMENT

The evidence-based treatment for an individual with OUD is MAT administered by qualified medical personnel, while for an opioid-related overdose, it is the administration of an opioid overdose reversal drug by a trained individual.

Medication-Assisted Treatment (MAT). MAT is the use of an FDA-approved medication in conjunction with a psychosocial intervention. Currently, three medications are approved for MAT: methadone, buprenorphine, and naltrexone.[40]

Methadone: a medication that reduces withdrawal symptoms and cravings and blocks the euphoric effects of opioids like heroin, morphine, oxycodone, and hydrocodone. For treatment of OUD, it must be prescribed and dispensed from a federally regulated opioid treatment program (OTP). It is taken daily and orally, typically in liquid form but can also be offered as a pill or wafer. It may cause serious side-effects and can be addictive. [41-42]

Buprenorphine: a medication that treats withdrawal symptoms and cravings and is less likely than methadone to cause intoxication or dangerous side effects such as respiratory suppression. It is commonly administered as a pill or buccal film that must be dissolved sublingually or attached to the cheek. It is also available as a monthly injection or subdermal implant that lasts for approximately 6 months. It may be prescribed and dispensed outside of a licensed OTP by physicians or qualified medical practitioners who have completed requisite training and earned a DATA-2000 waiver.[42-43]

Naltrexone: a medication that blocks the euphoric and sedative effects of opioids. It is not an opioid and is neither intoxicating nor addictive. It is administered as a daily pill or monthly injection by any licensed medical practitioner or pharmacist. An extended-release injectable form, Vivitrol, is approved for treatment of opioid and alcohol use disorders and its effects last for about 28 days.[42,44]

For additional information, see SAMHSA's TIP 63: Medications for Opioid Use Disorder.[45]

The second component to MAT is the psychosocial or behavioral intervention. Behavioral interventions target a broad range of problems and concerns not necessarily addressed by the medications (e.g. co-morbid mental health conditions, lack of social supports, risky behaviors, unstable housing, etc.). A few behavioral interventions such as contingency management, cognitive behavioral, and structured family therapy approaches are widely accepted as effective when used in conjunction with medications.[39] Some research has indicated that motivational interviewing may also be an effective behavioral intervention, but more research is needed.[39]

Opioid overdose reversal drugs. Currently, naloxone is the one FDA-approved medication used to reverse an opioid-related overdose.

Naloxone: a prescription medication to prevent overdose of opioids such as heroin, morphine, and oxycodone by blocking opioid receptor sites to reverse the toxic effects of the overdose; it is given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.[46]

Efforts to expand the use and availability of naloxone nationwide through federal, state, and local initiatives is a key strategy to tackling opioid overdose. The effectiveness of naloxone (Narcan) and the critical need for it during this time prompted the U.S. Surgeon General to issue a public health advisory in April 2018.[47] This advisory recommends increased availability of naloxone in communities with high rates of opioid use, including administration by a wide array of health professionals, first responders, overdose survivors, and their family members.[47-48] Similarly, in December 2018, the U.S. Department of Health and Human Services released new guidance on co-prescribing naloxone for patients at high risk for opioid overdose.[49]

COMMUNITY-INFORMED STRATEGIES TO ADDRESS OPIOID MISUSE AND OUD IN BLACK/AFRICAN AMERICAN COMMUNITIES

Five key strategies with specific community examples are described below. While not universally representative of all Black/African American communities, these strategies are examples of how some communities are addressing opioid misuse in their community.

1. Implement a comprehensive, holistic approach —*"Addiction is beyond the neuroreceptor level."*

A comprehensive, multi-layered approach is necessary to address opioid misuse and addiction. Some speculate that opioids are a way of coping in the absence of healing when a community has been traumatized by decades of violence, poverty, and neglect. As one key informant noted, *"thirty percent of the black community is under poverty in the state…these stats play into the sense of hopelessness, [people are] working full-time but not making livelihood, [there is a] sense of hopelessness that is fixed by opioids…[it's] more than just getting people into treatment."*

Another key informant stated: *"So much evidence that addiction is beyond the neuroreceptor level—it's the criminal justice system, daily life, the neighborhood—all have an impact on outcomes in addiction treatment… Medication is essential but not a magic bullet for treating opioid use disorders, [you] need more to recover successfully… not a single med that sustains recovery on its own, especially for those living in toxic environments…Rather, a comprehensive, holistic approach tailored to the community is required. For African Americans, addiction is embedded in a community context marked by limited opportunity, economic disinvestment, violence and intergenerational trauma. Research has confirmed that strong neighborhood cohesion and social ties are correlated with lower drug rates and related consequences."*

Key informants emphasized the value of community-led needs assessments and routine check-ins with the community that address the social determinants of health. Having the community's first-hand knowledge about where people live, work, learn, play, worship and age and how these places promote healthy functioning and quality of life is essential to addressing opioid misuse and OUD. Aspects of a community such as community engagement, economic stability, and neighborhood safety all have an impact on the well-being and health of its residents. These factors, often addressed by case managers, are a key component of treatment planning.

Understanding the existing assets in a community is essential. Where residents go for information, whom they trust to deliver care, and who the explicit and implicit community leaders are is critical information. In some Black/African American communities, places such as barber shops, beauty salons, and the church or faith-based community are critical for delivering prevention education and linking to treatment.[50-51] For residents reluctant to engage with the medical system, these "under the radar networks" are the essential entities to enlist in the opioid response. Using indigenous leaders, and individuals in recovery to spread education about naloxone kits, may have greater impact than the usual first responders such as police officers. Working with harm reduction networks and syringe services programs are needed to reduce harms among Black/African Americans who have an injection drug use problem, and among people who inject drugs, in general.[52] As noted by one key informant, *"Black community needs harm reduction because we are always under assault from drug use…[we] need prevention for STI (sexually transmitted infections). To not talk about this, [you are] not connected with Black communities."*

Community Snapshot: Creating safe, comprehensive healing spaces—Bellevue Hospital. Bellevue Hospital created a holistic addiction clinic built on the creative arts, self-care, and a recovery network of support for Black/African Americans. The clinic built in patient governance and established linkages with the community. The clinic created a home-like, welcoming environment, centered on a kitchen and cooking groups to foster a mindset of healthy eating. Patients and physicians in the clinic cooked together which was a way of establishing relationships in a non-hierarchical manner and building patient trust in a medical center. Therapeutic approaches incorporated both the structured cognitive behavioral therapy and patient groups based on the creative arts and spirituality, both highly valued within Black/African American culture. For some Black/African American groups, the cultural arts—visual, musical and drama—were an important participatory process for emotional expression, tapping into traumatic memories, and getting a sense of meaning and resilience outside of the SUD. The clinic established relationships with the surrounding community, including collaborating with Black/African American community-based organizations for housing, employment supports, food banks, churches, church-based addiction services and other trusted entities where patients could get ongoing support. The clinic assumption was that healing rests on relationships, and as described by one key informant, *"[you] can't just drop bupe into a clinic—the* *tenor of outreach and community relations is critical."*

2. Involve the community and develop multi-sectoral, diverse community partnerships—*"Community-based organizations are the engines managing crises before they get to the hospital."*

Involving the community—its residents, leaders and organizations—in solving community issues, particularly, opioid misuse, was underscored by the key informants. Involving the community in prevention, treatment, and recovery strategies relies on multi-sectoral partnerships and collaborations to leverage resources and expertise.

Community Snapshot: Developing a wide and diverse network of partners—Detroit Recovery Project (DRP). DRP is a multi-service agency, focusing on Black/African Americans. It is dedicated to supporting recovery, which strengthens, rebuilds, and empowers individuals, families and communities affected by SUDs. The agency provides a wide spectrum of support services to the city's recovery community, including GED preparation; twelve-step support groups; housing assistance; job readiness and employment assistance; HIV prevention, testing, counseling services; and ex-offender programs. Essential to the work of DRP is its diverse collaborations and partnerships. Examples of partnerships include the University of Michigan Injury Prevention Center, which provides real-time data from emergency medical services to identify opioid-related overdose incidents in the city of Detroit that are mapped and reported to community programs. DRP partners with the Detroit Police Department, churches, local businesses and Detroit Public Schools on prevention events such as "Prescription Drug Take Back Day." DRP develops memorandum of agreements with providers for provision of MAT and partners with federally qualified community health centers to host recovery coaches in their clinics. In conjunction with community leaders, DRP facilitates regular town hall meetings to address the opioid epidemic in Detroit. These robust collaborations strengthen ongoing prevention, treatment, and recovery supports tailored to the specific Black/African American community.

Community Snapshot: Building trust between community and law enforcement—Coffee with a Cop.[53] Efforts to address the distrust between Black/African Americans and law enforcement are underway in communities across the nation. Community-based organizations and counties are partnering with local law enforcement to create a program in which community members can have coffee with a police officer and talk about issues and community concerns without fear of being reported or arrested.[53] This strategy, "Coffee with a Cop" is taking place in Albany, Georgia to build rapport and trust between police officers and the local Black/African American community. The Morehouse School of Medicine—Dougherty Alliance for the Prevention of Opioid Use Disorders and Phoebe Putney Network of Trust School Health Program partnered with the Albany Police Department to implement "Coffee with a Cop" at the ASPIRE—The Change Center. The Change Center is an addiction recovery support center, which is peer-led and based on relationships that support a person's ability to promote their own recovery. This strategy allows for law enforcement and community members to get to know each other and to identify mutual community goals and common ground.

3. Increase culturally relevant public awareness—*"Campaigns are White-washed and make no sense in Black communities."*

The declaration of the opioid "epidemic" as a national emergency generated public awareness and social media campaigns. However, public awareness campaigns should be built on the needs assessments of the community. Communities are able to identify gaps in awareness and knowledge and provide key information in developing and tailoring health communication campaigns and subsequent prevention programs. Health communication campaigns on the opioid misuse and OUD in the Black/African American community need to include messages of hope and recovery and incorporate actors and images of people that look like the intended audience. They need to utilize communication mediums that are appealing and engaging for the community. There is high value placed on interpersonal relationships and establishing one-on-one connections with someone who has had similar experiences. Ensuring opioid education campaigns include Black/African Americans that are relatable to the intended audience is key to having an impact. This establishes credibility and counteracts the common theme, *"Where are all the Black people?"* repeatedly shared by key informants. Using plain language and language that is culturally appropriate to the community in educational materials, awareness campaigns, and presentations is needed. There is a lack of public awareness campaigns about opioid misuse and OUD for Black/African American communities, including campaigns focused on harm reduction strategies such as syringe services programs and naloxone education and distribution.

4. Employ culturally specific engagement strategies–*"The opposite of addiction is not abstinence, it's connection."*

A key component of some Black/African American cultures is the value placed on interpersonal relationships and one-on-one connections. Entering a Black/African American community and sharing data and statistics that paint a negative picture of the population before establishing a trusted relationship is culturally inappropriate. Ignoring history and context breeds mistrust and a sense of devaluing the community. Asking to learn from the community, recognizing their assets, and acknowledging failed and successful policies is critical to engaging the community.

Connect with culturally similar support groups. For people with SUDs, support groups are often a key component of their recovery. These groups bring together people who want a drug-free life, and to learn skills to conquer cravings. They are people who need support during difficult emotional times and who share similar life experiences around substance misuse and SUD. Support groups focused on SUDs can be organized around the particular substance, or by age, gender, religion, or another affiliation. These support groups bond individuals through a cultural tie.

Community Snapshot: Tailoring to midlife Black/African American women with OUD—Prime Time Sister Circles. The Prime Time Sister Circles® (PTSC) is a program of The Gaston & Porter Health Improvement Center, Inc., a non-profit developed by two midlife Black women health professionals. PTSC addresses the unique impact of gender, race, age and class experienced by midlife (40-75 years of age) Black/African American women. These women, continually underserved in the health care system, are at high risk for developing chronic emotional and physical health problems including opioid/heroin misuse and OUD. Even when they complete treatment programs, these women face stressors that often make it difficult for them to remain drug-free.

PTSC is an evidenced-based, culturally competent support group intervention that is community based, socially innovative, and holistic. The PTSC meets two hours a week for 13 weeks using a cognitive-behavioral approach. It provides a safe, supportive space in which women can learn to see themselves as more than their OUD. The general PTSC curriculum was adapted to address issues relevant to midlife Black/African American women with OUD. PTSC helps them address challenges such as single parenthood, incarceration, co-existing emotional and chronic

physical health conditions (e.g. depression, hypertension, diabetes, etc.), a history of childhood abuse, guilt and anger over their families' anger and lack of trust, difficulty in transitioning to a non-addiction culture, low self-esteem, and major financial difficulties. The PTSCs are conducted by trained facilitators and licensed and/or certified experts in mental health, hypertension, nutrition and fitness, who are all midlife Black/African American women. They are trusted messengers who can help Black/African American women receive the tools, skills and motivation needed to appropriately address some of their recovery issues.

Partnerships with community-based organizations are a core component to PTSC. The sites for the PTSC are in churches, public housing, and in health, recreation and substance abuse centers. Participants receive: a weekly ten-dollar stipend for transportation or child care costs; a blood pressure cuff, monitor and pedometer which they are taught to use; and a light meal to educate about healthy snacks. Women who participated in OUD focused PTSC shared that they valued the bonds with other Black/African American women, and made positive changes in their stress management, nutrition, fitness and blood pressure levels and increased their self-esteem.

Collaborate and partner with faith-based organizations and institutions. Historically in the U.S., the Black/African American church has been a key institution for providing support and spiritual leadership in addressing unmet needs including health and social concerns in Black/African American communities. Where traditional, mainstream social services have not addressed critical needs, the Black/African American church has stepped in. Where social justice has floundered, the church has initiated advocacy and social movements. This role continues to evolve as the Black/African American community changes over generations and the Black/African American faith-based community becomes increasingly diverse. In some communities, faith-based organizations may retain a strong leadership role and organize to address social issues and be a valuable trusted entity for the community. In other places, it may not assume such a position and may not be viewed as a critical leader or contributor to the overall well-being of the community. In this sense, it is important to have an understanding of the potential variability of faith-based institutions in different communities. For Black/African American communities in which the residents are engaged with the faith-based organizations, leveraging these organizations as trusted messengers may facilitate public awareness and linkage to prevention and treatment.

A common theme from the key informants was the use of faith leaders as trusted messengers to link faith communities to opioid prevention, education and treatment. In such communities, faith leaders are major influencers in large social networks. They know their community and the associated health and social issues tied to the community. They have been engaged in decades of health promotion. This includes prevention of wide-ranging conditions like diabetes, hypertension, HIV, mental health and substance use.[54-55] They are well positioned to promote awareness and education about opioid misuse and OUD. Most importantly, they know how to talk to their community, how to engage them in this issue more effectively than outsiders.

Community Snapshot: Activating faith-based organizations to be bridges to health—Bridges to Care and Recovery.
North St. Louis City and County have recognized that engaging faith-based organizations is a critical strategy to address behavioral health concerns for their predominantly Black/African American community. The Bridges to Care and Recovery is a community initiative with multisector partners including the faith community. It relies on the faith community to serve as extenders in identifying mental and SUDs and linking individuals to care. As of fall 2019, there were 65 churches engaged in the Bridges initiative and designated as "behavioral health- friendly churches." To receive this designation, church congregations completed 19 hours of training on basic behavioral health topics such as Mental Health Fist Aid, trauma awareness, and others. As part of their designation, these churches provide monthly meetings and presentations on behavioral health topics to their congregations. The Bridges initiative also has trained

220 church leaders and volunteers as Wellness Champions to reduce the stigma of mental illness. Community connectors are staff members who have established connections with the community and are able to link individuals to needed care and services. Pastors' wives, comprising the "First Ladies Network," are being trained as group facilitators and peer mentors for people with health and behavioral health conditions. The Bridges initiative is also working with the Missouri Opioid State Targeted Response Team to facilitate Opioid Crisis Management Training to churches that are interested in providing naloxone kits onsite. Church-based participants in the training learn about the signs and symptoms of OUD, the impact of trauma and OUD, access to medication-first treatment programs, and use of naloxone.

Community Snapshot: Providing support programs through the church—Imani Breakthrough Recovery Program. The Imani Breakthrough Recovery Program, supported by the Connecticut State Department of Mental Health and Addiction Services, and the Psychiatry Department of the Yale School of Medicine, is a 12-week intervention program for people with SUD that utilizes faith as a key support in recovery. Integral to the intervention is the involvement of faith-based entities like the church, which is why it is called Imani, meaning "faith" in Swahili. The intervention program seeks to get people with SUD into treatment and has two components to the program—a faith-based support group and wellness coaching.

Facilitators who are people with lived experience and members from the church lead the intervention. The developers of the intervention train the facilitators. The intervention addresses eight dimensions of wellness—emotional, health, occupational, financial, spiritual, wellness, intellectual and physical—and teaches a curriculum focused on "the five R's" (roles, resources, responsibilities, relationships and rights). The weekly meetings are held in church basements. The church provides necessities, including a shared meal, and for some individuals, a space for showering. Participants receive a ten-dollar stipend at each meeting for transportation and other needs. Each meeting has a theme and provides a safe space to share thoughts and feelings. The facilitator presents various scenarios to be discussed, and conveys specific skills to be shared and tested. Developing self-advocacy is a major focus of the program. One participant of the program stated, *"One of the things this program has done for me is being able to advocate for myself. It has also given me an opportunity to find resources in the community…to have a community of like-minded individuals."*[56] Another stated, *"The program gave me the opportunity to open up to others. If you don't have a place to go where you can talk about what's going on in your life, you're subject to going out and taking drugs."*[56]

Community Snapshot: Educating rural pastors on opioids and leveraging technology—Morehouse School of Medicine. Churches are highly valued in Black/African American communities in rural Georgia. Morehouse School of Medicine in Atlanta has subcontracted with these churches to collaborate on addressing various public health efforts including opioid misuse and OUD. The *"dual mission of the faith community to provide spiritual support as well as attend to unmet social issues and needs in the community"* is the basis for this partnership. Funding has supported collaborations among social service agencies and churches, and allowed for coordinated public awareness efforts. Pastors and faith leaders are included on advisory committees for grant funding to provide guidance on working with the faith community. In these communities, it is key to recognize the status of pastors in rural communities and connecting with pastor conferences to disseminate information and enlist support.

Morehouse has partnered with churches in micropolitan and rural settings that are leveraging technology such as radio broadcasts and podcasts to provide awareness and education on substance misuse and SUD. In one community, a faith leader after attending a training on the opioid crisis in the community, included the subject in a podcast with youth. Podcasts and similar online social media such as Facebook Live are innovative, current, inexpensive, and easily accessible ways to discuss important but stigmatized health issues with a community and particularly, the younger generations. Utilizing technology in the form of online sermons quickly—and at the convenience of the listener—provides information that is compatible with the target audience's lifestyle. Talking about stigmatized health issues such as OUD is a first step to dispelling misinformation and reducing stigma. Pastors can use this medium to convey that these are diseases and illnesses, not sins. Pastors without an online presence but who are involved in or educated on health and social issues in their communities are more likely to discuss these issues, like the opioid epidemic, in their Sunday morning sermons from the pulpit.

Identify community-embraced first responders. While the Surgeon General's call to action—for the use of naloxone for people living with OUD—may be embraced by mainstream, medically engaged communities, this is not always the case for communities that have historically been marginalized and underserved by the health care system. In some Black/African American communities, naloxone has had a mixed reception. Some community members express concern that the availability of naloxone could promote substance use among Black/African Americans. They also fear that seeking naloxone from traditional first responders, such as law enforcement and emergency medical technicians (EMTs), may result in punitive consequences.

Despite the mixed reaction to naloxone from some Black/African Americans, some communities are identifying their own first responders. These include community-based organizations, community health workers, family members, and faith-based leaders, and training them to administer naloxone. More education and awareness tailored to Black/African American communities and conveyed by "trusted messengers" is essential to create support for and a sense of urgency regarding the use of naloxone as a life-saving medication. Identifying where naloxone would make the most impact in saving lives within a community is critical. Some local leaders have advocated for access to naloxone for individuals re-entering neighborhoods from incarceration, given the high risk for opioid overdose at re-entry. By providing naloxone and training the use of it in prisons and jails before an individual's release, overall opioid-related overdose deaths could be reduced. As one key informant suggested, *"the best strategy is getting naloxone into incarceration."*

Community Snapshot: Engaging Black Pastors in the Quick Response Team (QRT)—City of Huntington QRT. The City of Huntington, WV partners with Cabell County Emergency Medical Services (EMS), Marshall University, local law enforcement, treatment and recovery providers, and pastors to form and deploy the QRT to locations with a high number of drug overdoses. The QRT includes a paramedic, treatment provider, law enforcement officer, and unique to Huntington, is the inclusion of a faith leader. Although Cabell County has a low population of Black/African Americans, opioid overdose deaths in Cabell County occur at a disproportionately high rate compared to the national rate. The City of Huntington QRT's emphasis on involving the faith community, especially for Black/African American communities, has been pivotal in developing trust between people with SUD and who are at risk for opioid overdose. Initially, there was some reluctance among the faith leaders. But with the opportunity to connect one on one with people in their communities living with OUD, many faith leaders in this community have become champions of this cause and are helping engage individuals to seek treatment. Faith leaders, spearheaded by the Huntington Black Pastors Association, are being trained in understanding opioid misuse and treatment and reducing stigma. They are educating faith communities and families to be supports for people with SUDs. As one key informant noted, *"With the Black community the stigma is there, even among the Black pastors. They felt individuals were replacing one drug for another (as in MAT programs), but now working on the streets [they] realize this is not the case."* The QRT offers their support in assisting high-risk individuals with OUD to not only seek treatment, but also educating about naloxone. They are linking with community partners to provide naloxone training and distribution to family members, individuals with OUD, and others in their community.

5. Create a culturally relevant and diverse workforce–*"[We] have trained Black peers, but not a Black supervisor."*

Communities know that when people feel welcomed, understood and comfortable, they are more likely to continue treatment. In many situations, it is important that staffing of treatment centers reflect the community being served. When Black/African Americans make the difficult decision to enter treatment, often they will not see any staff at the treatment facility that share a similar cultural background with them. Addressing the shortage of Black/African American medical personnel who are waivered to prescribe buprenorphine may reduce the inequity in access to evidence-based medications. Additionally, recruiting and training a diverse workforce and creating billable funding structures to pay for this workforce is critically needed. One key informant shared that although there is state funding allotted for peer mentoring there are policy barriers to hiring and paying Black/African American peer mentors, *"[We have] access to a peer mentor, but lack access to a supervisor. [We] can't bill without peer supervisor. [We] have trained Black peers, but not a Black supervisor. [We] don't have access to the other supervisors."* Adhering to the National Culturally and Linguistically Appropriate Services in Health and Health Care Standards (National CLAS Standards) can help provide a blueprint for organizations to provide quality and responsive care to diverse populations.[57]

Meet people where they physically are, again and again. To persuade someone to enter treatment for SUD is not simple. It is important to consider the context in which a person with SUD is living. It is equally important to consider the challenges that may prevent an individual with SUD from entering treatment. People are often unfamiliar with or untrusting of existing resources for SUD. They do not know who to ask for help nor what to ask for, or have a strong sense of belief that no one actually cares about them. The use of mobile outreach potentially increases the likelihood of getting people with SUD into treatment. This involves physically going to where people are, connecting with them, bringing authentic care and hope, and linking them with trusted treatment and recovery providers. Leveraging the experience and expertise of those with lived experience of having an OUD such as peer recovery coaches may be critical to getting a person into treatment.

Community Snapshot: Going into the streets—Detroit Recovery Project Mobile Outreach Team. DRP collaborates with local emergency departments to provide linkage to care for people with SUD in crises. The local hospital calls DRP to help get a patient with SUD into treatment. DRP responds by deploying a mobile outreach recovery van and peer recovery coach to the local site where the patient is. They provide the support and physical transportation needed to assist the patient in accessing and entering a treatment program. The DRP mobile outreach vans are custom-wrapped with images of Black/African Americans reflective of their community and include pictures and messages of hope and recovery. The mobile outreach team includes staff with lived experience or experience working with the population, ensuring a level of trust and understanding between the person with SUD and the outreach staff. In addition, the mobile outreach team knows the geography, neighborhoods, historical and social context of Detroit in order to know where to go to engage people on the street living with a SUD.

Community Snapshot: Engaging peer recovery coaches—Project RECOVER. In Boston, peer recovery coaches with ongoing supervision from a recovery coach supervisor are being used to link, engage and retain people with OUD in outpatient medication-based treatment for at least six months after completion of detoxification. Recent literature shows that the transition after completion of detoxification to be a critical touchpoint with elevated risk for opioid-related mortality.[58] Through a series of interventions including motivational interviewing, peer recovery supports, and strengths-based case management and development of recovery wellness plans, coaches work with individuals to address perceived barriers to one's recovery. The peer recovery coaches help link individuals to SUD focused primary care services where they can get comprehensive care (screening, treatment, and referral) for mental health disorders and injection related chronic diseases such as HIV and hepatitis B and C. Most importantly the peer recovery coaches provide overdose prevention education and naloxone distribution and training to all clients and a close member of their social network. In this model, the peer recovery coaches are from the Black/African American or Latino community and are people with lived experience of SUD. Eligibility to be a peer recovery coach includes being in recovery for at least two years and completing an intensive five-day training that includes courses on motivational interviewing; ethical considerations; addiction 101; cultural awareness and responsiveness—knowing the "street" language used; wellness recovery plans; and linkages with community resources, such as housing and primary care to address related infectious diseases. The peer recovery coaches are required to complete 500 hours of recovery coach work with 35 hours under supervision from a peer recovery coach supervisor. Once eligibility is met, they are certified by the State and their services are billable.

The peer recovery coaches are critical in outreach and engagement; they know the community, know the resources, and are able to communicate effectively, and are able to draw upon their own experiences with SUD and recovery. As one key informant noted, *"The key strength is that we [recovery coaches] understand addiction, we went through the same stuff. Also not going to tell you what to do, it is self-directed…we don't have a timeframe. Recovery coach is there to support and give guidance. We connect them with MAT, help with job seeking, housing applications; if relapse, recovery coach is there to help you pick up there all the time… sometimes can spend four hours in a day with getting them to appointments and assisting transportation…we can sit with you 3 hours in a courtroom. How many professionals can do that?"* Recovery coaches develop a unique connection with the client and have said that the most difficult challenge is the family. Families often do not understand SUD, have seen their family member relapse repeatedly, and do not believe in the possibility of recovery. In cases where family members are using drugs, the peer recovery coach teaches refusal skills.

Community Snapshot: Building and developing a culturally sensitive and diverse workforce—Detroit Recovery Project. DRP collaborates with local universities and Authority Health to establish DRP as a training facility for psychiatry and internal medicine interns and residents.[59] The partnership allows for mentoring the next generation of medical providers to be better equipped and experienced in working with low-income, Black/African Americans with SUD.

Moving Forward

Opioid misuse, OUD, and opioid-related overdoses have affected all population groups in the U.S. Strategies to address this issue need to be tailored to the diversity of the communities affected. Promoting a one-size-fits-all strategy may inhibit access to appropriate, quality prevention and treatment for culturally diverse populations. To reduce the impact of opioid misuse, OUD, and opioid-related overdoses on the Black/African American population, it is critical to understand the contextual issues, the treatment barriers, and the community-informed strategies that are working in these communities.

Reducing opioid misuse and overdoses in Black/African American communities requires an interdisciplinary, multi-level team approach. Collaboration among community leaders, associations, advocates and residents with policymakers, government agencies, educators, prevention specialists, and treatment and recovery providers is urgently needed. All must mobilize to educate and engage one another and identify and implement evidence-based and community-informed strategies that work best for this population and save lives.

Glossary

(Definitions from SAMHSA[60] and CDC[13,61])

Fentanyl: a synthetic opioid, approved for treating severe pain, typically advanced cancer pain. It is 50 to 100 times more potent than morphine. However, illegally made fentanyl is sold through illicit drug markets for its heroin-like effect, and it is often mixed with heroin or other drugs, such as cocaine, or pressed in to counterfeit prescription pills.

Heroin: an illegal, highly addictive opioid drug processed from morphine and extracted from certain poppy plants.

Methadone: a synthetic opioid that can be prescribed for pain reduction or for use in MAT for opioid use disorder (OUD). For MAT, methadone is used under direct supervision of a healthcare provider.

Natural opioids: a group of opioids that include such drugs as morphine and codeine.

Opioid misuse: any misuse of prescription opioids (also called prescription pain relievers) or the use of heroin (and synthetic opioids depending on the data source). Misuse of prescription opioids is the use of a prescription opioid in any way not directed by a doctor, including without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. It is sometimes also called "nonmedical prescription opioid use" or "misuse of prescription pain relievers" dependent on the data source, and refers only to misuse of prescription opioids.

Opioid use disorder (OUD): having either a heroin use disorder (i.e., dependence or abuse) or pain reliever use disorder related to their misuse of prescription pain relievers in the past year, or if they had both disorders.

Opioid use: any use of prescription opioids, heroin, or synthetic opioids (e.g., fentanyl).

Opioid-related overdose death: death resulting from unintentional or intentional overdose involving an opioid.

Prescription opioids: Opioids are a group of chemically similar drugs that include prescription pain relievers such as hydrocodone (e.g., Vicodin®), oxycodone (e.g., OxyContin®), morphine, and others. They are sometimes called "prescription opioid analgesics" or "prescription pain relievers" depending on the source.

Semi-synthetic opioids: a group of opioids that include such drugs as oxycodone, hydrocodone, hyrdromorphone, and oxymorphone.

Synthetic opioids other than methadone: a group of opioids that include such drugs as fentanyl, fentanyl analogs, and tramadol.

Resources

Centers for Disease Control and Prevention (CDC) Reducing Harms from Injection Drug Use and Opioid Use Disorder with Syringe Services Programs (Info Sheet) | https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf

SAMHSA Opioid Prevention Toolkit (Toolkit) | https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742

SAMHSA TIP 63: Medications for Opioid Use Disorder (Treatment Improvement Protocol) | https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder

SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants (Clinical Guidance) | https://www.store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054

SAMHSA Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings (Resource Guide) | https://store.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

SAMHSA Behavioral Health Barometer, Volume 5 (National Data Report) | https://store.samhsa.gov/product/Behavioral-Health-Barometer-Volume-5/sma19-Baro-17-US

SAMHSA Prevention Technology Transfer Center Network (Website) | https://pttcnetwork.org

SAMHSA Addiction Technology Transfer Center Network (Website) | https://attcnetwork.org/

SAMHSA TIP 59: Improving Cultural Competence (Treatment Improvement Protocol) | https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) (Webpage) | https://thinkculturalhealth.hhs.gov/clas

U.S. Department of Health and Human Services Office of Minority Health Improving Cultural Competency for Behavioral Health Professionals (Continuing Education e-Learning Program) | https://thinkculturalhealth.hhs.gov/education/behavioral-health

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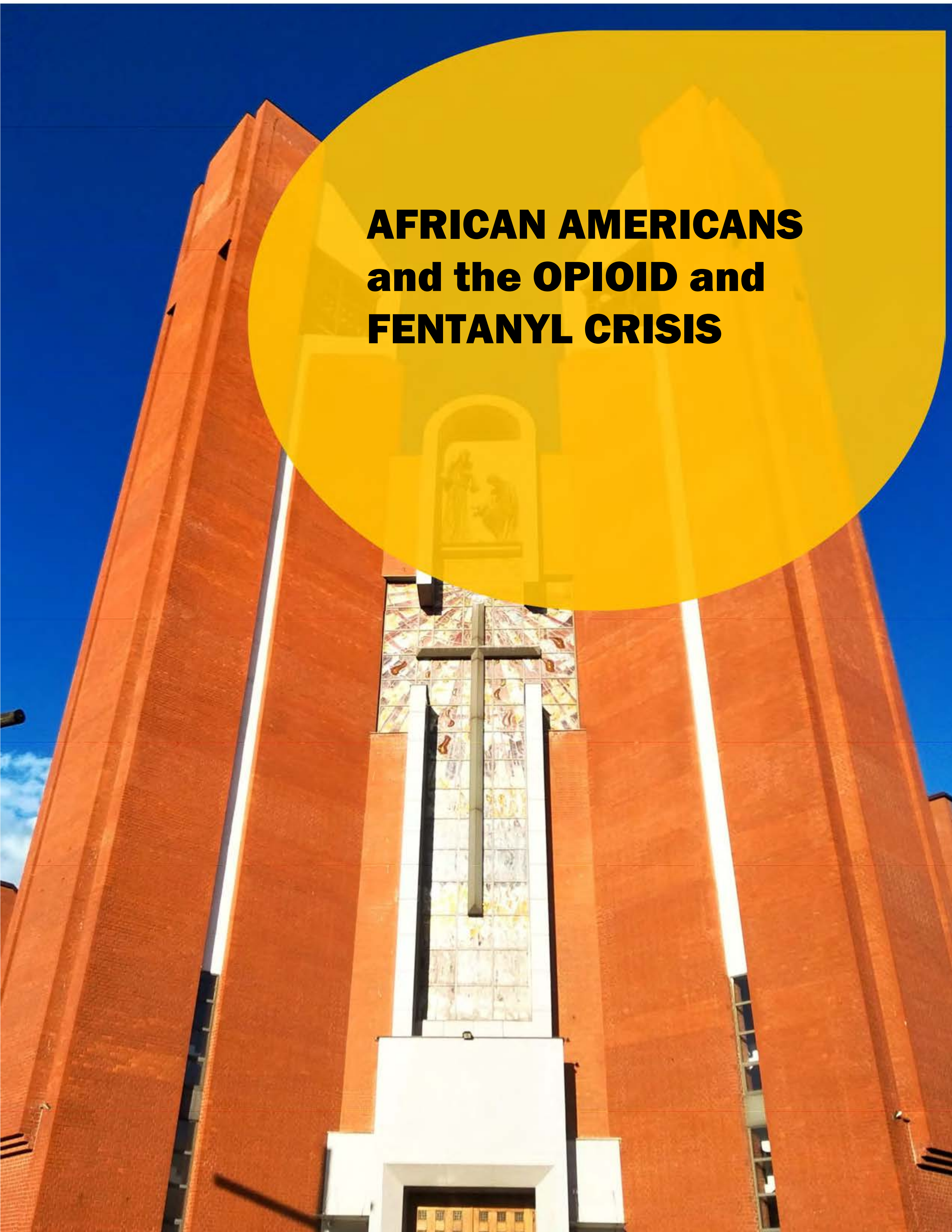
AFRICAN AMERICANS and the OPIOID and FENTANYL CRISIS



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"Bringing people together to serve humanity"

The Black Church Strategy in Controlling the Growth of the Opioid Crisis/Fentanyl for African American and Latinos: A Community-Focused, Church Imperative for a Culturally Responsive Approach

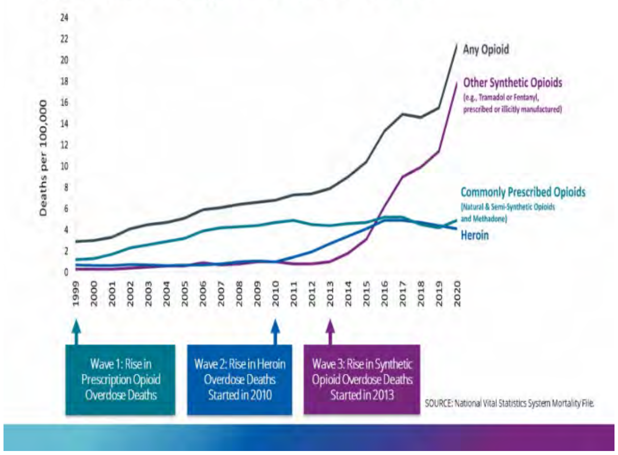
> "One day I received a call from an African American male who was in crisis and needed some type of services. I proceeded to ask him about what type of services he needed. He responded, "I am addict and that I was hooked on pain killers." The gentleman continued to tell me that "he was middle-class and that he felt ashamed of his situation." He also shared with me that "he could not tell his wife, his colleagues, or his pastor." I felt really helpless about the gentleman's situation because the phone call came to me during the height of the COVID crisis. The gentleman further shared with me that he "kept going back to my doctor for refills and he never refused to fulfill the prescription. And now, I am in crisis." I had prayer with him and suggested that he take the COVID vaccine and sit in the emergency room until he received services…We never heard back from him." -
>
> *Reverend Anthony Evans, NBCI President; 2020 Phone Dialogue*

In my leadership role as president of The National Black Church Initiative, a coalition of 150,000 African American and Latino churches working to eradicate racial disparities in healthcare, technology, education, housing, and the environment, I receive all types of phone calls or messages daily from both known and unknown persons across the country who are experiencing some type of crisis. Unlike other calls, what was different about this call in 2020 was not only that it occurred during COVID-19, but through the frantic and desperation tone of his voice, what I recall mainly was the unspoken anticipation and unapologetic expectation he, as an unnamed gentleman to me, had from me, as a named gentlemen to him, to do something about his situation. Out of everyone the unnamed gentleman could have called, even to this day, I have often wondered why did he call me? What about me and/or the work at the National Black Church Initiative made him want to reach out to me?

And, as I further reflect upon the call, I am reminded of how the spoken and unspoken issues for which emerged from the conversation with the unnamed gentleman (i.e.,need for help, need for compassion, need for safety, need for alternatives) were ones often missing as part of the public dialogue. I would venture to say that the unnamed gentleman was unaware of the broader persisting challenges African American and Latino communities encounter from opioid addictions, like him, and how those community members who comprise those churches, too, have encountered first-hand dire phenomena of opioid addictions and subsequent crises created. To that end, the unsettling phone call and persisting phenomena generated an urgent need for the National Black Church Initiative to examine the broader context of the opioid crisis in conjunction with governmental, pharmaceutical, and media viewpoints and explore opioid addictions through understanding perspectives, perceptions, and practices within church and community. Such combined insights serve as a community-focused, church imperative to forge a culturally-responsive opioid crisis plan with fentanyl impact for African Americans and Latinos.

Contextualizing the Opioid Crisis and Viewpoints of Governmental, Pharmaceutical, Media, and the Broader Public Arenas

Figure 1: Three Waves of Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

The opioid crisis has impacted the broader American public and the Centers for Disease Control and Prevention (2022) has particularly identified the opioid crisis as occurring within three different waves. Figure 1, as extracted from the Centers for Disease Control and Prevention (2022), has identified those waves as any opioid, other synthetic opioids, and commonly prescribed opioids. What the Center for Disease Control and Prevention (2022) indicates in their report, "Three Waves of Opioid Overdose Deaths," is that the "number of drug overdose deaths increased by nearly 30% from 2019 to 2020 and has quintupled since 1999 and that nearly 75% of the 91,799 drug overdose deaths in 2020 involved an opioid." The Centers for Disease Control and Prevention (2022) further reports that from 2019 to 2020, "there were significant changes in opioid-involved death rates: 1) Opioid-involved death rates increased by 38%; 2) Prescription opioid-involved death rates increased by 17%; 3) Heroin-involved death rates decreased by 7%; and 4) Synthetic opioid-involved death rates (excluding methadone) increased by 56%." Such findings show the steady increase of opioid deaths for the American public.

Regarding the origins of the opioid crisis, what has become evident is the commonality of the crisis linkages to the pharmaceutical companies with differences emerging in how those linkages unfolded (CBS News, 2020, U. S. Food and Drug Administration, 2022, American Council on Science and Health, 2018). Following below are highlighted activities across nearly a twenty-year period involving governmental, pharmaceutical, and media arenas. More detailed reports about these activities can be found at the respective websites.

U.S. Food and Drug Administration (2022) (*as extracted directly from the site*)

- 1995. OxyContin (oxycodone controlled release) approved; first formulation of oxycodone that allowed dosing every 12 hours instead of every 4 to 6 hours.

- Early 2000s. Reports of overdose and death from prescription pain drugs, especially OxyContin, began to rise sharply.

- 2001. OxyContin label was changed to add and strengthen warnings about the drug's potential for misuse and abuse.

- 2003. FDA issued a Warning Letter External Link Disclaimer (PDF - 149KB) to OxyContin's manufacturer for misleading advertisements.

- 2009. FDA held several public and stakeholder meetings, including May 27-28 public meeting External Link Disclaimer and December 4 stakeholder meeting External Link Disclaimer, to discuss opioid risks, misuse, and abuse.

- January 2013. On January 9, FDA issued a draft guidance to assist industry in developing new formulations of opioid drugs with abuse-deterrent properties: *Guidance for Industry: Abuse-Deterrent Opioids – Evaluation and Labeling* (PDF - 463KB).

- April 2013: On April 16, FDA took multiple actions related to OxyContin.

- December 2016: On December 16, the FDA approved several safety labeling changes (SLCs) about the serious risks of prescription opioid analgesics and opioids approved for medication assisted treatment (MAT) of opioid addiction including class-wide SLCs for immediate-release (IR) opioid pain medications, SLCs for methadone and buprenorphine products, and class-wide SLCs about the serious risks associated with the combined use of certain opioid medications with benzodiazepines or other central nervous system (CNS) depressants.

- June 2017. On June 8, FDA requested that Endo Pharmaceuticals remove its opioid pain medication, reformulated Opana ER (oxymorphone hydrochloride), from the market based on its concern that the benefits of the drug may no longer outweigh its risks.

- January 2018. On January 11, FDA Commissioner, Scott Gottlieb, M.D., announced the 2018 Strategic Policy Roadmap, which provides an overview of some of the key priorities the agency will pursue advance FDA's public health mission. Part of the Roadmap is reducing misuse and abuse of opioid drugs.

- February 2019. On February 12, FDA announced ongoing efforts to stop the spread of illicit opioids, further secure the U.S. drug supply chain and forcefully confront opioid epidemic.

- March 2019: On March 19, FDA took action against marketer of unapproved products claiming to treat addiction, chronic pain and other serious conditions.

- March 2019: On March 27, FDA announced new steps to strengthen agency's safety requirements aimed at mitigating risks associated with transmucosal immediate-release fentanyl products.

- February 2021**:** On February 16, the FDA issued a warning letter to AcelRx Pharmaceuticals, Inc. for the false and misleading promotion of Dsuvia (sufentanil sublingual tablet), a potent opioid analgesic.

- April 2022: On April 20, FDA published a Federal Register notice seeking public comment on a potential change that would require opioid analgesics used in outpatient settings to be dispensed with prepaid mail-back envelopes and that pharmacists provide patient education on safe disposal of opioids.

- September 2022: On September 22, the FDA published the immediately-in-effect guidance, Exemption and Exclusion from Certain Requirements of the Drug Supply Chain Security Act (DSCSA) for the Distribution of FDA-Approved Naloxone Products During the Opioid Public Health Emergency, which is intended to clarify the scope of the public health emergency (PHE) exclusion and exemption under the DSCSA as they apply to the distribution of FDA-approved naloxone products to harm reduction programs during the opioid PHE. This guidance supports the FDA Overdose Prevention Framework.

American Council on Science and Health (2018) (*as extracted directly from the site*):

- #1. In 1995, Purdue Pharma received approval for OxyContin, a powerful opioid. Many patients got hooked and began doctor shopping. More importantly, some people began abusing OxyContin, by crushing and injecting it.

- #2. In 2007, Purdue paid a $634-million fine for lying about OxyContin, which they claimed was less addictive than other opioids.

- #3. Prescriptions for opioids tripled between 1991 and 2011. This was probably due to some doctors over-prescribing the drugs, for instance by giving a one-month supply of drugs for a pain issue that might last for only a week. As a result, a lot of opioids flooded the market, and they fell into the wrong hands, such as drug dealers, addicts, and teenagers. In response, the government decided to crack down on opioid prescriptions.

- #4. In 2010, Purdue released an abuse-resistant formulation of OxyContin. If a drug abuser tried to crush it for injection, it would turn into an unusable gummy mess.

Simultaneously, doctors became reluctant to give opioids to patients, so prescriptions began to decrease.

- #5. This marked the beginning of the heroin epidemic. Despite all the good intentions in #4, addicts and other recreational drug users -- who could no longer get easy access to OxyContin, Vicodin, or other opioids -- turned to heroin. As a result, *opioid-related deaths have continued to increase.*

- #6. Deaths from prescription opioids alone are rare. The reason so many people, usually recreational drug users, overdose is because they are mixing opioids with other drugs, such as alcohol or benzodiazepines. This is a lethal cocktail. Additionally, heroin is often adulterated with illegal fentanyl, a drug that is 50 times more potent than morphine. (A lethal dose of fentanyl looks like a few grains of table salt.) Fentanyl is largely coming into the country from China via Mexico.

CBS News (2022) (*as extracted directly from the site*):

- The opioid epidemic, which started around 2005 and began to peak around 2010, was created by pharmaceutical executives that hail from companies like Cardinal Health, Cephalon Pharmaceuticals, Insys Therapeutics, McKesson Pharmaceuticals, Mallinckrodt Pharmaceuticals, and Purdue Pharmaceuticals.

- Although it is impossible to pinpoint which human being or company thought of it first, the inspiration behind the opioid crisis was to sell drugs that would soon sell themselves to addicted human beings and bring a lot of income to pharmaceutical companies. No one cared what kind of toll this took on human health.

- First, the drug companies had to sell the idea to their staffs and their distributors and try to rearrange both their thinking and their characters. "I was taught to forget the patient, to not think about the patient, take the human aspect out of it," former Insys senior vice president of sales Alec Burlakoff told Bill Whitaker of the TV show 60 Minutes. "It's like selling widgets. The less of a conscience you had, the better."

- In January of 2020, a jury found five Insys executives guilty of racketeering and fraud for recklessly and illegally conspiring to boost profits from the opioid painkiller Subsys. While Insys CEO John Kapoor was sentenced to five and a half years in prison, the victims of the opioid epidemic, 19,416 of whom died in the first three months of 2020 alone (CDC and NIDA), have been sentenced to a lifetime of suffering and struggle. The COVID-19 pandemic has made things even worse.

- Between March 2019 and March 2020, approximately 75,500 people overdosed, a 10% increase over the same period between 2018 and 2019.

What becomes evident in the highlighted activities are the pursuit of policy and public buy-in efforts that governmental, pharmaceutical, and media arenas sought to accomplish. Each arena utilized the depth and breadth of its platform to advocate positions unique to constituencies served.

Perspectives Matter on the Church involving African Americans and Latinos and the Opioid Crisis

Perspectives surrounding the role of the church, as a faith-based community, and the broader community surrounding the church are critical, yet somewhat, underutilized components in efforts toward combatting the opioid addiction. Burdette et.al (2018) report that church attendance was connected with the reduction in the risk of illicit drug use and not connected with prescription drug misuse. Another study indicated that opioid misuse may be considered as more socially acceptable than illicit drug use. Consequently, there might be an underlying belief that there are less legal consequences (Inciardi et.al, 2009; Mui et.al, 2014). A remaining study, as conducted by Ransome et.al (2019) revealed that church attendance was linked to a reduced likelihood of fulfilling any of the criteria for opioid use disorder. All of these studies indicate the influence of the opioids within the faith-based community.

With regards to the opioid crisis, often times individuals experience challenges with mental health given the emotional needs that are a result of addiction. Lukacho, Myer, and Hankerson (2015) highlight how the cultural background of individuals dealing with mental health indicate that “professional mental health care may clash with sociocultural religious norms” (p. 578). Hechanova and Waelde (2017) identify five areas for which mental health professionals need to be concerned: 1) emotional expression; 2) shame; 3) power distance; 4) collectivism; and 5) spirituality and religion. The focus on spirituality and religion particularly highlights how individuals access spirituality and religion in such a manner that is transferable into coping skills of mental health and the challenges therein (i.e.,depression, anxiety). More specifically, within the Ellison in the Nashville Stress and Health Study (2017), as it relates to the Black Church, assert the following:

> Church-based social support may be particularly important for African Americans. On average, they tend to exchange instrumental and socioemotional aid informally with fellow church members more often than Whites from comparable backgrounds (Krause 2002, 2008). Several studies report that such congregational support, particularly socioemotional assistance, is linked with health and well-being among African Americans (Chatters et al. 2011, 2015; Ellison, Musick, and Henderson 2008; Head and Thompson 2017; Hope et al. 2017), perhaps more so than among Whites (Krause 2003, 2008a). Among African Americans, church-based support often augments and complements – rather than replicates the support that is available from family members and other non-kin ties (Nguyen, Chatters, and Taylor 2016).

The perspectives of the Ellison in the Nashville Stress and Health Study (2017) indicate the intricate role of the church within the mental health affairs. African Americans tend to gravitate toward the church as a source of inspiration and comfort to respond to the varying pressures. More specifically, with Latinos, Caplan (2019) reports the following:

> "Among the Hispanic/Latino faith-based communities in this study, mental illness and depression were culturally defined and often perceived to be a spiritual problem rather than a "sickness." This non-biomedical interpretation of illness is consistent with the findings of Breslau et al. (2017), indicating that Hispanics/Latinos (particularly Spanish-speaking individuals) have very low perceived need for mental health services

> irrespective of severity of illness. The importance of religion and religious coping as a means of treating of depression, as well as *Familismo*, or the necessity of family and community support, illustrate the cultural and religious values of many Latinos in the United States (Dalencour et al., 2017; Moreno, & Cardemil, 2013)."

Findings from Caplan (2019) show how Latinos rely upon churches as a critical reliance of support for social, educational, and spiritual resources. Cultural values among Latinos are identified as a source of strength, but also serves as a contributor as a stigma. Within the faith-based community for Latinos, there is need for mental health literacy and anti-stigma interventions. Understanding what we know from broader and specific trends on mental health, particularly as it relates to opioid addiction, becomes critically important for contextualizing the role of the religious community to respond in intentional and relevant ways.

Earls (2019) from Lifeway Research reports the implications of the opioid crisis for the church and the impending need for focused outreach. Based upon a phone survey of 1,000 Protestant Pastors, the interviews were conducted with the senior pastor, minister, or priest of the particular church. In the article, "Half of Pastors Say the Opioid Epidemic Has Hit Their Church," offer insightful perspectives about opioid addictions for and within their congregation. Earls (2019) indicate the following:

- Two-thirds of pastors (66%) say a family member of someone in their congregation has been personally affected by opioid abuse.
- More than half (55%) say they or someone in their congregation knows a local neighbor suffering through opioid abuse.
- For half of pastors (52%), someone directly in their church is dealing with an opioid addiction.

- Pastors in the Northeast (11%) are least likely to say they don't have any such personal connections.

Such findings offer perspectives that show how church leadership, particularly with pastors, serve as a direct and indirect conduit to the community of those affected by the opioid crisis.

Thus, what becomes particularly evident through the findings is how the majority of the pastors know of someone who is directly involved with opioid addiction. Knowing someone who is facing the opioid crisis is quite telling since according to the U. S. Department of Health and Human Service's Substance Abuse and Mental Health Services Administration (2020), 11.4 million people in the United States, aged 12 and older, experienced some type of opioid misuse (i.e., 4.2%). And consequently, according to the article, "Larger churches—those with more resources and more personal connections to the crisis-are most likely to say they offer both spiritual and practical help for those with an opioid addiction." The relational dynamics between those affected and not affected with opioid addictions become an important component when considering how to address the opioid addiction.

What also becomes particularly evident is that pastors who are least likely to know of someone experiencing opioid addiction is geographically located within the northeastern region of the country. Data from the U. S. Department of Health and Human Services' Substance Abuse and Mental Health Administration Report (2022) show the top five states with highest percentage of opioid deaths are Ohio, Florida, New York, Pennsylvania, and New Jersey while the top five states with the highest percentage of opioid death rates are West Virginia, Maryland, New Hampshire, and New Jersey. As indicated, New Hampshire ranks as the fourth state with the highest percentage of opioid death rates and is the only state that is identified as having notable percentages about death and death rates for opioid related incidents. To that end, more deliberate and geographically-situated responses are needed to address the opioid crisis.

Earls (2019) further provides perspectives that show next steps for how churches might address those who are dealing with opioid addiction. The article, "Half of Pastors Say the Opioid Epidemic Has Hit Their Church," again, asserts the following:

> "Gallaty said one simple way churches can address the problem is by 'educating our people of the dangers of addition by talking about it publicly and preaching sermons about the topic. Pastors shouldn't shy away from it. As people with addictions come to the attention of the church, however, Gallaty said congregations and leaders must be ready. When people come to our churches as hospitals for healing, pastors should have a game plan to help them,' he said." We can stick our heads in the sand and hope the issue dissolves or we can recognize the need and take steps to come alongside those struggling."

The role of church and community leadership is critical toward ensuring those affected by the opioid epidemic are responded to in an impactful way. Leaders must be strategic in their approach, yet courage is required by those persons in positions of access and opportunity to advocate meaningfully for these vulnerable populations.

Notwithstanding, the article by Becker (2017), "*Churches Step Up to Help With Opioid Epidemic, But Spirituality's Role In Treatment Is Controversial*," shows how the demonstration of spirituality to be a reflection of principles of outreach and connection. Rev. Janice Ford, one of the article respondents who serves as an episcopal pastor, states the following:

> We're not looking to convert folks. That's not what this is about. Ford said. When you provide spiritual care, you're trying to find, where is God in their addiction? Where is

> God in their life? That's lived spirituality means. Lived spirituality, Ford tells the group, could mean many things such as providing informational resources at the church about addiction and treatment or connecting congregants with others. Mostly, she says, it's letting people know that the church might be able to help.

Lived spirituality shows the importance of putting into practice the beliefs that are held as well as the recognition of an unfolding, individual journey of life. Being able to offer information or experiences that speak to the life phases of those involved becomes a critical component of what is needed to ensure needs are fulfilled. In this case, with opioid crisis, how to ensure both conventional or convenient needs (i.e., physical resources) and non-conventional or inconvenient needs (i.e., emotional, and mental support) are being addressed of individuals and their respective families is important and extended responsibility of the church.

To that end, the members of the church and broader community must reckon with the following (Lance Dodes in Becker, 2017):

> What does spirituality or morality or a good feeling toward others have to do with addiction? Zero. Addiction isn't about that. Addiction is a psychological symptom to help you get through feelings of being overwhelmed.

Such question, as posed by Lance Dodes in Becker (2017), demonstrates the need to ensure addiction is being addressed within the context of what it is and what it is not. For example, the opioid crisis and the emerging addiction may be viewed to some within faith-based as a result of sin. And while that might be part of a broader theological debate, the question put forth by Lance Dodes in Becker (2017) situates addiction in a particular place of being a 'psychological symptom' and encourages others to focus on addiction within that manner. Such approach prioritizes directly what is important in the opioid crisis.

Lastly, Mike Clark in Becker (2017) highlights how addiction requires honesty on both parts of those who are addicted and those who are trying to serve the addicted. To the extent that type of honesty is accomplished is the extent to which the help provided is success. The article indicates the following:

> In my experience, there are as many active alcoholics and addicts upstairs in churches as there are recovering alcoholics and addicts downstairs," Clark said. "But the ability to be honest about and seek help unfortunately is a challenge for most people. So, we've approached it here as not only trying to offer support to folks in the congregation, but also trying to find some appropriate ways for two very separate communities, historically, to say, actually, we might have some things in common."

The level of interest, participation, and engagement required by both communities (i.e., those who are addicted, those who are trying to serve the addicted), again, is critical to cultivate success. Being able to establish commonality between those communities allows for transparency to be assumed and aligning motivations to be achieved. Consequently, what gets known about the perspectives of church matters and the opioid crisis involve a need to be responsive to an expanded view of mental health and spirituality as a community-focused endeavor.

More specifically, Christensen, Berkley-Patton, and Bauer (2020) examines how the population of African Americans, as predominant church goers, are influenced by the opioid crisis. The study focused on understanding factors related to opioid use among midwestern church-affiliated African Americans to inform what future faith-based interventions might be. Christensen, Berkley-Patton, and Bauer (2020) assert the following:

> African Americans in the Midwest are more likely to die from an opioid overdose compared to Whites, despite lower rates of use…African Americans have the highest rate of church attendance among all racial/ethnic groups and the black church may be an appropriate setting for prevention efforts…Participants were predominantly female (71%) and church members (74%) with an average age of 47…The Black Church is a highly influential, trusted institution in African American communities that could play an important role in responding to this call. Also, African Americans have the highest rate of church attendance among all racial/ethnic groups, with greatest attendance in the Midwest and South (Pew Research Center, 2014).

The study highlighted the particular influence of the church on the African American community. Within this study, African American women were a significant part of the study. The work of Christensen, Berkley-Patton, and Bauer (2020) resulted in the following findings:

- 53% of the participants had prescription opioid use at some point in their lifetime.
- Opioid use was higher in this sample than the general population which is surprising given that African Americans are less likely to be prescribed prescription opioids than white counterparts (Santoro & Santora, 2018). This may be due to medical indications, such as increased sensitivity to pain among African Americans (Ostrom et. al, 2017) and well-established disparities in cancer incidence (Singh & Jemal, 2017). Opioid prescribing rates are also typically higher in middle-aged/older adults and females (Center for Disease Control, 2019a), a population that is typically highly concentrated in African American churches (Bauer, Berkley-Patton, Bowe Thompson, & Christensen, 2018; Christensen et al, 2020).

- Given the possible high overlap amongst substances among church-affiliated African Americans, interventions may benefit from educating African Americans on substance use generally, discussing healthy coping strategies, and providing community referrals when appropriate.
- Discussion of coping strategies may be particularly salient given that African Americans are less likely to see mental health care than Whites (Cook et al, 2014) and misuse of substances may be means of coping with emotional distress and racial stressors (Gerrard et al, 2012; Pittman, Brooks, Kaur, & Obasi, 2019).

Consequently, the work of Christensen, Berkley-Patton, and Bauer (2020) suggests the importance of focusing on holistic approaches to opioid additions and addictive behaviors. The physical, emotional, mental, and spiritual needs of the person who is being treated for addictions and addictive behaviors cannot utilize a cookie cutter or one-size fits all approach, but instead, a more intentional and specialized approach is needed for those involved. Christensen, Berkley-Patton, and Bauer (2020), additionally, indicates the need to have more African Americans educated on the type of opioids that have higher incidences of addition. Having the appropriate knowledge and information can provide the necessary insight toward identifying the prescriptions that are least addictive in accordance with body disposition.

The article, "A collaborative culturally-centered and community-driven faith-based opioid recover initiative: The Imani Breakthough Project," as authored by Bellamy et. al (2021), offers practical, solutions-oriented approaches for African Americans and Latinos dealing with opioid addictions. The church is considered as an influential force within African American and Latino communities and thereby becomes a place of refuge for any of their needs that may or may not be spiritual. Bellamy et. al (2021) asserts the following:

> "…religion and spirituality play important roles in the lives of Black and Latinx people, and the church exists as a prominent fixture in both communities, historically serving those in need (Blank, Mahmood, Fox, & Guterbock, 2002; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). In a national survey of religious beliefs and practices, a higher proportion for Black and Latinx people indicated attended weekly religious services and an absolute belief in God, when compared to White people (Oxhandler, Edward, & Achenbaum, 2018; Pew Research Center 2014). Given the high cultural importance of religion and spirituality, Blacks and Latinx individuals may perceive their mental illness or addiction a as problem in need of a spiritual solution, reinforcing the help seeking behavioral pattern of engaging with clergy or attending church services instead of (or in addition to) exploring formal treatment options (Ayalon & Young, 2005). Continued education and outreach to faith-based institutions may provide a viable path to improve access to substance use treatment for these historically excluded populations" (p. 560).

Bellamy et. al (2021) pinpoint the various roles for which the church has historically assumed. While the church appears to more likely link addiction to something that is not being fulfilled spiritually, the church still maintains a disposition of having an open-armed approach to addressing the needs of those it serves. Bellamy et. al (2021) also pinpoint the level of church engagement for which African Americans and Latinos have within the church. Being able to engagement in the church in this capacity shows a clear understanding of the meaning the church assumes within their respective lives. The church is fundamental to the lives and livelihoods of these two communities.

Moreover, when considering the practical, solutions-oriented approach put forth by Bellamy et. al (2021), what becomes evident is how the Imani program responded to the presence of opioid addiction as requiring a broader approach to addressing their needs. Bellamy et. al (2021) state the following:

> The findings showed many aspects of how the program helped participants improve their lives such as building goals, being recognized as productive and valued members of society, connecting with others, and having a positive relationship with their loved ones and their community. Eight main themes emerged from these focus groups. They reflect the collective view of participants such as: Empowerment and decision making; relationships and self-reflective; autonomy and freedom; spirituality and belief; choice and trust; and options and engagement. The voices and perspectives of participants reflected the thoughts shared by the facilitators about their perceptions of the program.

The emerging eight themes show the interdependence of internal and external components required for the successful identification and implementation of a programmatic approach to opioid addiction. For example, empowerment contributes to the types of choices and decision that get or does not get made and, consequently, without empowerment, the quality choices and decisions are minimized. Quality relationships, too, are a critical component because quality relationships cultivate healthy engagement and, consequently, without relationship, the level of options and trust get compromised. Being able to implement programmatic endeavors for opioid addictions that are interdependent provides more sustainable, long-term approaches.

Perceptions Matter in the Demographic Intersections of Race, Age, Money, and Location

Perceptions matter for those involved in the opioid crisis as they are often viewed through the lens of who they are, what they do, and where they are from. Ascunce (2020) offers a unique perspective about how opioid crisis gets problematized or not, humanized or not, and under what circumstances either as a problem or as a human condition within the broader society. The manner in which the opioid addiction is problematized or humanized becomes based upon racialized, genderized, and economicalized perspectives. Ascunce (2020) asserts the following:

> For decades, the opioid crisis has made the headlines of U.S. news. Yet whether it was in its first wave or in its most recent one, there has always been a common factor in the opioid crisis in America: its portrayal as solely a white problem. Regardless of data to the contrary, testimonials, op-eds, and academic research continue to depict the crisis as one-sided, portraying how hardworking white men and women have "fallen" into addiction.

The characterization of opioid addiction as inclusive of individuals who have fallen into addiction appears to abdicate any level of personal responsibility, systemic practices, bias consciousness, and/or related inequitable or unequal treatment for persons of a certain race and gender. The characterization of opioid addition as indicative of individuals who are hardworking appears to suggest only persons who are not perceived as hardworking are the ones who fall into addition and not those who are in positions of privilege, power, and prestige. Characterization of opioid addiction as commonly considered as a 'white problem' diminishes the harsh reality and shared human experiences of the opioid addition of those individuals and their respective families.

More specifically, with regards to fentanyl, a synthetic form of opioid, African Americans are experiencing higher levels of overdosages and deaths. The Washington Post (2019) indicated the disproportionate rates of

> The synthetic opioid fentanyl has been driving up the rate of fatal drug overdoses across racial and social lines in the United States, with the sharpest increase among African Americans, according to a new analysis by the Centers for Disease Control and Prevention. The death rate among African Americans from fentanyl-involved drug overdoses rose 141 percent each year, on average, from 2011 to 2016, the study showed, with a particularly dramatic spike starting in 2014. The death rate for Hispanics rose 118 percent in that period every year on average, and 61 percent for non-Hispanic whites. The CDC did not have reliable data on Asian Americans and Native Americans.

Thus, consideration of the multi-dimensional roles of race, gender, and class as influencing perceptions of those involved in the opioid crisis and fentanyl is unfortunate given the widespread impact caused. The Washington Post (2019) further states:

> Overdoses related to fentanyl — which is often mixed with heroin, cocaine, and other drugs — remain more common among non-Hispanic whites, about 7.7 deaths per 100,000 annually, compared to a death rate of 5.6 for blacks and 2.5 for Hispanics. But the report's lead author, Merianne Rose Spencer, a health statistician for the CDC's Center for Health Statistics, pointed to the change in death rates as the most significant revelation. The report provides a reminder that deadly opioids are increasingly taking the lives of urban drug users. Fentanyl is a factor in the recent rise in death rates across U.S. demographic groups and the drop in life expectancy.

What becomes evident is the need to view the opioid crisis, particularly regarding fentanyl, and the experiences of individuals and families within and across different groups. Such culturally relevant approach offers the opportunity for considering the broader and subsequent implications of this dreadful occurrence.

To that end, broader and subsequent implications of the opioid crisis involve matters beyond the addiction itself and redirects focus on how perceptions of those within the crisis receive attention. Ascunce (2020) asserts:

> The humanity afforded to the opioid-dependent white person stands in stark contrast to the disproportionate incarceration of and lack of treatment available to Black and Latinx people with the same substance use disorder. Latinx people, in particular, encounter obstacles — implicit biases, language barriers, and immigration statuses, for example — that bar them from seeking and receiving proper treatment to counter their opioid addiction. As a result, between 2014 and 2017, the number of opioid deaths per year nearly doubled for Latinx people. With poverty rates at 19 percent in 2018, over double that of whites, the Latinx community is also more prone to being underinsured or uninsured. Despite all the statistics revealing this population's vulnerability, the Latinx voice in the opioid crisis has not been heard. If the opioid crisis in America is to be addressed, it must include all communities affected and adjust to these communities' respective needs.

The racialized, genderized, and economicalized viewpoints of the opioid crisis do not have to be addressed from a culturally-deficit position. Viewing the opioid crisis in this manner relegates the issue to something less than what it is intended to be.

And while there are shared experiences irrespective of who is involved as part of the opioid crisis, there is a need to recognize how individuals and their respective families experience the opioid in a culturally different manner. Thus, by looking at the opioid crisis in a culturally different manner and not a culturally-deficit manner, the integrity and dignity for those involved is maintained through the perceptions that are held as either real or imagined. At minimum, those who are addicted deserve this type of response.

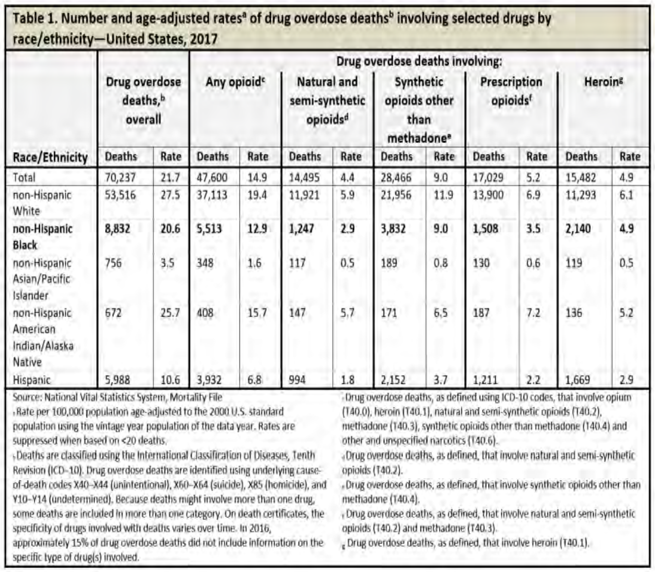


Table 1. Number and age-adjusted rates[a] of drug overdose deaths[b] involving selected drugs by race/ethnicity—United States, 2017

	Drug overdose deaths,[b] overall		Drug overdose deaths involving: Any opioid[c]		Natural and semi-synthetic opioids[d]		Synthetic opioids other than methadone[e]		Prescription opioids[f]		Heroin[g]	
Race/Ethnicity	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**
Total	70,237	21.7	47,600	14.9	14,495	4.4	28,466	9.0	17,029	5.2	15,482	4.9
non-Hispanic White	53,516	27.5	37,113	19.4	11,921	5.9	21,956	11.9	13,900	6.9	11,293	6.1
non-Hispanic Black	**8,832**	**20.6**	**5,513**	**12.9**	**1,247**	**2.9**	**3,832**	**9.0**	**1,508**	**3.5**	**2,140**	**4.9**
non-Hispanic Asian/Pacific Islander	756	3.5	348	1.6	117	0.5	189	0.8	130	0.6	119	0.5
non-Hispanic American Indian/Alaska Native	672	25.7	408	15.7	147	5.7	171	6.5	187	7.2	136	5.2
Hispanic	5,988	10.6	3,932	6.8	994	1.8	2,152	3.7	1,211	2.2	1,669	2.9

Source: National Vital Statistics System, Mortality File

[a] Rate per 100,000 population age-adjusted to the 2000 U.S. standard population using the vintage year population of the data year. Rates are suppressed when based on <20 deaths.

[b] Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD-10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined). Because deaths might involve more than one drug, some deaths are included in more than one category. On death certificates, the specificity of drugs involved with deaths varies over time. In 2016, approximately 15% of drug overdose deaths did not include information on the specific type of drug(s) involved.

[c] Drug overdose deaths, as defined using ICD-10 codes, that involve opium (T40.0), heroin (T40.1), natural and semi-synthetic opioids (T40.2), methadone (T40.3), synthetic opioids other than methadone (T40.4) and other and unspecified narcotics (T40.6).

[d] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2).

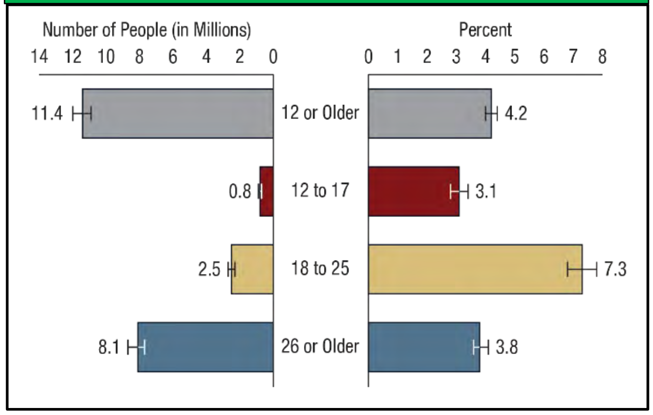
[e] Drug overdose deaths, as defined, that involve synthetic opioids other than methadone (T40.4).

[f] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2) and methadone (T40.3).

[g] Drug overdose deaths, as defined, that involve heroin (T40.1).

As extracted from the *Opioid Crisis and the Black/African American Population: An Urgent Issue*, as published in 2020 by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration Office of Behavioral Health Equity, Table 1 highlights important findings about the drug overdose deaths and death rates. Such findings are inclusive of racial and ethnic groups as well as age adjusted rates which indicates the rates would have existed if the population under study had the same age distribution as the standard population. Of the various racial/ethnic groups, Table 1 indicates Blacks/African Americans as having 8,832 deaths which was the second highest among other reported racial/ethnic groups. With regards to any type of opioid, Table 1 also shows Blacks/African Americans as having 5,513 deaths which, too, ranked as the second highest among other reported racial/ethnic groups. The remaining figures in Table 1 further depicts the deaths of Blacks/African Americans from specific types of opioid drugs (i.e., natural and semi-synthetic opioids, synthetic opioids, prescription opioid, heroine). When compared to non-Hispanic Whites, the largest racial group within our country, Blacks/African American lead in overall opioid deaths and death rates with Hispanics following closely behind.

Figure 2: Past Year Opioid Misuse Among People Aged 12 or older: 2017



When focusing on the age grouping within the context of the broader population, Figure 2, as extracted from the 2017 Substance Abuse and Mental Health Administration, 11.4 million people in the United States, aged 12 and older, experienced some type of opioid misuse (i.e., 4.2%). Figure 1 highlights how the percentage of usage of those between the ages of 12 to 17 is slightly behind those between the ages of 26 or older. Figure 1 shows how those between the ages 18 to 25 is almost double each of those within the age groups of 12 to 17 and 26 or older. Thus, while the type of drug use or misuse might have varied, those who are within the age group of 18 to 25 are experiencing drug misuse or use more prevalently than others within the identified age categories.

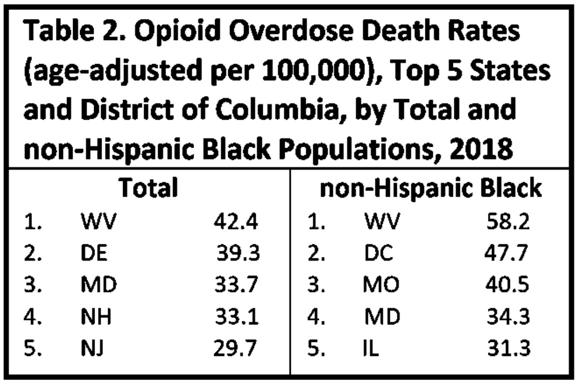


Table 2. Opioid Overdose Death Rates (age-adjusted per 100,000), Top 5 States and District of Columbia, by Total and non-Hispanic Black Populations, 2018

Total			non-Hispanic Black		
1.	WV	42.4	1.	WV	58.2
2.	DE	39.3	2.	DC	47.7
3.	MD	33.7	3.	MO	40.5
4.	NH	33.1	4.	MD	34.3
5.	NJ	29.7	5.	IL	31.3

More specifically, when considering the data from the Substance Abuse and Mental Health Services Administration Report (2020), *The Opioid Crisis and the Black/African American Population: An Urgent Issue*, as based upon using two indicators of measurements, death rate and absolute number, made compelling cases about the areas in which opioid overdoses and subsequent deaths are occurring. Table 2, as extracted from the U. S. Department of Health and

Human Services' Substance Abuse and Mental Health Services Administration Report (2020) and age-adjusted per 100,000, shows West Virginia and Delaware as the top two states with the highest percentage of opioid overdose death rates and, for non-Hispanic Black, West Virginia, Washington, DC, Missouri, Maryland, and Illinois had the second, third, fourth, and fifth highest percentage of opioid-related overdose death rates. With that said, the death rates of non-Hispanic Blacks were disproportionately higher compared to the general populations within all 50 states. Additionally, what Table 2 shows is that West Virginia and Maryland appear in both percentage groups for the general population among non-Hispanic Blacks for percentages of opioid-related overdose death rates.

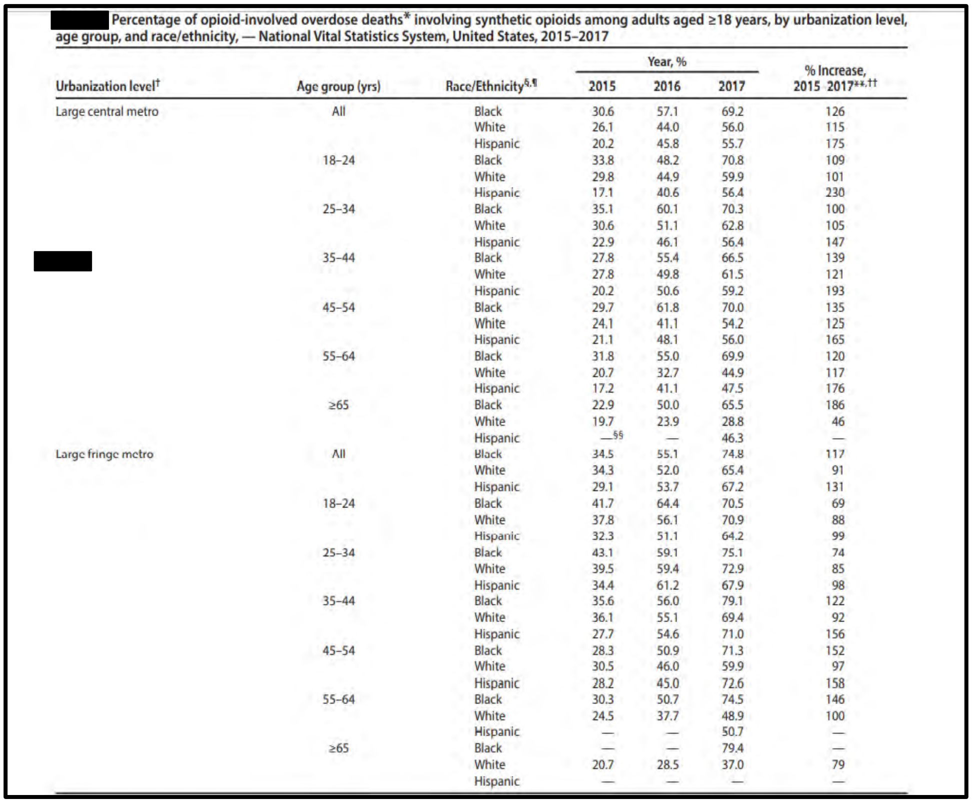
Table 3. Number of Opioid Overdose Deaths, Top 5 States, by Total and non-Hispanic Black Populations, 2018

Total			non-Hispanic Black		
1.	OH	3237	1.	MD	709
2.	FL	3189	2.	IL	598
3.	NY	2991	3.	NJ	459
4.	PA	2866	4.	MI	426
5.	NJ	2583	5.	OH	402

Table 3, as extracted from the U. S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration Report (2020) as based upon 2018 data, Ohio, Florida, New York, Pennsylvania, and New Jersey had the highest, second highest, third highest, fourth highest, and fifth highest number of opioid overdose deaths. With regards to non-Hispanic Blacks, Maryland, Illinois, New Jersey, Michigan, and Ohio had the first, second, third, fourth, and fifth highest number of opioid overdose deaths. When considering both sets of data within Table 3, what becomes interesting is how Ohio and New Jersey ranks the highest when considering the general population and the non-Hispanic Black populations regarding the number of opioid overdose deaths. Irrespective of whether it is the number of deaths or the percentage of death rates for both the general population and non-

Hispanic Black populations, the impact of opioid addiction is disproportionately occurring within the states of Ohio, New Jersey, West Virginia, and Maryland.

Table 4 provides a summative view of the percentage of opioid deaths within the country. Table 4, formerly Table 2 as extracted from Morbidity and Mortality Weekly Report, as published by Lipphold et. al. (2019) of the U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, the following results have been provided:



[redacted] **Percentage of opioid-involved overdose deaths* involving synthetic opioids among adults aged ≥18 years, by urbanization level, age group, and race/ethnicity, — National Vital Statistics System, United States, 2015–2017**

Urbanization level†	Age group (yrs)	Race/Ethnicity§,¶	Year, % 2015	2016	2017	% Increase, 2015 2017**,††
Large central metro	All	Black	30.6	57.1	69.2	126
		White	26.1	44.0	56.0	115
		Hispanic	20.2	45.8	55.7	175
	18–24	Black	33.8	48.2	70.8	109
		White	29.8	44.9	59.9	101
		Hispanic	17.1	40.6	56.4	230
	25–34	Black	35.1	60.1	70.3	100
		White	30.6	51.1	62.8	105
		Hispanic	22.9	46.1	56.4	147
[redacted]	35–44	Black	27.8	55.4	66.5	139
		White	27.8	49.8	61.5	121
		Hispanic	20.2	50.6	59.2	193
	45–54	Black	29.7	61.8	70.0	135
		White	24.1	41.1	54.2	125
		Hispanic	21.1	48.1	56.0	165
	55–64	Black	31.8	55.0	69.9	120
		White	20.7	32.7	44.9	117
		Hispanic	17.2	41.1	47.5	176
	≥65	Black	22.9	50.0	65.5	186
		White	19.7	23.9	28.8	46
		Hispanic	—§§	—	46.3	—
Large fringe metro	All	Black	34.5	55.1	74.8	117
		White	34.3	52.0	65.4	91
		Hispanic	29.1	53.7	67.2	131
	18–24	Black	41.7	64.4	70.5	69
		White	37.8	56.1	70.9	88
		Hispanic	32.3	51.1	64.2	99
	25–34	Black	43.1	59.1	75.1	74
		White	39.5	59.4	72.9	85
		Hispanic	34.4	61.2	67.9	98
	35–44	Black	35.6	56.0	79.1	122
		White	36.1	55.1	69.4	92
		Hispanic	27.7	54.6	71.0	156
	45–54	Black	28.3	50.9	71.3	152
		White	30.5	46.0	59.9	97
		Hispanic	28.2	45.0	72.6	158
	55–64	Black	30.3	50.7	74.5	146
		White	24.5	37.7	48.9	100
		Hispanic	—	—	50.7	—
	≥65	Black	—	—	79.4	—
		White	20.7	28.5	37.0	79
		Hispanic	—	—	—	—

Liphold (2019) shows that within the large central metropolitan urban areas, large fringe areas, and medium and small areas from 2015-2017, Hispanics received an overall 175% increase in opioid deaths (large central metropolitan area), 131% increase synthetic opioid deaths (large fringe areas), and 168% increase in synthetic opioid deaths (medium and small areas). The highest percentage increases occurring from 2015-2016 in each of the locational areas within the age group between 18-24. Notwithstanding, according to the Guardian (2022), the following perspectives emerge:

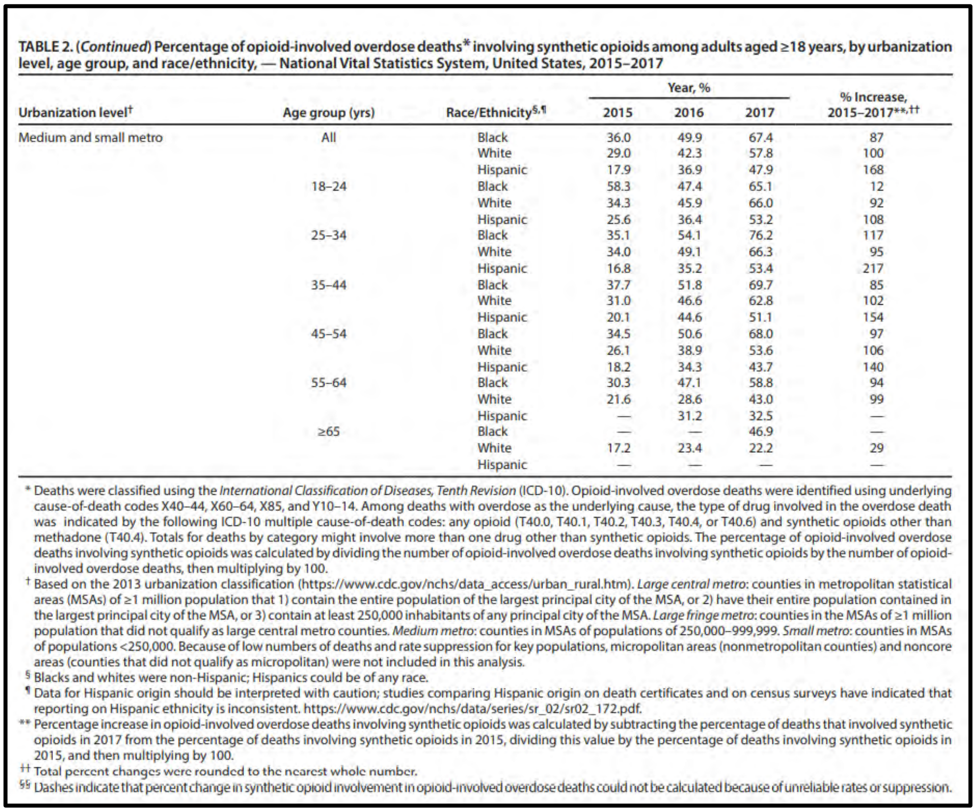


TABLE 2. (*Continued*) **Percentage of opioid-involved overdose deaths[*] involving synthetic opioids among adults aged ≥18 years, by urbanization level, age group, and race/ethnicity, — National Vital Statistics System, United States, 2015–2017**

Urbanization level[†]	Age group (yrs)	Race/Ethnicity[§,¶]	Year, %			% Increase, 2015–2017[**,††]
			2015	2016	2017	
Medium and small metro	All	Black	36.0	49.9	67.4	87
		White	29.0	42.3	57.8	100
		Hispanic	17.9	36.9	47.9	168
	18–24	Black	58.3	47.4	65.1	12
		White	34.3	45.9	66.0	92
		Hispanic	25.6	36.4	53.2	108
	25–34	Black	35.1	54.1	76.2	117
		White	34.0	49.1	66.3	95
		Hispanic	16.8	35.2	53.4	217
	35–44	Black	37.7	51.8	69.7	85
		White	31.0	46.6	62.8	102
		Hispanic	20.1	44.6	51.1	154
	45–54	Black	34.5	50.6	68.0	97
		White	26.1	38.9	53.6	106
		Hispanic	18.2	34.3	43.7	140
	55–64	Black	30.3	47.1	58.8	94
		White	21.6	28.6	43.0	99
		Hispanic	—	31.2	32.5	—
	≥65	Black	—	—	46.9	—
		White	17.2	23.4	22.2	29
		Hispanic	—	—	—	—

[*] Deaths were classified using the *International Classification of Diseases, Tenth Revision* (ICD-10). Opioid-involved overdose deaths were identified using underlying cause-of-death codes X40–44, X60–64, X85, and Y10–14. Among deaths with overdose as the underlying cause, the type of drug involved in the overdose death was indicated by the following ICD-10 multiple cause-of-death codes: any opioid (T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6) and synthetic opioids other than methadone (T40.4). Totals for deaths by category might involve more than one drug other than synthetic opioids. The percentage of opioid-involved overdose deaths involving synthetic opioids was calculated by dividing the number of opioid-involved overdose deaths involving synthetic opioids by the number of opioid-involved overdose deaths, then multiplying by 100.

[†] Based on the 2013 urbanization classification (https://www.cdc.gov/nchs/data_access/urban_rural.htm). *Large central metro*: counties in metropolitan statistical areas (MSAs) of ≥1 million population that 1) contain the entire population of the largest principal city of the MSA, or 2) have their entire population contained in the largest principal city of the MSA, or 3) contain at least 250,000 inhabitants of any principal city of the MSA. *Large fringe metro*: counties in the MSAs of ≥1 million population that did not qualify as large central metro counties. *Medium metro*: counties in MSAs of populations of 250,000–999,999. *Small metro*: counties in MSAs of populations <250,000. Because of low numbers of deaths and rate suppression for key populations, micropolitan areas (nonmetropolitan counties) and noncore areas (counties that did not qualify as micropolitan) were not included in this analysis.

[§] Blacks and whites were non-Hispanic; Hispanics could be of any race.

[¶] Data for Hispanic origin should be interpreted with caution; studies comparing Hispanic origin on death certificates and on census surveys have indicated that reporting on Hispanic ethnicity is inconsistent. https://www.cdc.gov/nchs/data/series/sr_02/sr02_172.pdf.

[**] Percentage increase in opioid-involved overdose deaths involving synthetic opioids was calculated by subtracting the percentage of deaths that involved synthetic opioids in 2017 from the percentage of deaths involving synthetic opioids in 2015, dividing this value by the percentage of deaths involving synthetic opioids in 2015, and then multiplying by 100.

[††] Total percent changes were rounded to the nearest whole number.

[§§] Dashes indicate that percent change in synthetic opioid involvement in opioid-involved overdose deaths could not be calculated because of unreliable rates or suppression.

While the data is not broken down by drug type, experts point toward one driving force: the explosion of synthetic opioids such as fentanyl, a highly potent drug that has flooded the US market and often ends up mixed into street drugs such as heroin, methamphetamines or cocaine. Researchers say the numbers highlight the shifting dynamics of who is most at risk from the opioid crisis, which has in recent decades been viewed as an epidemic of rural, white America. Between 2019 and 2020, the overdose death rate for Black and Indigenous Americans surpassed that of white Americans, who were already dying in unprecedented numbers. “We’re at a historically tragic moment,” said UCLA addiction researcher Joseph Friedman, who co-authored the study. “The increasing toxicity of the drug supply has disproportionately affected communities of color.”

Such viewpoints reveal the historical and adverse impact of what is occurring among black and indigenous people. The fentanyl and covid crises are affecting these traditionally underserved communities disproportionate and thereby the depth and breadth of the capacity needed for emotional and social responsiveness becomes even more pertinent given the short-term and long-term implications of agonizing outcomes.

Practices Matter for Public Relations and Diverse Communities of the Opioid Crisis

Practices matter with regards to how the opioid crisis originated and how it is influencing diverse communities within the broader society. Ascunce (2021), in her report in the *Harvard Political Review*, highlights how the adverse impact of opioid within the Latino communities has not received the level of attention needed to combat the wide-spread impact. As a matter of public relations, Ascunce (2021) argues that the manner in which the opioid crisis is addressed within communities of color is quite different than communities who do not demographically reflect them. Ascunce (2021) assert the following:

> "This racially-charged dichotomy continues today: while people of color are met with declarations of war, white people are met with declarations of public health emergencies. For example, while members of the Latinx community only represent 17 percent of the U.S. population, 50 percent of federal drug cases are brought against people in this demographic group. Furthermore, from the beginnings of the War on Drugs in 1974 to 2001, the chances of a Hispanic male being incarcerated in his lifetime skyrocketed from 4.0 percent to 17.2 percent. In contrast, in 2019, Health and Human Services announced $1.8 billion in funding to combat the current opioid epidemic by increasing focus on treatment. As this epidemic largely affected white communities, the objective

> was to treat, not to incarcerate. This would once again cement the government and healthcare system as unjustly skewed toward the needs of white people."

Such perspectives indicate the level of discrimination exercised against socially underserved and financially underprivileged communities faced with opioid additions. Implications of public relations often paints a picture for selected communities that might not be favorable for how they are viewed within the disease of addiction. Clearly, internal challenges associated with opioid additions are difficult (i.e., family dynamics, self-esteem, professional mobility), the external challenges of how opioid additions get treated according to who is and who is not addicted is even more challenging given the subjective nature of the positions taken.

The U. S. Department of Health and Human Services' Substance and Mental Health Services Administration Report (2020), *The opioid crisis and the Black/African American population: An urgent issue*, have identified five key best practice that can be used to address opioid misuse (pp. 10-18):

1) Implement a comprehensive, holistic approach—"Addition is beyond the neuroreceptor level."
2) Involve the community and develop multi-sectoral, diverse community partnerships—"Community-based organizations are the engines managing crises before they get to the hospital."
3) Increase culturally relevant public awareness—"Campaigns are White-washed and make no sense in Black communities."
4) Employ culturally specific engagement strategies—The opposite of addiction is not abstinence, it's connection.

5) Create culturally relevant and diverse workforce—"[We] have trained Black peers, but not a Black supervisor."

Different best practices that can be used, as identified above, show the need to address addiction from the inside out. How the administrative and program leadership are trained or prepared to address opioid issue is critical and needs to be done in a strategic manner. How the community is trained or prepared to address the needs of this population has to be done in a culturally responsive or Culturally Relevant manner.

Additionally, it important to note that practices of opioid use and substance abuse occurs within urban minority communities, according to Local Youth Risk Behavioral Surveillance System of the Centers for Disease Prevention and Control (2014). The most frequently reported drivers of opioid and other drug use included living in resource poor, unstable homes and neighborhood environments and experiencing and witnessing adverse events (e.g., abuse, assault, violence) (Linton et al., 2021). These circumstances were characterized as causing mood and anxiety disorders, that when left untreated, caused youth to self-medicate with opioids and other drugs (Linton et al., 2021). Psychosocial theorists argue that young people who are bullied experience depression, low self-esteem, or anxiety and may consequently turn to drug use as a way of coping with victimization (Powers et.al, 1996). Such victimization approach shows the self-imposed ways that practices among young people, particularly black youth, utilize drugs to address their internal and often hidden needs.

According to USA Today, in the article reported by Emerling (2018), "The Opioid Epidemic Hit Black America the Hardest Last Year," recent report, by the Centers for Disease Control and Prevention, shows that African Americans experienced the largest surge in opioid overdose deaths among any racial and ethnic group from 2016 to 2020. The article report that

5,513 blacks died of overdoses involving opioids in 2017 – up 26 percent from 4,374 in 2016 – and the rate of such deaths adjusted for age increased by more than 25 percent. While the number of opioid-involved overdose deaths among whites was far greater at 37,113 in 2017, it represented only an 11 percent increase in both total deaths and death rate over 2016. Emerling (2018) further highlighted these key findings about the epidemic and the practices therein:

- Through 2017, the drug overdose epidemic continues to worsen and evolve, and the involvement of many types of drugs (e.g., opioids, cocaine, and methamphetamine) underscores the urgency to obtain more timely and local data to inform public health and public safety action," the report states.
- Among states assessed, West Virginia had the highest death rate tied to synthetic opioids, at 37.4 per 100,000, while Arizona saw the largest rate increase in that category at 122 percent.
- "Deaths involving (illicitly manufactured fentanyl) have been seen primarily east of the Mississippi River," the report says. "However, recent increases occurred in eight states west of the Mississippi River, including Arizona, California, Colorado, Minnesota, Missouri, Oregon, Texas, and Washington."
- Overall in 2017, the U.S. saw 70,237 drug overdose deaths – up from 63,632 in 2016 – with opioids involved in 47,600 of those fatalities.

What becomes very telling about the report is the number of opioid-related deaths involved particular types of drugs. Such findings are critically important about having certain types of programs that might be geared toward particular communities.

When considering practices involving research, the existing research on barriers to addressing adolescent opioid use and abuse emphasizes: (1) socioeconomic and environmental factors (Ford & Rigg, 2015; Hudgins et al., 2019; Lankenau et al., 2012; McCabe et al., 2013), (2) limited access to medications for opioid use disorder, naloxone for overdose reversal, and behavioral health services, and (3) inability to receive care in the earlier stages of use (Carson, 2019; Wilson et al., 2018; Yedinak et al., 2016). Structural barriers to behavioral health and social services highlighted the dearth of youth-centered services at every stage of care (i.e., prevention, treatment, and recovery (Linton et al.,2021).

Stakeholders also described practices, as unique to institutional barriers to service delivery, to include lack of youth-centered approaches, one-size-fits-all programming, zero-tolerance policies in multiple service settings (e.g., mental health treatment, juvenile system), and lack of integrated mental health and drug treatment (Linton et al., 2021). Such practices particularly focused on youth and family-level barriers that may or may not include cognitive development, perceived invincibility, and lack of knowledge about opioids that hinder drug treatment and harm reduction efforts. In fact, researchers found that Black teens were 85% less likely to be prescribed Naloxone treatment after an overdose than white teens (Alinsky et al., 2020). Such racial disparity exists among Black adults as well, who are also significantly less likely to be prescribed this medication (Noakrawczyk et al., 2020).

Other practices, as unique to behavioral health professionals, described one wave of research as tailoring services to the needs and interests of youth and their families, delivering services in an informal way, and integrating substance-use education into curricula or programs as not being focused on health (Linton et al., 2021). Stakeholders also noted efforts to reduce organizational and structural barriers by establishing flexible hours of operation, providing transportation, delivering medications to youth (e.g., extended-release injectable naltrexone), and integrating mental health and substance use services, helping youth and their families acknowledge and address stigma, empowering youth through self-guided action planning, educating youth on the impacts of trauma on cognitive development and behavior, and explicitly preparing youth for the challenges associated with recovery (Linton et al., 2021). A second wave of research focused on culturally tailored strategies. Culturally competent interventions are needed to target populations at risk. These interventions include increasing awareness about synthetic opioids in the drug supply and expanding evidence-based interventions, such as naloxone distribution and medication-assisted treatment (Linton et al, 2021).

Community-Focused, Culturally Responsive Plan for the National Black Church Initiative to Address the Opioid Crisis for African Americans and Latinos

The depth and breadth of the insights gained from perspectives, perceptions, and practices involving African Americans and Latinos unique to the opioid crisis has generated a unique opportunity for the National Black Church Initiative to offer a community-focused, culturally responsive plan. The National Black Church Initiative is thereby poised to propose a community-focused, culturally responsive program inclusive of a goal and objectives with relevant, rigorous, and results oriented (R^3) endeavors to address the opioid crisis for African Americans and Latinos.

<u>Proposed Goal</u>: To provide comprehensive support of church-going African Americans and Latinos who have been directly or indirectly affected by the opioid crisis within the most highly affected areas within the United States.

<u>Proposed Objectives</u>: 1) To offer educational opportunities to enhance the knowledge and skills of dealing directly with the opioid crisis as a victim or indirectly dealing with the opioid crisis as a supporter of victim(s); 2) To utilize financial resources to enhance mental health and/or social

conditions for those victims or supporters of victims of the opioid crisis; and 3) To establish *intra*- and *inter*-support networks and resources for those victims or supports of opioid victim(s).

Action Items:

- The Relevancy of a Community-Focused, Culturally Responsive Comprehensive Plan
  - Our Structural Capacity: The organizational structure of the National Black Church Initiative (NBCI) involves the Washington, DC headquarters along with five faith-based command centers comprised of both denominational and non-denominational churches. The five command centers are located in major urban areas throughout the country (i.e., Atlanta, Georgia; New York, New York; Chicago, Illinois, Oakland, California; Dallas Texas).

Figure 3 highlights the organization of NBCI:

- These church-based studies suggest that churches may be well-positioned to reduce drug use and associated risks by provide education on general substance abuse risk factors, disparities in substance abuse treatment among African Americans and alternative strategies for managing stress and/or pain which may lead to substance abuse

The membership of the National Black Church Initiative is comprised of 150,000 churches constituting some 27.7 million members.

  - <u>Our Structural Commitment</u>: With the broad reach of the structure of the National Black Church Initiative, based upon what became evident this paper, the proposed Community-Focused, Culturally Relevant Program will do the following:
    - ✓ Utilize our faith-based command centers to identify a collective 30,000 members from the Southeast, Northeast, and Midwest regions who have been affected directly or indirectly by the opioid crisis (i.e., 10,000 per region). These command centers comprise the states where the highest rates of opioid deaths, death rates, and-/or overdoses have been occurring (i.e., Ohio, Delaware, West Virginia, Maryland, Florida, Illinois, New Jersey, Michigan, Missouri, Pennsylvania). The remaining two regions of Western and South Western faith-based command centers would target a combined 10,000 participants from those regions who, too, fit the aforementioned criteria.
      - ➢ Participants for this program will be selected from the churches within each of these faith-based commands. On overall candidate profile will be developed and disseminated to the church memberships.

- <u>The Rigor of a Community-Focused, Culturally-Responsive Comprehensive Plan</u>
  - <u>Our Strategic Components</u>: The mission of the National Black Church Initiative is to provide critical wellness information to all of its members, congregants,

churches and the public. The programs of the National Black Church Initiative are governed by credible statistical analysis, science-based strategies and techniques, and methods that work and offers faith-based, out-of-the-box and cutting-edge solutions to stubborn economic and social issues.

- <u>Our Strategic Commitment</u>: With the strategic commitment of the National Black Church Initiative, based upon what became evident this paper, the proposed Community-Focused, Culturally Relevant Program will do the following:
  - ✓ Build upon the notable successes of our current Sickle Cell, COVID-19 Initiative, and NBCI Immunization Program particularly as it relates to understanding the vulnerabilities of underserved populations.
    - ➢ Expanding the implementation of our current Health Emergency Declaration Model to not only be inclusive of targeted outreach, education, community-based clinics, schools, African American professional clinicians, National Medical Association, National Hispanic Medical Association, and use of government data, but also to include addiction, drug abuse, and opioid experts and current best practices related to opioid crisis for African American and Latinos.

- <u>The Results of a Community-Focused, Culturally-Responsive Comprehensive Plan</u>
  - <u>Our Sustainable Components</u>: The National Black Church Initiative utilizes faith and sound health science and partners with major organizations and officials reduce racial disparities in the variety of areas cited above.

- Our Sustainable Commitment: With the sustainable commitment of the National Black Church Initiative, based upon what became evident this paper, the proposed Community-Focused, Culturally Relevant Program will do the following:
  - ✓ As informed by the overarching Community-Focused, Culturally Relevant Program, best and/or promising practices of the opioid crisis will be disseminated across broadly the entirety of the membership as well as targeted groups within the National Black Church Initiative.

Concluding Statements

To that end, using structural, strategic, sustainable components, the National Black Church Initiative seeks to partner with you in this comprehensive effort to address the opioid crisis within the African American Latino populations. Our community-focused, culturally relevant program is poised to affect 40,000 persons (i.e.,30,000 from the three highest affected faith-based command center affected regions and10,000 from the two lowest faith-based command center affected regions) who are considered as victims or supporters of the victims of the opioid crisis. This type of initiative is projected to cost $1 to $3 million dollars for the next two years. Depending on their size and resources, a total of 1500 churches among the three faith-command centers will be designated as primary program locations that will be inclusive of the 40,000 participants who will be better informed and/or prepared to respond to the opioid crisis. More specifically, to achieve such outcomes in what needs to be done, by enhancing the level of buy-in from African American and Latino Mental Health Professionals and Addiction Experts, the National Black Church Initiative will provide research-based, data driven, opioid preventive or interventions to its congregants with the utmost confidentiality. Thus, the Community-Focused, Culturally Relevant Program will provide a top to bottom collection of organizational and individual professional resources, including training to develop community-focused, culturally prepared clinicians to be able to offer comprehensive support to those who are considered as victims or supporters of the victims of the opioid crisis.

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GROTHMAN, BANKS INTRODUCE THE STOP FENTANYL ACT

(Washington, D.C.) – Congressman Glenn Grothman (WI-06) and former Republican Study Committee Chairman, Congressman Jim Banks (IN-03), have introduced the *Standardizing Thresholds Of Penalties for (STOP) Fentanyl Act*, a bill to reduce the threshold for mandatory minimum penalties for fentanyl-related offenses, putting it on par with quantity thresholds for another deadly drug, methamphetamine.

Grothman and Banks are joined by 20 cosponsors, including Congressman Scott Fitzgerald (WI-05), Congresswoman Claudia Tenney (NY-22), Congressman Doug Lamborn (CO-05), Congressman Rick Allen (GA-12), Congressman Ronny Jackson (TX-13), Congressman Brad Finstad (MN-01), Congressman Ralph Norman (SC-05), Congressman Pat Fallon (TX-04), Congressman Bill Posey (FL-08), Congressman Doug LaMalfa (CA-01), Congressman Brian Babin (TX-36), Congressman Ryan Zinke (MT-01), Congressman Bill Huizenga (MI-04), Congressman Burgess Owens (UT-04), Congressman David Rouzer (NC-07), Congressman Joe Wilson (SC-02), Congressman Jim Baird (IN-04), Congresswoman Marjorie Taylor Greene (GA-14), Congressman Russell Fry (SC-07), and Congressman Scott DesJarlais (TN-04).

Currently, to trigger a 10-year mandatory minimum sentence under the *Controlled Substances Act*, an offense must involve 400 or more grams of a mixture or substance containing fentanyl. Because the average lethal dose of fentanyl is 2 milligrams, the offense would need to contain roughly 200,000 lethal doses in order to trigger the 10-year mandatory minimum.

By comparison, to trigger the 10-year mandatory minimum for methamphetamine, the offense would have to involve at least 500 grams, which contains roughly 2,500 lethal doses.

“We recently surpassed 100,000 drug overdose deaths within 12 months for the first time in American history, largely driven by the use of fentanyl,” **said Grothman.** *“This is a large-scale epidemic in need of immediate attention.*

“The lack of leadership from the White House concerning the border is encouraging drug traffickers to profit from the Administration’s open border policies. Border Patrol agents have told me that the cartels intentionally overflow certain areas of the Southern border, diverting resources, and creating vulnerable spots in other areas along the border that would otherwise be guarded. If the Biden Administration adequately supported Border Patrol, these agents would be more prepared to detect and confiscate the copious amount of fentanyl entering our country.

“It is an ongoing tragedy that Americans are paying the price of bad immigration policy in tens of thousands of human lives. This bill will bring a sorely needed increase to the penalty of trafficking deadly fentanyl.”

“Fentanyl is impacting every family and community in America. This legislation will help ensure the criminals selling and trafficking this extremely potent drug are held accountable,” **said Congressman Banks**.

Background Information

Current mandatory minimum penalties for fentanyl-related offenses are not sufficient because they are not proportionate to the drug's public health hazard. For example, fentanyl is 50 times more deadly than heroin, but, shockingly, fentanyl offenders often receive more lenient sentences than purveyors of other drugs, like methamphetamine, for trafficking the same amount of lethal doses. This inconsistency has been underscored by the fact that a record 379 million lethal doses of deadly fentanyl was seized by the Drug Enforcement Administration (DEA) in 2022, more than enough to kill every American.

Fentanyl is officially the leading cause of death for Americans ages 18 to 49.

The *STOP Fentanyl Act* corrects the discrepancy between fentanyl and other drugs by reducing the threshold for mandatory minimum penalties for fentanyl-related offenses. Specifically, the bill:

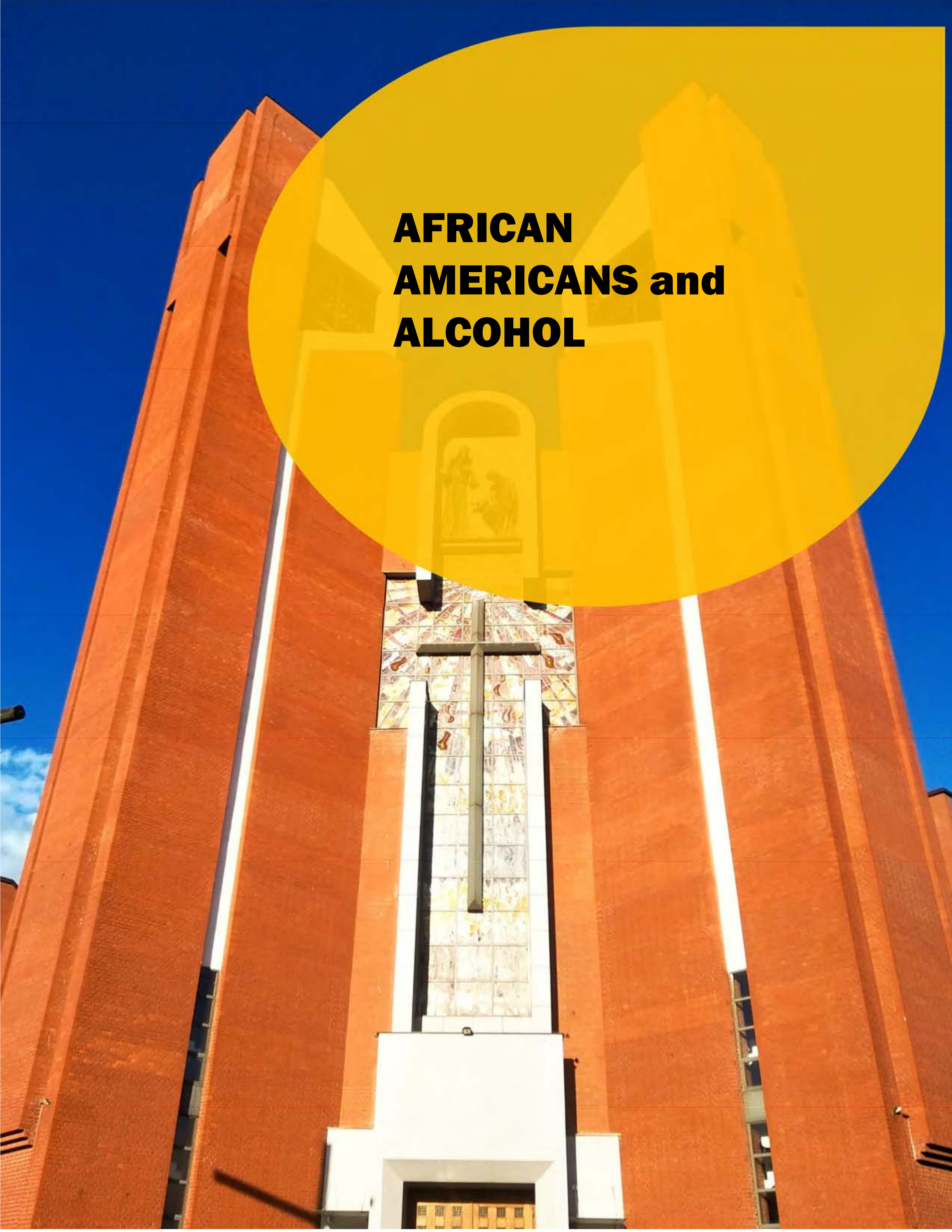
- Amends the *Controlled Substances Act* and *Controlled Substances Import and Export Act* to reduce the 10-year mandatory minimum threshold for fentanyl offenses from 400 grams to 5 grams and fentanyl analogue offenses from 10 grams to 0.05 grams;

- Amends the *Controlled Substances Act* and *Controlled Substances Import and Export Act* to reduce the 5-year mandatory minimum threshold for fentanyl offenses from 40 grams to 0.5 grams and fentanyl analogue offenses from 10 grams to 0.005 grams;

- Clarifies that fentanyl analogues can include both scheduled and unscheduled.

In addition, to address the flow of fentanyl coming through the Southern border, the bill amends the *Controlled Substances Import and Export Act* to create a mandatory minimum of 20 years imprisonment for importing any amount of fentanyl and its analogues specifically across the Southern border with Mexico.

U.S. Rep. Glenn Grothman (R-Glenbeulah) is serving his fifth term representing Wisconsin's 6th Congressional District in the U.S. House of Representatives.



AFRICAN AMERICANS and ALCOHOL

African Americans and Alcohol

Binge drinking among African Americans (23%) is slightly less common than in Hispanics (24.6%) and Caucasians (25.7%). The rate of heavy drinking among African Americans (4.3%) is much less than the general population (6.1%) and Caucasians (7.2%).Sep 14, 2022

African Americans are reported to drink less than their Caucasian counterparts. However, alcohol impacts the African American community differently and can have extremely damaging and long-lasting effects.

African Americans And Alcohol Abuse

Alcohol is the most widely-used drug in America and impacts different demographics differently, not excluding African-Americans. A 2010 Johns Hopkins study concluded 20.4% of African Americans between the ages of 12 and 20 consumed alcohol in a 30-day period. As a result, alcohol consumption has been responsible for "contributing to 3 leading causes of death" in African American communities recently.

African Americans have been victims of alcohol-related illnesses, although alcohol consumption is lower compared to Caucasian-Americans. Historically, African Americans have consumed lower amounts of alcohol, partially due to "religious beliefs and social disapproval." This, however, makes many African Americans more likely to be intoxicated under lower amounts of alcohol.

African Americans, Minority Stress, And Alcoholism

Varying factors contribute to alcoholism in African-Americans, such as minority stress and anxiety or depression. Similar to the LGBTQ community, African Americans endure unique social stigmas and violence due to racial discrimination. Social pressure to conform to behavioral expectations based on societal ideals, as well as projected prejudice is often a chronic source of stress and ill health. In response to higher levels of minority stress, coupled with the stress of daily life, some can develop anxiety or psychosis. Others can self-medicate by drinking alcohol and gradually increase their alcohol intake.

African Americans And Alcohol-Related Health Problems

Although African Americans drink less alcohol then Caucasian counterparts, African-Americans are more likely to suffer alcohol-related health problems. Death from conditions such as cirrhosis is “1.27 times” more common in African American drinkers compared to Caucasians. Additionally, there is a “10% higher” rate of death from alcohol-abuse in African Americans despite overall lower alcohol rates.

Hypertension, liver disease, oral cancer, major depression, and stroke from alcohol abuse are other common consequence of increased drinking. Lastly, because African Americans are less likely to get help for alcoholism, it may further complicate alcohol-related health risks and lead to higher mortality rates.

African American Youth and Alcohol Advertising

Alcohol adverting can greatly impact people being exposed to media. The Johns Hopkins study also focused on alcohol marketing in media to African American youth. The connections between African-Americans and exposure to alcohol through music and television may have impacted the rate of alcohol consumption in the population. For instance, African Americans aged 18 to 20 witnessed the following amount of exposure to alcohol advertisements compared to former years:

32% more advertisements with alcohol

22% more advertisements with beer

38% more advertisements with distilled spirits

92% more advertisements with alcopops (e.g. Mike’s Hard Lemonade)

Along with such findings, popular magazines in African American communities featured twice the exposure of alcohol brands to African Americans compared to other ethnic groups. Sadly, the effect is often the influence of young, vulnerable African Americans becoming curious about alcohol, or trying it. The younger someone drinks, the more likely they will suffer an alcohol use disorder in adulthood.

African Americans, Alcoholism, And Depression

Depression and alcohol abuse tend to compliment the other. According to statistics, African Americans are “20% more likely to report serious psychological distress” when compared to other members of other ethnicities. Those most at risk are African American men in a low-income community. A lack of a stable career can make him feel emasculated and develop continuous frustration. Since financial problems create stress and create feelings of hopelessness, many can find a false sense of comfort in the form of alcohol.

Perceived feelings of discrimination can add more anger to feelings of inadequacy. Feelings of despair and hopelessness often reflect underlying depressive feelings. Discrimination combined with feeling victimized by ignorance and anger is an ongoing frustration some African Americans face. If they develop depression in response to internalized feelings, the alcohol intake can greatly increase.

Healthy Coping for African Americans with Alcoholism

Since much of the alcoholism plaguing African Americans stems from various factors like external social harm or internal battles with frustration, healthy coping is essential. A major element of healthy coping is identifying what alcoholism is being used to self-medicate. For example, if someone abuses alcohol because they have lost faith in their ability to overcome challenges, he or she may benefit from finding support groups.

Alternatively, support groups focusing on ethnic sensitivity can help to restore someone’s faith in humanity. Therapy is another healthy coping tool for many suffering unique emotional conditions.

Spirituality or religious groups can bring a source of connection and empathy, encouraging positivity while enduring social prejudice and social stress. Releasing anger through social awareness and forgiveness can decrease internalized feelings of discrimination and racism.

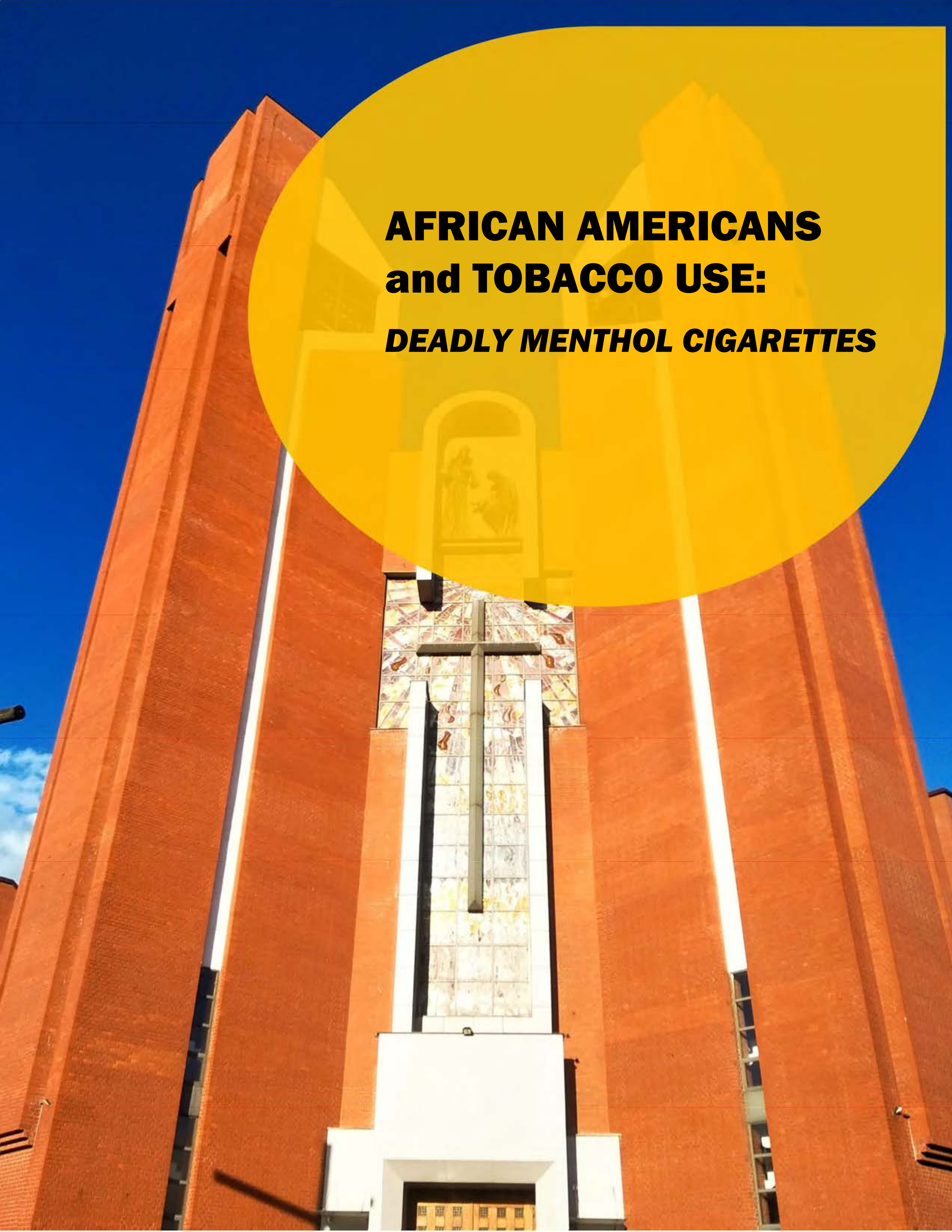
Help Is Out There

African Americans struggling with alcohol use disorders suffer on many levels, and unfortunately often do not get the help needed for recovery. Help is available, and treatment providers are standing by. Contacting a treatment provider can help the individual focus on getting treatment.

It is important to consider all available treatment options. Treatment providers can help future patients explore budget-friendly or cost-effective options for care. Take the next step and change your life today by contacting a treatment provider.

AFRICAN AMERICANS and TOBACCO USE:

DEADLY MENTHOL CIGARETTES



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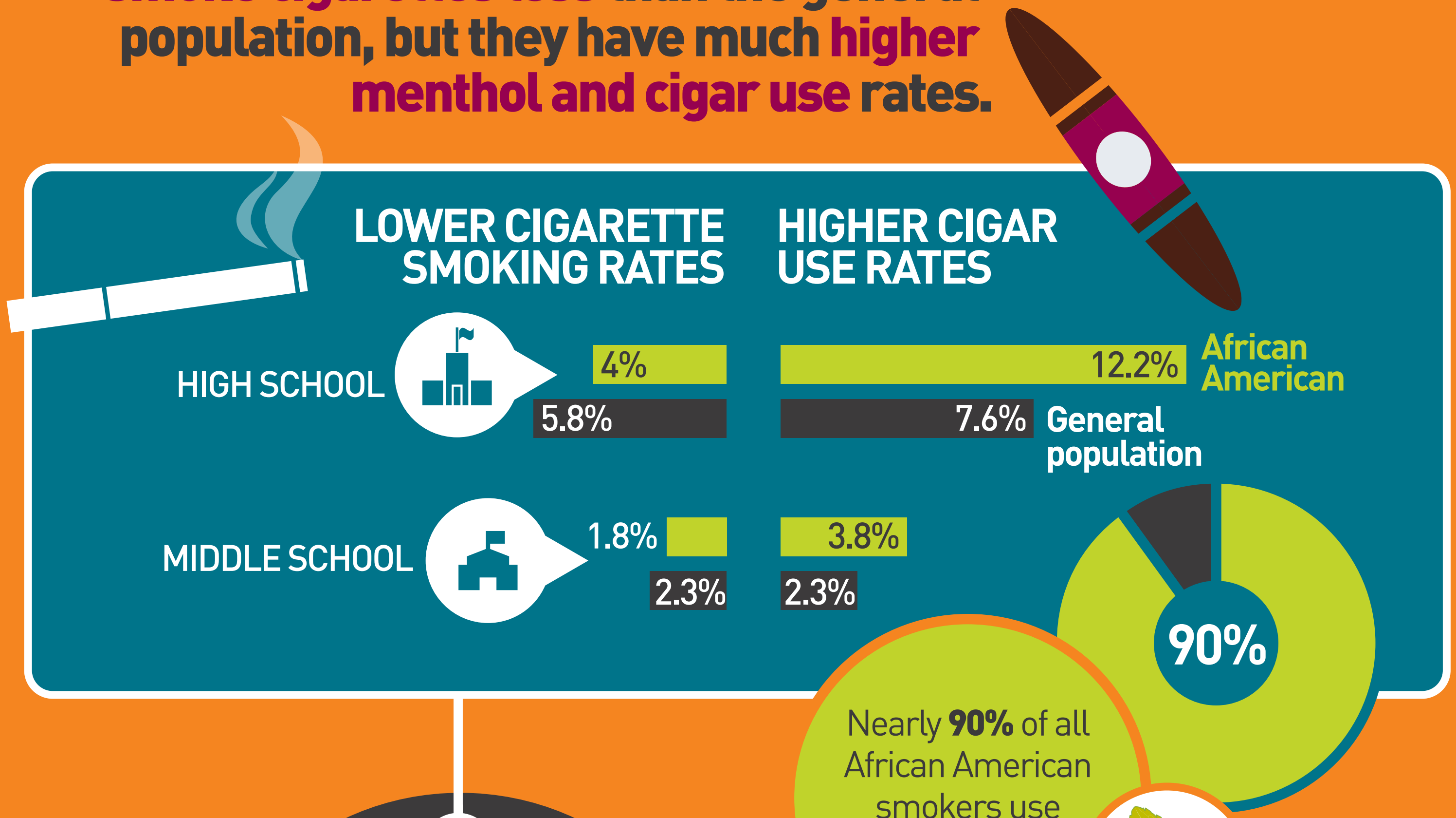
INSPIRING LIVES
FREE FROM SMOKING,
VAPING & NICOTINE

AFRICAN AMERICANS

African American youth tend to smoke cigarettes less than the general population, but they have much higher menthol and cigar use rates.


LOWER CIGARETTE SMOKING RATES

HIGHER CIGAR USE RATES

Nearly **90%** of all African American smokers use menthol cigarettes.

African Americans have been **targeted with menthol cigarette advertising** in predominantly black neighborhoods and in publications that are popular with black audiences.

More than 39,000 **African Americans die** from tobacco-related cancers each year.

x39,000

truth initiative®
INSPIRING LIVES FREE FROM SMOKING, VAPING & NICOTINE

AFRICAN AMERICANS

BACKGROUND

Although African Americans smoke at lower or similar rates compared with other racial and ethnic groups, they are disproportionately affected by tobacco use in several ways. For example, African Americans have higher death rates from tobacco-related causes and are more likely to be exposed to secondhand smoke.

The tobacco industry has targeted African Americans and strategically marketed its products to appeal to the community for decades, including placing more advertising in predominantly black neighborhoods and in publications that are popular with black audiences. The most striking example is menthol cigarettes, which are easier to smoke and harder to quit. Today, nearly 90% of all African American smokers use menthol cigarettes, and more than 39,000 African Americans die from tobacco-related cancers each year. Experts believe that racial differences in smoking habits, socioeconomic factors and the metabolism of tobacco carcinogens may all play a role.[1,2]

90% of all African American smokers use menthol cigarettes.

PATTERNS OF USE IN THE U.S.

CIGARETTES

Youth

- According to the 2019 National Youth Tobacco Survey, the current **cigarette smoking rate was 4% among African American high school students** compared with 5.8% of all high schoolers.[3]
- The current **cigarette smoking rate among African American middle schoolers was 1.8%** compared with 2.3% of all middle schoolers.[3]

Young Adults and Adults

- According to the 2018 National Health Interview Survey (NHIS), among adults ages 18 and above, **14.6% of African Americans are current smokers**, compared with **15% of whites** and **9.8% of Hispanics**.[4]

MENTHOL CIGARETTES

Menthol is a chemical compound extracted from peppermint or corn mint plants, or created synthetically. It reduces the harshness of cigarette smoke due to its characteristic cooling effects on the mouth and throat. It also **suppresses the coughing reflex**, which makes inhaling smoke from cigarettes more tolerable. For more information, see the Truth Initiative® fact sheet on menthol tobacco products.

- Nearly 9 in 10 **(88.5%) African American smokers ages 12 and older** use menthol cigarettes.[5]
- African American youth who smoke menthol cigarettes have greater nicotine dependence and a greater desire to smoke than nonusers,[6] and therefore have a harder time quitting.[7]

- In 2014, among middle and high school students, **70.5% of African American smokers** used menthol cigarettes, compared with **52.3% of Hispanic smokers** and **51.4% of white smokers**.[8]
- Data from nationally representative samples show that the youngest age groups use menthol at the highest rates.[5,9]
  - From 2008 to 2010, **94.8% of African American teenage smokers aged 12-17 smoked menthol cigarettes**, compared with 93.9% of smokers aged 18-25, 91.6% of smokers aged 26-34, 89.9% of smokers aged 34-49 and 80.9% of smokers aged 50 and over.[5]
- Despite starting to smoke later and smoking fewer packs per day, African American menthol smokers successfully quit smoking at a lower rate than non-menthol smoking African Americans.[9]
  - Research shows that if menthol cigarettes were banned nationally, **44.5% of African American menthol smokers would try to quit**.[10]

LITTLE CIGARS, CIGARILLOS AND CIGARS

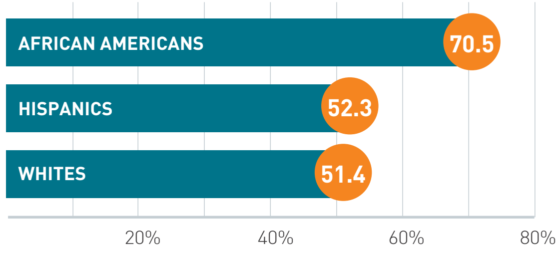
African Americans have the highest rate of cigar use. Cigars include a variety of products, including traditional large cigars, longer and slimmer versions of large cigars called cigarillos, and little cigars, which are like cigarillos, but generally have a filter like cigarettes.

Youth

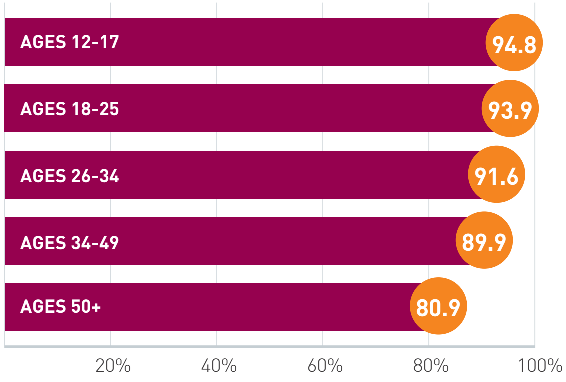
- **African American middle and high school students** have the **highest rates** of cigar use compared to other races.[3]

African Americans have the highest rate of cigar use.

Menthol use among middle school students



African American menthol use by age



- Among African American high school students, **cigars were the most common tobacco product used after e-cigarettes**, at 12.2% in 2019.[3]
- Among African American middle school students, 3.8% were current users of cigars in 2019.[3]
- Cigars, particularly little cigars and cigarillos, come in a variety of flavors. As is the case with flavored cigarettes, such **flavors may appeal to youth** and young people.[11-13]

Young Adults and Adults

- In a study that used data from 18- to 34-year-olds, African Americans were shown to have **greater odds of currently using little cigars and cigarillos**.[14]
- According to the 2018 NHIS, 4.9% of African Americans aged 18 and over used cigars, cigarillos and filtered little cigars “every day” or “some days.”[15]

E-CIGARETTES

E-cigarette use among young people has **skyrocketed** in recent years, **jumping 135% among high schoolers** between 2017 and 2019 alone.[3]

Youth

- In 2019, 17.7% of African American high school students and 8.6% of African American middle school students currently used e-cigarettes. These **rates are lower than the general population** rates of 27.5% for high school students and 10.5% for middle school students.[3]

Young Adults and Adults

- In 2017, **10.3% of African American adults** had ever tried an e-cigarette.[16]
- In 2017, **current e-cigarette use was highest among white adults** (3.3%), compared with African American (2.2%), Hispanic/Latino American (1.8%) and Asian American (0.9%) adults.[15]

SECONDHAND SMOKE

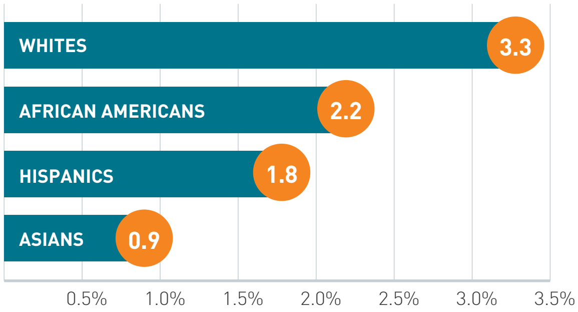
African American children and adults are more likely to be exposed to secondhand smoke than any other racial or ethnic group.[17] The surgeon general has concluded that there is **no safe level of exposure** to secondhand smoke.[18]

- African American nonsmokers generally have **higher cotinine levels** (an indicator of recent exposure to tobacco smoke) than nonsmokers of other races and ethnicities.[17]
- Deaths caused by secondhand smoke exposure have a **disproportionate impact** on African Americans and Hispanic/Latino Americans.[19]

INDUSTRY TARGETING

- Evidence from tobacco industry documents shows that tobacco companies have a long **history of specifically targeting African Americans with menthol cigarette advertising** and promotions and making large financial contributions to **African American groups** and political leaders.[20-24]

E-cigarette use among adults



E-cigarette use among young people has skyrocketed in recent years, jumping 135% among high schoolers between 2017 and 2019 alone.

- A 2013 study found that **African American children were three times** more likely to recognize advertisements for **Newport** brand menthol cigarettes than other children.
- A review of menthol marketing found **more advertising** in publications and venues that target African American audiences.
- A 2014 study found that **Newport** print advertising in 2012 and 2013 "focused on themes of sociability and sexuality, and were placed in **magazines targeting African Americans** and younger consumers."
- A 2011 review concluded that **Ebony magazine** was almost 10 times more likely than People magazine to contain an **advertisement** for menthol cigarettes.
- A study found that, as a high school's **African American student population increased**, the likelihood of **Newport promotions went up** and the **cost of Newport packs went down**.

  - In November 2015, Mother Jones published a thorough exploration of the strategic partnerships tobacco companies made in African American communities and the possibility that those partnerships prevented stronger regulation of menthol products.
- Several studies have found a greater number of tobacco advertisements and a larger presence of tobacco advertising in African American neighborhoods.[24-28]
  - Researchers in Washington, D.C. found that stores in predominantly black neighborhoods were up to 10 times more likely to display tobacco ads inside and outside than retailers in areas with fewer black residents.
  - Other studies have shown that predominantly black communities across the country have more **advertising and cheaper prices for menthol cigarettes**.
  - Studies have found that **little cigars and cigarillos are more available, cheaper** and highly **advertised** in African American neighborhoods.
- Tobacco companies have used experiential marketing — the tactic of encouraging consumers to experience or interact with a brand at recreational venues and events, such as concerts, bars or nightclubs — to **specifically target certain populations, including African Americans**.[29]

HEALTH EFFECTS

- Smoking is a major cause of **heart disease**, **cancer and stroke**, which are the three leading causes of deaths for **African Americans** in the U.S.[30]
- Smoking is responsible for about 30% of all cancer deaths.[18] **Lung cancer is the second most common cancer in both African American men and women.** African Americans have the highest rates of tobacco-related cancer of all racial and ethnic groups, and are more likely to die because of the disease. In 2019, 25,390 new cases of lung cancer are estimated to occur among African Americans.[31]
- **More than 72,000 African Americans** are diagnosed with a **tobacco-related cancer** each year.[1]

Stores in predominantly black neighborhoods of Washington, D.C. were up to 10 times more likely to display tobacco ads than retailers in areas with fewer black residents.

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Support Removing Menthol Cigarettes from the Market: FDA Action Will Protect Kids, Save Lives, and Advance Health Equity

FDA has issued a proposed rule to remove menthol cigarettes from the market. In April 2022, FDA announced a proposed rule to prohibit menthol as a characterizing flavor in cigarettes. Its decision was based on clear evidence that prohibiting menthol cigarettes would significantly reduce smoking-caused disease and death by reducing the number of youth who start smoking and increasing the number of smokers who quit.[1] All other characterizing flavors are already prohibited in cigarettes.

Menthol makes it easier for youth to start smoking and become addicted smokers. Menthol is a chemical compound that cools and numbs the throat. When used in cigarettes, it reduces the harshness of tobacco smoke and makes menthol cigarettes more appealing to youth. As a result, menthol cigarettes increase the number of kids who experiment with cigarettes and who become regular smokers.[2] Half of youth who have ever tried smoking started with menthol cigarettes.[3] Between 1980 and 2018, menthol cigarettes were responsible for 10.1 million additional new smokers, an average of 265,000 new smokers a year over the 38-year period.[4]

Menthol cigarettes have had a devastating and disproportionate impact on the health of Black Americans. For more than 60 years, tobacco companies have targeted Black communities with marketing for menthol cigarettes. They have used sponsorship of community and music events, free samples, magazine advertising, and retail promotions to market menthol cigarettes to Black communities.[5] Black neighborhoods have more tobacco retailers, more advertising for menthol cigarettes, and more price promotions for menthol cigarettes.[6] This decades-long marketing campaign is the primary reason why use of menthol cigarettes is highest among Black Americans: 85% of Black smokers smoke menthol cigarettes compared to 29% of white smokers.[7]

Menthol cigarettes also disproportionately harm other communities. In addition to youth and Black Americans, other population groups also have high rates of menthol use. Half of Hispanic smokers, 47% of Asian American smokers, 51% of lesbian or gay smokers, 46% of bisexual smokers, 45% of smokers with mental health conditions and 47% of smokers living in poverty use menthol cigarettes. Women are also more likely than men to use menthol cigarettes, and 60% of pregnant smokers use menthol cigarettes.[8]

Prohibiting menthol cigarettes would reduce youth smoking, decrease the number of people harmed by tobacco, and advance health equity. The evidence is clear that menthol cigarettes have caused substantial harm to public health. A 2013 FDA report determined that menthol cigarettes lead to increased smoking initiation among youth and young adults, greater addiction, and decreased success in quitting smoking.[9] By increasing youth smoking and decreasing quitting, menthol cigarettes magnify the public health harms of smoking. A recent study found that menthol cigarettes were responsible for 378,000 premature deaths from 1980 to 2018.[10] A related study found that Black Americans represented 41% of premature deaths from menthol cigarettes over this period despite accounting for 12% of the population.[11]

Action to remove menthol cigarettes from the market is long overdue. More than a decade has passed since FDA's Tobacco Products Scientific Advisory Committee (TPSAC) reviewed the science and concluded, "Removal of menthol cigarettes from the marketplace would benefit public health in the United States."[12] In 2018, FDA Commissioner Scott Gottlieb announced the agency's intent to prohibit menthol cigarettes, but the agency did not issue a proposed rule. Now that FDA has followed the science and issued a proposed rule, any effort to block or delay FDA's rulemaking should be opposed. Removing menthol cigarettes from the market is supported by public health, medical, and civil rights groups, including the African American Tobacco Control

Leadership Council, the American Medical Association, NAACP, and many others.[13] It is critical that FDA work quickly to finalize and implement this rule.

Prohibiting menthol cigarettes does not criminalize individual users. Opponents of FDA's proposal have argued that prohibiting menthol cigarettes will lead to increased policing in communities of color. Racial bias in policing is an urgent problem and fixing that problem should be a priority. But regulation of tobacco products is also needed to protect children from tobacco addiction, advance health equity and save lives, especially among Black Americans. We can and must do both. The FDA's proposed rule explicitly states that enforcement will only apply to manufacturers and retailers, and the rule will not make it illegal for individuals to possess or use menthol cigarettes. That is how FDA has enforced the current prohibition on other flavored cigarettes and the current prohibition on sales to minors. There is no reason to expect that FDA would enforce a prohibition on menthol cigarettes any differently.

Campaign for Tobacco-Free Kids / December 15, 2022

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[3] Ambrose, BK, et al., "Flavored Tobacco Product Use Among US Youth Aged 12-17 Years, 2013-2014," *Journal of the American Medical Association*, published online October 26, 2015.

[4] Le, TT, "An estimation of the harm of menthol cigarettes in the United States from 1980 to 2018," *Tobacco Control*, published online February 25, 2021.

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[7] Delnevo, CD, et al., "Banning Menthol Cigarettes: A Social Justice Issue Long Overdue," *Nicotine & Tobacco Research*, 22(10): 1673-1675, 2020.

[8] Delnevo, CD, et al., "Banning Menthol Cigarettes: A Social Justice Issue Long Overdue," *Nicotine & Tobacco Research*, 22(10): 1673-1675, 2020.

[9] FDA. *Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol versus Nonmenthol Cigarettes* (2013).

[10] Le, TT, "An Estimation of the Harm of Menthol Cigarettes in the United States from 1980 to 2018," *Tobacco Control*, published online on February 25, 2021.

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Support Removing Flavored Cigars from the Market to Protect Kids

FDA has issued a proposed rule to remove flavored cigars from the market. In April 2022, FDA announced a proposed rule to prohibit all characterizing flavors in cigars. Its decision was based on clear evidence that flavors increase the appeal of cigars and make them easier to use, particularly for youth, and that removing flavored cigars from the market would reduce the number of youth cigar smokers.[1] Characterizing flavors are already prohibited in cigarettes except for menthol-flavored cigarettes, which FDA is also proposing to prohibit.

Cigar manufacturers have flooded the market with flavored cigars. Sales of all cigars more than doubled between 2000 and 2021, from 6.2 billion cigars to 14.6 billion,[2] largely driven by increased sales of smaller types of cigars, many of which are flavored. Cigars come in hundreds of kid-friendly flavors like "Berry Fusion," "Maui Pineapple," and "Cherry Dynamite," and can be as cheap as 3 for 99 cents.[3] Nielsen convenience store data show that flavored cigars' share of the overall cigar market increased to 53.3% in 2020.[4]

Flavored cigars are particularly appealing to youth. Flavors improve the taste and mask the harshness of tobacco, making flavored tobacco products more appealing and easier for beginners, who are often youth, to smoke.[5] As documented in the proposed rule, flavors in cigars increase youth initiation, progression to regular use and are associated with greater potential for addiction.[6] Many youth who smoke cigars report smoking flavored cigars. In 2021, 41.1% of high school cigar smokers and 59.9% of middle school cigar smokers smoked a flavored cigar in the past month.[7] Earlier data found that nearly three quarters of youth cigar smokers said they smoked cigars "because they come in flavors I like."[8] Not surprisingly, the top five most popular cigar brands among 12-17 year olds who have used cigars all come in flavor varieties.[9] Teens and young adults are more likely than adults 25 years and older to report smoking flavored cigar brands.[10]

Young people smoke cigars, especially Black youth. While cigar smoking is often perceived as an activity of older men, many of today's cigar smokers are youth or young adults. The wide assortment of flavors, colorful packaging, and affordability of many cigars make them an appealing tobacco product for youth. In 2022, 500,000 youth were cigar smokers, and cigars were the second most popular tobacco product among youth.[11] Black youth have the highest rates of cigar smoking compared to other races and ethnicities. Cigar smoking among Black high schoolers is 1.5 times higher than White high schoolers.[12]

Cigar smoking harms health. Cigar smoke is composed of the same toxic and carcinogenic constituents found in cigarette smoke.[13] Cigar smoking causes cancer of the oral cavity, larynx, esophagus and lung, and daily cigar smokers have an increased risk of heart disease, chronic obstructive pulmonary disease (COPD), and an aortic aneurysm.[14] The level of risk is likely related to the level of exposure to the toxic constituents in the smoke, such as the frequency of use and whether or how much smoke is inhaled. But any cigar use increases health risks compared to those who do not use tobacco at all.[15]

Action to remove flavored cigars from the market is long overdue. In 2016 and again in 2018, FDA said it intended to prohibit flavored cigars but did not issue a proposed rule. Now that FDA has followed the science and issued a proposed rule, any effort to block or delay FDA's rulemaking should be opposed. Every day that passes, more than 800 kids try cigar smoking for the first time.[16] The evidence about the role flavors play in attracting youth to cigars is extensive, and FDA should quickly finalize and implement a rule to prohibit flavored cigars.

Campaign for Tobacco-Free Kids / January 17, 2023

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[1] FDA, FDA Proposes Rules Prohibiting Menthol Cigarettes and Flavored Cigars to Prevention Youth Initiation, Significantly Reduce Tobacco-Related Disease and Death, April 28, 2022. https://www.fda.gov/news-events/press-announcements/fda-proposes-rules-prohibiting-menthol-cigarettes-and-flavored-cigars-prevent-youth-initiation

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[10] Delnevo, C, et al., "Preference for flavoured cigar brands among youth, young adults and adults in the USA," *Tobacco Control* 24(4):389-94, 2015.

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[12] CDC, *MMWR* 71(45), November 11, 2022.

[13] Pickworth, WB, et al., "Dual Use of Cigarettes, Little Cigars, Cigarillos, and Large Cigars: Smoking Topography and Toxicant Exposure," *Tobacco Regulatory Science* 3(Suppl 1):S72-S83, April 2017. Chen, J, et al., "Biomarkers of Exposure among U.S. Cigar Smokers: An Analysis of 1990-2012 National Health and Nutrition Examination Survey (NHANES) Data," American Association for Cancer Research, 2014.

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[15] NCI, *Cigars: Health Effects and Trends*, 1998. National Academies of Sciences, Engineering, and Medicine, *Premium Cigars: Patterns of Use, Marketing, and Health Effects*, Washington, DC: The National Academies Press, 2022, https://doi.org/10.17226/26421.

[16] Substance Abuse and Mental Health Administration (SAMHSA), HHS, *Results from the 2021 National Survey on Drug Use and Health, NSDUH: Detailed Tables,* Table 4.9A, https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables. Cigars are defined as cigars, cigarillos or little cigars.

March 16, 2023

The Honorable Robert Aderholt	The Honorable Rosa DeLauro
Chairman	Ranking Member
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies	Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations	Committee on Appropriations
United States House of Representatives	United States House of Representatives
Washington, DC 20515	Washington, DC 20515

Dear Chairman Aderholt and Ranking Member DeLauro:

As your Subcommittee moves forward with the FY 2024 Labor, Health and Human Services, Education and Related Agencies Appropriations bill, we urge you to increase funding for the Centers for Disease Control and Prevention's (CDC) Office on Smoking and Health (OSH) by $63.5 million, for a total of $310 million. This increase would help OSH respond to high rates of e-cigarette use among youth and the devastating toll that tobacco[1] continues to take on our nation's health.

Tobacco use has long been the leading preventable cause of death in the United States. Tobacco is responsible for more than 480,000 deaths and approximately $241 billion in health care costs in the United States each year. Nearly one in three heart disease deaths and cancer deaths and nearly eight in 10 chronic obstructive pulmonary disease (COPD) deaths are caused by tobacco use. Tobacco use almost always begins during adolescence, and most adult smokers want to quit, but overcoming an addiction to nicotine is difficult and often requires multiple quit attempts.

Youth continue to use e-cigarettes at alarming levels. CDC and the Food and Drug Administration's (FDA) most recent National Youth Tobacco Survey showed that more than 2.5 million middle and high school

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[1] References to tobacco in this letter refer to commercial tobacco and not ceremonial tobacco which is used by some American Indian communities.

students reported using e-cigarettes last year. Alarmingly, 46 percent of high school e-cigarette users reported use on 20 days or more a month, including 30.1 percent who reported daily use, a sign that youth are addicted. According to the Surgeon General, e-cigarettes expose users to nicotine and other potentially harmful substances and are not safe for youth and young adults. A more robust public health response is needed to prevent e-cigarettes from placing a new generation at risk for nicotine addiction and tobacco use.

While smoking rates overall have declined, over 31 million people in the U.S. continue to smoke cigarettes. Smoking is higher among certain groups and in particular regions of the country, including people with lower incomes and lower levels of education, Native Americans, people living in rural communities, people with behavioral health conditions, and the LGBTQ community. Black Americans die from smoking-caused diseases at far higher rates than other Americans despite starting to smoke at a later age, smoking fewer cigarettes per day, and being more likely to make a quit attempt. Communities with higher rates of tobacco use are often the targets of tobacco industry marketing and have fewer resources for tobacco cessation. Targeted action is needed to reduce tobacco use where it remains high.

OSH has a vital role to play in addressing tobacco use. OSH provides grants to states and territories to support tobacco prevention and cessation programs, runs a highly successful national media campaign called Tips from Former Smokers (Tips), conducts research on tobacco use, and develops best practices for reducing it. Additional resources will allow OSH to address the threat to public health posed by high rates of youth e-cigarette use while continuing to prevent and reduce other forms of tobacco use. With additional resources:

- CDC could strengthen efforts to assist groups who are disproportionately harmed by tobacco products, including by designing and implementing prevention and cessation programs that are tailored to address their specific needs.

- CDC could enhance efforts to end youth and young adult tobacco use, including e-cigarette use, by providing more resources to state and local health departments; educating youth, parents, health professionals, communities, and others about tobacco products and the harms associated with their use; and identifying evidence-based strategies to protect youth and young adults from initiating tobacco use.

- CDC could expand a program that we know works to reduce tobacco use: the Tips media campaign. From 2012 through 2018, CDC estimates that more than 16.4 million people who smoke attempted to quit and approximately one million smokers have quit for good because of the Tips campaign. As a result, the Tips campaign has helped prevent an estimated 129,100 smoking-related deaths and saved an estimated $7.3 billion in health care costs.

We appreciate that the Consolidated Appropriations Act, 2023 (P.L. 117-328) increased funding for OSH by $5 million in FY 2023. Additional investments in tobacco prevention and cessation will save lives, reduce tobacco-related health disparities, and reduce the cost of treating tobacco-caused disease. We urge you to increase funding for CDC's OSH from $246.5 million to $310 million, which will enable CDC to address the challenges posed by e-cigarettes, continue to make progress reducing the death and disease caused by other tobacco products, and strengthen efforts to assist groups disproportionately harmed by tobacco products.

Sincerely,

Action on Smoking and Health
African American Tobacco Control Leadership Council (AATCLC)
Allergy & Asthma Network
American Academy of Family Physicians
American Academy of Nursing
American Academy of Otolaryngology- Head and Neck Surgery
American Academy of Pediatrics
American Association for Cancer Research
American Association for Dental, Oral, and Craniofacial Research
American Association for Respiratory Care
American Cancer Society Cancer Action Network
American College of Cardiology
American College of Preventive Medicine
American Federation of Teachers
American Heart Association
American Lung Association
American School Health Association
American Society of Addiction Medicine
American Thoracic Society
Americans for Nonsmokers' Rights
Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
Association for Clinical Oncology
Association for the Treatment of Tobacco Use and Dependence (ATTUD)
Association of Black Cardiologists
Association of Maternal & Child Health Programs
Association of State and Territorial Health Officials
Asthma and Allergy Foundation of America
Big Cities Health Coalition
Breathe Southern California
Campaign for Tobacco-Free Kids
CATCH Global Foundation
Catholic Health Association
Center for Black Equity
Commissioned Officers Association of the USPHS
Community Wellness Alliance
COPD Foundation
Corporate Accountability
Emphysema Foundation of America
Family, Career and Community Leaders of America (FCCLA)
First Focus Campaign for Children
For Future Lungs
GLMA: Health Professionals Advancing LGBTQ+ Equality
March of Dimes
Mesothelioma Applied Research Foundation
National Alliance to Advance Adolescent Health
National Association of County and City Health Officials
National Association of Hispanic Nurses
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Association of Secondary School Principals
National Association of Social Workers
National Black Church Initiative
National Black Nurses Association
National Hispanic Medical Association
National LGBT Cancer Network
National Network of Public Health Institutes
National Tongan American Society
North American Quitline Consortium
Oncology Nursing Society
Parents Against Vaping e-Cigarettes
Prevent Cancer Foundation
Preventing Tobacco Addiction
Foundation/Tobacco 21
Preventive Cardiovascular Nurses Association
Public Health Solutions
Respiratory Health Association
Society for Cardiovascular Angiography and Interventions
Society For Research on Nicotine and Tobacco
Society of State Leaders of Health and Physical Education
Students Against Destructive Decisions (SADD)
The Society of Thoracic Surgeons
Trinity Health
Trust for America's Health

March 16, 2023

The Honorable Tammy Baldwin
Chair
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

The Honorable Shelley Moore Capito
Ranking Member
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Chair Baldwin and Ranking Member Capito:

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We were pleased that the FY 2023 Senate Labor, Health and Human Services, Education and Related Agencies Appropriations bill included a $20 million increase for OSH and appreciated that the Consolidated Appropriations Act, 2023 (P.L. 117-328) increased funding for OSH by $5 million in FY 2023. Additional investments in tobacco prevention and cessation will save lives, reduce tobacco-related health disparities, and reduce the cost of treating tobacco-caused disease. We urge you to increase funding for CDC's OSH from $246.5 million to $310 million, which will enable CDC to address the challenges posed by e-cigarettes, continue to make progress reducing the death and disease caused by other tobacco products, and strengthen efforts to assist groups disproportionately harmed by tobacco products.

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GLMA: Health Professionals Advancing LGBTQ+ Equality
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National Association of Hispanic Nurses
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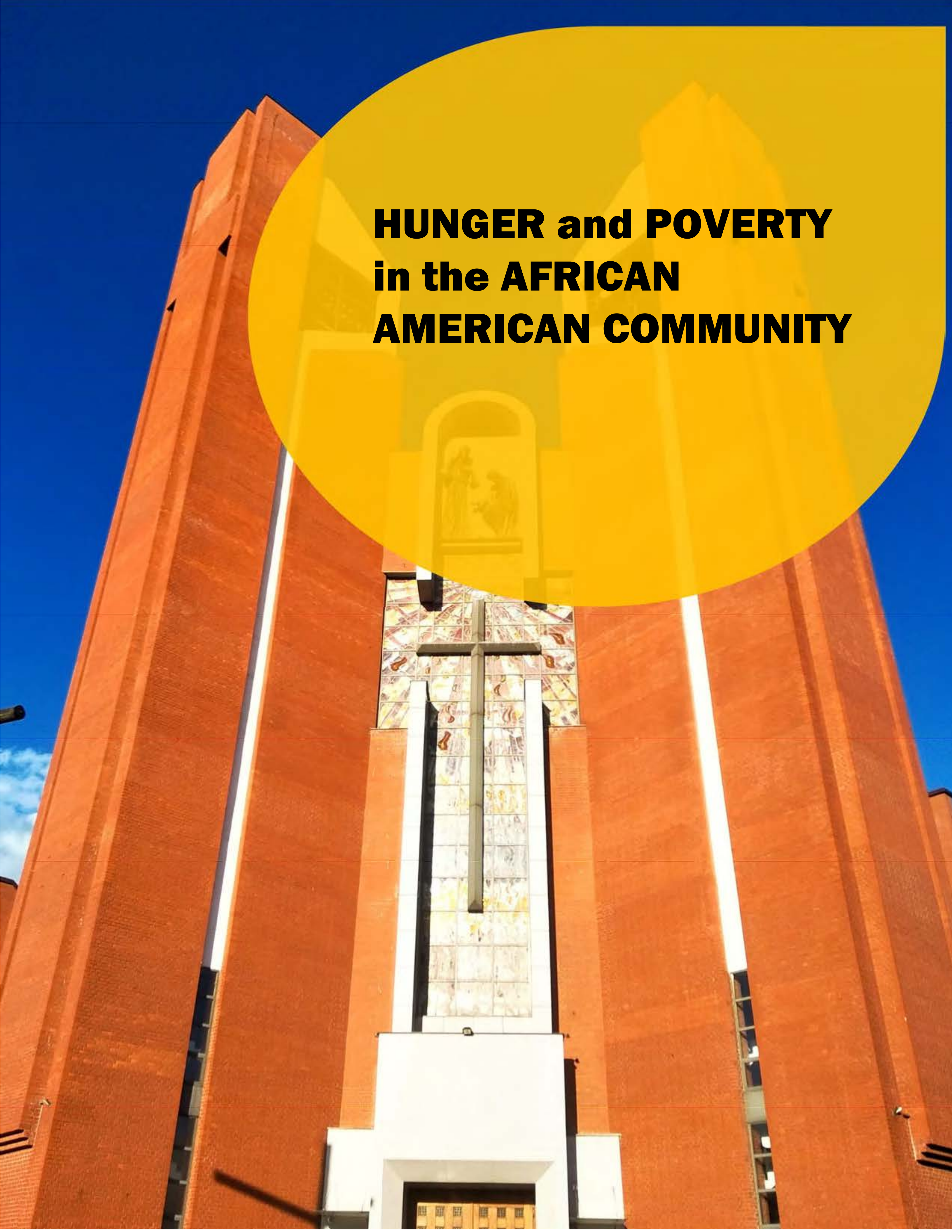
National Association of School Nurses
National Association of Secondary School Principals
National Association of Social Workers
National Black Church Initiative
National Black Nurses Association
National Hispanic Medical Association
National LGBT Cancer Network
National Network of Public Health Institutes
National Tongan American Society
North American Quitline Consortium
Oncology Nursing Society
Parents Against Vaping e-Cigarettes
Prevent Cancer Foundation
Preventing Tobacco Addiction
Foundation/Tobacco 21
Preventive Cardiovascular Nurses Association
Public Health Solutions
Respiratory Health Association
Society for Cardiovascular Angiography and Interventions
Society For Research on Nicotine and Tobacco
Society of State Leaders of Health and Physical Education
Students Against Destructive Decisions (SADD)
The Society of Thoracic Surgeons
Trinity Health
Trust for America's Health

HUNGER and POVERTY in the AFRICAN AMERICAN COMMUNITY



Hunger and Poverty in the African American Community

According to the USDA, in 2021, nearly 20% of Black individuals lived in a food insecure household. In addition, Black people are almost three times as likely to face hunger as white individuals. Black children are more likely to experience hunger than children of other races.

FACT SHEET FEBRUARY 2017

breadfortheworld
HAVE FAITH. END HUNGER.

Hunger and Poverty in the African-American Community

What's the Problem?

While hunger and poverty among African-Americans has declined from last year, African-Americans are still more likely to be food-insecure and live in poverty than other Americans. Being food-insecure, according to the U.S. Department of Agriculture, means that a person or household does not have regular, reliable access to the foods needed for good health.

This condition is a direct result of poverty, racial discrimination, and gender discrimination. While the United States has a high poverty rate (13.5 percent), according to the U.S. Census, African-Americans have a poverty rate of about 24 percent. This rate is even higher in African-American female-headed households (35.7 percent).

African-Americans are more likely to lack access to food.

- Only 8 percent of African-Americans live in areas with a supermarket, compared to 31 percent of whites[1]. Almost 94 percent of the nation's majority African-American counties are food-insecure.[2]

FOOD INSECURITY

	General Population	African-Americans
All households	12.7%	21.5%
Households with children	16.6%	24.7%
Female-headed household with children	30.3%	N/A*

*The percentages of food-insecure African-Americans are believed to be higher than the corresponding food-insecurity levels in the general population, however, data from USDA is not publicly available.

Source: Food Security in the United States, 2015. U.S. Department of Agriculture Economic Research Service.

Since poverty rates are much higher and income levels are much lower in African-American female-headed households compared to the general population, we expect that food-insecurity levels are also much higher among African-American female-headed households. This would suggest that hunger and poverty levels could be reduced with safety-net programs and policies that support female-headed households with children, target men who might have children but are unable to secure employment, and do not penalize married couples.

WHAT FACTORS CONTRIBUTE TO HUNGER AND POVERTY IN THE AFRICAN-AMERICAN COMMUNITY?

- Unemployment and low wages
- Less access to quality and affordable education
- Higher healthcare costs
- Less access to credit
- Higher debt levels
- Higher levels of incarceration


Joseph Molieri/Bread for the World

The median income of African-American households is nearly $20,000 less than the median income of other households.

$36,898
African-American households

$56,516
other households

As a result, African-Americans are more than
FOUR TIMES
as likely as whites to face what the USDA calls **"very low food insecurity."**

MORE ON THE CONTRIBUTING FACTORS TO HUNGER AND POVERTY:

Lower Employment and Income

African-Americans are more likely to be unemployed, and to hold low-wage jobs with few or no benefits.

- 10.4 percent of African-Americans are unemployed, not counting part-time workers seeking full-time work or those returning from incarceration.

INCOME

	General Population	African-Americans
Median income	$56,516	$36,898
Men	$40,762	$38,060*
Women	$29,022	$23,165*
Female-headed households	$37,797	$26,169*
Returning citizens	$18,272*	$13,924*

Source: Income, Poverty, and Health Insurance Coverage in the United States: 2014. U.S. Department of Commerce, U.S. Census Bureau, September 2015.
*Data based on 2013 estimates from the U.S. Department of Commerce, U.S. Census Bureau.

Poorer Education

Education can predict a person's earnings. Lower-resourced schools are located disproportionately in African-American communities.

- About 40 percent of African-American students (3.2 million children) attend high-poverty schools—six times the rate of whites.
- African-American college students have the highest level of student debt[3] ($29,344 on average) of any racial group.

Poorer Health

Lack of nutritious food causes serious medical conditions, including obesity and diabetes. Healthcare expenses lead to higher debt levels and worsen financial stress.

- 55 percent of African-Americans have out-of-pocket medical costs[4] on credit cards because they cannot pay in full.
- 34 percent of African-Americans did not see a doctor when ill for financial reasons.

Poor Credit

African-Americans are more likely to have poor credit histories than whites with similar incomes. Poor credit can prevent people from securing:

- A job, place to live, or reliable car since many low-wage employers, housing units, and companies consider credit scores when hiring and accepting applicants.

Higher Levels of Debt

African-Americans have lower incomes and higher debt levels. In addition, predatory lenders that charge higher interest rates concentrate in low-income communities, which increases the probability of falling into debt.

- African-Americans spend more than half their incomes repaying debts.[5]
- Due to higher interest rates on loans, African-Americans were 80 percent more likely to lose their homes during the Great Recession.

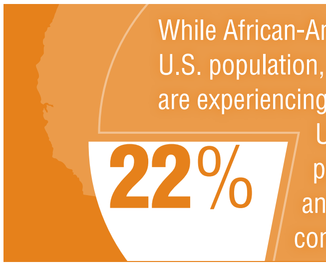
Mass Incarceration

African-Americans are more likely than others charged with similar offenses to be incarcerated. Soaring incarceration rates deplete community resources and money.

- African-Americans are seven times as likely[6] to be incarcerated as whites who commit the same offenses.
- The family of someone in prison owes on average more than $13,000 in court costs alone.

African-American Leaders Fight Hunger

African-American leaders on the local, state, national, and international levels have done their part to fight hunger and poverty in their communities. To learn more about the role of African-American leaders in combating hunger and poverty, please visit bread.org/rise to see the contributions of African-Americans throughout this century.



While African-Americans make up only 13 percent of the U.S. population, they represent **22 percent** of those who are experiencing poverty and hunger, according to the U.S. Census. With advocacy for the right policies, we can reduce these numbers and move toward ending hunger in this community.

Almost **50 PERCENT** of all black children younger than 6 live in poverty—more than three times the proportion of young white children[7].

Endnotes

[1] Access to Affordable and Nutritious Food: Report to Congress, June 2009. U.S. Department of Agriculture, Economic Research Service. www.ers.usda.gov/media/242675/ap036_1_.pdf

[2] Map the Meal 2015: Highlights of Findings for Overall and Child Food Insecurity. Feeding America. www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/2013/map-the-meal-gap-2013-exec-summ.pdf

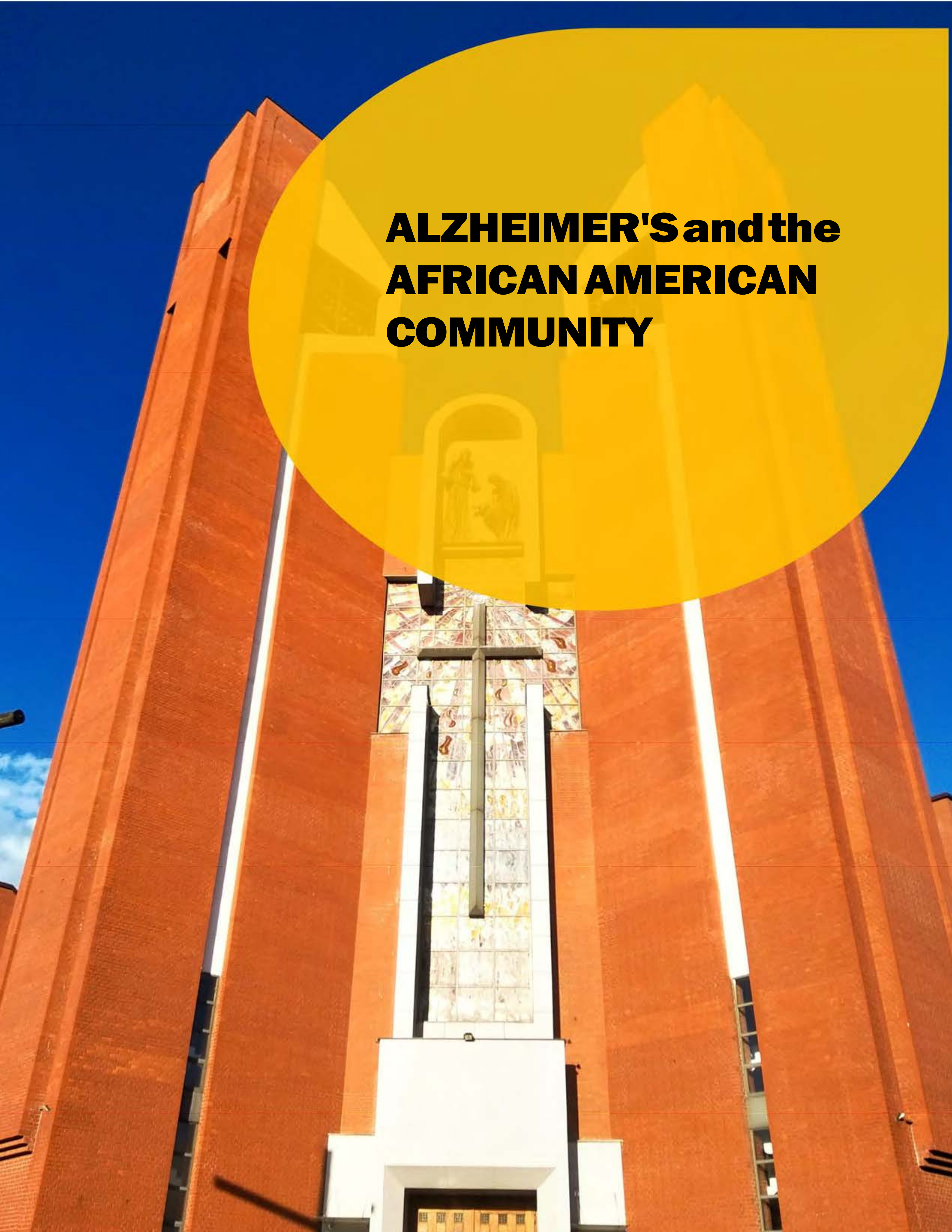
[3] The Debt Divide: The Racial and Class Bias Behind the "New Normal" of Student Borrowing. Demos. http://www.demos.org/sites/default/files/publications/Mark-Debt%20divide%20Final%20(SF).pdf

[4] The Color of Debt: Credit Card by Race and Ethnicity Demos Fact Sheet. Demos. www.demos.org/sites/default/files/publications/FACTSHEET_TheColorofDebt_Demos.pdf

[5] Ibid.

[6] Who Pays? The True Cost of Incarceration on Families. September 2015. http://ellabakercenter.org/sites/default/files/downloads/who-pays.pdf

[7] State of Working America. Economic Policy Institute. http://stateofworkingamerica.org/files/book/factsheets/poverty.pdf



ALZHEIMER'S and the AFRICAN AMERICAN COMMUNITY

Alzheimer’s and the African American Community

Black Americans and Alzheimer's | Alzheimer's Association

Among Black Americans ages 70 and older, 21.3% are living with Alzheimer's. Learn what the Alzheimer's Association is doing to address disparities and provide care and support for African Americans living with Alzheimer's or another dementia.

Quick facts

While older Black Americans are twice as likely as older Whites to have Alzheimer's or another dementia, research hasn't yet identified the cause. Higher rates of cardiovascular (heart and blood vessels) disease may play a role. Some studies indicate that after correcting for overall health and socioeconomic status, these differences disappear.

Only 20% of Black Americans say that they have no barriers to excellent health care and support for Alzheimer's or other dementias.

Half of African Americans say that they **have experienced discrimination** while seeking care for a person living with Alzheimer's.

Only 48% of Blacks report being confident they can access culturally competent care.

Only 53% of Blacks **believe that a cure for Alzheimer's will be distributed fairly**, without regard to race, color or ethnicity.

Only 35% of African Americans say that they are concerned about Alzheimer's or dementia.

65% of Black Americans say that they **know somebody with Alzheimer's or dementia**.

55% of Blacks **think that significant loss of cognitive abilities or memory is a natural part of aging** rather than a disease.

For more information, please see the Association's Alzheimer's Disease Facts and Figures special report on *Race, Ethnicity and Alzheimer's in America* (PDF).

Perceptions of clinical trials

A history of exclusion from medical trials and a lasting history of discrimination from the medical establishment, including but not limited to the infamous Tuskegee syphilis study, contribute to high levels of mistrust of clinical trials among Black Americans. Nearly two-thirds of Black Americans (62%) believe that medical research is biased against people of color.

The most common reasons Black Americans do not want to participate in a clinical trial are:

- The fear of being a guinea pig, which 69% of African Americans name as a concern.
- Black Americans are also far more likely than other racial groups to be concerned about getting sick from treatment, with 45% describing this as a reason.

However, Black Americans are the least likely group to report cost as a concern, with only 24% saying cost and time are reasons not to participate.

Other studies identified reasons such as not expecting to benefit from participating in research and not being given enough information about research studies. Many of these findings persist across socioeconomic groups. In another study, Black Americans rated study risks, the requirement of a study partner, study procedures, the ratio of drug to placebo, and study location as important factors in the decision of whether to enroll.

In this webinar discussion, hosted by Beverly Berry from the Alzheimer's Association, three expert panelists discuss how to build trust and remove barriers to greater Black participation in research. It features the Rev. Dr. Ruben Warren, former director of the National Center for Bioethics in Research and Health Care; the Rev Dr. Ann Marie Bentsi-Addison, senior director of faith-based initiatives at NYC Health + Hospitals; and the Rev. Dr. Miriam J. Burnett, medical director for the International Health Commission of the African Methodist Episcopal Church.

Serving the community

At the Alzheimer's Association, we believe that diverse perspectives are critical to achieving health equity — meaning that all communities have a fair and just opportunity for early diagnosis and access to risk reduction and quality care. The Association is committed to engaging underrepresented and underserved communities and responding with resources and education to address the disproportionate impact of Alzheimer's and dementia.

Unforgettable: A play about the lived experience of Alzheimer's

"Unforgettable" shows how a Black American family comes together when the grandmother develops signs of dementia.

Learn About the Play

The Alzheimer's Association actively serves the African American community by providing culturally appropriate services and working to reduce health disparities. You can do something to help by becoming an Association volunteer. Make a difference in your community by delivering support and education, raising funds, advocating for Alzheimer's and more.

New IDEAS is a new clinical study from the Alzheimer's Association and the American College of Radiology on mild cognitive impairment (MCI) and dementia. At least 4,000 of the planned 7,000 New IDEAS participants will be Black or African American and Hispanic or Latino. Historically, Black and Hispanic people haven't been represented fully in Alzheimer's and dementia clinical studies. This study seeks to ensure that the results apply to all racial and ethnic groups.

If you are unable to participate in New IDEAS, you can still help advance Alzheimer's research. Alzheimer's Association TrialMatch is a free and private tool that connects individuals living with Alzheimer's, caregivers and healthy volunteers to clinical trials. Search open studies or sign up to receive email alerts of new studies through TrialMatch.

The Association's Northern California and Northern Nevada chapters of the Alzheimer's Association created the videos Black Men and Dementia and Black Women and Dementia: Two Sides of the Story.

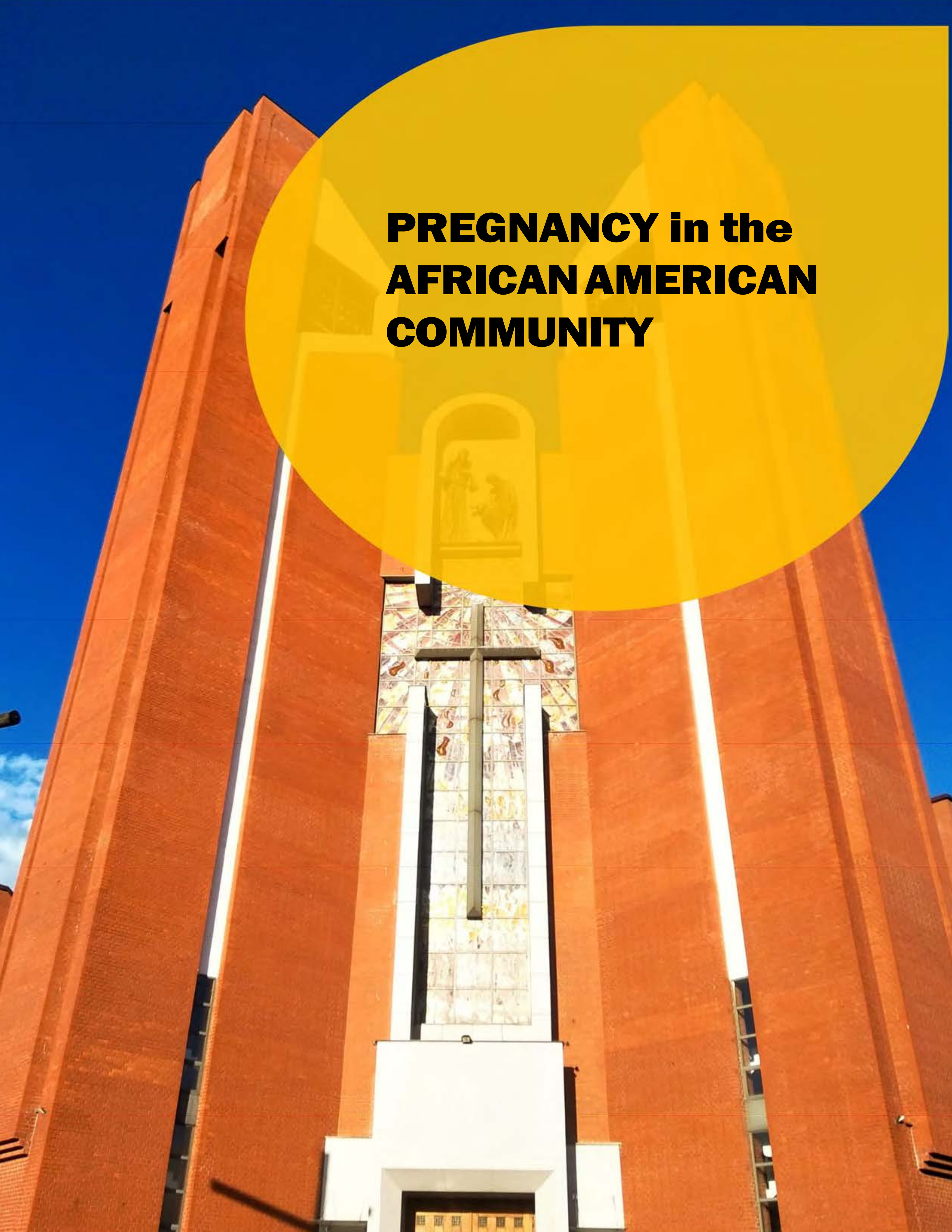
Dr. Robert W. Turner II is an author, researcher and former NFL player. He describes the impact of dementia on his family and on Black Americans, his work as lead researcher for the Brain Health & Aging Study and how the Alzheimer's Association's partnerships are helping to advance research.

Association partnerships

The Alzheimer's Association actively partners to advance diversity, equity and inclusion in Alzheimer's prevention and treatment. Its partners dedicating to serving the Black community include:

- The African Methodist Episcopal Church (AME)
- The Association of Black Women Physicians (ABWP)
- Black Nurses Rock Foundation (BNRF)
- Chi Eta Phi Sorority, Incorporated (CEP)
- National Black Nurses Association (NBNA)
- National Caucus and Center on Black Aging (NCBA)
- National Council of Negro Women (NCWN)
- Omega Psi Phi Fraternity, Inc (OPP)
- Thurgood Marshall College Fund (TMCF)
- Zeta Phi Beta Sorority, Inc. (ZΦB)

Learn more about our partners and partnerships as part of our commitment to diversity and inclusion.



PREGNANCY in the AFRICAN AMERICAN COMMUNITY

Pregnancy in the African American Community

Black Maternal Health Resources - Every Mother Counts (EMC) | Improving Maternal Health

Black women and pregnancy complications | News | Harvard T.H. Chan School of Public Health

Why black women face a high risk of pregnancy complications

Black women are three to four times more likely to die from pregnancy-related complications than white women, according to the Centers for Disease Control and Prevention—and a big reason for the disparity may be racism, say experts.

"It's basically a public health and human rights emergency because it's been estimated that a significant portion of these deaths could be prevented," said Harvard T.H. Chan School of Public Health's Ana Langer in a February 20, 2019 American Heart Association article.

Lack of access to care and poor quality of care play a role in the disparity, particularly among women at lower socioeconomic levels, according to the article. But Langer, professor of the practice and director of the Women and Health Initiative, thinks there's a bigger problem. "Basically, Black women are undervalued," she said. "They are not monitored as carefully as white women are. When they do present symptoms, they are often dismissed."

For instance, tennis star Serena Williams experienced a pulmonary embolism after giving birth to her daughter via cesarean section last year, but medical employees initially dismissed her concerns.

Langer said that publicizing cases such as Williams' could help. "It's important to illustrate what's happening and make the public aware because it can encourage the health establishment to take on this crisis much more seriously," she said.

Read the American Heart Association article: Why are black women at such high risk of dying from pregnancy complications?

INFANT MORTALITY and AFRICAN AMERICANS

Infant Mortality and African Americans

What is Infant Mortality?

According to the Centers for Disease Control and Prevention (CDC), infant mortality is the death of an infant before his or her first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving us key information about maternal and infant health, the infant mortality rate is an important marker of the overall health of a society.

How Does Infant Mortality Affect African American Populations?

- Non-Hispanic blacks/African Americans have 2.4 times the infant mortality rate as non-Hispanic whites.
- Non-Hispanic black/African American infants are almost four times as likely to die from complications related to low birthweight as compared to non-Hispanic white infants.
- Non-Hispanic black/African American infants had 2.9 times the sudden infant death syndrome mortality rate as non-Hispanic whites, in 2020.
- In 2020, non-Hispanic black/African American mothers were twice as likely to receive late or no prenatal care as compared to non-Hispanic white mothers.

Infant Mortality Rate

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
10.4	4.4	2.4

Source: CDC 2022. Infant Mortality Statistics from the 2020 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports. Table 2.
https://stacks.cdc.gov/view/cdc/120700

Leading Causes of Infant Mortality

Infant deaths and mortality rates for the top 5 leading causes of death for African Americans, 2020 (Rates per 100,000 live births)

Cause of Death (By rank)	# Non-Hispanic Black Deaths	Non-Hispanic Black Death Rate	# Non-Hispanic White Deaths	Non-Hispanic White Death Rate	Non-Hispanic Black / Non-Hispanic White Ratio
(1) Low birthweight	1,136	214.4	1,040	56.4	3.8
(2) Congenital malformations	705	133.1	1, 976	107.2	1.2

Infant deaths and mortality rates for the top 5 leading causes of death for African Americans, 2020 (Rates per 100,000 live births) – con't					
Cause of Death (By rank)	**# Non-Hispanic Black Deaths**	**Non-Hispanic Black Death Rate**	**# Non-Hispanic White Deaths**	**Non-Hispanic White Death Rate**	**Non-Hispanic Black / Non-Hispanic White Ratio**
(3) Sudden infant death syndrome (SIDS)	472	89.1	563	30.5	2.9
(4) Accidents (unintentional injuries)	375	70.8	547	29.7	2.3
(5) Maternal Complications	337	63.6	370	20.1	3.2

Source: CDC 2022. Infant Mortality Statistics from the 2020 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports. Table 2.

https://stacks.cdc.gov/view/cdc/120700

Characteristics of Mother

Percentage of mothers who received prenatal care (first trimester), 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
68.4	82.8	0.8

Source: CDC 2022. Births: Final Data for 2020 National Vital Statistics Reports. Table 13. https://stacks.cdc.gov/view/cdc/112078

Percentage of mothers who received late or no prenatal care, 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
9.1	4.5	2.0

Source: CDC 2022. Births: Final Data for 2020 National Vital Statistics Reports. Table 13. https://stacks.cdc.gov/view/cdc/112078

Percentage of mothers who smoked during pregnancy, 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
4.5	8.1	0.6

Source: CDC 2022. Births: Final Data for 2020 National Vital Statistics Reports. Table 13.
https://stacks.cdc.gov/view/cdc/112078

Infant mortality rate per 1,000 live births, 2020			
Age of Mother	**Non-Hispanic Black**	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Under 20 years	12.4	8.2	1.5
20-24 years	10.8	5.6	1.9
25-29 years	10.3	4.3	2.4
30-34 years	9.8	3.6	2.7
35-39 years	9.4	4.0	2.4
40-54 years	11.6	5.5	2.1

Source: CDC 2022. Infant mortality in the United States, 2020: Data from the period linked birth/infant death file. National Vital Statistics Reports. Table 2.
https://stacks.cdc.gov/view/cdc/120700

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SIDS Rate Increases in Black Infants, Tips For Protecting Your Child

During the first year of the pandemic, the United States saw a spike in the number of Black infants who died suddenly — worsening a longstanding disparity, a new government study finds.

The increase was seen in what's called sudden unexpected infant death, or SUID. It's a term used when a baby younger than one year dies from no immediately obvious cause, often during sleep. SUID includes cases of the much better-known SIDS (sudden infant death syndrome), as well as incidents where babies accidentally suffocate during sleep, and deaths where no cause can be determined.

Overall, the United States has seen a drop in those sudden infant deaths since the 1990s, according to the U.S. Centers for Disease Control and Prevention.

That success is attributed largely to public health campaigns encouraging safer infant sleep practices. For years, parents have been advised to put their baby to sleep on the back, not the tummy; keep cribs free of blankets and other loose bedding; and avoid bed-sharing with their baby.

Despite the declining overall rate of SUID, however, racial disparities have persisted.

RELATED: SIDS Awareness: 5 Things You Can Do To Protect Your Child

Why the spike in Black infants?

Now, in this latest study, the CDC found that sudden deaths among Black infants rose between 2019 and 2020, but held steady or declined among babies of other races and ethnicities.

The result was a widening in the disparity that already existed pre-pandemic, says Sharyn Parks, one of the CDC researchers who worked on the study.

In 2020, Black families had over double the risk of losing an infant to SUID, versus the average for the country as a whole. For every 100,000 Black infants born that year, 214 died suddenly — up from about 190 per 100,000 in 2019, the study found.

Meanwhile, SUID rates were lower, and did not spike in 2020, among white, Hispanic or Asian-American infants.

There is no single reason that Black infants are dying at a higher rate, experts say.

“It’s obviously a complex issue,” says Dr. Rebecca Carlin, a pediatrician at Columbia University Irving Medical Center, in New York City. She is co-author of an editorial published with the CDC study in the journal *Pediatrics.*

Carlin says that while safe sleeping practices are critical to preventing SUID, there are also social and economic disparities at work.

For one, Black women in the United States are less likely to have access to early prenatal care, which, among other benefits, can reduce the risk of preterm birth. Preterm birth is a risk factor for SUID, Carlin notes.

Similarly, when Black families cannot get to routine pediatrician visits, they may not learn about safe sleep practices.

Meanwhile, Carlin says, many Black moms lack paid maternity leave from their jobs. That means they have to rely on other caregivers, who may not always know how to put infants to sleep safely. Plus, those same moms may find it impossible to breastfeed — which helps lower the risk of SUID.

The pandemic only worsened the situation, Parks and Carlin add.

“We know the COVID-19 pandemic and mitigation efforts — such as stay-at-home orders — disproportionately affected racial and ethnic minority communities,” according to Parks.

On top of having even more difficulty accessing health care, she says, people of color suffered more job losses, and stress over paying the rent and buying food. Some people lost their homes, and may have moved in with family or friends.

“These factors may have led to more unsafe sleep practices like bed-sharing, thereby increasing the occurrence of SIDS and other sudden unexpected infant deaths,“ Parks add.

Plus, Carlin says, many Black Americans who did keep their jobs were “essential workers” who had no option to work from home. So mothers had to go to work at a time when childcare centers closed, and many scrambled to find a replacement — perhaps, Carlin notes, family or friends with little infant care experience.

On top of that, she says, those same moms were probably exhausted and emotionally drained: If their babies slept better in bed with them, they may have made that choice.

Parks says the CDC is continuing its routine monitoring of SUID, and it remains to be seen whether rates among Black babies changed as the pandemic wore on.

But even if things improved from 2020, Carlin pointed out, the disparity has always been there.

What’s needed, she says, are “systems where new mothers are supported and can focus on parenting instead of paying the rent.”

RELATED: The Best Way To Put Babies To Sleep To Reduce SIDS Risk

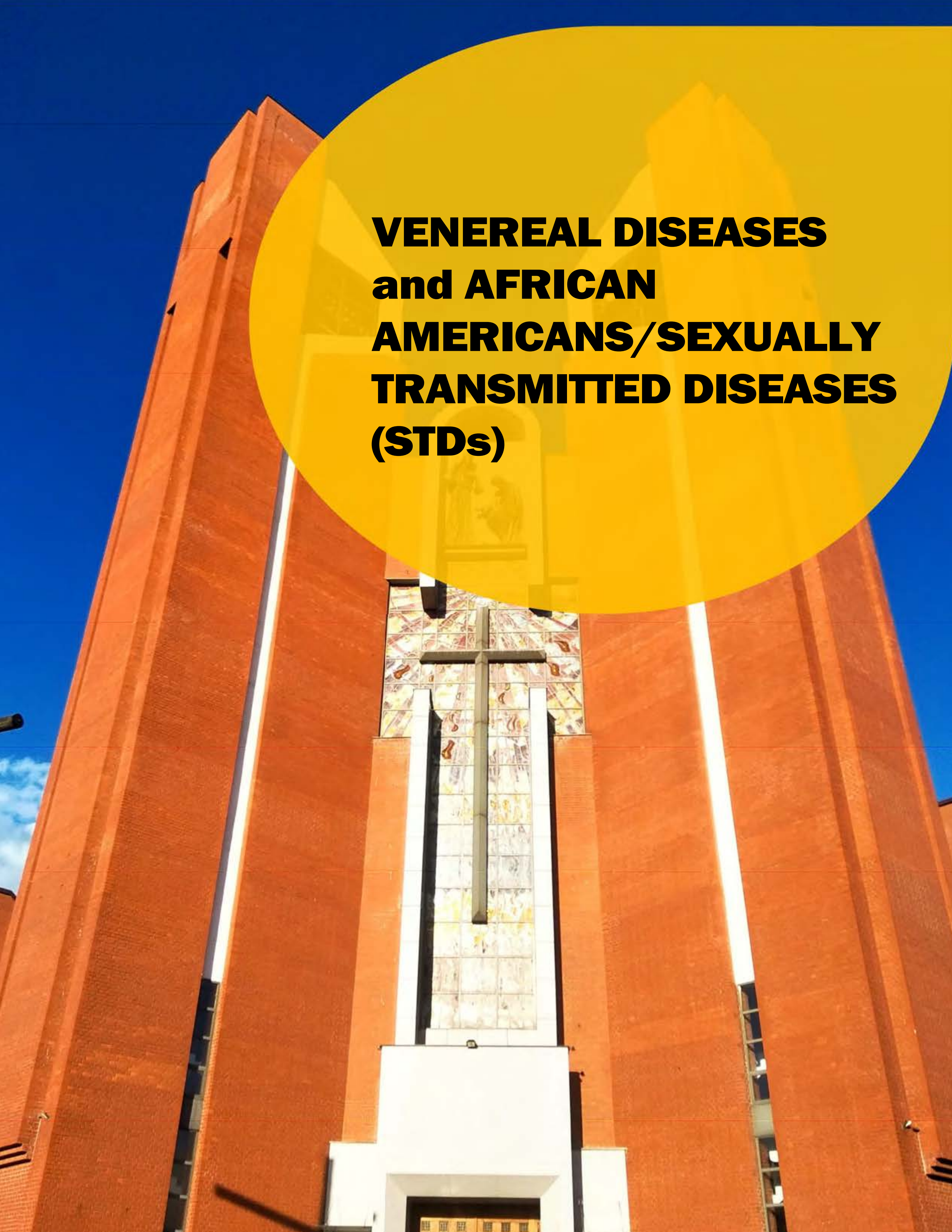
How to protect your child

A safe sleep environment lowers the risk of SIDS. You can help create a safe sleep environment in the following ways according to the American Academy of Pediatrics (AAP):

- **Put your baby on their back for all naps & at night:** AAP recommends placing infants to sleep in a supine position for every sleep until the child reaches one year of age. Side sleeping is not advised and is not safe.
- **Use a firm, flat sleep surface:** A firm, flat, non-inclined sleep surface is recommended to reduce the risk of suffocation or wedging/entrapment.
- **Feed your baby breast milk:** Breastfeeding is associated with a reduced risk for sudden infant death syndrome (SIDS) and is recommended, unless contraindicated or the parent is unable to do so.
- **Never sleep with your baby:** It isn’t recommended that you share a bed with your baby under any circumstances.
- **Instead of bed sharing, room share with your baby:** Infants should sleep in the parents’ room, but on a separate surface designed for infants, ideally for at least six months.

- **Keep soft objects & loose bedding out of your baby's sleep area:** Soft objects such as pillows, comforters, and loose bedding should be kept away from the infant's sleep area.
- **Don't let your baby get overheated:** Overheating can increase the risk of SIDS. Your baby only needs one more layer than you would wear in the same environment to be comfortable.
- **Try giving your baby a pacifier at nap time and bedtime:** A pacifier should be offered at nap time and bedtime to reduce the risk for SIDS.
- **Don't smoke or use nicotine during pregnancy or after your baby is born:** Smoke and nicotine exposure and alcohol, marijuana, opioids, and illicit drug use should be avoided during pregnancy and after birth.

March 13, 2023 by Jason Henderson



VENEREAL DISEASES and AFRICAN AMERICANS/SEXUALLY TRANSMITTED DISEASES (STDs)

Venereal Diseases and African Americans/ Sexually Transmitted Diseases (STD)

Venereal Diseases and the African American community

African Americans/Blacks | Health Disparities | CDC

- HIV
- STDs
- Viral Hepatitis
- Tuberculosis

Health disparities are differences in the incidence, prevalence, and mortality of a disease and the related adverse health conditions that exist among specific population groups. These groups may be characterized by gender, age, race or ethnicity, education, income, social class, disability, geographic location, or sexual orientation. These health disparities are one reason why HIV, viral hepatitis, STDs, and TB take a greater toll in one population group over another. Find information about how these diseases affect African American/Black populations.

HIV

In 2018, African Americans/Blacks accounted for 42% of the 37,968 new HIV diagnoses in the United States and dependent areas. Of the 37,968 new HIV diagnoses in the US and dependent areas in 2018:

- 42% were among adult and adolescent African Americans/Blacks
- 31% were among African American/Black men
- 11% were among African American/Black women

In 2018, in the United States, the death rate for African Americans/Blacks was higher (16.3 per 100,000) compared with any other racial/ethnic group (2.5 Whites). In 2018, African Americans/Blacks represented 43% of all deaths of people diagnosed with HIV. (Note that deaths could be from any cause.) A recent study showed that African Americans/Blacks diagnosed with HIV are less likely than other groups to be linked to care, retained in care, receive antiretroviral treatment, and achieve adequate viral suppression.

In 2018, African American/Black adult and adolescent men accounted for 39% of new HIV diagnoses among men in the United States and dependent areas. Most (79%) new HIV diagnoses among African American/Black men were attributed to male-to-male sexual contact, while 15% were attributed to heterosexual contact.

Among African American/Black adult and adolescent women in the United States and dependent areas, most (92%) new HIV diagnoses were attributed to heterosexual contact in 2018.

Sexually Transmitted Diseases (STD)

Chlamydia

In 2018, the overall rate of reported chlamydia cases among Blacks in the United States was 1,192.5 cases per 100,000 population. The rate of reported chlamydia cases among Black females was five times the rate among White females (1,411.1 and 281.7 cases per 100,000 population, respectively. The rate of reported chlamydia cases among Black males was 6.8 times the rate among White males (952.3 and 140.4 cases per 100,000 population, respectively). Rates of reported cases of chlamydia were highest for Blacks aged 15–19 and 20–24 years in 2018. The rate of reported chlamydia cases among Black females aged 15–19 years (6,817.3 cases per 100,000 population) was 4.5 times the rate among White females in the same age group (1,520.1 cases per 100,000 population). The rate of reported chlamydia cases among Black females aged 20–24 years was 3.7 times the rate among White females in the same age group (7,087.7 and 1,935.8 cases per 100,000 population, respectively). Among females aged 15–24 years, the population targeted for screening, rates were highest among Blacks in all US regions.

Similar racial disparities in reported chlamydia rates exist among males. Among males aged 15–19 years, the rate of reported chlamydia cases among Blacks was 9.1 times the rate among Whites (2,668.6 and 293.0 cases per 100,000 population, respectively. The rate of reported chlamydia cases among Black males aged 20–24 years was 5.3 times the rate among White males of the same age group (3,867.1 and 732.6 cases per 100,000 population, respectively).

Gonorrhea

In 2018, the overall rate of reported gonorrhea cases among Blacks in the United States was 7.7 times the rate among Whites. This disparity was similar for Black males (8.5 times the rate among White males) and Black females (6.9 times the rate among White females). As in previous years, the disparity in gonorrhea rates for Blacks in 2018 was larger in the Midwest and Northeast than in the South and West.

Considering Hispanic ethnicity and all race and age categories, rates of reported gonorrhea cases were highest for Blacks aged 20–24, 15–19, and 25–29 years in 2018. The rate of reported gonorrhea cases among Black females aged 20–24 years (2,040.3 cases per 100,000 population) was 6.9 times the rate among White females in the same age group (297.5 cases per 100,000 population). The rate of reported gonorrhea cases among Black females aged 15–19 years

(1,756.4 cases per 100,000 population) was 8.8 times the rate among White females in the same age group (200.1 cases per 100,000 population). Among Black males aged 20–24 years, the rate of reported gonorrhea cases (2,212.1 cases per 100,000 population) was 9.4 times the rate among White males in the same age group (236.3 cases per 100,000 population). The rate of reported gonorrhea cases among Black males aged 25–29 years (1,860.7 cases per 100,000 population) was 7.0 times the rate among White males in the same age group (265.5 cases per 100,000 population).

Primary and Secondary Syphilis

In 2018, 34.7% of reported P&S syphilis cases with known race/Hispanic ethnicity information occurred among Blacks. The rate of reported P&S syphilis cases among Blacks was 4.7 times the rate among Whites (28.1 versus 6.0 cases per 100,000 population, respectively). This disparity was similar for Black females and males. Similar disparities were seen in all regions of the United States.

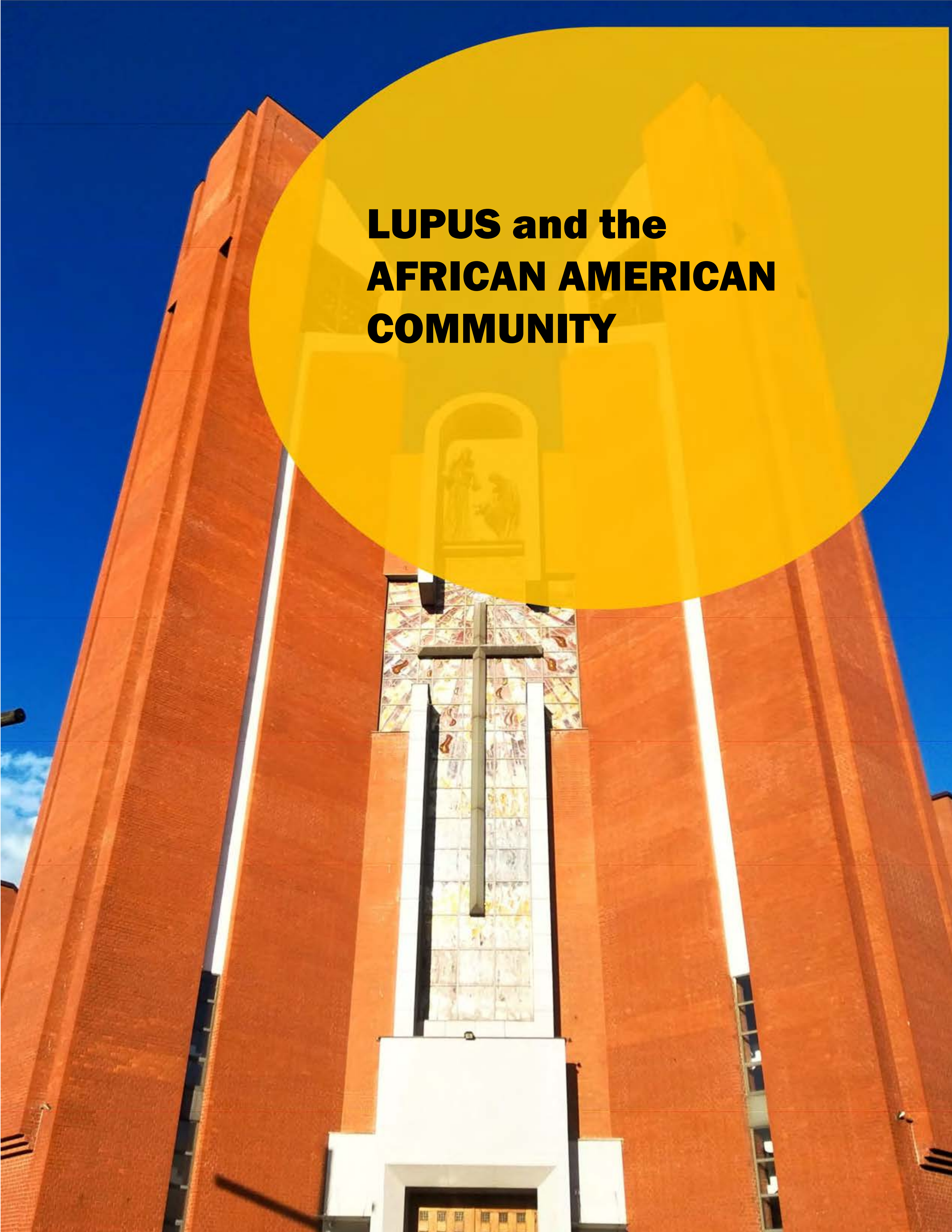
Congenital Syphilis

From 2014 to 2018, the rate of reported congenital syphilis increased 126.7% among Blacks (38.2 to 86.6 cases per 100,000 live births). In 2018, the rate of reported cases of congenital syphilis among Blacks was 6.4 times the rate among Whites (86.6 versus 13.5 per 100,000 live births, respectively).

Viral Hepatitis

In 2018, there were 1,649 death certificates among US residents that listed hepatitis B as the underlying or a contributing cause of death. Of these, 304 (18.4%) were among African Americans resulting in a hepatitis B death rate of 0.7 deaths per 100,000 population.

In 2018, there were 15,713 death certificates among US residents that listed hepatitis C as the underlying or a contributing cause of death. Of these 15,713 hepatitis C related deaths, 2,978 (18.9%) were among African Americans. Thus, the 2018 hepatitis C related death rate for African Americans was 6.31 deaths per 100,000 population.



LUPUS and the AFRICAN AMERICAN COMMUNITY

QUICK GUIDE

African Americans and Lupus

1 Facts about lupus

- People of all races and ethnic groups can develop **lupus.**
- Women develop lupus much more often than men: nine of every 10 people with lupus are women. Children can develop lupus, too.
- Lupus is three times more common in African American women than in Caucasian women.
- As many as 1 in 250 African American women will develop lupus.
- Lupus is more common, occurs at a younger age, and is more severe in African Americans.
- It is not known why lupus is more common in African Americans. Some scientists think that it is related to genes, but we know that hormones and environmental factors play a role in who develops lupus. There is a lot of research being done in this area, so contact the LFA for the most up-to-date research information, or to volunteer for some of these important research studies.

It is not known why lupus is more common in African Americans. Some scientists think that it is related to genes, but we know that hormones and environmental factors play a role in who develops lupus.

2 What is lupus?

- Lupus is a **chronic autoimmune disease** that can damage any part of the body (skin, joints and/or organs inside the body). Chronic means that the signs and symptoms tend to persist longer than six weeks and often for many years. With good medical care, most people with lupus can lead a full life.
- With lupus, something goes wrong with your **immune system,** which is the part of the body that fights off viruses, bacteria, and germs ("foreign invaders," like the flu). Autoimmune means your immune system cannot tell the difference between these foreign invaders and your body's healthy tissues and goes after healthy tissue as well. This causes **inflammation** (redness and swelling) and pain.
- People with lupus have **flares** (the disease gets worse and you feel bad) and **remissions** (the disease gets better and you feel good).
- Lupus can be mild or serious but should ***always*** be treated by a doctor.

Help Us Solve
The Cruel Mystery
LUPUS™
FOUNDATION OF AMERICA

3 There are several types of lupus

- **Cutaneous (Discoid) lupus** affects only the skin and shows up as a rash, usually on the face, neck, and scalp. **Systemic lupus (SLE)** is more serious than cutaneous lupus and affects not only the skin but other parts of the body such as the joints, heart, lungs, kidneys, liver, brain, or blood. **Drug-induced lupus** is caused by taking certain types of medicines. It is usually not as serious and should go away when the person stops taking the medicine. Although it is rare, **neonatal lupus** can occur in the fetus of a woman with lupus. Symptoms range from a rash that goes away to a permanent heart defect.
- When people just say "lupus," they generally are talking about systemic lupus.
- Lupus has also been called by other names such as "butterfly fever."

Because the disease is different for each person, not everyone will take the same medicines.

4 What are the symptoms of lupus?

- Because lupus can affect any part of the body, the disease is different for everyone and no two people feel the same way.

The most common symptoms are:

- rash or redness on the face across the nose and cheeks (known as the "butterfly" rash)
- scaly rash that scars the skin
- sores in the nose or mouth
- joint pain and swelling
- fatigue (feeling very tired)
- fever and/or feeling of having the flu
- chest pain when breathing deeply
- unusual hair loss, usually on the scalp
- pale or purple fingers or toes from cold or stress
- getting a rash or feeling sick after being in the sun
- depression
- memory problems
- kidney disease (there are no obvious symptoms when people with lupus have kidney disease; it has to be shown by certain urine and blood tests)
- problems with the blood, such as anemia or low red blood cell count, which only show up in lab tests
- certain other blood test results

5 What causes lupus?

- No one knows what causes lupus. Scientists think that people are born with the genes to get lupus and that something brings on or "triggers" the disease and symptoms.
- Some common lupus triggers are:
  ·infection ·certain medicines ·sunlight ·stress
- Lupus is not contagious. You ***cannot*** "catch" lupus, and you cannot "give" it to anyone.

6 What is the treatment for lupus?

- There is no cure for lupus, but there are medicines to help a person feel better.
- Because the disease is different for each person, not everyone will take the same medicines.
- Many people with systemic lupus are treated by a **rheumatologist.** People with cutaneous lupus are treated by a **dermatologist.**
- It is very important to keep taking all of the medicines your doctor prescribes, not to stop taking any medicines without talking with your doctor first, and to tell your doctor about any new symptoms.
- Also, tell your doctor if you are taking any herbs or supplements, or if you are planning to add them to your diet. There may be interactions with medications, and we don't yet know whether traditional therapies will be helpful or harmful for people with lupus.
- Sometimes it may seem like folk remedies, such as magnets or copper bracelets, are stopping pain or easing stiffness, but the truth is that the symptoms of lupus can come and go. So far the scientific studies of magnets and copper have not found proof that they are effective in relieving pain or any other symptoms. That doesn't mean you should stop using them if you find them helpful, but you shouldn't rely on them instead of medication your doctor prescribes.

Low-impact exercise can help keep you strong and give you energy.

7 How do you know if you have lupus?

- There is no single test to see if you have lupus. One blood test that doctors use is the ANA test, which measures activity by your immune system against certain foreign invaders. About 97 percent of people with lupus test positive for ANA. However, people with other diseases also test positive for ANA, and even people with no illness can test positive. On the other hand, it is very rare for a person who has lupus to test negative for ANA.
- Since so many other diseases can look like lupus, doctors use a list of 11 criteria (symptoms and laboratory test results) to help tell if you have lupus. You must have had at least four of the 11 to have lupus.
- Because you do not have to have all of the symptoms at the same time, it is very important to tell your doctor about any health problems you have had over the years. It is also important to let your doctor know if anyone in your family—parents, brothers, sisters, grandparents, aunts, or uncles—has lupus or another autoimmune disease.

8 Living with lupus: If you have lupus, you should…

- **Protect yourself from the sun.** People of all skin colors with lupus are often very sensitive to sunlight, and exposure to the sun may trigger a flare. So try to stay out of the sun, especially between 10:00 a.m. and 4:00 p.m. Use sunscreen and wear a hat and other sun-protective clothing when you go outdoors, even if it's cloudy.
- **Eat a well-balanced diet.** There is no special diet for lupus, but you should try to maintain a healthy diet, one that contains plenty of fruits, vegetables, and foods that are low in fat, salt, and sugar.
- **Exercise regularly and moderately.** Low-impact exercise can help keep you strong and give you energy.
- **Don't smoke.** Chemicals in cigarette smoke make symptoms of lupus worse. Avoiding areas with heavy cigarette smoke is also recommended, because of additional dangers of second-hand smoke.
- **Get plenty of rest.** Alternate rest periods with activities. Staying in bed can cause muscles to become weak, but too much activity can cause lupus to flare.
- **Talk to your doctors if you are planning to get pregnant.** Lupus pregnancies are high-risk and need to be planned and managed by you and your medical team.
- **Call your doctor if your temperature is over 99.6.** This could mean an infection or a lupus flare.
- **Understand that depression can be caused by lupus.** Feeling overwhelmed, hopeless, or helpless are all symptoms of depression. Depression is very common for people with lupus, but it can be treated and controlled.
- **Reach out to the people in your support system.** They may be family, friends, neighbors, members of a group you belong to, or co-workers. Remember that knowing others care about you can have a positive influence on your health.

There is no special diet for lupus, but you should try to maintain a healthy diet, one that contains plenty of fruits, vegetables, and foods that are low in fat, salt, and sugar.

The Lupus Foundation of America is the only national force devoted to solving the mystery of lupus, one of the world's cruelest, most unpredictable, and devastating diseases, while giving caring support to those who suffer from its brutal impact. Through a comprehensive program of research, education, and advocacy, we lead the fight to improve the quality of life for all people affected by lupus. Contact the LFA or a chapter that serves your area to find out how you can become involved in our mission and how we can help you.

Reviewed 3/13

National Black Church Initiative

Health Emergency Declaration

LUPUS EDUCATION PROGRAM

Do you have lupus? We need your help to improve lupus treatment for African Americans.

The National Black Church Initiative plan to launch a comprehensive lupus education program to address the needs of Black women in our congregations.

We need your help. Thanks!

What is Lupus?

Lupus is an autoimmune disease which means that the body begins to fight against itself and we don't know why. The immune system normally fights off invaders like viruses, bacteria, and germs. But when someone has lupus, their immune system can't tell the difference between these invaders and the body's healthy tissue, so it attacks the healthy tissue too.

Additional facts about lupus

that you should know:

16,000

Number of new cases of lupus reported each year.

- Lupus can affect any organ in the body, including the skin, heart, kidneys, and brain
- There is no cure for lupus yet
- Lupus is not contagious... you can't catch Lupus from someone else!
- Scientists don't know what causes lupus, but they think it may be caused by a combination of genetics and environmental triggers (like sunlight)
- People with lupus experience flare ups (when the disease gets temporarily worse and you have a lot of symptoms) and remissions (when the disease gets better and you feel better)
- It is believed that 5 million people throughout the world have a form of lupus.
- Lupus strikes mostly women of childbearing age. However, men, children, and teenagers develop lupus, too. Most people with lupus develop the disease between the ages of 15-44.
- Women of color are two to three times more likely to develop lupus than Caucasians.
- People of all races and ethnic groups can develop lupus.

What are the common symptoms of lupus?

It is hard to know if you might have Lupus just based on symptoms. Many of the symptoms mentioned below are common to other diseases and everyday life. *Common Symptoms*

- Rash or redness across the nose and cheeks ("butterfly rash")

- Joint pain and swelling
- Fatigue (feeling tired all the time and needing lots of rest)
- Getting a rash or feeling sick after being in the sun
- Unusual hair loss
- Fingers or toes that turn lighter or purple from being cold or feeling stressed

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Who gets lupus?

15-44

Most people who develop lupus are in this age range.

- Lupus is three times more common in Black women than in White women. The reason for this is not known
- As many as 1 in 250 African American women will develop lupus
- 9 out of 10 people with lupus are women. However, men and children can also develop lupus

How is lupus diagnosed?

- If you have any of the symptoms of lupus, you may want to talk to your doctor about lupus. It is better to be diagnosed sooner rather than later so your doctor can begin treating your symptoms. If lupus goes untreated for a long time, it can cause organ damage
- There is no single test that will show if you have lupus, but one blood test doctors often use is the ANA or anti-nucleic acid test

How is lupus treated?

- There are four different types of lupus:
    - Cutaneous (discoid)lupus affects only the skin
    - Systemic lupus erythematosus (SLE) affects internal organs such as the heart and kidneys
    - Drug-induced lupus is caused by taking certain medications and should stop when you stop taking the medication
    - Neonatal lupus is a rare type that can occur in the fetus of a woman with lupus and may cause a heart defect

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There are different types of lupus

- People with systemic lupus (lupus that affects the joints and internal organs)are treated by a rheumatologist (a doctor that focuses on joints and autoimmune disease)
- People with cutaneous lupus (lupus that appears on the skin) are treated by a dermatologist
- People with lupus may need to see other kinds of doctors, too, depending on how the disease affects them. For example, if someone's kidneys are affected by their lupus, they should also see a nephrologist or kidney doctor

Living with Lupus

- People with lupus can still work towards their goals and live a healthy, fulfilling life.

They can do this by having a healthy lifestyle in addition to working with their doctors to find the medications that work best for their disease

> *"It has given me a different outlook on life, a reminder that life is precious."*

Toni Grimes, an African American military veteran on her work to raise lupus awareness

Lifestyle Tips for People with Lupus

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- Eat a healthy diet— The challenge that many Black people have is balancing our traditional cooking with more healthy options. You can start by drinking more water and adding more fruits and vegetables

- Having brown skin doesn't keep you from being sun burned. People with Lupus, especially skin Lupus should take precautions and always use sun protection. Exercise—getting regular exercise can help you manage your joint pain and fatigue.

The level and amount of exercise you do during a workout depends on how you feel. It is important to listen to your body and make sure that you don't push yourself too hard. If you are new to exercising or are experiencing a lot of pain, you may want to try something as simple as going for a walk or doing light yoga. It may help to talk to other people with lupus about how they exercise even when they are not feeling well.

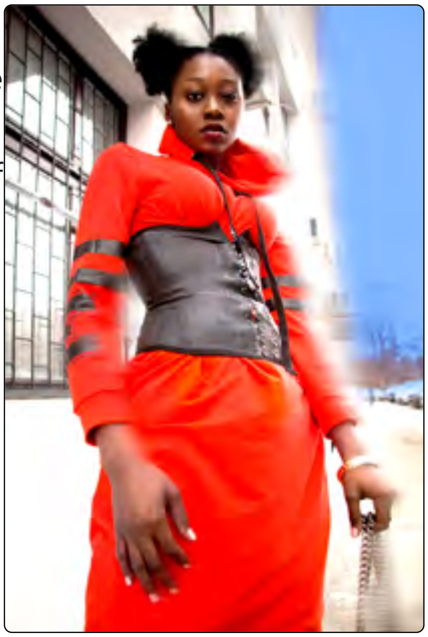
- Don't smoke—The chemicals in cigarette smoke can make lupus worse

- Get plenty of rest— with our busy lives, it is hard to get the extra rest that your body requires when you have lupus. When you don't take the time to rest consistently, your body will let you know by shutting down, usually at the worst possible time

- Talk with friends and family about your lupus— Lupus can be an invisible disease, so your friends and family may not understand that you are sick even if you look OK. Be patient with them and explain your disease and what you need to do to control your symptoms. When they understand, they will be better able to support you.

For More information

If you are a lupus patient or family member of a lupus patient and need more information please send us an email to: NBCILupus@gmail.com to the attention of Rev. Anthony Evans. Please put in the Subject Line Lupus patient and please also give us your zip code.



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Do You Want to Help NBCI?

If you are an individual, part of a faith-based community or member of a Black Women organization and want to participate and help NBCI raise funds for lupus, please send us an email to: NBCILupus@gmail.com, add your full name and address, the name of your church or organization and place in the subject line of the email "Want to Help". We will then forward you written instructions on how you and your organization can participate in this exciting movement to defeat lupus in our lifetime.

If you would like to sponsor a --Lupus High Tea Affair-- at your Church, please email NBCI for the instructions at NBCILupus@gmail.com.

We need your help. Thanks!

DONATE TO NBCI with
Square

Do You Have Lupus?

please feel free to contact NBCI: NBCILupus@gmail.com


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What the funds will be used for:

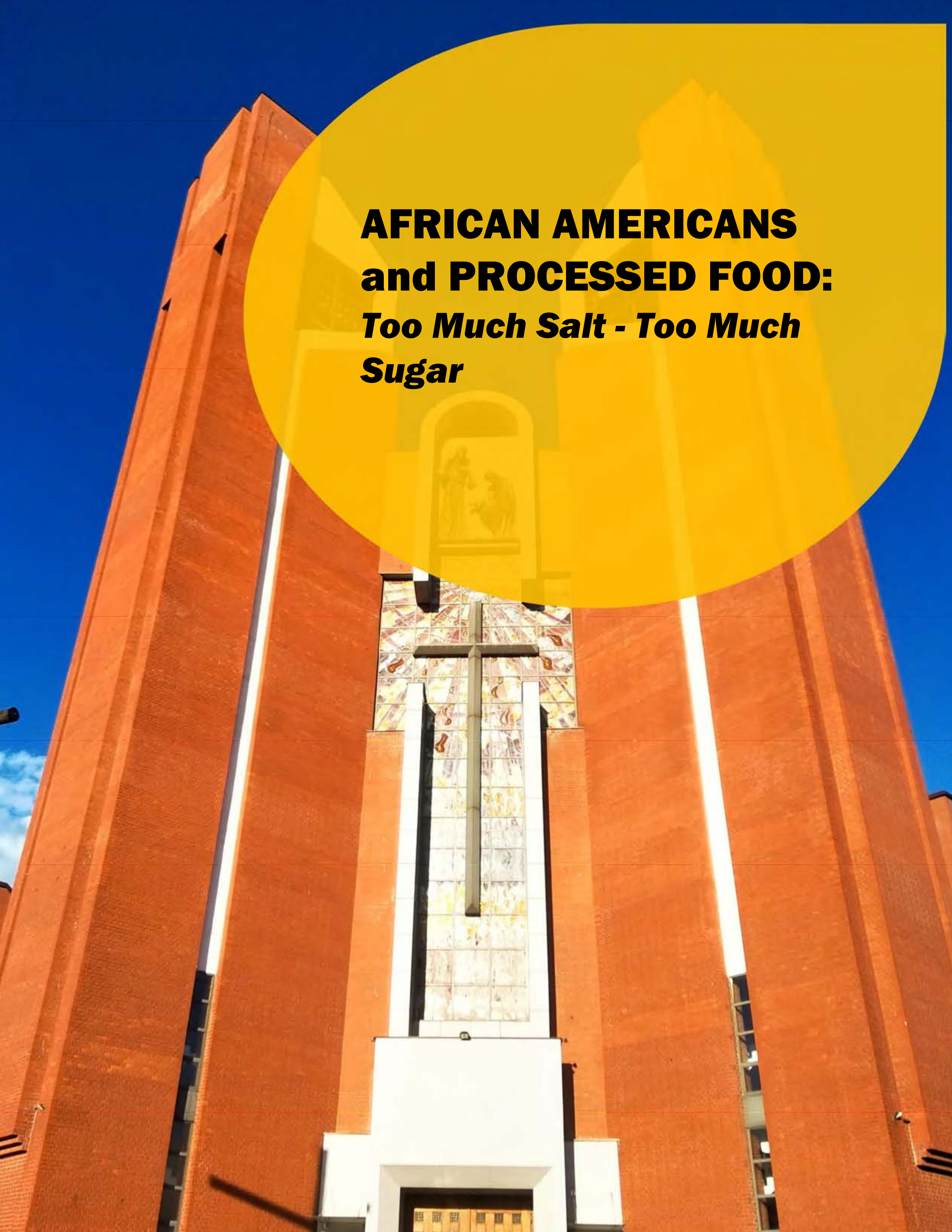
We need your help. Thanks!

DONATE TO NBCI with
Square

- To support African American Clinicians and researchers in finding effective treatment and therapies to manage and cure Lupus.
- To provide the latest scientific and comprehensive education for African American women and their support network on the different aspects and challenges of Lupus.
- To assist lupus patients in resolving the issues around transportation so that they can receive adequate treatment.
- To help conduct scientific surveys among lupus patients so that early and effective diagnosis can be made.
- To create helpful literature on the different aspects of the Lupus disease that will be helpful to lupus patients and families.
- To create a national scientific team of African American Clinicians and researchers who will provide the lupus patients with a clearinghouse of information where they can get their questions answered.
- To hold seminars and workshops in NBCI faith-based communities across the country in every region.
- To create black women of faith healing circles as a nationwide means of support network.

AFRICAN AMERICANS and PROCESSED FOOD:

Too Much Salt - Too Much Sugar



African Americans And Processed Food Too Much Salt - Too Much Sugar

Black adults in U.S. who consume ultra-processed foods at greater risk for hypertension

Research Highlights:

- A study of almost 6,000 adults ages 45 and older found that Black adults who ranked within the top 25% of all participants for consumption of ultra-processed food were 55% more likely to have high blood pressure compared to white adults who consumed a similar amount of ultra-processed foods.
- Men and adults who had less education, lower household income and lower levels of physical activity were the most likely to consume ultra-processed foods.

Embargoed until 10 a.m. CT/ 11 a.m. ET, Thursday, May 20, 2021

DALLAS, May 20, 2021 — Black adults in the U.S. who consumed significant amounts of ultra-processed foods were at 55% increased risk for high blood pressure compared to white adults who ate a similar amount of ultra-processed foods, according to according to preliminary research to be presented at the American Heart Association's Epidemiology, Prevention, Lifestyle & Cardiometabolic Health Conference 2021. The meeting is virtual, May 20-21 and offers the latest science on population-based health and wellness and implications for lifestyle.

Ultra-processed foods (UPF) are ready-to-eat formulations of industrially formulated products, typically containing added flavors, colors, and other cosmetic additives, that have been extracted or refined from whole foods, and are typically high in salt, added sugar, and fat. These food products are inexpensive, heavily marketed, and are readily available with a long shelf life.

People experiencing food insecurity, the state of not having reliable access to enough affordable, nutritious food, are more likely to eat UPF. While there is growing evidence that UPF have little nutrients and contribute to energy imbalance, few studies have examined the impact of UPF on high blood pressure, a condition that can be affected by high salt intake and disproportionately affects people from diverse racial and ethnic groups.

"The increase in food insecurity over the past year as a result of the COVID-19 pandemic makes this research especially timely," says the study's lead author Carol R. Oladele, Ph.D., M.P.H., assistant professor at the Equity Research and Innovation Center of the Yale University School of Medicine in New Haven, Connecticut. Oladele explains that "people experiencing food insecurity are more likely to purchase and eat UPF because they cost less and have a longer shelf life. These foods may have become more central in the diet of population groups that were disproportionately affected by the pandemic."

For this analysis, researchers extracted data from the ongoing Reasons for Geographic and Racial Disparities in Stroke (REGARDS) study to examine the differences in UPF consumption among Black and white adults and its association with high blood pressure rates. REGARDS is a National Institutes of Health-sponsored study that enrolled more than 30,000 Black and white adults across the United States between 2003-2007.

The NOVA system, the international criteria developed by the Center for Epidemiological Studies in Health and Nutrition at the University of Sao Paulo in Brazil, defines the level of processing in foods from 1 (minimal processing) to 4 (ultra-processed). The United Nations-recognized system was used in this analysis to categorize the level of processing for foods consumed.

A total of nearly 6,000 participants (23% Black and 77% white, ages 45 and older) were included in the analysis, and researchers defined "incident hypertension" as a blood pressure reading higher than 140/90 mm Hg. (Note: the American Heart Association's 2017 hypertension guidelines define high blood pressure as ≥130/80 mm Hg).

Researchers used food consumption data from study participants to calculate total ultra-processed calories consumed and analyzed participants in quartiles of the least to the most ultra-processed foods consumed. The analysis found:

- Black adults who were in the top 25% of all participants for total ultra-processed food consumption were 55% more likely than white adults to have incident hypertension.
- More Black adults (27%) compared to white adults (24%) fell within the top 25% of all participants who consumed the most ultra-processed foods.
- Men and adults who had less education, lower levels of physical activity and household income below $35,000 annually were more likely to regularly consume ultra-processed foods.

"We believe that these results indicate the need for lifestyle interventions to address the inequities in access to affordable, healthy food," noted Oladele "Additionally, we suggest a reexamination of food policies to advance food justice in the U.S."

Co-authors are Neha Khandpur, Sc.D.; Timothy B. Plante, M.D.; Ya Yuan, M.S.; Gina S. Lovasi, Ph.D.; and Suzanne E. Judd, Ph.D. Author disclosures are listed in the abstract. The study authors reported no funding resources for this study.

Additional Resources:

- Multimedia is available on the right column of release link https://newsroom.heart.org/news/black-adults-in-u-s-who-consume-ultra-processed-foods-at-greater-risk-for-hypertension?preview=9c2d04bb357b7a9a7e1165cf8dd926cf
- Processed vs. ultra-processed food, and why it matters to your health
- Too much ultra-processed food linked to lower heart health
- Food insecurity linked to higher risk of cardiovascular death

- Fighting Food Insecurity
- Food insecurity rates high among people with heart disease
- Managing blood pressure with a heart-healthy diet
- Can processed foods be part of a healthy diet
- For more news from AHA EPI Lifestyle Conference 2021, follow us on @HeartNewsTwitter #EPILifestyle21.

Statements and conclusions of studies that are presented at the American Heart Association's scientific meetings are solely those of the study authors and do not necessarily reflect the Association's policy or position. The Association makes no representation or guarantee as to their accuracy or reliability. The Association receives funding primarily from individuals; foundations and corporations (including pharmaceutical, device manufacturers and other companies) also make donations and fund specific Association programs and events. The Association has strict policies to prevent these relationships from influencing the science content. Revenues from pharmaceutical and biotech companies, device manufacturers and health insurance providers are available here, and the Association's overall financial information is available here.

The American Heart Association's EPI | LIFESTYLE 2021 Scientific Sessions is the world's premier meeting dedicated to the latest advances in population-based science. The virtual meeting will be held **Thursday and Friday, May 20–21, 2021**. The primary goal of the meeting is to promote the development and application of translational and population science to prevent heart disease and stroke and foster cardiovascular health. The sessions focus on risk factors, obesity, nutrition, physical activity, genetics, metabolism, biomarkers, subclinical disease, clinical disease, healthy populations, global health, and prevention-oriented clinical trials. The Councils on Epidemiology and Prevention and Lifestyle and Cardiometabolic Health (Lifestyle) jointly planned the EPI/Lifestyle 2021 Scientific Sessions. Follow the conference on Twitter at **#EPILifestyle21**.

About the American Heart Association

The American Heart Association is a relentless force for a world of longer, healthier lives. We are dedicated to ensuring equitable health in all communities. Through collaboration with numerous organizations, and powered by millions of volunteers, we fund innovative research, advocate for the public's health and share lifesaving resources. The Dallas-based organization has been a leading source of health information for nearly a century. Connect with us on heart.org, Facebook, Twitter or by calling 1-800-AHA-USA1.

Too much salt
Sodium intake in US ethnic subgroups and potential impact of a new sodium reduction technology: NHANES Dietary Modeling - PMC (nih.gov)

Because excessive dietary sodium intake is a major contributor to hypertension, a reduction in dietary sodium has been recommended for the US population. Using the National Health and Nutrition Examination Survey (NHANES) 2007–2010 data, we estimated current sodium intake

in US population ethnic subgroups and modeled the potential impact of a new sodium reduction technology on sodium intake.

Methods

NHANES 2007–2010 data were analyzed using The National Cancer Institute method to estimate usual intake in population subgroups. Potential impact of SODA-LO® Salt Microspheres sodium reduction technology on sodium intake was modeled using suggested sodium reductions of 20-30% in 953 foods and assuming various market penetrations. SAS 9.2, SUDAAN 11, and NHANES survey weights were used in all calculations with assessment across age, gender and ethnic groups.

Results

Current sodium intake across all population subgroups exceeds the Dietary Guidelines 2010 recommendations and has not changed during the last decade. However, sodium intake measured as a function of food intake has decreased significantly during the last decade for all ethnicities. “Grain Products” and “Meat, Poultry, Fish, & Mixtures” contribute about 2/3rd of total sodium intake. Sodium reduction, using SODA-LO® Salt Microspheres sodium reduction technology (with 100% market penetration) was estimated to be 185–323 mg/day or 6.3-8.4% of intake depending upon age, gender and ethnic group.

Conclusions

Current sodium intake in US ethnic subgroups exceeds the recommendations and sodium reduction technologies could potentially help reduce dietary sodium intake among those groups.

Keywords: Sodium intake, Ethnic subgroups, Sodium reduction modeling, NHANES, Sodium reduction technology

Background

The prevalence of hypertension in America has increased over the past 20 years in men, women, Blacks, and Whites [1]. Based on 2007 to 2010 data, 33% (about 78 million) of US adults have hypertension and African American adults have among the highest prevalence of hypertension (44%) in the world [2]. In 2010, high blood pressure was estimated to be responsible for $156 billion in direct and indirect health care cost [3]. Because excessive dietary sodium intake is a significant contributor to hypertension [3–9], limiting sodium intake has been recommended for the US population by US public health agencies and other expert scientific organizations, such as the American Heart Association [5, 7, 10, 11]. The Dietary Guidelines for Americans 2010 [11] recommend a maximum dietary sodium intake of 2,300 mg/day for the general population and 1500 mg/day for at-risk groups, including African Americans, older adults (age 51 years and above), and persons of any age with hypertension, diabetes, or chronic kidney disease (about half of the US population). The World Health Organization (WHO) [12] recommends adults consume less than 2,000 mg of sodium, or 5 grams of salt. Regardless of these recommendations, dietary sodium intake in the US is well above that needed for physiological function and is greater than recommended.

Sodium is primarily consumed as sodium chloride and the majority of sodium in the diet comes from sodium added during food processing as an ingredient for flavor, processing aid, and for food safety purposes [11, 13]. Processed foods contribute more than 75% of dietary sodium intake in the US diet; about 10% of dietary sodium occurs naturally in foods and another 5-10% is discretionary salt [4].

In this study, we used the most recent (2007–2010) data from the National Health and Nutrition Examination Survey (NHANES) to estimate the current sodium intake in population subgroups and modeled the potential impact of SODA-LO® Salt Microspheres sodium reduction technology on sodium intake. SODA-LO® is a sodium-reduction ingredient that can reduce sodium in certain applications through its technology that turns standard salt crystals into free-flowing, hollow salt microspheres, which efficiently delivers salt taste and functionality by maximizing surface area.

Methods

Study population

NHANES, a large dietary survey of a nationally representative sample of the non-institutionalized US population, was used to assess sodium intake and its sources in the diet of ethnic subgroups in the US population [14]. The NHANES data are collected and released by the National Center for Health Statistics (NCHS) of the Center for Disease Control and Prevention (CDC), every two years. All participants or proxies provided written informed consent and the Research Ethics Review Board at the NCHS approved the survey protocol. Dietary intake data with reliable 24-hour recall dietary interviews (day one via in-person interview at the Mobile Examination Center and day two via telephone interview) using USDA's automated multiple-pass method (AMPM) were used. The data from NHANES 2007–2008 and 2009–2010 were combined for the analyses [15]. The combined sample included 3,626 Mexican American; 5,559 other Hispanic; 7,369 non-Hispanic White and 3,568 non-Hispanic Black participants ages 2 years and older. Children under age 2 years and pregnant and/or lactating females were excluded from the analyses.

Estimation of sodium intake

The USDA Nutrient Database for Standard Reference (SR) Releases 22 & 24 were used in conjunction with the Food & Nutrient Database for Dietary Studies (FNDDS) versions 4.1 & 5.0, to determine the sodium derived from foods consumed by NHANES 2007–2008 and NHANES

2009–2010 participants respectively [16–19]. Unadjusted sodium values were used in all analyses. The mean usual intakes (long-run average daily intakes) of sodium from all foods were determined using the National Cancer Institute (NCI) method [20] for a single dietary component, because sodium is consumed at some level on most days. All analyses were adjusted for the complex survey design of NHANES using the appropriate sample weight. Covariates in the usual intake models included age and gender groups, day of the week of dietary recall (weekend/weekday), and interview sequence of the dietary recall (in person versus via telephone).

Estimation of food sources of sodium

Food groups for NHANES 2007–2008 and NHANES 2009–2010 dietary intake data were defined using the USDA FNDDS 4.1 & FNDDS 5.0 databases, respectively [16, 18]. Data for over 7000 foods were collapsed into 9 broad categories of FNDDS food groups. Sodium consumption (mg/day) and amount of sodium as percent of total dietary intake (mg/kcal and mg/g food) were computed for all FNDDS food groups.

Sodium intake modeling analysis

SODA-LO® Salt Microspheres is a sodium-reduction ingredient which can reduce sodium in certain applications through its technology that turns standard salt crystals into free-flowing, hollow salt microspheres which efficiently delivers salt taste and functionality by maximizing surface area. A 20% to 30% reduction in sodium content in 953 foods (17 foods in “Milk & Milk Products” for 20% reduction, 304 foods in “Meat, Poultry, Fish & Mixtures” for 20 to 25% reduction, 20 foods in “Egg” for 25% reduction, 30 foods in “Dry Beans, Peas, Other Legumes, Nuts & Seeds” for 25% reduction, 511 foods in “Grain Products” for 25% reduction, 35 foods in “Vegetable” for 20 to 30% reduction, and 36 foods in “Fats, Oils & Salad Dressings” for 25% reduction) was modeled. Various scenarios for potential reduction in usual intake of sodium were then computed by using a 0-100% reduction factor and 10-100% market penetration. The individual reductions were computed for foods using the reduction factor and market penetration factor, and were used to model usual intake after sodium reduction.

Statistical methods

SAS 9.2 (SASs Institute, Inc.; Cary, NC) and SUDAAN 11 (Research Triangle Institute, Research Triangle Park, NC, USA,) were used for all calculations. NHANES survey weights, strata and primary sampling units were used in all calculations to adjust for oversampling of certain groups, non-response by some selected sample persons, and to adjust for the complex sample design of NHANES to ensure nationally representative results. Data are presented as means ± standard errors (SE). $P < 0.01$ was considered statistically significant.

Results

Usual intakes of sodium across age, gender and ethnic groups are shown in Figure 1. Intake of sodium was dependent on age, gender and ethnicity. The usual intake of adults (age 19–50 years) of any gender and ethnicity was higher compared to children (age 2–18 years) and older adults (age 51 years and above) of the same gender and ethnicity. The age related differences in usual intakes were much more pronounced in males than in females of any ethnicity. Males of any age and ethnic group consumed more sodium than females of the corresponding age and ethnic group. Non-Hispanic White (especially males) consumed more sodium than other ethnic groups (Figure 1). Usual intakes of all age, gender and ethnic groups were higher than 2300 mg/day. Intakes of sodium were below 1500 mg/day for less than 5% population of any age, gender and ethnicity (except for older adult Other Hispanic females).

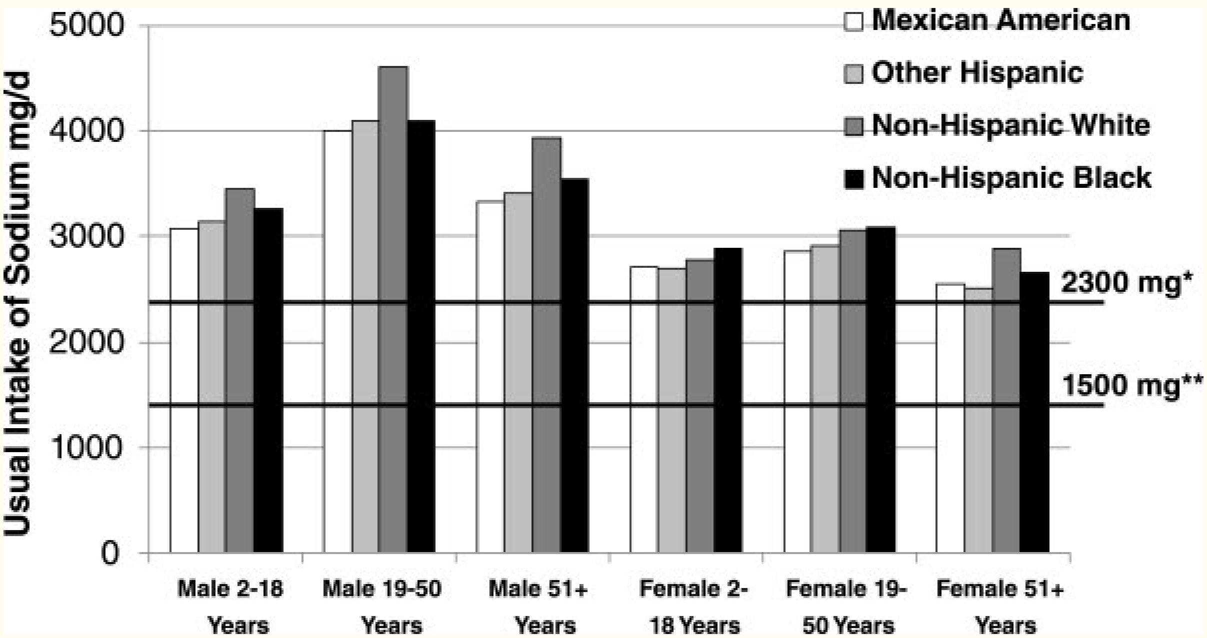


Figure 1

Usual intake of sodium by age and gender groups in population subgroups. Data from NHANES 2007–2010. Usual intakes from foods were estimated by using the National Cancer Institute method. *Dietary Guidelines for Americans 2010 recommended level for general population; **Dietary Guidelines for Americans 2010 recommended level for at risk group.

Trends in sodium intake over the last 10 years (5 NHANES cycles) among adults (ages 19–50 years) and older adults (age 51 years and above) of different ethnicity are shown in Figure 2. Average sodium intake in each NHANES cycle was higher than 1500 mg/day as well as 2300 mg/day for all adults and older adults irrespective of gender and ethnicity. Moreover, in each NHANES cycle, male adults (ages 19–50 years) and male older adults (age 51 years and above) consistently consumed more sodium than female adults and female older adults respectively in all ethnic groups. Average intake of sodium (mg/day) during the past 5 NHANES cycles did not change significantly ($P > 0.01$) for adults and older adults for any gender or ethnic group (Figure 2). Similarly, the average intake of sodium among children (ages 2–18 years) over the past 5 NHANES cycles was always higher than 2300 mg/day and did not change significantly (P > 0.01) for any gender and ethnic group (data not presented).

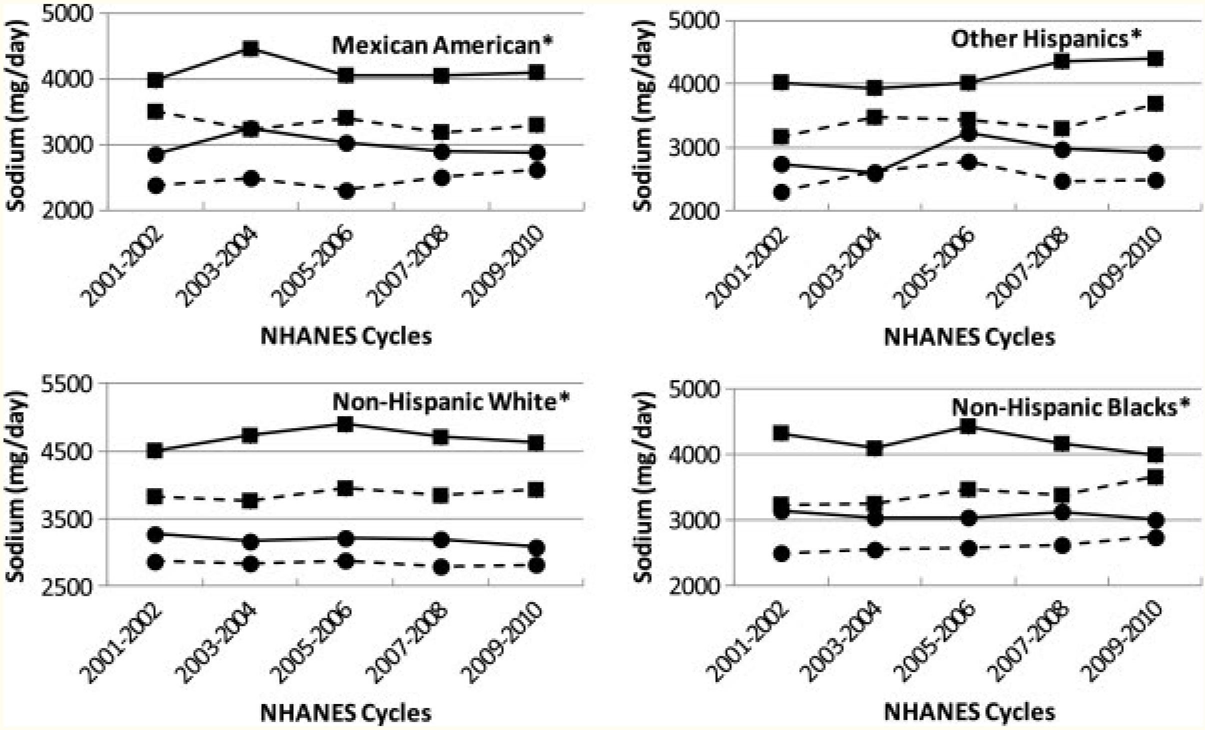


Figure 2

Sodium intake trends by age and gender groups over 5 NHANES cycles in population subgroups. Data from NHANES 2001–2010. Square: male, Circles: females, solid line: 19–50 years, dotted line: 51 + years. Usual intakes from foods were estimated by using the National Cancer Institute method. *No change over 5 NHANES cycles, P > 0.01.

Sodium intake was also measured as a function of energy intake (mg/kcal) and as a function of total food intake (mg/g food) in addition to absolute intake (mg/day) for all NHANES cycles in males and females of all ethnicities. Table 1 shows trends in sodium intake by different measures over the last 10 years (5 NHANES cycles). While there was no change in sodium intake measured as mg/day (absolute amount) and as mg/kcal (function of energy intake) for male or female adults or older adults of any ethnic subgroup, sodium intake measured as a function of food intake (mg/g food) decreased significantly (P < 0.01) among all adult and older adult males and females of all ethnicity (except for older adult male other Hispanic). The sodium intake values in adults (age 19 years and older) of all ethnicity were 3586 mg or 1.68 mg/kcal or 1.56 mg/g food in 2001–2002 and 3607 mg or 1.72 mg/kcal or 1.12 mg/g food in 2009–2010.

Table 1

Sodium intake trends by age and gender groups in population subgroups over 5 NHANES cycles

Ethnicity	Age (Years)	Gender	Sodium intake trend					
			mg/day		mg/g food		mg/kcal	
			beta*	P**	beta*	P**	beta*	P**
Mexican American	19-50	Male	−19.33	0.7652	−0.10	<0.0001	0.03	0.0342
		Female	−34.38	0.2673	−0.14	<0.0001	0.02	0.0544
	51+	Male	−39.13	0.4792	−0.09	<0.0001	−0.01	0.5585
		Female	53.75	0.1116	−0.13	<0.0001	0.02	0.1729
Other Hispanic	19-50	Male	110.83	0.0913	−0.10	<0.0001	0.04	0.0327
		Female	63.23	0.1697	−0.12	0.0004	0.04	0.0635
	51+	Male	91.07	0.4067	−0.11	0.0508	0.03	0.4286
		Female	26.09	0.6285	−0.14	<0.0001	0.03	0.1452
Non-Hispanic White	19-50	Male	23.42	0.5281	−0.12	<0.0001	0.03	0.0012
		Female	−34.81	0.1798	−0.15	<0.0001	0.01	0.2341
	51+	Male	29.05	0.3438	−0.11	<0.0001	0.00	0.6550
		Female	−13.25	0.4582	−0.13	<0.0001	−0.01	0.1134
Non-Hispanic Black	19-50	Male	−59.10	0.2367	−0.14	<0.0001	0.02	0.1816
		Female	−18.59	0.6458	−0.19	<0.0001	0.02	0.0936
	51+	Male	100.06	0.0619	−0.12	<0.0001	−0.02	0.3977
		Female	56.50	0.1167	−0.14	<0.0001	0.03	0.0242

Data from NHANES 2001–2010. Sodium intake was measured as absolute intake (mg/day) as a function of energy intake (mg/kcal) and as a function of food intake (mg/g food).

*beta – regression coefficient; **$P < 0.01$ significant.

The contribution of various food groups (FNDDS defined 9 food groups) to the sodium in the diets of US adults and older adults by population subgroups is shown in Figure 3. No major overall age, gender or ethnicity related differences were noted. “Grain Products” were the topmost contributors of dietary sodium, followed by “Meat, Poultry, Fish & Mixtures”. These two food groups contributed 60-70% of total sodium intake in adults and older adults. “Milk & Milk Products”, and “Vegetables”, were the next two major sodium contributors, providing more than 15% of total sodium. These four food groups (“Grain Products”, “Meat, Poultry, Fish & Mixtures”, “Milk & Milk Products”, and “Vegetables”) combined were responsible for more than 85% of total dietary sodium for all ethnic subgroups. The remaining five food groups

("Eggs", "Dry Beans, Peas, Other Legumes, Nuts & Seeds", "Fruits", "Fats, Oils & Salad Dressings", and "Sugars, Sweets & Beverages") contributed less than 15% of the sodium in the diet (Figure 3).

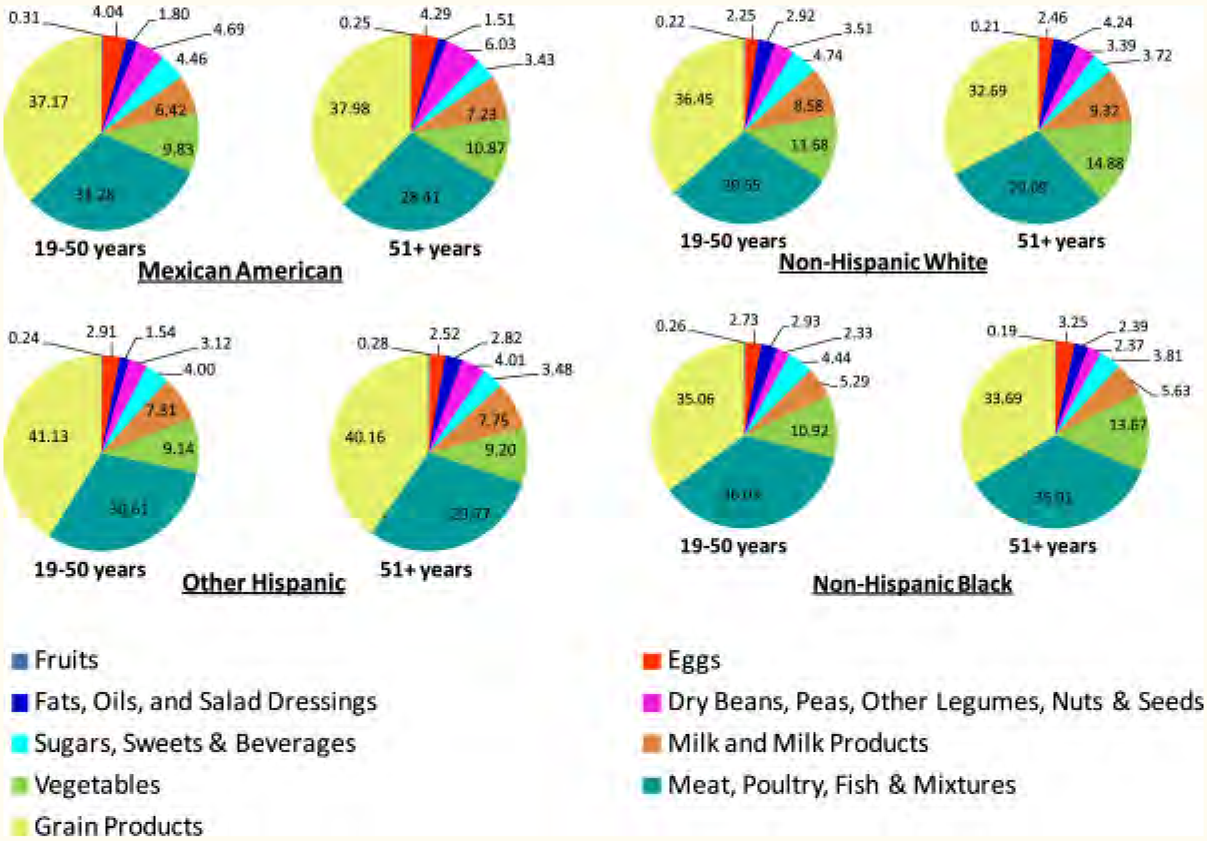


Figure 3

Dietary sodium contribution from nine FNDDS food groups by age groups in population subgroups. Data from NHANES 2007–2010. Data is presented as % of total dietary sodium.

Table 2 shows the maximum achievable reduction (using the maximum reduction factor and 100% market penetration) in sodium intake across all food categories to be 185–323 mg (6.3-8.4%). A lower reduction factor and/or lower market penetration would provide lower reductions. A somewhat higher reduction is expected for non-Hispanic Whites and non-Hispanic Blacks compared to Mexican Americans and Other Hispanics (Table 2). "Grain Products" and "Meat, Poultry, Fish & Mixtures" were the main contributors of sodium reduction, contributing to more than 80% of total sodium reduction. Sodium reduction in "Grain Products" contributed to 60-70% of total sodium reduction for Mexican Americans, other Hispanics and non-Hispanic Whites, and 50-60% of total sodium reduction for non-Hispanic Black adults and older adults. Sodium reduction in "Meat, Poultry, Fish & Mixtures" contributed about 16-24% of total sodium reduction for Mexican Americans, other Hispanics and non-Hispanic Whites, and about 25-30% of total sodium reduction for non-Hispanic Blacks adults and older adults (Table 3).

Table 2

Potential sodium intake reduction with SODA-LO® Salt Microspheres (Sodium Replacement Technology) in population subgroups

Ethnicity	Age	Potential reduction* (mg)	Current intake (mg)	Potential intake after reduction (mg)	% Reduction*
Mexican American	19-50 years	250 ± 14	3558 ± 68	3309 ± 59	6.8 ± 0.3
	51+ years	196 ± 12	2898 ± 86	2702 ± 78	6.8 ± 0.4
Other Hispanic	19-50 years	252 ± 11	3599 ± 45	3347 ± 39	6.9 ± 0.3
	51+ years	185 ± 11	2916 ± 68	2731 ± 63	6.3 ± 0.3
Non-Hispanic White	19-50 years	323 ± 8	3903 ± 55	3581 ± 53	8.3 ± 0.2
	51+ years	242 ± 5	3320 ± 49	3078 ± 47	7.3 ± 0.2
Non-Hispanic Black	19-50 years	296 ± 10	3544 ± 66	3248 ± 60	8.4 ± 0.2
	51+ years	222 ± 9	3046 ± 74	2824 ± 67	7.2 ± 0.2

Open in a separate window

Data from NHANES 2007–2010. Potential reduction was modeled using 20% to 30% targeted maximum reduction in sodium content in 953 foods with 100% market penetration.

*Average of reductions in individuals.

Table 3

Potential sodium intake reduction with SODA-LO® salt microspheres in population subgroups by FNDDS food groups

Potential sodium intake reduction, mg & (%) Mean ± SE				
	Mexican American	**Other Hispanic**	**Non-Hispanic white**	**Non-Hispanic black**
All foods (953 foods; 20-30% targeted reduction in sodium content)				
Male, 19–50 Years	294 ± 20 (6.9 ± 0.4)	297 ± 15 (7.0 ± 0.3)	398 ± 13 (8.7 ± 0.2)	338 ± 13 (8.3 ± 0.3)

Issues around disability

Cancer - Breast, colon, prostate, lung..etc/How Does Cancer Affect African American Populations?

Black/African Americans have the highest mortality rate of any racial and ethnic group for all cancers combined and for most major cancers.

NBCI support the President Biden Cancer Moonshot Program
New Goals Announced for Cancer Moonshot Program - NFCR

Cancer and African Americans - The Office of Minority Health (hhs.gov)

AACR Cancer Disparities Progress Report 2022 | Cancer Progress Report

Alcohol abuse- There are too many liquor stores and no Education on drinking Responsibly.

African-Americans And Alcohol - Alcohol Rehab Guide

African Americans and Alcohol-Related Health Problems

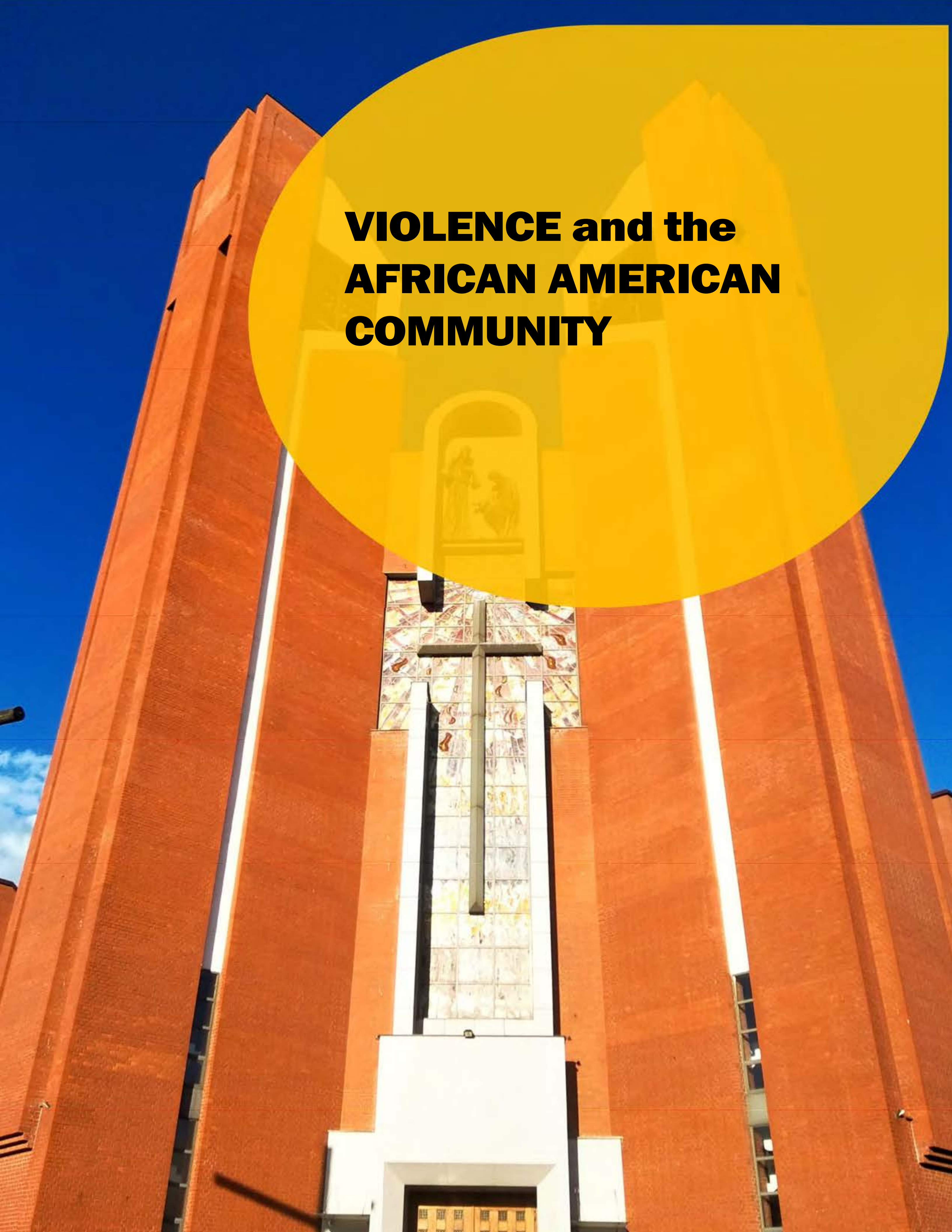
Death from conditions such as cirrhosis is "1.27 times" more common in African-American drinkers compared to
Caucasians. Additionally, there is a "10% higher" rate of death from alcohol-abuse in African-Americans despite overall lower alcohol rates.

Latinos

Latino Americans and Alcohol Addiction Treatment

Approximately 9.9% of Latino Americans qualified as having an Alcohol Use Disorder (AUD) in the past year that required treatment. Of that number, less than 10% received any addiction treatment from a facility designed to provide it. Oct 26, 2022

VIOLENCE and the AFRICAN AMERICAN COMMUNITY



The Violence Epidemic in the African American Community: A Call by the National Medical Association for Comprehensive Reform

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Conflict of interest: All Authors have no disclosures and there are no conflict of interests.

Abstract: While much progress has occurred since the civil rights act of 1964, minorities have continued to suffer disparate and discriminatory access to economic opportunities, education, housing, health care and criminal justice. The latest challenge faced by the physicians and public health providers who serve the African American community is the detrimental, and seemingly insurmountable, causes and effects of violence in impoverished communities of color. According to statistics from the Centers for Disease Control (CDC), the number one killer of black males ages 10–35 is homicide, indicating a higher rate of violence than any other group. Black females are four times more likely to be murdered by a boyfriend or girlfriend than their white counterparts, and although intimate partner violence has declined for both black and white females, black women are still disproportionately killed. In addition, anxiety and depression that can lead to suicide is on the rise among African American adolescents and adults. Through an examination of the role of racism in the perpetuation of the violent environment and an exploration of the effects of gang violence, intimate partner violence/child maltreatment and police use of excessive force, this work attempts to highlight the repercussions of violence in the African American community. The members of the National Medical Association have served the African American community since 1895 and have been advocates for the patients they serve for more than a century. This paper, while not intended to be a comprehensive literature review, has been written to reinforce the need to treat violence as a public health issue, to emphasize the effect of particular forms of violence in the African American community and to advocate for comprehensive policy reforms that can lead to the eradication of this epidemic. The community of African American physicians must play a vital role in the treatment and prevention of violence as well as advocating for our patients, family members and neighbors who suffer from the preventable effects of violence.

Keywords: Violence■Police use of force■Public health■Racism■Social determinants

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INTRODUCTION

Over the last 122 years, the NMA has advocated for health equity across all disciplines by promoting health policy positions on issues such as Women and Minorities in Clinical Trials, the Paris Climate Agreement and equity in the Affordable Health Care Act. Most recently, the NMA has taken a position against Police Use of Excessive and Unnecessary Force.[1] At the NMA 2015 Annual Convention & Scientific Assembly, in response to the killings of unarmed African American men, in particular, Eric Garner, Michael Brown and Freddie Gray, a resolution was passed by the House of Delegates regarding lethal and sub-lethal injury resulting from law enforcement altercations. This resolution called for law enforcement agents to end the police practice of subjecting unarmed suspects to physical force that includes a ‘chokehold’ or placing the knees or body weight on a person’s chest, neck or head, which can result in debilitating or deadly injury. In July 2016, the NMA Statement on Police Use of Force[2] was released in recognition of the continuing and growing number of killings of unarmed African Americans by police officers. The NMA further established the Working Group on Gun Violence and Police Use of Force, which was charged with advocating for a public health approach in addressing the broad topic of gun violence as well as confronting the ongoing problem of excessive and unnecessary use of force by police officers within communities of color. To facilitate these efforts, the NMA joined the Movement towards Violence as a Health Issue and endorses their recently released Framework for Action.[3]

Of equal importance is the continuing work to eradicate policies and social norms that create barriers for African Americans to achieve health equity in the United States. The paradigm, defined as the ‘Social Determinants of Health’, makes clear that understanding where one lives, works, plays and builds relationships will affect an individual's ability to achieve healthy outcomes. This paradigm has enormous consequences for the health and well-being of our patients.

It is impossible for medical and public health communities to have a conversation about health equity without speaking about violence. Overall rates of homicide have decreased in the United States since 1999. Despite this decline, a significant increase in the homicide rate continues to be observed in the African American community and is a major concern for the NMA.[4] The July 2016 U.S. Census data reports that white Americans are 61.3% of the population while African Americans represent 13.3% of the U.S. population.[5] In 2016, 15,070 homicides were recorded in the United States of which 7881 were African American victims and 6576 were white victims.[6] In many communities of color, homicidal violence is one of the leading manners of death. This type of violence has a 'ripple effect', adversely affecting a community's ability to gain equitable access to education, economics, housing and health care. Whether it takes the form of youth/gang, intimate partner/domestic, child abuse/maltreatment or police use of excessive force/legal intervention, violence can cause deadly and debilitating injuries for the individual as well as long lasting adverse effects on the community.

The purpose of this paper is to reinforce the need to treat violence as a public health issue, to highlight the effect of particular forms of violence in the African American Community and to advocate for comprehensive policy reforms that can lead to the eradication of this epidemic.

HISTORY OF THE NATIONAL MEDICAL ASSOCIATION

> *"The National Medical Association (NMA) is the nation's oldest and largest organization representing African American physicians and health professionals in the United States. Established in 1895, the NMA is the collective voice of more than 30,000 African American physicians and the patients they serve.*
>
> *The NMA was founded in 1895, during an era in US history when the majority of African Americans were disenfranchised. The segregated policy of "separate but equal" dictated virtually every aspect of society. Racially exclusive "Jim Crow" laws dominated employment, housing, transportation, recreation, education, and medicine. Black Americans were subjected to all of the injustices inherent in a dual medical care system. Under the backdrop of racial exclusivity, membership in America's professional organizations, including the American Medical Association (AMA), was restricted to whites only. The AMA determined medical policy for the country and played an influential role in broadening the expertise of physicians. When a group of black doctors sought membership into the AMA, they were repeatedly denied admission. Subsequently, the NMA was created for black doctors and health professionals who found it necessary to establish their own medical societies and hospitals.*
>
> *"Conceived in no spirit of racial exclusiveness, fostering no ethnic antagonisms, but born out of the exigency of the American environment ..." the NMA extended equal rights and privileges to all physicians. Although the NMA has led the fight for better medical care and opportunities for all Americans, its primary focus targets health issues related to minority populations and the medically underserved. The NMA remains committed to improving the health status and outcomes of African Americans and the disadvantaged."*[53]

VIOLENCE AS A PUBLIC HEALTH ISSUE

The World Health Organization (WHO) defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.[7] In 1986, US Surgeon General C. Everett Koop presented findings from the *Workshop on Violence and Public Health* which highlighted the need for cooperative and collaborative efforts among health and health-related professions and institutions to address violence.[8] This mandate was further developed by US Surgeon General David Satcher in the article, "Violence as a Public Health Issue" presented during the Annual Meeting of the Institute of Medicine in October 1994. Dr. Satcher, in his 1994 report, stated "we have identified violence as an important threat to the public's health and we have developed a program in violence prevention that applies a problem-solving approach to the issue."[9]

According to the Centers for Disease Control (CDC), homicide is the leading manner of death for African American males ages 10–35 and the second leading manner of death for Hispanic males of this same age group. A review of data from 2012 to 2014, regarding fatal gun deaths, reports that guns are the third leading cause of deaths for children under the age of 17.[10] Nearly 80% of all homicides are due to firearm related injury. There are approximately 30,000 hospitalizations for gunshot wounds (GSW) each year in the United States. Nearly 6000 African American men die due to gun violence each year.[7] Men are nine times more likely to be hospitalized for GSW when compared to women; and African American men are twice as likely as whites to require life-saving measures. Moreover, African American men make up only six percent of the population but make up greater than 50% of firearm related deaths.[11] Cook et al. reviewed epidemiological data from the National Inpatient Sample (NIS) 2004−2013 and found that the majority of GSW hospitalizations resulted from assaults on young African American males and suicides among older white males. They also identified that these injuries were associated with elevating health care costs. It was determined that the costs of hospital treatment and admissions for GSW from 2006 to 2010 were approximately $88.6 billion and that single year productivity losses due to GSW approaches $35 billion dollars.[12] The annual cost of gun violence is projected to be $229 billion dollars or $700 per American citizen.

The costs of violence in our communities and its effect on our patients exceed what can be measured in dollars and cents. The epidemic of violence affects not only the individual victim of violence or perpetrator of violence but impacts the entire community. Psychological trauma from exposure to violence, defined as post-traumatic stress disorder (PTSD), increases a person's risk of adopting violent behavior. This informs our understanding of the disease quality of violence. Violent behavior has the ability to transmit, spread and cluster based on exposure − consistent with an epidemic disease.[3] Thus, the presence of violence in a community increases not only the potential number of victims of violence but also increases the likely number of perpetrators of violence, fostering an ongoing cycle of violence in the communities afflicted by this public health disease.

The disease quality of violence is also exemplified by its ability to affect different systems. Researchers in the Jackson Heart Study measured the impact of neighborhood social conditions, including social cohesion and violence, documenting that poor neighborhood economic and social conditions may contribute to an increased risk of cardiovascular disease among African American women.[13] More recently, The Washington Post reports that, "In four separate studies, researchers found that conditions that affect blacks disproportionately compared with other groups — such as poor living conditions and stressful events such as the loss of a sibling, the divorce of one's parents or chronic unemployment — have severe consequences for brain health."[14] These risk factors have been identified as being correlated with an increased risk for Alzheimer's Disease among African Americans. Furthermore, violence has the potential to not only affect the health of women in a community but also their gestating offspring. In an article published this year in the American Journal of Obstetrics and Gynecology, researchers identified an association between a high rate of youth violence and preterm births.[15] The mechanism through which community violence and other environmental factors influence prenatal health is not well understood but it is proposed that increased stress of the mother as well as logistical barriers to receiving prenatal care (i.e. transportation, employment, childcare for other children) may play a significant role in this finding. In addition to birth outcomes and an increased risk of cardiovascular disease and Alzheimer's disease, violence in a community has a deleterious effect on how individuals gain access to food; in turn, household food insecurity is linked to an increased risk for intimate partner violence and adverse childhood experiences.[16,26]

Current research documents that violence not only erodes the health of community members but also the physical environment of a community. The place where a person lives, eats, sleeps and breathes, can foster and perpetuate individual violent behavior. A well-publicized example is the overwhelming evidence that documents the devastating impact of lead toxicity on individual behavior. Excessive lead exposure has been shown to limit an individual's learning potential and increases the risk for impulsive and aggressive behavior.[17,18] Communities most impacted by lead exposure often have other confounding risk related variables such as poverty and public school systems where older buildings in disrepair increase the risk for exposure to lead paint and lead contaminated water sources.[18] In contrast, community neighborhoods that promote health provide easy access to physical activity, healthy nutrition, education and jobs as well as ensuring environments free from exposure to toxins, such as lead. These healthy communities become resilient-to and protective-against violence.

The decrease or absolute removal of poverty, crime, environmental toxins and food deserts inoculates against the presence and persistence of violence in the community. When violence does occur, the implementation of a violence interruption protocol, to break the cycle of violence, is an important tool to ensure that the spread of violence in a community is controlled. All of these factors have the potential to eliminate the cycle of violence and subsequently improve the health outcomes of the individual patient and the entire community. The African American physician, representing minority communities that are disproportionately impacted by violence, must effectively articulate violence as a public health issue and take a leadership role not only in the intervention, treatment and prevention of violence but also in advocating for a comprehensive public policy in addressing violence.

IMPACT OF VIOLENCE IN THE AFRICAN AMERICAN COMMUNITY

In order to appreciate the fundamental role and impact violence has on the African American community, it is imperative that we review in greater depth patterns of violence that cluster in communities of color. Gang Violence, Intimate Partner Violence (IPV) and Child Maltreatment as well as Police Use of Excessive Force are major subsets of violence that disparately and disproportionately affect communities of color. In the following sections, we will give a brief overview to highlight how these forms of violence adversely affect our communities.

Gang violence

Violence in the African American community is often associated with youth or gang violence. This limited context identifies the perpetrator and the victims of violence as "thugs, predators or monsters" - individuals engaged in immoral behavior that will inevitably lead to the death, injury, or imprisonment of all involved.[19] Newspaper headlines in urban centers like Chicago, Detroit, Newark and Washington, D.C. often highlight the scourge of gun violence and its destructive role within these communities. However, to understand violence in America's cities one must be cognizant of the influence of structural racism and racial discrimination on the health outcomes of an entire people. In the review paper entitled, "Racial Discrimination: A Continuum of Violence Exposure for Children of Color", K. Sanders-Phillips defines the major theoretical models that establish racism as a risk factor toward violent behavior. Sanders-Phillips asserts that racial discrimination (1) causes trauma by creating isolation, alienation, marginalization, psychological harm and perceived danger; (2) limits the ability of the community and parents to protect children and promote resiliency; and (3) creates a level of psychological distress affecting a child's ability to cope with external stress.[20] The impact of racism on access to education, economics, housing and healthcare is complex and multifaceted. Racism is baked into the foundation of the American experience and therefore requires a separate analysis to comprehend its complete influence on violence in the African American community. Nonetheless, the effects of structural racism are integral to the causative risk factors that lead to individual, family and societal violence. Therefore, the physician who advocates against violence in the African American community must also take into account the effects of institutional/structural racism, its significance in communities of color and its effect on health equity.[21]

One can argue that the social environment that leads to a lack of equity in America also lends itself to a propensity for young people to seek gang membership. The National Gang Center has defined a gang as a "group {that} has three or more members generally 12–24. Members share an identity typically linked to a name, and often other symbols. Members view themselves as a gang and are often involved in an elevated level of criminal activity".[22] According to the National Crime Prevention Council, young people join gangs for a myriad of reasons. Risk factors for gang involvement include but are not limited to poverty, a perceived need for protection, truancy, peer pressure and poor community conditions. Compared to similar at-risk youth, gang members are twenty times more likely to commit a drive-by shooting, ten times more likely to commit homicide and four times more likely to commit assault.[22] Because gang membership tends to occur during adolescence, members are exposed to violence during a critical period of psychological and biological maturation. Gang members are reported to have higher levels of anxiety and psychosis and are more likely to attempt suicide.[22] These facts reinforce the postulate that exposure to violence is profoundly detrimental to normal development and mental health. Research performed by Wood and Dennard found that gang affiliated prisoners had a greater exposure to violence, increased levels of anxiety, PTSD and paranoia when compared to the non-gang affiliated prisoners.[22]

It is of critical importance that effort be directed towards diversion of young people away from gang affiliation and membership. In the recent report by the National Institute of Justice (NIJ) *Changing Course: Preventing Youth from Joining Gangs*, experts call for a comprehensive integrated public health and public safety approach. Strong and resilient family and community structures were identified as protective against gang membership and its violent outcomes. Gang membership and its associated violence is preventable and requires the unique tools of the public health sector with its ability to leverage multiple agency partners, community organizations and faith-based community resources. The public health approach is inherently capable of developing the definitions, data elements and data systems required to elucidate the enormity of gangs and gang-related violence in communities of color.[23]

In addition, the public health model is structured to help communities develop, fund, implement and evaluate a comprehensive strategy. The physician practitioner can play an integral role in facilitating these efforts and representing the interests of patients who may be gang members and/or the victims of gang violence. Physicians must be willing to ask their youth and young adult patients about their involvement in crew, gang, or violent behavior and their sense of safety at home and school. The healthcare provider must be willing and able to connect their patients to the resources needed to make responsible life choices. Physicians dedicated to serving at risk youth must maximize opportunities to be mentors in their communities and neighborhood schools and to advocate for investments in out-of-school time, community-based workforce development programs that target 12—24 year olds. Physicians will also need to advocate for restorative justice practices which divert youth, who are low level offenders, from the criminal justice system and instead utilize community service activities to promote career based opportunities.

Intimate partner violence & childhood maltreatment

The gang culture is also associated with high-risk sexual activity and a culture that reinforces the stereotypes of black boys as “sexually insatiable” and black girls as “objects of sexual availability”. It is important to note that African American woman, regardless of gang affiliation, bear a disproportionately high burden of violence including intimate partner violence (IPV).[24] The CDC’s 2010 National Intimate Partner and Sexual Violence Survey reported that more than one in three women have been the victims of IPV.[25] It is estimated that IPV costs exceed $5.8 billion each year and child maltreatment ultimately costs the nation $134.6 billion annually in medical and other costs.[25,26] Exposure to violence also results in psychological sequelae which can include chronic stress, depression and symptoms consistent with PTSD, affecting children and adults. For children, violence can induce high levels of stress “which manifests itself in children’s compromised cognitive functioning, as well as in their academic performance, emotional responses and social interactions.”[27] Exposure to violence during childhood is also associated with a higher risk of deliberate self-harm in adolescence and later suicide attempts. More importantly, intervention into the cycle of childhood maltreatment may decrease the potential negative impact on the subsequent well-being of victims of abuse and reduce the potential mental health outcomes of such maltreatment.[28]

Research into the physical and psychological effects of IPV and child maltreatment documents a variety of short and long-term ramifications.[29,50] A study of children living in a high crime neighborhood conducted by Theall et al. found that neighborhood level violence resulted in biological changes and changes at the cellular level, which included shortening of telomere length and blunted recovery of cortisol levels with steeper diurnal rhythms. These findings suggest that violence may be a significant factor in changes associated with the physiological and cellular markers of stress in children and may have implications for long-term health outcomes.[30] Recent studies have suggested that IPV exposed African American women are more likely to engage in deliberate self-harm (DSH) in an effort to escape or avoid symptoms of PTSD.[24] In addition, food insecurity has been shown to particularly increase the risk for IPV, child abuse and neglect.[16,26] In a study of predominately African American women, researchers found that women who are victims of IPV and suffer PTSD were nearly 15 times more likely to have daily co-occurrence of drug and alcohol use when compared with the control group.[31] These, along with other examples, reinforce the complex co-morbidities that are integral to understanding violence in the African American community and the risks associated with adverse childhood experiences.

Individual physicians serving at risk communities must ask patients questions regarding safety in the home and make referrals to appropriate service providers, advocates and/or legal authorities; refer patients to early childhood development and parenting skills programs that are designed to reduce the risk of child maltreatment; and counsel teens, adolescents and young adults regarding healthy relationships. Physicians may also establish his/her practice as a “Safe Haven” for victims of IPV.

Police use of excessive force

Compounding the presence of violence within communities of color is the fear of the potential for unjustified use of force by police officers. The use of excessive and unnecessary force by law enforcement is both disproportionately and disparately directed towards the African American community. According to the Bureau of Justice Statistics (BJS), African Americans are more likely to have face-to-face contact with law enforcement and are 2.5 times more likely to experience threat or use of non-fatal force by police.[32] The BJS reports that African Americans are also more likely to experience excessive force.[32,33] A Harvard study examining patterns of law enforcement injuries in America demonstrated that police-related firearm injuries requiring hospitalization were more likely to be suffered by Black and Hispanic males between the ages of 18 and 39 years old.[33] Police officers, who are tasked with protecting and serving the community, frequently engage in intrusive policing practices in high crime neighborhoods, where the subjects of their policing are young men who are often experiencing barriers to equity. Researchers have shown that young men who experience these intrusive police practices display higher levels of stress, anxiety and trauma associated with these police interactions.[34,35] The reality is that the fear and anxiety that accompanies law enforcement interactions is justified. This fear is justified by the documented practice of racially biased use of unnecessary, excessive and, on occasion, fatal force by police.[36,51]

Law enforcement's use of excessive and/or unnecessary force adds to the disenfranchisement and oppression felt by many living in communities of color. There must be an end to unwarranted violence by the police against the communities they are duty bound to protect and serve. We reject the notion that communities of color must be policed in a way that results in the increased injury, death and unjustified incarceration of any of our patients. A survey conducted by DeVylder et al. to determine the prevalence and magnitude of police victimization within an affected community found that up to 6.1% of civilian participants in public-police interactions experienced physical violence; an additional 2.8% reported sexual violence and 3.3% physical violence with a weapon. Of equal significance, 18.6% reported psychological violence.[34] A history of negative interactions with police was also associated with psychological distress and depression. More importantly, DeVylder et al. found disparity in the treatment of particular cultural groups reporting, "Police victimization was more frequently reported by racial/ethnic minorities, males, transgender respondents and younger adults."[34] In a subsequent study, DeVylder et al. reported an increased incidence of suicidal attempts by the victims of police violence.[35] The psychological harm resulting from adverse police interactions is as important as the physical injury.

While psychological injuries may be more difficult to ascertain, the physical injuries that result from excessive police use of force are apparent and extensively documented. Physical injuries that occur due to excessive police use of force may include, but are not limited to, gunshot wounds, blunt force injuries that can result in multiple bone fractures as well as closed head injury. Many of these injuries can cause permanent disability and even death.[36,37] When an arrest is indicated, it is imperative that police officers have been properly trained in techniques designed to safely restrain individuals with the goal of safe transport of the individual to the police station or area hospital. Life threatening techniques, such as the 'choke hold' and the practice of one or more officers placing their body weight on top of the restrained person must be banned. These techniques were the direct cause of fatality in the widely publicized deaths of both Eric Garner and John Hernandez. Furthermore, de-escalation techniques, which are similar to those employed in hostage negotiation, should be utilized whenever safely possible and uniformly used on all suspects regardless of race, mental health status, ethnicity or gender. The Salt Lake City Police Department, which embraced de-escalation tactics following a series of questionable officer involved fatal shootings, has had no fatal shootings in over 20 months as a result of de-escalation training.[38,39] Appropriate and safe restraint techniques should be the standard and in the event a person in custody is injured, the individual must receive prompt and appropriate medical attention.

One of the most daunting limitations in understanding police use of excessive force is the paucity of data. The reporting that occurs from each of the 18,000 jurisdictions is completely voluntary. The legislation that provides federal funding for agencies to warehouse and analyze this data must be renewed by Congress. The Death in Custody Reporting Program (DICRP) of the Bureau of Justice Statistics which reports on all deaths that occur in local jails or state prisons, was authorized in 2000 but expired in 2006. Although the BJS continued the program it was not reauthorized by legislation until 2013. The Arrest Related Deaths Report which is a part of the DICRP, reports on deaths that occur during an arrest. The legislation guidelines, which authorized the program, excluded death reports from categories such as: (1) Deaths of bystanders, hostages, or law enforcement personnel (2) Deaths perpetuated by Federal Law Enforcement Agents (3) Deaths of wanted criminal suspects before police contact and (4) Deaths of vehicular pursuits without any direct police action.

As a result, legislatively mandated reporting of arrest-related deaths still does not accurately reveal the complete toll that police use of excessive force has on our communities. The NMA can be an advocate for legislation that accurately measures the impact of police use of excessive force, particularly in communities of color. Appropriate parameters should include a medical examiner system dedicated to the proper investigation, examination, certification and reporting of arrest related deaths in custody to ensure an objective and accurate assessment of these fatalities.

The public health community can no longer be silent regarding the impact of police violence on the mental and physical health of our patients. As described by Cooper and Fullilove, there must be a coordinated multifaceted approach that develops viable solutions in the "life-cycle" that leads to excessive police use of force. This approach will require prevention and intervention strategies that focus on poverty, crime, policies of mass incarceration, police review and oversight, police culture and unions, as well as implicit bias to name a few.[40,51] The public health practitioner must advocate for community policing. A community policing policy that requires officers walk or ride in the neighborhoods they patrol and includes culturally competent training will afford officers an opportunity to develop the relationships necessary to reduce crime and have a positive impact on the communities they serve.

GUN RELATED RESEARCH IN THE UNITED STATES

Reports confirm that there are nearly 33,000 firearm related deaths in the United States annually.[54] Whether fatalities are due to homicides or suicides, the weapon of choice is the gun. Research performed by Kalesan and Galea found that gun safe counties in the United States were primarily white, less poor, with higher household income, lower unemployment and more likely to be urban. The counties more likely to be violent due to firearms had higher rates of minority population, greater poverty, higher unemployment and were mostly rural. The study reported a direct relationship with gun ownership and homicide rates.[41] During the March 2016 Health Policy Colloquium convened by the NMA, *Violence and Its Impact on Health* panelist Dr. Steven Weinberger gave an overview of the ongoing effort to reduce gun violence in the United States. The USA is the global leader in firearm related deaths by almost three times the next highest country which is Finland.[42] Dr. Weinberger noted that there are approximately 90 firearm fatalities per day, the majority of which are suicides.[43]

Research into gun related injury and death has a sordid history. In order to understand the current state of gun related injury research it is important to be aware of this narrative. A CDC funded research study by Kellerman et al. published in the New England Journal of Medicine in 1993, reported that keeping a gun in the home increased the risk for homicide, most often suicide, independent of any other factor.[44] In retaliation, the National Rifle Association (NRA) successfully lobbied Congress to ban research into the association of firearms with fatal and non-fatal violence. This effort by the NRA resulted in the Dickey Amendment to the Consolidated Appropriations Act of 1997. The Dickey Amendment is a provision first inserted as a rider into the 1996 federal government omnibus spending bill which mandated that “none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control.”[45]

Following the 2012 Newton, CT School shooting, President Obama ordered the CDC to resume research into gun violence. Despite this mandate, Congress provided zero funding to the CDC for gun violence research. The medical community has subsequently united, demanding an end to this restriction on the legitimate effort to understand and reduce gun violence in America. In 2014, the American College of Physicians (ACP) presented position papers on gun violence. Subsequently, in 2015, the ACP proceeded with a “Call to Action” that combined the collaborative efforts of seven medical professional associations in conjunction with the American Public Health Association and the American Bar Association.[52] This “Call to Action” was endorsed by 52 organizations, including the National Medical Association (NMA).

Clear recommendations to reduce gun violence are outlined as follows:

- Universal background checks of gun purchasers
- Elimination of physician ‘gag laws’, which prevent physicians from asking about or documenting a patient’s possession of firearms in the home
- Restricting the manufacture and sale of military-style assault weapons and large capacity magazines for civilian use
- Research to support strategies for reducing firearm-related injuries and deaths
- Improved access to mental health services
- Waiting periods to reduce impulsive suicides
- Guns should be subject to consumer product regulations regarding access, safety and design
- Guns should be subject to law enforcement measures to aid in the identification of weapons used in crimes[45]

* It should be noted that none of these recommendations violates the 2nd amendment or prior Supreme Court Decisions.

RECOMMENDATIONS FOR VIOLENCE PREVENTION

The effort to treat and prevent violence in our communities is both difficult and complex. Historically, physicians have never been discouraged by challenge and are now called upon to treat violence as a public health epidemic and apply the same tenacity that has been necessary in the fight against AIDS, tuberculosis, cancer and other diseases. If meaningful and sustainable change is to occur in ameliorating violence, it will require a systemic, well-coordinated public health approach on both the local and national level that should include:

PUBLIC HEALTH SURVEILLANCE

- Establish local *Violence Fatality Review Boards* and the development of local systems that interface with

at risk youth who are the victims or perpetrators of violence.
- Establish the *National Violent Death Reporting System* of the CDC (NVDS– CDC) which will identify, qualify and quantify the problem.

RESEARCH CONDUCTED WITH UNIVERSITY PARTNERSHIPS

- National Gun Violence Research Studies to be funded by the Centers For Disease Control.
- Establish best practices in violence prevention, that can be evaluated and reproduced, with testable methods and solutions to treat and prevent violence.

PROGRAMMING

- Multidisciplinary Services/Access utilizing Community Partnerships, Community Building Strategies (**Interrupter Model) and Community Stabilization Programs with an acute and sustained approach to Wrap Around Services
  - Promote Equitable Access to Economics, Education, Housing, Healthcare, Mental Health, Social Services & Criminal Justice
  - **Interrupter's Model which integrates workers who are community based and trained to identify persons or situations that pose a risk for violence in the community and act to utilize systems in place to break the cycle of violence.

- Promotion of 'healthy community' initiatives, i.e. community gardens, safe spaces to exercise, community education programs, safe affordable childcare and senior care options. Aggressive screening for lead toxicity with early intervention in high-risk communities.

PARTNERSHIPS/COLLABORATION

- Establish an extensive network with coordination across disciplines, comprised of community based organizations, faith-based organizations and public institutions such as law enforcement departments, public health departments, academic institutions, hospitals and public schools.

DETERRENCE/INVESTIGATION

- Police Departments to train officers in, and promote, community policing.
- Uniform Standards requiring police officers to receive implicit bias training, mental health assessment and deescalation response training.
- Officer re-certification requirements
- Establish sites for Safe Fugitive Surrender.

COMMUNICATION

- Technical and Strategic Communication Assistance for Community based initiatives

INVESTMENT

- In addition to investment in the above listed recommendations, grant and local/federal funds will be needed for programming aimed at public education on the risk factors for violence and violence prevention strategies.

SUSTAINABILITY

- Review of Efficacy & Data Outcomes that will drive legislation including Health Care cost savings derived from decreased ER/Trauma visits
- Reduced societal costs that result from reductions in lost human potential and crime rates.

ADVOCACY

- "Public Health Approach Towards Violence Prevention" - development of a policy statement with quarterly reviews of ongoing practice guidelines and actionable recommendations

In addition to the above criteria, Excessive Police Use of Force will require the following at the federal, state and local levels:

ACCOUNTABILITY

- Transparency: Endorse and support the use of both body cams and dashboard cams.
- Oversight: Police and citizen review boards to address police officer misconduct and complaints

against officers. Establish a Police Registry, which lists law enforcement agents that are fired from any police department due to misconduct, insubordination or knowingly falsifying an application to a police department. This registry is designed to prevent unqualified officers from moving from one department to another.

- Impartiality: Support and advocate for local municipalities, state and federal mandates that require special prosecutors be assigned to review and prosecute, if indicated, all officer involved misconduct and fatal shootings.
- Documentation: Physicians to routinely screen patients for any history of interactions with police, the nature of these interactions and any physical or mental symptoms that are a result of these interactions. These histories and any physical exam findings to be documented in the patient's record.
- Establish a Police Registry, which lists law enforcement agents that are fired from any police department due to misconduct, insubordination or knowingly falsifying an application to a police department and is designed to prevent disqualified officers from moving from one department to another.

REBUILD COMMUNITY TRUST AND ENGAGEMENT

- Community Initiatives: Training in community policing with 'top down' leadership. Listening sessions for open and civil dialogue lead by community leaders. Involvement of police officers in local community activities. Encourage officers to live in communities they police. Work with and organize neighborhood watch groups. Maintain anonymous tip lines.
- Youth Initiatives: Create mentoring programs designed to expose youth to police officers as positive role models and inform youth on opportunities in police and community work. Work with local community leaders to engage youth in strategies to prevent gang membership.

RESEARCH AND TRAINING

- Review and assess current state, local and federal law enforcement hiring practices, criteria for selection and required training protocols.
- The immediate and universal ban on police use of dangerous takedown techniques such as, but not limited to, the 'chokehold' or the placing of knees or body weight on a person's chest, neck or head which has the potential for severe consequences.
- Recommend research into appropriate techniques for restraining suspects that will not carry a high potential risk for permanent or life threatening injury to an individual in circumstances of no immediate danger.
- The immediate implementation of De-Escalation Training for all officers
- Training in bias mitigation modalities such as computer simulation training designed to reduce racial bias in shooting unarmed suspects.[46]

LAW ENFORCEMENT OFFICER SUPPORT MODALITIES

- Review and assess current state, local and federal law enforcement training criteria, continuing education requirements and mental health risk assessment.
- Further development of psychological support services, bias mitigation, de-escalation techniques, conflict resolution protocols and ongoing training in community policing.

REPORTING STANDARDS FOR DEATHS IN CUSTODY

- Establish a uniform practice to capture all relevant details regarding cause and manner of deaths in custody to include the *pre-custody period* (interval during commission of a crime, during a fight, chase and apprehension, during a siege or hostage situation or during restraint or submission); *in custody* period (interval soon after being admitted to jail, during interrogation, during incarceration or legal execution); and *post custody period* (interval after re-entry into the community when at risk for revenge by rival criminals or by police).
- Require mandatory state, local and federal adherence to H.R. 1447- Death in Custody Reporting Act of 2013 amended to require the inclusion of Independent Medical Examiner reports and the US Standard Death Certificate.

CONCLUSION

The case for Violence as a Public Health Issue has been studied and clearly documented by healthcare leaders for more than two decades. Workshops like the 2013 Contagion of Violence, organized by the Institute of Medicine, National Research Council and the Movement towards Violence as a Public Health Issue Framework for Action have outlined treatment programs and strategies that successfully interrupt patterns of community violence.[3,47,48,50] The comprehensive Framework for Action gives a detailed breakdown of the role that systems, institutions and physician leaders will have to play in the effort to reduce violence in our communities and in the lives of our patients. Any violence intervention strategy must take into account the complex multifactorial aspects of violence, incorporating racism and issues related to police use of excessive and unnecessary force, in order to achieve a successful outcome. There is evidence that formal police-public health partnerships can play a key role in reducing violence in impacted communities. These partnerships can augment the effort to reduce violence and garner greater community support. Examples of such partnerships were reviewed by Shepherd and Sumner in a March 2017 editorial published in JAMA.[49] By recognizing violence as a public health disorder and implementing key intervention and prevention strategies we can and will reduce the ramifications of this devastating disease in our communities. Communities of color and other marginalized communities are disproportionately impacted by violence and thus it is imperative that the NMA, currently representing over 50,000 predominately African American physicians nationally, take a leadership role and partner with other physician organizations in the effort to eliminate violence in our communities.

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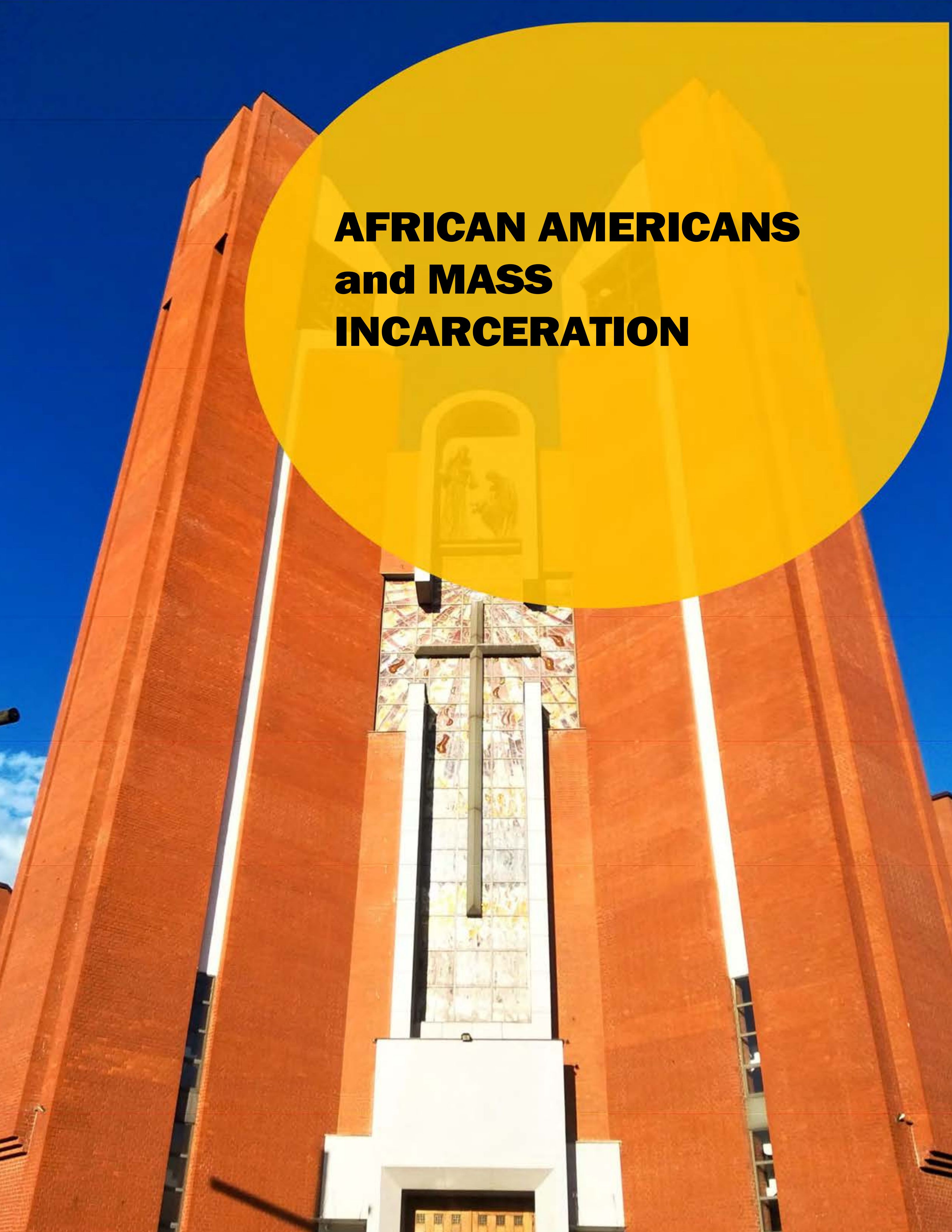
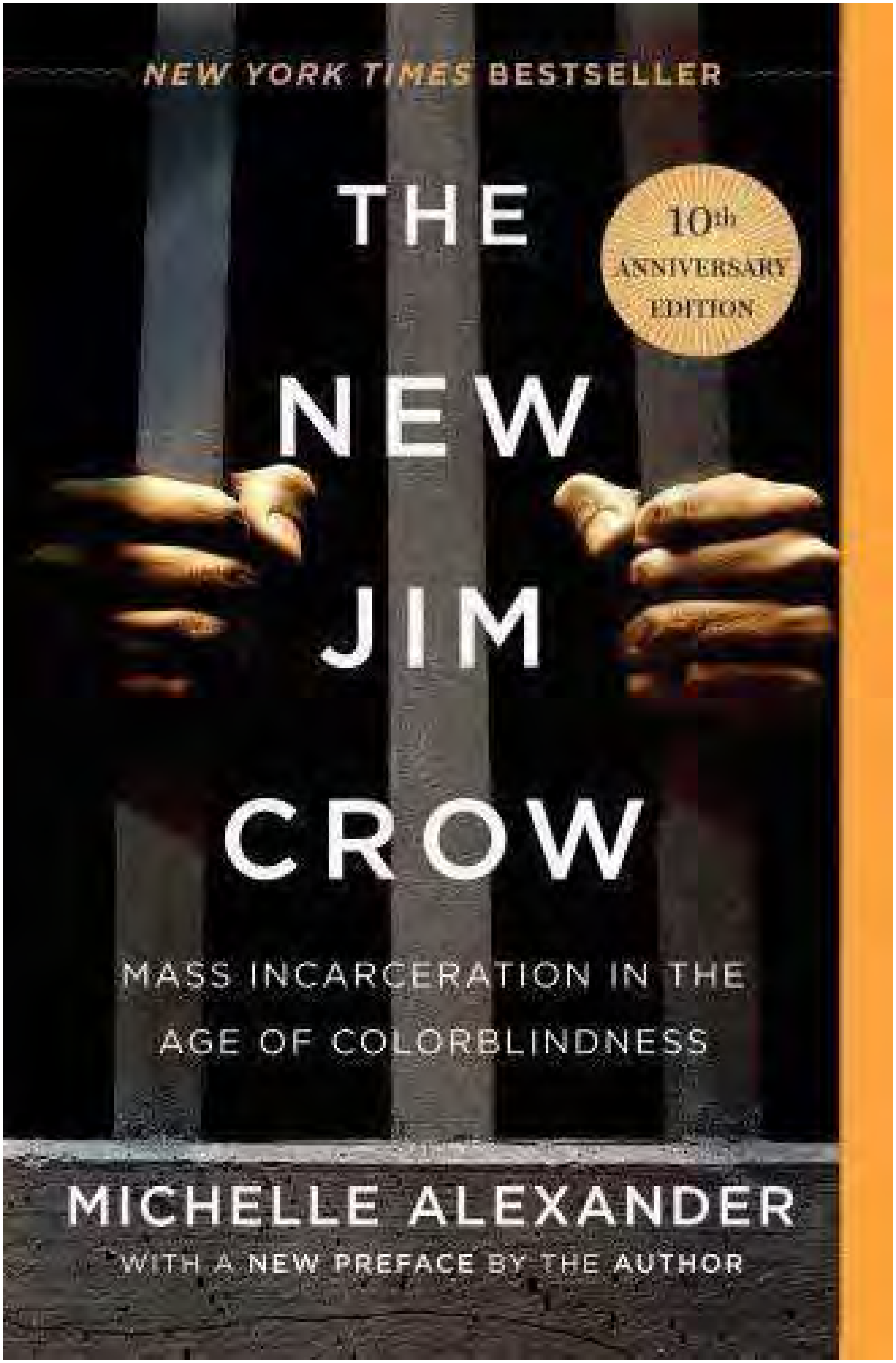


AFRICAN AMERICANS and MASS INCARCERATION

African Americans and Mass Incarceration



Black Americans are incarcerated in state prisons at nearly 5 times the rate of white Americans. Nationally, one in 81 Black adults in the U.S. is serving time in state prison. Wisconsin leads the nation in Black imprisonment rates; one of every 36 Black Wisconsinites is in prison.

The Color of Justice: Racial and Ethnic Disparity in State Prisons

This report documents the rates of incarceration for white, Black and Latinx Americans in each state, identifies three contributors to racial and ethnic disparities in imprisonment, and provides recommendations for reform.

Executive Summary

When former Minneapolis police officer Derek Chauvin killed George Floyd by kneeling on his neck in 2020, the world witnessed the most racist elements of the U.S. criminal legal system on broad display. The uprisings that followed Floyd's death articulated a vision for transforming public safety practices and investments. Almost one year later, Chauvin was convicted for Floyd's death, a rare outcome among law enforcement officers who kill unarmed citizens. The fight for racial justice within the criminal legal system continues, however. The data findings featured in this report epitomize the enormity of the task.

This report details our observations of staggering disparities among Black and Latinx people imprisoned in the United States given their overall representation in the general population. The latest available data regarding people sentenced to state prison reveal that Black Americans are imprisoned at a rate that is roughly five times the rate of white Americans. During the present era of criminal justice reform, not enough emphasis has been focused on ending racial and ethnic disparities systemwide.

Going to prison is a major life-altering event that creates obstacles to building stable lives in the community, such as gaining employment and finding stable and safe housing after release. Imprisonment also reduces lifetime earnings and negatively affects life outcomes among children of incarcerated parents.[1] These are individual-level consequences of imprisonment but there are societal level consequences as well: high levels of imprisonment in communities cause high crime rates and neighborhood deterioration, thus fueling greater disparities.[2] This cycle both individually and societally is felt disproportionately by people who are Black. It is clear the outcome of mass incarceration today has not occurred by happenstance but has been designed through policies created by a dominant white culture that insists on suppression of others.

At the same time, states have begun to chip away at mass incarceration. Nine states have lowered their prison population by 30% or more in recent years: Alaska, New Jersey, New York, Connecticut, Alabama, Rhode Island, Vermont, Hawaii, and California.[3] This decline has been accomplished through a mix of reforms to policy and practice that reduce prison admissions as well as lengths of stay in prison.

Still, America maintains its distinction as the world leader[4] in its use of incarceration, including more than 1.2 million people held in state prisons around the country.[5]

Truly meaningful reforms to the criminal justice system cannot be accomplished without acknowledgement of its racist underpinnings. Immediate and focused attention on the causes and consequences of racial disparities is required to eliminate them. True progress towards a racially just system requires an understanding of the variation in racial and ethnic inequities in imprisonment across states and the policies and day-to-day practices that drive these inequities.[6]

This report documents the rates of incarceration for whites, African Americans, and Latinx individuals, providing racial and ethnic composition as well as rates of disparity for each state.[7] The Sentencing Project has produced state-level estimates twice before[8] and once again finds staggering disproportionalities.

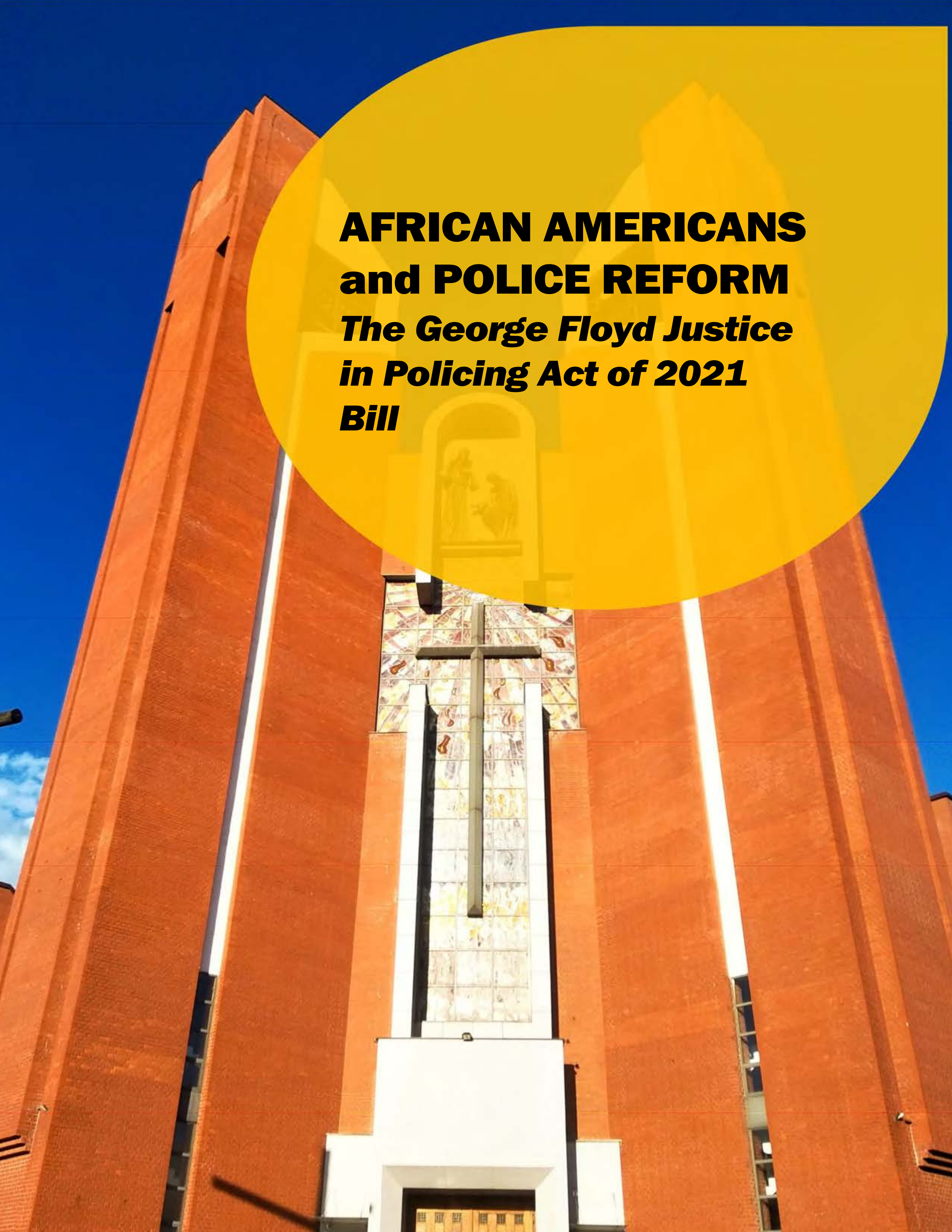
Key findings

1. Black Americans are incarcerated in state prisons at nearly 5 times the rate of white Americans.
2. Nationally, one in 81 Black adults in the U.S. is serving time in state prison. Wisconsin leads the nation in Black imprisonment rates; one of every 36 Black Wisconsinites is in prison.
3. In 12 states, more than half the prison population is Black: Alabama, Delaware, Georgia, Illinois, Louisiana, Maryland, Michigan, Mississippi, New Jersey, North Carolina, South Carolina, and Virginia.
4. Seven states maintain a Black/white disparity larger than 9 to 1: California, Connecticut, Iowa, Maine, Minnesota, New Jersey, and Wisconsin.
5. Latinx individuals are incarcerated in state prisons at a rate that is 1.3 times the incarceration rate of whites. Ethnic disparities are highest in Massachusetts, which reports an ethnic differential of 4.1:
6.

Recommendations

1. **Eliminate mandatory sentences for all crimes.**
   Mandatory minimum sentences, habitual offender laws, and mandatory transfer of juveniles to the adult criminal system give prosecutors too much authority while limiting the discretion of impartial judges. These policies contributed to a substantial increase in sentence length and time served in prison, disproportionately imposing unduly harsh sentences on Black and Latinx individuals.
2. **Require prospective and retroactive racial impact statements for all criminal statutes.**
   The Sentencing Project urges states to adopt forecasting estimates that will calculate the impact of proposed crime legislation on different populations in order to minimize or eliminate the racially disparate impacts of certain laws and policies. Several states have passed "racial impact statement" laws. To undo the racial and ethnic disparity resulting from decades of tough-on-crime policies, however, states should also repeal existing racially biased laws and policies. The impact of racial impact laws will be modest at best if they remain only forward looking.

3. **Decriminalize low-level drug offenses.**
   Discontinue arrest and prosecutions for low-level drug offenses which often lead to the accumulation of prior convictions which accumulate disproportionately in communities of color. These convictions generally drive further and deeper involvement in the criminal legal system.



AFRICAN AMERICANS and POLICE REFORM

The George Floyd Justice in Policing Act of 2021 Bill

African Americans and POLICE REFORM George Floyd Bill

Passed House (03/03/2021)

George Floyd Justice in Policing Act of 2021 Bill

This bill addresses a wide range of policies and issues regarding policing practices and law enforcement accountability. It increases accountability for law enforcement misconduct, restricts the use of certain policing practices, enhances transparency and data collection, and establishes best practices and training requirements.

The bill enhances existing enforcement mechanisms to remedy violations by law enforcement. Among other things, it does the following:

- lowers the criminal intent standard—from willful to knowing or reckless—to convict a law enforcement officer for misconduct in a federal prosecution,
- limits qualified immunity as a defense to liability in a private civil action against a law enforcement officer, and
- grants administrative subpoena power to the Department of Justice (DOJ) in pattern-or-practice investigations.

It establishes a framework to prevent and remedy racial profiling by law enforcement at the federal, state, and local levels. It also limits the unnecessary use of force and restricts the use of no-knock warrants, chokeholds, and carotid holds.

The bill creates a national registry—the National Police Misconduct Registry—to compile data on complaints and records of police misconduct. It also establishes new reporting requirements, including on the use of force, officer misconduct, and routine policing practices (e.g., stops and searches).

Finally, it directs DOJ to create uniform accreditation standards for law enforcement agencies and requires law enforcement officers to complete training on racial profiling, implicit bias, and the duty to intervene when another officer uses excessive force.

VOTING RIGHTS BILL

Representative John Lewis

VOTING RIGHTS BILL Rep. John Lewis

Passed House (08/24/2021)

John R. Lewis Voting Rights Advancement Act of 2021

This bill establishes new criteria for determining which states and political subdivisions must obtain preclearance before changes to voting practices may take effect. Preclearance is the process of receiving preapproval from the Department of Justice (DOJ) or the U.S. District Court for the District of Columbia before making legal changes that would affect voting rights.

A state and all of its political subdivisions shall be subject to preclearance of voting practice changes for a 10-year period if

- 15 or more voting rights violations occurred in the state during the previous 25 years;
- 10 or more violations occurred during the previous 25 years, at least 1 of which was committed by the state itself; or
- 3 or more violations occurred during the previous 25 years and the state administers the elections.

A political subdivision as a separate unit shall also be subject to preclearance for a 10-year period if three or more voting rights violations occurred there during the previous 25 years.

States and political subdivisions that meet certain thresholds regarding minority groups must preclear covered practices before implementation, such as changes to methods of election and redistricting.

Further, states and political subdivisions must notify the public of changes to voting practices.

Next, the bill authorizes DOJ to require states or political subdivisions to provide certain documents or answers to questions for enforcing voting rights.

The bill also outlines factors courts must consider when hearing challenges to voting practices, such as the extent of any history of official voting discrimination in the state or political subdivision.

U.S. JUSTICE DEPARTMENT SUES GOOGLE for MONOPOLIZING DIGITAL ADVERTISING TECHNOLOGIES

Justice Department Sues Google for Monopolizing Digital Advertising Technologies

Through Serial Acquisitions and Anticompetitive Auction Manipulation, Google Subverted Competition in Internet Advertising Technologies

Today, the Justice Department, along with the Attorneys General of California, Colorado, Connecticut, New Jersey, New York, Rhode Island, Tennessee, and Virginia, filed a civil antitrust suit against Google for monopolizing multiple digital advertising technology products in violation of Sections 1 and 2 of the Sherman Act.

Filed in the U.S. District Court for the Eastern District of Virginia, the complaint alleges that Google monopolizes key digital advertising technologies, collectively referred to as the “ad tech stack,” that website publishers depend on to sell ads and that advertisers rely on to buy ads and reach potential customers. Website publishers use ad tech tools to generate advertising revenue that supports the creation and maintenance of a vibrant open web, providing the public with unprecedented access to ideas, artistic expression, information, goods, and services. Through this monopolization lawsuit, the Justice Department and state Attorneys General seek to restore competition in these important markets and obtain equitable and monetary relief on behalf of the American public.

As alleged in the complaint, over the past 15 years, Google has engaged in a course of anticompetitive and exclusionary conduct that consisted of neutralizing or eliminating ad tech competitors through acquisitions; wielding its dominance across digital advertising markets to force more publishers and advertisers to use its products; and thwarting the ability to use competing products. In doing so, Google cemented its dominance in tools relied on by website publishers and online advertisers, as well as the digital advertising exchange that runs ad auctions.

“Today’s complaint alleges that Google has used anticompetitive, exclusionary, and unlawful conduct to eliminate or severely diminish any threat to its dominance over digital advertising technologies,” said Attorney General Merrick B. Garland. “No matter the industry and no matter the company, the Justice Department will vigorously enforce our antitrust laws to protect consumers, safeguard competition, and ensure economic fairness and opportunity for all.”

“The complaint filed today alleges a pervasive and systemic pattern of misconduct through which Google sought to consolidate market power and stave off free-market competition,” said Deputy Attorney General Lisa O. Monaco. “In pursuit of outsized profits, Google has caused great harm to online publishers and advertisers and American consumers. This lawsuit marks an important milestone in the Department’s efforts to hold big technology companies accountable for violations of the antitrust laws.”

“The Department’s landmark action against Google underscores our commitment to fighting the abuse of market power,” said Associate Attorney General Vanita Gupta. “We allege that Google has captured publishers’ revenue for its own profits and punished publishers who sought out alternatives. Those actions have weakened the free and open internet and increased advertising costs for businesses and for the United States government, including for our military.”

“Today’s lawsuit seeks to hold Google to account for its longstanding monopolies in digital advertising technologies that content creators use to sell ads and advertisers use to buy ads on the open internet,” said Assistant Attorney General Jonathan Kanter of the Justice Department’s Antitrust Division. “Our complaint sets forth detailed allegations explaining how Google engaged in 15 years of sustained conduct that had — and continues to have — the effect of driving out rivals, diminishing competition, inflating advertising costs, reducing revenues for news publishers and content creators, snuffing out innovation, and harming the exchange of information and ideas in the public sphere.”

Google now controls the digital tool that nearly every major website publisher uses to sell ads on their websites (publisher ad server); it controls the dominant advertiser tool that helps millions of large and small advertisers buy ad inventory (advertiser ad network); and it controls the largest advertising exchange (ad exchange), a technology that runs real-time auctions to match buyers and sellers of online advertising.

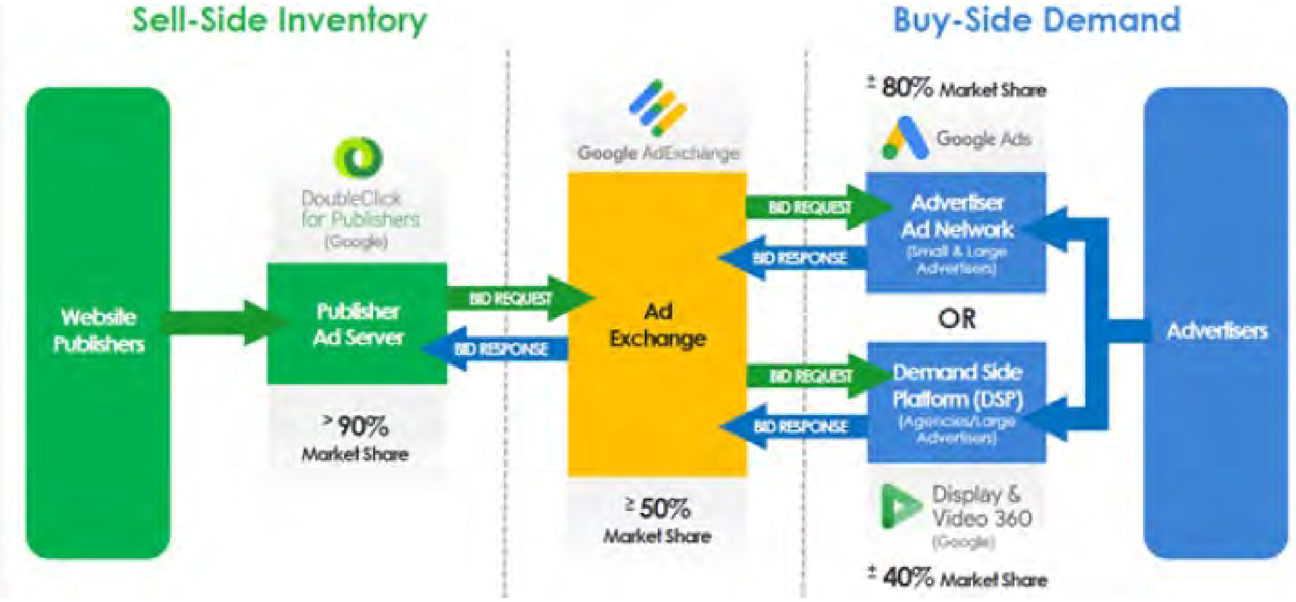


Image description: Graphic of digital advertising market.

The digital advertising market is divided into three sections: sell-side inventory on the left, buy-side demand on the right, and an ad exchange in the middle. Sell-side inventory is made up of website publishers that that flow to Google’s “DoubleClick for Publishers” Publisher Ad Server, which has >90% of market share. Google AdExchange, which is greater than or equal to 50% of the ad exchange market share, receives bid requests from the publisher ad server, sends them to the buy-side demand, receives bid responses from the buy side demand and sends them back to the publisher ad server. Buy-side demand is made up of advertisers that flow to either:

"Google Ads" Advertiser Ad Network (Small and Large Advertisers) which has +/- 80% market share; or Google's "Display & Video 360" Demand Side Platform (DSP) Agencies/Large Advertisers which has +/-40% share.

Google's anticompetitive conduct has included:

Acquiring Competitors: Engaging in a pattern of acquisitions to obtain control over key digital advertising tools used by website publishers to sell advertising space;

Forcing Adoption of Google's Tools: Locking in website publishers to its newly-acquired tools by restricting its unique, must-have advertiser demand to its ad exchange, and in turn, conditioning effective real-time access to its ad exchange on the use of its publisher ad server;

Distorting Auction Competition: Limiting real-time bidding on publisher inventory to its ad exchange, and impeding rival ad exchanges' ability to compete on the same terms as Google's ad exchange; and

Auction Manipulation: Manipulating auction mechanics across several of its products to insulate Google from competition, deprive rivals of scale, and halt the rise of rival technologies.

As a result of its illegal monopoly, and by its own estimates, Google pockets on average more than 30% of the advertising dollars that flow through its digital advertising technology products; for some transactions and for certain publishers and advertisers, it takes far more. Google's anticompetitive conduct has suppressed alternative technologies, hindering their adoption by publishers, advertisers, and rivals.

The Sherman Act embodies America's enduring commitment to the competitive process and economic liberty. For over a century, the Department has enforced the antitrust laws against unlawful monopolists to unfetter markets and restore competition. To redress Google's anticompetitive conduct, the Department seeks both equitable relief on behalf of the American public as well as treble damages for losses sustained by federal government agencies that overpaid for web display advertising. This enforcement action marks the first monopolization case in approximately half a century in which the Department has sought damages for a civil antitrust violation.

In 2020, the Justice Department filed a civil antitrust suit against Google for monopolizing search and search advertising, which are different markets from the digital advertising technology markets at issue in the lawsuit filed today. The Google search litigation is scheduled for trial in September 2023.

Google is a limited liability company organized and existing under the laws of the State of Delaware, with a headquarters in Mountain View, California. Google's global network business generated approximately $31.7 billion in revenues in 2021. Google is owned by Alphabet Inc., a publicly traded company incorporated and existing under the laws of the State of Delaware and headquartered in Mountain View, California.

U.S. FEDERAL TRADE COMMISSION (FTC) SUES FACEBOOK for ILLEGAL MONOPOLIZATION

FTC Sues Facebook for Illegal Monopolization

Agency challenges Facebook's multi-year course of unlawful conduct

December 9, 2020

Tags:

- Competition
- Bureau of Competition
- Merger
- Nonmerger
- Single Firm Conduct
- Unfair Methods of Competition
- Big Data
- Technology

The Federal Trade Commission today sued Facebook, alleging that the company is illegally maintaining its personal social networking monopoly through a years-long course of anticompetitive conduct. Following a lengthy investigation in cooperation with a coalition of attorneys general of 46 states, the District of Columbia, and Guam, the complaint alleges that Facebook has engaged in a systematic strategy—including its 2012 acquisition of up-and-coming rival Instagram, its 2014 acquisition of the mobile messaging app WhatsApp, and the imposition of anticompetitive conditions on software developers—to eliminate threats to its monopoly. This course of conduct harms competition, leaves consumers with few choices for personal social networking, and deprives advertisers of the benefits of competition.

The FTC is seeking a permanent injunction in federal court that could, among other things: require divestitures of assets, including Instagram and WhatsApp; prohibit Facebook from imposing anticompetitive conditions on software developers; and require Facebook to seek prior notice and approval for future mergers and acquisitions.

"Personal social networking is central to the lives of millions of Americans," said Ian Conner, Director of the FTC's Bureau of Competition. "Facebook's actions to entrench and maintain its monopoly deny consumers the benefits of competition. Our aim is to roll back Facebook's anticompetitive conduct and restore competition so that innovation and free competition can thrive."

Video by Ian Conner, Director of the Bureau of Competition

Download MP4 (11.43 MB)
Statement by Ian Conner, Director of the Bureau of Competition

According to the FTC's complaint, Facebook is the world's dominant personal social networking service and has monopoly power in a market for personal social networking services. This unmatched position has provided Facebook with staggering profits. Last year alone, Facebook generated revenues of more than $70 billion and profits of more than $18.5 billion.

Anticompetitive Acquisitions

According to the FTC's complaint, Facebook targeted potential competitive threats to its dominance. Instagram, a rapidly growing startup, emerged at a critical time in personal social networking competition, when users of personal social networking services were migrating from desktop computers to smartphones, and when consumers were increasingly embracing photo-sharing. The complaint alleges that Facebook executives, including CEO Mark Zuckerberg, quickly recognized that Instagram was a vibrant and innovative personal social network and an existential threat to Facebook's monopoly power.

The complaint alleges that Facebook initially tried to compete with Instagram on the merits by improving its own offerings, but Facebook ultimately chose to buy Instagram rather than compete with it. Facebook's acquisition of Instagram for $1 billion in April 2012 allegedly both neutralizes the direct threat posed by Instagram and makes it more difficult for another personal social networking competitor to gain scale.

Around the same time, according to the complaint, Facebook perceived that "over-the-top" mobile messaging apps also presented a serious threat to Facebook's monopoly power. In particular, the complaint alleges that Facebook's leadership understood—and feared—that a successful mobile messaging app could enter the personal social networking market, either by adding new features or by spinning off a standalone personal social networking app.

The complaint alleges that, by 2012, WhatsApp had emerged as the clear global "category leader" in mobile messaging. Again, according to the complaint, Facebook chose to buy an emerging threat rather than compete, and announced an agreement in February 2014 to acquire WhatsApp for $19 billion. Facebook's acquisition of WhatsApp allegedly both neutralizes the prospect that WhatsApp itself might threaten Facebook's personal social networking monopoly and ensures that any future threat will have a more difficult time gaining scale in mobile messaging.

Anticompetitive Platform Conduct

The complaint also alleges that Facebook, over many years, has imposed anticompetitive conditions on third-party software developers' access to valuable interconnections to its platform, such as the application programming interfaces ("APIs") that allow the developers' apps to interface with Facebook. In particular, Facebook allegedly has made key APIs available to third-party applications *only* on the condition that they refrain from developing competing functionalities, and from connecting with or promoting other social networking services.

The complaint alleges that Facebook has enforced these policies by cutting off API access to blunt perceived competitive threats from rival personal social networking services, mobile messaging apps, and other apps with social functionalities. For example, in 2013, Twitter launched the app Vine, which allowed users to shoot and share short video segments. In response, according to the complaint, Facebook shut down the API that would have allowed Vine to access friends via Facebook.

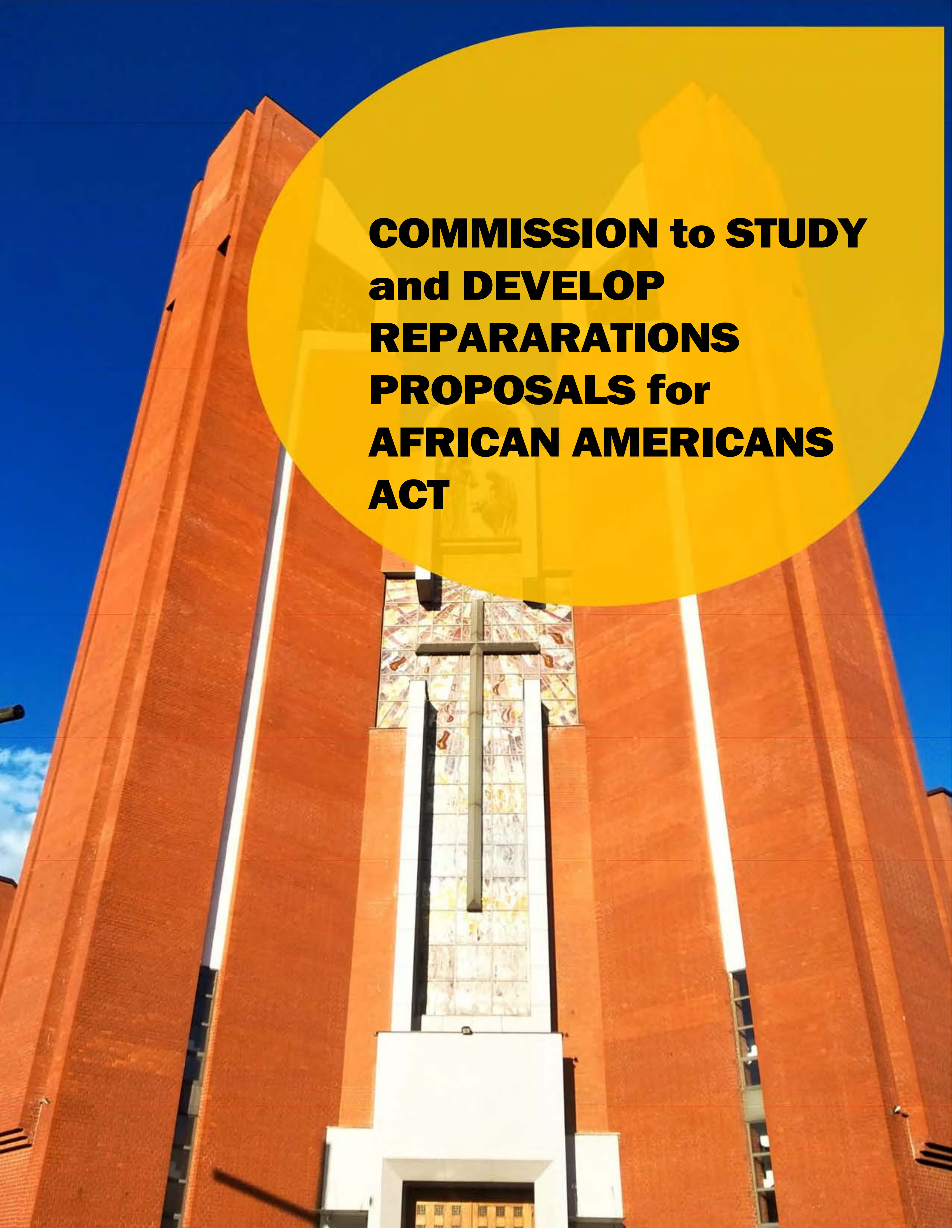
The lawsuit follows an investigation by the FTC's Technology Enforcement Division, whose staff cooperated closely with a coalition of attorneys general, under the coordination of the New York State Office of the Attorney General. Participating Attorneys General include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

The Commission vote to authorize staff to file for a permanent injunction and other equitable relief in the U.S. District Court for the District of Columbia was 3-2. Commissioners Noah Joshua Phillips and Christine S. Wilson voted no.

NOTE: The Commission issues a complaint when it has "reason to believe" that the law has been or is being violated, and it appears to the Commission that a proceeding is in the public interest.

The Federal Trade Commission works to promote competition, and protect and educate consumers. You can learn more about how competition benefits consumers or file an antitrust complaint.

https://oag.dc.gov/sites/default/files/2018-12/Facebook-Complaint.pdf



COMMISSION to STUDY and DEVELOP REPARARATIONS PROPOSALS for AFRICAN AMERICANS ACT

118TH CONGRESS
1ST SESSION

H. RES. 414

Recognizing that the United States has a moral and legal obligation to provide reparations for the enslavement of Africans and its lasting harm on the lives of millions of Black people in the United States.

IN THE HOUSE OF REPRESENTATIVES

MAY 17, 2023

Ms. BUSH (for herself, Ms. LEE of California, Ms. TLAIB, Ms. PRESSLEY, Mr. BOWMAN, Mrs. RAMIREZ, Ms. LEE of Pennsylvania, Ms. OMAR, Mr. JACKSON of Illinois, and Mr. GREEN of Texas) submitted the following resolution; which was referred to the Committee on the Judiciary

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RESOLUTION

Recognizing that the United States has a moral and legal obligation to provide reparations for the enslavement of Africans and its lasting harm on the lives of millions of Black people in the United States.

Whereas Black people are, and have always been, human beings, yet the Federal Government has historically failed to recognize our dignity and humanity;

Whereas reparations are defined as a victim-centered process by which survivors of atrocities and serious human rights violations, and their descendants, have the right to seek restitution, compensation, rehabilitation, satisfaction, and guarantees of nonrepetition for past and ongoing harms;

Whereas to meet the international legal obligation of reparations, the Federal Government must compensate descendants of enslaved Black people and people of African descent in the United States to account for the harms of chattel slavery, the cumulative damages of enslavement, and the epochs of legal and de facto segregation;

Whereas the Federal Government is responsible for—

(1) policies that led to the economic, political, and social erosion of Black communities;

(2) failing to keep Black people safe from or actively sanctioning White domestic terrorism and failing to prosecute it when it occurred;

(3) the impacts of government-imposed segregation leading to harmful health outcomes and environmental racism;

(4) the ongoing harms of racialized mass incarceration and family separation, oppressive and abusive criminalization, and the continued impact of embedded historical harms of the criminal legal system on Black people and Black communities; and

(5) banking, consumer, housing, health, education, and employment discrimination;

Whereas reparations must be administered by the Federal Government to descendants of enslaved Black people and people of African descent for sanctioning the kidnapping and trafficking of human beings, creating and maintaining a violent racial hierarchy, embedding slavery and other methods of economic exploitation into the fabric of society, and emboldening White supremacy with legal, social, and economic tools of control;

Whereas the full length of legalized slavery's impact on Black wealth creation and well-being today, including the nearly

300 years of chattel slavery from the year 1502, when enslaved Africans were brought to Hispaniola and later their descendants brought to United States territory, to the year 1789, when the first Congress met, must be recognized and fully accounted for;

Whereas, over the course of nearly 300 years, at least 12,500,000 Africans were kidnapped from their homelands by European traders and forcibly brought across the Atlantic Ocean in one of the largest forced displacements in human history, and at least 2,000,000 did not survive the horrifying, brutal, and grueling journey across the Atlantic, also known as the Middle Passage and Maafa;

Whereas forcibly separating Black families, often with members being transferred to the Caribbean, was a murderous and tortuous reality for millions of enslaved people who had to endure separation from loved ones they could no longer talk to or keep in contact with, perpetuating deep psychological and emotional trauma;

Whereas Spanish colonizers brought enslaved Africans to modern-day Florida in 1565;

Whereas 1619, a year before the Mayflower arrived on American shores, marked the first year White Virginians purchased around 30 enslaved Angolans from Portuguese traders who were forcefully transported through the trans-Atlantic slave trade, thereafter launching a violent system of racial subjugation, exploitation, and genocide;

Whereas, from the Nation's founding in 1776, Federal policies produced and sustained the institution of slavery, thus voluntarily accepting the British legacy of the institution, and with it, the responsibility to provide reparations;

Whereas the Founders in drafting the Constitution preserved slavery and racialized social stratification through systemic measures, without needing to explicitly mention harmful intent and racialized impacts;

Whereas the Founders and their contemporaries understood freedom and liberty in direct relation to enslaved people and in their capacity to enslave Black people;

Whereas the trade in and chattelization of human beings is referenced in 3 sections of the Constitution, namely article I, section 9, clause 1, which expressly sanctioned the continuation of the international slave trade for 20 years, article I, section 2, clause 3, which upheld the further dehumanization of the African by relegating their status to that of three-fifths of a White man, and article IV, section 2, clause 3, which egregiously mandated the capture and return to enslavement of fugitives;

Whereas the system of enslavement served to unite all Thirteen Colonies under the banner of White supremacy;

Whereas, of the Nation's first 12 Presidents, 10 enslaved Black people;

Whereas President James K. Polk traded enslaved Black people from the Oval Office;

Whereas enslaved Black people built the United States Capitol and the White House;

Whereas more than 1,700 United States Congressional Members who served in the 18th, 19th, and 20th centuries had enslaved Black people, including the first woman elected to the United States Senate, Senator Rebecca Latimer Felton;

Whereas the Dred Scott v. Sanford legal ruling in 1857, which decided that enslaved Black people were not citizens of the United States under article III, was decided by 5 slaveholding Supreme Court Justices, including Chief Justice Roger B. Taney and Associate Justices John Campbell, John Catron, Peter Daniel, and James Moore Wayne;

Whereas the horrors of chattel slavery are immeasurable and have led to generational trauma for millions of Black people;

Whereas enslaved people were prohibited and denied the right to maintain their indigenous languages, faiths, and cultural practices and traditions from Africa;

Whereas the most productive enslaved people were often whipped the most violently and were often used as breeders to save slave owners from purchasing enslaved persons;

Whereas the ban on importation of Africans for enslavement was implemented in 1808, driving trade underground and increasing the numbers of enslaved people through childbirth as the sole method available;

Whereas millions of enslaved Black women were routinely raped, sexually assaulted, and tortured at the hands of their White enslavers, and others were purchased and forced to staff brothels, all of which reinforced White male dominance and gender hierarchy;

Whereas the rape of enslaved Black women grew so routine that some have calculated that over 60 percent of enslaved women and girls experienced sexual coercion and rape in their lives, and that 1 out of every 6 Black persons born into captivity in 1860 was born as a byproduct of the rape of a young, teenage, enslaved girl;

Whereas infant mortality rates on plantations were incredibly high, and in the South, 50 percent of enslaved infants were stillborn or died within the first year of life in the early 1800s;

Whereas the enslavement of Black people became an indispensable economic driver in the United States, allowing White Americans in both the South and the North to enjoy the profit of unpaid and dehumanizing labor;

Whereas the enslavement of Black people and the country's commitment to using unflinching violence and oppression created an endless supply of labor-enriched White slaveowners and their descendants, fueled the country's economy while suppressing self-determination and wealth-building for enslaved Black people, and postemancipation, left newly freed Black people with zero wealth and landless, with a lack of education, poor health, and severed family and homeland ties;

Whereas the economy of the United States was founded on the production of tobacco, rice, sugar, and cotton, all of which were planted, harvested, and produced by enslaved Black people;

Whereas the economy of the United States, in both the North and South, flourished as a result of Black trafficking, torture, and exploitation;

Whereas, while New York began to abolish slavery in 1799, New Yorkers invested heavily in the Southern plantations, insured enslaved people as collateral, produced the agricultural tools that were used in Southern plantations, and funded the building of ships that were used to traffic enslaved people;

Whereas, by 1831, the United States was delivering nearly half the world's raw cotton crop as a result of chattel slavery;

Whereas, from 1801 to 1862, the amount of cotton picked daily by an enslaved person increased by 400 percent;

Whereas cotton produced by enslaved people accelerated worldwide commercial markets in the 19th century, creating demand for innovative contracts, novel financial products, and modern forms of insurance and credit that will define financial markets for centuries to come;

Whereas, in 1861, the value placed on cotton produced by enslaved Black people was $250,000,000, or more than $8,200,000,000 today;

Whereas the bodies of enslaved people, gorged and congealed in the name of White supremacist hate, became the single largest financial asset of property in the United States that were purchased through loans, repaid with interest, and insured with exorbitant policies;

Whereas the vending, bartering, and selling of enslaved people, and with it the forced separation of Black families, became a self-sustaining economy bringing in trillions of dollars across the United States;

Whereas White slaveowners used enslaved people as partial to full collateral in 8 out of 10 loans to access more wealth and resources, often to purchase more enslaved people;

Whereas enslaved people themselves became commodities that, by 1860, were valued at over $4,000,000,000;

Whereas, in 1857, in the Dred Scott v. Sanford decision, the Supreme Court held that Black people were not citizens of the United States, and therefore, had no rights to be respected, thereby further codifying White supremacy into law;

Whereas the institution of slavery was so powerful and corrosive that it helped to both create the wealth of the United States, and also threatened to entirely destroy the fabric of the Union during the Civil War;

Whereas 78 percent of military-age free Black men served in the Union Army, and 200,000 Black men enlisted in the Union to fight during the Civil War, accounting for 1 in 10 Union soldiers;

Whereas Confederate soldiers often killed Black soldiers rather than capture them, and also enslaved Black war captives during the Civil War;

Whereas President Abraham Lincoln signed the Homestead Act in 1862, which by 1934, when the Act ended, had granted more than 270,000,000 acres of land in the West to White people virtually for free;

Whereas, even after the Emancipation Proclamation, Confederate States ignored Lincoln’s emancipation order and maintained the institution of slavery;

Whereas slavery did not legally end until 1865, with the close of the Civil War;

Whereas, while the 13th Amendment is known to have abolished slavery and indentured servitude, it made an exception for those convicted of crimes;

Whereas, rather than shrinking after the technical abolition of slavery, Southern plantations increased in size, as for example, the number of Louisiana plantations in selected parishes increased by 286 percent between 1860 and 1880;

Whereas, following the Civil War, in 1865, Confederate veterans founded the Ku Klux Klan, a group that would unleash genocidal violence and a reign of terror across the country for decades to come;

Whereas the Federal Government provided reparations to White slaveowners in the District of Columbia for the loss of human property through the Compensated Emancipation Act of 1862, while never addressing the need for restitution to enslaved Black people and their descendants;

Whereas the Bureau of Refugees, Freedmen, and Abandoned Lands Bureau, also known as the Freedmen's Bureau, was established to provide economic and social aid to formerly enslaved Black people in 1865, but was eventually looted and corrupted by White politicians and businessmen, resulting in its demise in 1872, and in more than 60,000 Black people and organizations losing their deposits and having to wait years for only a fraction of them to be returned;

Whereas, Callie House, a formerly enslaved Black woman, alongside Reverend Isaiah Dickerson, founded the Ex-Slave Mutual Relief, Bounty and Pension Association in 1898, in a mass effort to pass Federal pension legislation for formerly enslaved people, and whose efforts were ultimately shut down by Federal agencies;

Whereas an estimated 6,500 racial terror lynchings took place between 1865 and 1950;

Whereas, in a series of outbreaks of race-related violence, an estimated 39 to 150 Black people were murdered in 1917 in the East St. Louis "Riots" and another 6,000 were left homeless;

Whereas the East St. Louis "Riots" has been described as the "worst case of labor-related violence in 20th-century American history";

Whereas more than 200 Black people were killed and another 6,000 were left homeless during the 1919 attack and lynching in Moberly, Missouri, costing $400,000 ($8,460,000 in 2022) in property damage;

Whereas White supremacists, deputized by Tulsa officials, raided, mobbed, massacred, and completely burned down nearly 40 city blocks of Tulsa's Greenwood District, a self-sustaining Black economy, also known as "Black Wall Street", in 1921;

Whereas White supremacists raided, mobbed, massacred, and completely burned down a small but thriving Black community, Rosewood, Florida, in 1923, in addition to countless other Black communities across the United States;

Whereas the massacres in Tulsa and Rosewood were only 2 of more than 100 White supremacist massacres that occurred from the end of the Civil War to the 1940s;

Whereas Black voters and political candidates were intimidated, harassed, violently suppressed, and sometimes murdered for simply exercising their constitutional right to vote;

Whereas participation of Black voters in electoral processes were routinely suppressed by poll taxes and literacy tests to preserve White supremacy;

Whereas the Supreme Court codified the "separate but equal" doctrine in Plessy v. Ferguson in 1896, thereby allowing racial segregation laws to exist and enshrining a racial caste system in the United States;

Whereas not only were enslaved people never granted any form of compensation after the abolition of slavery, they were thrust into a near-century-long epoch of legal segregation through Jim Crow laws;

Whereas, after emancipation, laws that governed slavery were retooled into Black Codes to control free Black people, thereby establishing a criminal legal system that sanctified the continuation of slavery by another name;

Whereas so unbearable were these Black Codes and the brutality of Jim Crow, that 6,000,000 Black people were displaced and forced to migrate to the North seeking some form of safety and political asylum within the border of their own country during ‘‘The Great Migration’’, also known as ‘‘The Great Displacement’’;

Whereas the Federal Government abdicated its responsibility to protect its own citizens from relentless violence, resulting in the displacement of millions of Black people between 1916 and 1970, many of whom were refugees from White supremacist violence;

Whereas, from Mississippi to Minnesota, States began to criminalize any form of resistance to racial hierarchies and expand their criminal codes as ‘‘The Great Migration’’ began to expose racial fault lines across the country;

Whereas medical experimentation on Black people without their consent, including forced gynecological experiments on enslaved Black women and the Government-sponsored Tuskegee Syphilis Experiment on Black men, led to major medical discoveries, at the full expense of Black people's humanity, dignity, and rights;

Whereas, at the end of World War I, Black veterans returned to their homes and were assaulted for daring to wear the United States uniform;

Whereas Black people were intentionally and systematically excluded from Federal social service programs;

Whereas, despite being disproportionately affected by unemployment during the Great Depression, Black people were largely excluded from New Deal programs;

Whereas Black people were excluded from the Social Security and Wagner Acts of 1935 and the Fair Labor Standards Act of 1938;

Whereas 65 percent of Black people nationally and 70 to 80 percent of Black people in the South were ineligible for Social Security when it was signed into law by President Roosevelt in 1935;

Whereas Black neighborhoods have been divided and effectively destroyed by Federal highways systems and the fraudulent use of eminent domain;

Whereas the racist origins of the Federal Housing Administration, subsequent discriminatory housing policies, coupled with anti-Black business practices, conspired to concentrate wealth in White neighborhoods;

Whereas, from the 1930s to the 1960s, Black people across the country were effectively barred from the home-mortgage market, thereby locking Black people out of the greatest opportunity for wealth accumulation in the history of the United States;

Whereas many States barred Black people from fully participating in the Aid to Dependent Children Program;

Whereas Black veterans were disqualified from receiving title III benefits of the G.I. Bill, benefits which provided veterans with access to low-income home loans;

Whereas this form of exclusion from Federal programs that provide economic and Social Security measures has continued well into the 21st century;

Whereas, well into the 1960s, Black people in the Deep South were unaware they were freed and forced to work, violently tortured, and raped;

Whereas, despite the historic Brown v. Board of Education ruling deeming racial segregation in public schools as unconstitutional, public schools serving Black students remain inherently separate and unequal, receiving $23,000,000,000 less in school funding;

Whereas, in 1948, Missouri was a catalyst in securing equal housing for Black people across the country with the passage of Shelley v. Kraemer, striking down racial restrictive housing that prevented people of the "Negro or Mongolian Race" from purchasing homes;

Whereas, in 1963, Governor George Wallace blocked Black students at the schoolhouse door of the University of Alabama;

Whereas mass protests erupted across the United States during the civil rights era demanding an end to racial segregation, disenfranchisement, and institutionalized racism that resulted in the passage of the Civil Rights Acts of 1964 and 1968, the Voting Rights Act of 1965, and the end of legalized school segregation;

Whereas the FBI established the Counterintelligence Program, also known as COINTELPRO, in 1956, with one of its major goals to target Black activists fighting for self-determination, reparations, and racial justice;

Whereas, in 1985, the Philadelphia Police Department dropped a bomb laced with Tovex and C–4 explosives on the MOVE organization, a Black liberation organization, who were living in a West Philadelphia rowhome leaving 11 dead, including 5 children;

Whereas, while the United States was founded based on Black plunder, it has yet to acknowledge, reconcile, and provide adequate redress for the sanctioned system of slavery and its vestiges resulting in modern-day disparities;

Whereas Black people are still presumed dangerous and therefore are systematically targeted and criminalized under our legal system, including through the war on drugs, mandatory minimum sentencing laws, the prosecution of children as adults, and the disproportionate targeting, stopping, and arresting of Black people by law enforcement;

Whereas 1 in 16 Black people of voting age is barred from actively participating in the democracy of the United States, including through disenfranchisement due to felony convictions;

Whereas Black agricultural landowners have been dispossessed from at least 90 percent of their land due to racially discriminatory practices by the Department of Agriculture and private companies;

Whereas Black communities bear the brunt of environmental racism and remain disproportionately impacted by ex-

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Whereas Black agricultural landowners have been dispossessed from at least 90 percent of their land due to racially discriminatory practices by the Department of Agriculture and private companies;

Whereas Black communities bear the brunt of environmental racism and remain disproportionately impacted by extreme temperatures and environmental hazards due to the close proximity to places like chemical plants, oil refineries, trash incinerators, construction sites, and waste dumping sites, as a result of lacking of greenery and tree canopies;

Whereas Black women with children remain disproportionately barred from accessing the Temporary Assistance for Needy Families program;

Whereas, while the legacy of slavery still affects our society today, it is rarely taught comprehensively in our school systems;

Whereas the school systems of the United States are committing educational malpractice by treating this country's history of slavery and racial hierarchy as an aberration;

Whereas, since January 2021, over 44 States have proposed legislation or taken other steps to ban teaching of the ways in which racism has shaped the law and way of life in the United States, and 18 States have already imposed bans;

Whereas Black students are suspended from school at a rate 4 times greater than White students, and Black girls, despite being only 19 percent of preschoolers, make up 54 percent of girls suspended from preschool, effectively funneling Black children into the school-to-prison pipeline;

Whereas the legacy of racialized barriers to education is still so prevalent today, that Black women graduate from a 4-year degree with 60 percent more debt than their White male peers;

Whereas the Federal Government repeatedly abdicated its responsibility to adequately acknowledge and provide redress for the crimes of enslavement and the continuation of racial subjugation, and cannot absolve itself of its responsibility today;

Whereas, under fundamental international human rights law, governments have an obligation to provide full and effective remedies for violations of human rights, including acts of racial discrimination, and victims of human rights violations have the right to pursue such remedies;

Whereas Black people are often funneled into some of the most difficult jobs with lower wages, and continue to be targets of wage and land theft, exploitation, and deprivation of fundamental human rights;

Whereas the racial wealth gap is a direct legacy of chattel slavery in the United States and the continued displacement, exploitation, and sanctioned theft of formerly enslaved Black people and their descendants;

Whereas the Federal Government must eliminate the Black-White racial wealth gap as it is a direct legacy of chattel slavery and the cumulative impact of legal and de facto segregation that followed;

Whereas financial reparations must be paid by the Federal Government for an amount that respected economists have estimated totals, at minimum, $14,000,000,000,000 to eliminate the racial wealth gap that currently exists between Black and White Americans;

Whereas scholars have estimated that the United States benefitted from 222,505,049 hours of forced labor between 1619 and the end of slavery in 1865, which would be valued at $97,000,000,000,000 today;

Whereas if the United States closed racial gaps for Black people in the areas of housing, education, wages, and investment 20 years ago, $16,000,000,000,000 could have been added to the economy;

Whereas the damage experienced by Black people stemming from enslavement and its evolutions is not confined solely to economics or the racial wealth gap, and should take in account centuries of forced labor postenslavement, denials of employment, predatory lending practices, and ongoing banking discrimination, as well as educational inadequacies, health disparities, cultural degradation, and the criminal punishment system;

Whereas the Federal Government must formally apologize for the state-sanctioned institution of chattel slavery and subsequent anti-Black institutions, laws, and practices;

Whereas reparations call for the interrogation, overhauling, and end of abusive Federal institutions that continue to inflict unjustifiable harms on Black people today;

Whereas the Federal Government must compensate the descendants of enslaved Black people and people of African descent in the form of direct monetary reparations for the harms and vestiges of chattel slavery and its evolutions, as well as with other targeted benefits;

Whereas the Federal Government must return, restore, or provide adequate remedy for property unjustly stolen from Black families through the use of racially restrictive covenants and eminent domain;

Whereas the Federal Government must pay its debt, in all necessary forms, to descendants of enslaved Black people and people of African descent in order to support a continuous and holistic healing process;

Whereas a holistic program for reparations must address the wealth extracted from our communities through environmental racism, slavery, food apartheid, housing discrimination, and racialized capitalism in the form of corporate and government reparations focused on healing ongoing physical and mental trauma, and ensuring access to and control of food sources, housing, and land;

Whereas a comprehensive reparations program must include rehabilitative measures such as trauma-informed care to address inheritance of historical and intergenerational traumas;

Whereas the historical and present systemic harms stemming from slavery are multifaceted and were inflicted at multiple levels, and thus the establishment and implementation of reparations can never truly restore the physical, psychological, and cultural damage done, however, as a form of redress, it can address harms and cumulative damages;

Whereas the Federal Government has provided compensation and other forms of redress to other communities against which it has committed gross human rights violations, including Japanese Americans pursuant to the Civil Liberties Act of 1988, who were forcibly removed and incarcerated in concentration camps in World War II;

Whereas the Federal Government abdicated its responsibility time and time again to adequately acknowledge and provide redress for the crimes of enslavement and the continuation of racial subjugation and never enacted resolutions formally apologizing for slavery or H.R. 40, the Commission to Study and Develop Reparation Proposals for African Americans Act;

Whereas the Federal Government must engage in a holistic reparations process of repair, healing, and restoration of a people injured, because of their group identity, by governments, corporations, institutions, and families;

Whereas a holistic program for reparations must address the cultural and educational exploitation, erasure, and extraction of Black communities by establishing public school curricula that critically examine the political, economic, and social impacts of chattel and slavery, Jim Crow, and post Jim Crow era discrimination and funding to support, build, preserve, and restore cultural assets and sacred sites to ensure the recognition and honoring of our collective struggles and triumphs;

Whereas the Federal Government via the National Parks Services must seek to erect markers on every site where a Black person was lynched, a massacre of Black people was committed, and Black towns or neighborhoods were destroyed;

Whereas the Federal Government must restore and preserve African burial grounds, Black cemeteries, and other significant cultural and historical sites;

Whereas the Federal Government must recover and identify physical remains of victims of state-sanctioned racial violence and help resource proper burial of remains at the direction of connected family and community members;

Whereas the Federal Government must restore the voting rights of all formerly and currently incarcerated persons;

Whereas the Federal Government must amend the 13th Amendment to the Constitution, which formally abolished slavery, to repeal the punishment clause, which reads "except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction", which implies that Black people convicted of crimes can be legally held in bondage;

Whereas the Federal Government must exonerate Marcus Mosiah Garvey and Callie House for their unjust targeting and imprisonment, and the President should issue a posthumous pardon to them;

Whereas the Federal Government should establish targeted funds to be administered by the National Publishers Association and the National Association of Black Owned Broadcasters to support the work of Black-led news programs, radio and television broadcasting dedicated to cultural education, and civic engagement for the benefit of Black Americans;

Whereas the Federal Government should provide free education to students attending historically Black colleges and universities, who are committed to serving Black communities, provide monetary incentives to local school districts that adopt and implement a curriculum on the history of people of African descent, and ensure that the Department of Education provides and supports educational programming that comprehensively and deliberately encourages the incorporation of lessons and curricula on slavery and its vestiges;

Whereas the Federal Government must support Black farmers and enable them to seek adequate judicial remedies, as well as expand and compete in the United States and global economy;

Whereas the Federal Government must institutionalize and support culturally appropriate, holistic, preventive, mental health, and curative treatment services to Black communities;

Whereas the Federal Government must support and strengthen community-based infrastructure such as hospitals and medical facilities that specialize in services for Black communities;

Whereas, in 2021, the United Nations High Commissioner for Human Rights urged the United States to end anti-Black racial discrimination, violence and systemic racism against people of African descent by providing comprehensive reparations;

Whereas, in 2022, the United Nations Committee on Elimination of All Forms of Racial Discrimination recommended implementation of a Federal reparations commission to develop reparation proposals as key strategy for achieving racial justice;

Whereas, in other countries, including South Africa, Canada, Colombia, and others, poorly designed reparations processes have not only failed to bring complete justice, but have created new forms of harm;

Whereas reparations are fundamentally a justice and accountability process that should carry more symbolic and practical power than traditional social policy; and

Whereas reparations programs should be distinguishable from the Federal Government's responsibility for people's general welfare, including routine social services and development aid: Now, therefore, be it

Resolved, That the House of Representatives—

(1) recognizes the responsibility of the Federal Government to provide reparations, in all necessary forms, including financial compensation, to rectify ongoing harms resulting from violations, by the Fed-

eral Government, of Black people's human right to self-determination and freedom from discrimination, including with respect to housing, health, education, life, security of person, water and sanitation, and a healthy environment;

(2) encourages support, passage and implementation of H.R. 40, the Commission to Study and Develop Reparation Proposals for African-Americans Act, which has been introduced every year since 1989, via Congress or the executive branch;

(3) encourages the reintroduction, passage, and implementation of legislation establishing the United States Commission on Truth, Racial Healing, and Transformation;

(4) acknowledges and apologizes for the state-sanctioned institution of chattel slavery, and encourages the reintroduction and enactment of resolutions apologizing for slavery, without any limiting clauses;

(5) acknowledges the significance of and momentum brought by legacy organizations as well as additional grassroots and national organizations leading the modern-day reparations movement;

(6) encourages the creation of local, State, and Federal initiatives to identify sources of reparations

demands arising from chattel slavery and its longstanding impact on Black people; and

(7) honors the lives and legacies of those named and unnamed whose lives were stolen by the institution of chattel slavery and other forms of state-sanctioned violence in the United States.

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As individuals who historically have supported the passage of H.R. 40 and the movement for Black reparations, we are available for consultation on the subject and look forward to a favorable response.

We thank you in advance.

Sincerely

Organizations
AAPI Montclair
Academy for Diaspora Literacy, Inc.
Accomplices of the Dayton Area SURJ
African American Future Society
African Diaspora for Justice (AD4Justice.org)
AJ Williams-Myers Africanroots Center
All Souls Movement
American Humanist Association
Amherst extensions & beauty salon
Amnesty International USA
Artists for Reparations
Austin Justice Coalition
Beacon UU Congregation
Bend the Arc: Jewish Action
Berkeley Chapter, Japanese American Citizens League
Bethel AME CHURCH
Biddeford Saco Area SURJ
Black Jewish Justice Alliance
Black Mental Health Task Force
Black Music Action Coalition
Black Veterans Project
Blacks in Law Enforcement
Black Voters Matter Fund
BLK FLWR MRKT
Blount County (TN) SURJ (Showing Up for Racial Justice)
Blue
Boston Workers Circle
Campaign For Justice: Redress NOW for Japanese Latin Americans!
Cash Reparations for Slavery
Central VT SURJ (Showing Up for Racial Justice)
Church WORLD SERVICE
Collaborating Voices Foundation
Collective Grant Writing & Consulting
Coming to the Table
Coming To The Table Tucson Chapter

Community Healing Network, Inc.
Community Health Councils
Congressional black Caucus
CTTT Denver
Dayton Chapter Japanese American Citizens League
DC Justice Lab
Decolonizing Wealth Project
Democrats Abroad Reparations Task Force
Difficult Conversations About Race
Drug Policy Alliance
Edfu Foundation Inc.
Embracing Race
Emmett Till Legacy Foundation
Executive Director/Community Stabilization Project
Faith for Black Lives
Faith in New Jersey
Father's Alive In The Hood Inc
FirstRepair
Friends Committee on National Legislation
Friends of the African Union
Fund For Reparations NOW!
Global Progressive Caucus, Democrats Abroad
Grassroots Reparations Campaign
Green Earth Goods
High School Democrats of America National Black Caucus
Human Rights Watch
https://amcrecordsmedia.com/
IKAR
Incarcerated Nation Network
Insight 2 Heal, Inc.
Integrative Wellness, Inc
Inter-Racial Wellbeing and Racial Justice Committee, West Knoxville Friends Meeting
Interfaith Council of Franklin County, MA
International Black Women's Congress
International Black Women's Congress
International Center for MultiGenerational Legacies of Trauma
International Civil Society
International Institute for Health and Wellness
Islamophobia Studies Center
It Takes A Village Family of Schools
Japanese American Citizens League
Japanese American Citizens League, Florin-Sacramento Valley Chapter
Japanese American Citizens League, Seattle Chapter

Japanese American Citizens League, Twin Cities Chapter
Japanese American Families for Justice
Japanese American Museum of Oregon
Japanese American National Museum
Japanese Community Youth Council
Japanese Peruvian Oral History Project
JBS FOUNDATION, INC.
Johnson & Klein Law
JP Consulting LCSW PLLC
Jrinks By Jenn
Loretto Community
Lost River Racial Justice (SURJ affiliate)
Lowenstein International Human Rights Clinic
Make It Plain
Mindbridge
N'COBRA "Chicago Chapter"
NAACP Newark, NJ

National Black Church Initiative
National Black Justice Coalition
National Coalition of Blacks for Reparations in America
National Coalition of Blacks for Reparations in America - New England Chapter
National Conference of Black Lawyers (NCBL)
National Consumers League
National Council of Churches
National Council of Jewish Women San Francisco
National Council of Negro Women, Inc - Hudson Valley Section
National Japanese American Historical Society, Inc.
National LGBTQ+ Bar Association
National Nikkei Reparations Coalition (NNRC)
National Organization for Women
NAWS Central Queens
NETWORK Lobby for Catholic Social Justice
New Brunswick Area NAACP
New England Peace Pagoda
New Jersey Institute for Social Justice
New York State Democrat Party
Next Generation Action Network (NGAN)
Not in Our Town Princeton
One-People, One Each
Oranges & Maplewood NAACP
Outta Bound Sportz
People's Organization for Progress
Portland Japanese American Citizens League

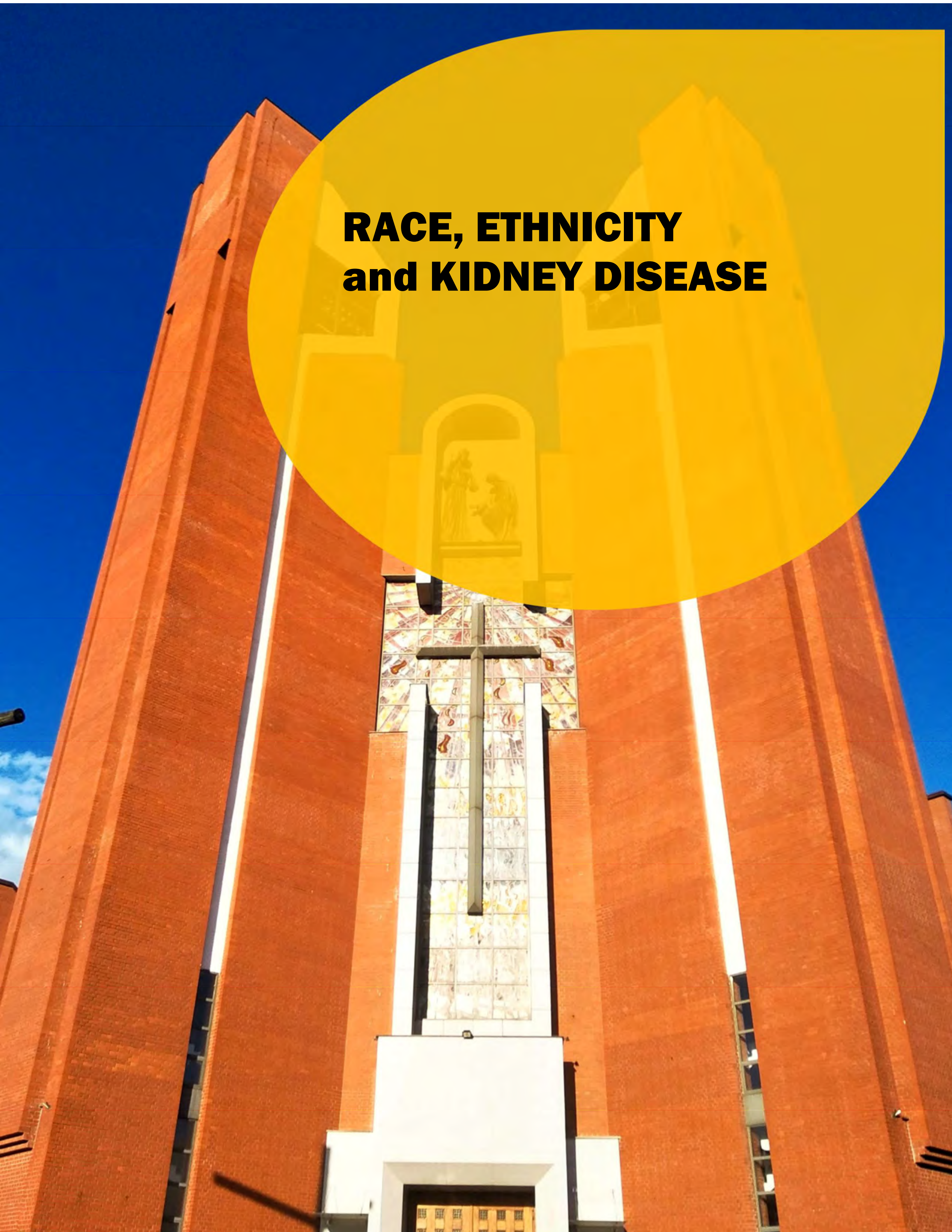
Putney Friends Meeting
Racial Justice Project
Ramapough Mountain Indians, Inc.
RASR
Reparation Education Project
Reparation Generation
Reparations Circle Denver
Reparations Committee of the Jewish Community of Amherst
Reparations Community of Practice
Reparations Finance Lab
Reparations United
Reparations4Slavery.com
Restorative Genealogy
Rising Voices, a Project of Center for Empowered Politics
SAFES
Samuel DeWitt Proctor Conference, Inc.
San Francisco Black & Jewish Unity Coalition
San Jose Nikkei Resisters
Sankofa Farm at Bartram's Garden
Showing Up for Racial Justice - St. Johns, Portland OR
Showing Up for Racial Justice -- Twin Cities Chapter
Showing Up for Racial Justice (SURJ) Boston
Showing Up for Racial Justice (SURJ) Rochester
Showing Up for Racial Justice Annapolis and Anne Arundel County (SURJ3A)
Showing Up for Racial Justice NYC
Showing Up for Racial Justice, Santa Barbara Chapter
Showing Up for Racial Justice, Santa Cruz County
Singles Pop Up
Sisters of Charity of Nazareth Congregational Leadership
Sisters of Charity of Nazareth Western Province Leadership
Sisters of Mercy of the Americas Justice Team
Sketch House Games
Social Justice at Trinity Asbury Park
Social Justice Matters, Inc.
Springfield Unity Project
Standing Up for Racial Justice (SURJ), San Diego Chapter
Standpipe Hill Strategies
Storywiz Records
SURJ Marin
SURJ Mendo Coast
SURJ Sacramento (Showing Up for Racial Justice)
Synergy Unlimited LLC
Take Action Advocacy Group

Temple Isaiah (Lexington MA) Reparations Committee
Terence Crutcher Foundation
The Asbury Park Affordable Housing Coalition
The Asbury Park Transformative Justice Project
The Cardinal Recreation Park
The Diocese of New Jersey
The E Pluribus Unum Project
The Goodnight Initiative
The International Institute for Health and Wellness
The Northampton Reparations Committee
The Nuance Company
The Reparations Collective
The Taifa Group
The Who We Are Project
The Workers Circle
Tremain Smith Studio
Tsuru for Solidarity
Tule Lake Committee
Tulsa African Ancestral Society
UN PFPAD - International Civil Society Working Group
UNESCO Inclusive Policy Lab | People of African Descent & the SDGs E-Team
Union for Reform Judaism
United Asian Voices of West Orange
United Parents Against Lead & Other Environmental Hazards (UPAL)
University of California, Santa Cruz
Until Freedom
Vashon-Maury SURJ - Showing Up for Racial Justice
Virginia Environmental Justice Collaborative (VEJC)
West Knoxville Friends Meeting
Westchester Black Women's Political Caucus
Where Is My Land
Whm Msw Healing Well Inc
YAH's House
Yonkers City Council, District 1
Young Buddhist Editorial

Individuals
Ms. Sharin Alpert
Alice Pierce-Bonifaz, Ph.D.
Ms. Zia Bowen
Ms. Olivia Dennen, University of California, Santa Cruz
Jacqueline A. Faison, ESL Teacher
Ms. Giovanna
Regina Goodwin, Oklahoma State Representative

Ms. Lee Guion, Coming to the Table
Ms. Beverly Head, Coming to the Table
Ms. Cynthia Henebry
Waymon R. Hinson, Ph.D.
Ms. Diane R. Irvin
Ollie Johnson
Kevin Jones
Keisha Lanell, DBA: Dr. Coach Kay
Sierra Morton, Social Worker
Albert Mosley, Professor Emeritus, Smith College
Effie Phillips, National Council of Negro Women, Inc – Hudson Valley Section
Ms. Elizabeth Sand
Tamara Scott, Attorney
Dee Seligman, Ph.D.
Kisha Skipper, 1st Vice President, YONKERS NAACP UNIT 2188
Imani Williams, Private Teacher
Anthony Lee Williams

Cc: Rep. Sheila Jackson Lee, Lead Sponsor of H.R. 40; Rep. Yvette Clark, 1st Vice Chair; Rep. Troy Carter, 2nd Vice Chair; Rep. Marilyn Strickland, Whip; Rep. Lucy McBath, Secretary; Rep. Hakeem Jeffries, House Minority Leader



RACE, ETHNICITY and KIDNEY DISEASE

Race, Ethnicity, & Kidney Disease

33% of American adults are at risk for kidney disease.

Yes, one in three people.

If you are Black or African American, Hispanic or Latino, Asian American, Pacific Islander, American Indian, or Alaska Native, or Native Hawaiian or Other Pacific Islander, heritage you may be at an increased risk for kidney disease.

Black or African Americans are more than 3 times as likely and Hispanics or Latinos are 1.3 times more likely to have kidney failure compared to White Americans.

Minority populations have much higher rates of high blood pressure, diabetes, obesity and heart disease, all of which increase the risk for kidney disease. Access to healthcare may also play a role.

The key is to find kidney disease as early as possible and understand its risk factors before the trouble starts. Regular testing for everyone is important and is especially important for people at risk.

What is kidney disease?

Healthy kidneys have many important jobs. They remove waste products and extra water from your body, help make red blood cells, help keep your bones healthy and help control blood pressure.

When you have kidney disease, kidney damage keeps the kidneys from doing these important jobs the way they should. Kidney damage may be due to a physical injury or a disease like diabetes, high blood pressure, or other health problems.

If you have kidney disease, you may need to take medicines, limit salt and certain foods in your diet, get regular exercise, and more.

Finding and treating your kidney disease early can help slow or even stop kidney disease from getting worse. But if your kidney disease gets worse, it can lead to kidney failure. If your kidneys fail, you will need dialysis or a kidney transplant to stay alive.

Can anyone get kidney disease?

Yes, anyone can get kidney disease at any age. However, some people are more likely than others to get it.

These are the 5 main risk factors of kidney disease:

- Diabetes (you or your family)
- High blood pressure (you or your family)
- Heart disease (you or your family)
- Family history of kidney failure, diabetes, or high blood pressure
- Obesity

Other important risk factors for kidney disease:

- Black or African American, Hispanic or Latino, Asian American, American Indian, or Alaska Native, or Native Hawaiian or Other Pacific Islander heritage
- Age 60 or older
- Low birth weight
- Prolonged use of NSAIDs, a type of painkillers, such as ibuprofen and naproxen
- Lupus, other autoimmune disorders
- Chronic urinary tract infections
- Kidney stones

Knowing if you are at risk for kidney disease is the first step toward leading a healthier life. We’ve made it easier than ever to know your risk.

It takes just a minute to take our **Kidney Risk Quiz** and find out if you are at risk for developing kidney disease.

Why are minority populations at greater risk for kidney disease?

Some minority populations are more likely to have diabetes as compared to White Americans. In fact, 13% of Black or African Americans adults and 13.2% of Hispanic or Latino adults have been diagnosed with diabetes. American Indians and Alaska Natives are twice as likely to have diabetes as White Americans. Having diabetes can lead to kidney disease and kidney failure.

The rates of kidney failure caused by diabetes have doubled in Asian Americans ages 30-39 between 2000-2010. Diabetes also causes kidney failure more often in Hispanics or Latinos than in White Americans.

High blood pressure is also a serious problem for minorities. High blood pressure strikes more than 1 out of 3 Blacks or African Americans, one of the highest rates in the world. Nearly 1 in 4

Hispanics or Lations has high blood pressure and most do not know that high blood pressure can cause kidney disease.

How does healthcare access play a role?

Minority populations may have less access to healthcare than other Americans. For example, studies found that about one-third of Hispanics or Latinos, 20% Blacks or African Americans, and nearly 1 out of 3 American Indians and Alaska Natives were uninsured.

Many people from minority populations do not even know they have kidney disease until it's in the latest stages. By then it is too late to slow or stop the kidney damage from getting worse.

What can I do to prevent kidney disease?

First, see if you are at risk by taking our one-minute quiz at **MinuteForYourKidneys.org**.

Not all minorities will get kidney disease. And not everyone who has diabetes, high blood pressure, heart disease, older age, or a family history of kidney failure will get it. But if you have any of these risk factors you should:

Get tested for kidney disease. There are two **simple tests** for kidney disease:

- A simple urine test checks to see if you have protein in your urine. Your body needs protein. But it should be in the blood, not the urine. Having a small amount of protein in your urine may mean that your kidneys are not filtering your blood well enough. This can be an early sign of kidney disease.
- A simple blood test for GFR, which stands for glomerular filtration rate. Your GFR number tells you how well your kidneys are working. The lab estimates your GFR using a simple blood test called creatinine (a waste product), along with your age, race, and gender.

Get tested for diabetes, high blood pressure, and heart disease. If you don't know whether you have diabetes, high blood pressure, or heart disease, it's important for you to find out.

Live a healthy lifestyle. Be sure to exercise, eat a healthy diet, lose weight if needed, avoid smoking, and limit alcohol. A healthy lifestyle can keep you from getting kidney disease, and it can also help slow or stop kidney disease from getting worse. Read our 6-Step guide to protecting your kidney health.

If you would like more information, please contact us.

HEALTHCARE DISPARITIES

What’s behind racial disparities in kidney disease?

February 3, 2021

- **By** J. Kevin Tucker, MD, Contributor

My first exposure to kidney disease and its impact on communities of color occurred when I was in high school. An elderly neighbor, who was like a grandfather to me, had been diagnosed with kidney failure. At about the same time, my older first cousin, who had children about my age, was starting dialysis due to kidney failure attributed to hypertension. She would go on to get a kidney transplant. If you ask any African American, he or she is likely to have at least one relative with kidney disease requiring dialysis or transplantation.

Disparities in kidney disease not noted in medical literature until early 1980s

When I began my training in nephrology (kidney disease) in 1993 in Birmingham, Alabama, it was already apparent to me that people of African descent were much more likely to suffer from kidney disease than people of European descent. The dialysis units in Birmingham were filled with black and brown people of all ages, and sometimes multiple family members. In one of the dialysis units, my patients included an African American grandfather and grandson, an African American mother and daughter, and two African American sisters.

Nephrologists had noted anecdotally the striking disparities in rates of kidney disease in African Americans relative to white patients, but it was not widely reported in the medical literature until 1982, when a report titled "Racial Differences in the Incidence of Treatment for End-Stage Renal Disease" was published in the *New England Journal of Medicine*. The authors found that in

Jefferson County, Alabama, the risk of end-stage renal disease due to hypertension was approximately *18 times greater* for African Americans relative to whites.

Underlying conditions do not adequately explain disparities

The explanations for the higher rates of kidney disease in African Americans have generally fallen into two broad categories: higher rates of diseases such as diabetes and hypertension that lead to kidney disease; and poorer access to insurance and medical care, leading to delayed diagnosis and faster progression of kidney disease. Therefore, efforts to reduce the rates of kidney disease in African Americans typically focused on diagnosing and treating diabetes and hypertension.

Despite these efforts, the disparities have persisted. The most recent report from the United States Renal Data Service shows an end-stage renal disease prevalence of 5,855 cases per million for African Americans, compared to 1,704 cases per million for white Americans.

Genetics and biology play only minor role in excess risk

A game-changer in terms of understanding some of the excess risk for kidney disease in African Americans relative to other racial and ethnic groups came in

2010, with the publication of reports showing that variants in the APOL1 gene could confer additional risk. Inheriting two copies of the APOL1 risk alleles carries a significantly higher risk of kidney disease. HIV-positive African Americans with two copies of the risk allele are essentially the only people who develop kidney disease associated with HIV infection. African Americans who develop COVID-19 and carry two of these risk alleles also appear to be at higher risk of acute kidney injury related to the coronavirus infection.

Just as the sickle cell gene carried evolutionary benefits in the form of protection against malaria, the APOL1 risk alleles conferred protection against the parasite that causes African sleeping sickness.

Social determinants of health, race, and racism are key to health disparities in African Americans

While we now understand more about the genetics and biology of kidney disease in African Americans, they play a relatively minor role in their excess risk. Social determinants of health, race, and *racism* are equally — if not more — important in explaining the excess risk of kidney disease in African Americans relative to white Americans.

Kidney disease is not unique in having a clear difference among ethnic groups with respect to risks and outcomes. The same can be said for many chronic diseases including diabetes, heart failure, peripheral arterial disease, asthma, and cancer, as well as for pregnancy. Maternal and fetal outcomes are known to be worse for African American women and infants compared to their white counterparts, even after accounting for education and income.

These disparate health outcomes are indelibly linked to decades of social and economic injustice rooted in racism, the legacy of Jim Crow segregation laws, unfair housing laws, the redlining of communities of color, separate and unequal education systems, environmental racism, an unfair criminal justice system — and the list goes on.

In her presentation for Harvard Medical School's webinar series, "Addressing Health Disparities: Clinical Insights on Race and Social Justice," the Reverend Traci Blackmon, a former nurse and nationally known social justice advocate, described divides found in major cities across the United States, in which African Americans live in neighborhoods that are food deserts with depressed home values, few jobs, and inferior schools. These divides result from governmental policies and societal choices. In order to move the needle on disparities in kidney disease outcomes, it is not enough solely to understand the genetics and the biology of the condition. The societal and institutional barriers that have been erected to benefit one group of individuals over another must be torn down.

Access and advocacy will help, but systemic change is needed to meaningfully improve outcomes

As an additional step to improve outcomes of people of color with kidney disease, individuals with kidney disease should receive timely referrals for specialty care. Those from under-resourced communities are less likely to see a nephrologist prior to starting dialysis, and are therefore also more likely to have poorer outcomes on dialysis. Furthermore, they are less likely to have been evaluated and listed for kidney transplantation prior to starting dialysis. Patients with kidney disease should be empowered to understand the stage of their kidney disease by knowing their eGFR (a way of measuring the kidney's filtering function), to advocate for themselves for referral to a nephrologist, and to advocate for themselves for referral for kidney transplantation.

It will take patients, families, clinicians, and community health advocates working cooperatively to eliminate disparities in rates of kidney disease and its outcomes.

About the Author

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John Kevin Tucker, MD is Chief of Renal Medicine at Brigham/Faulkner Hospital, former director of the BWH/MGH Joint Nephrology Fellowship Program and an Assistant Professor of Medicine at Harvard Medical School. Dr. Tucker has received recognition … See Full Bio

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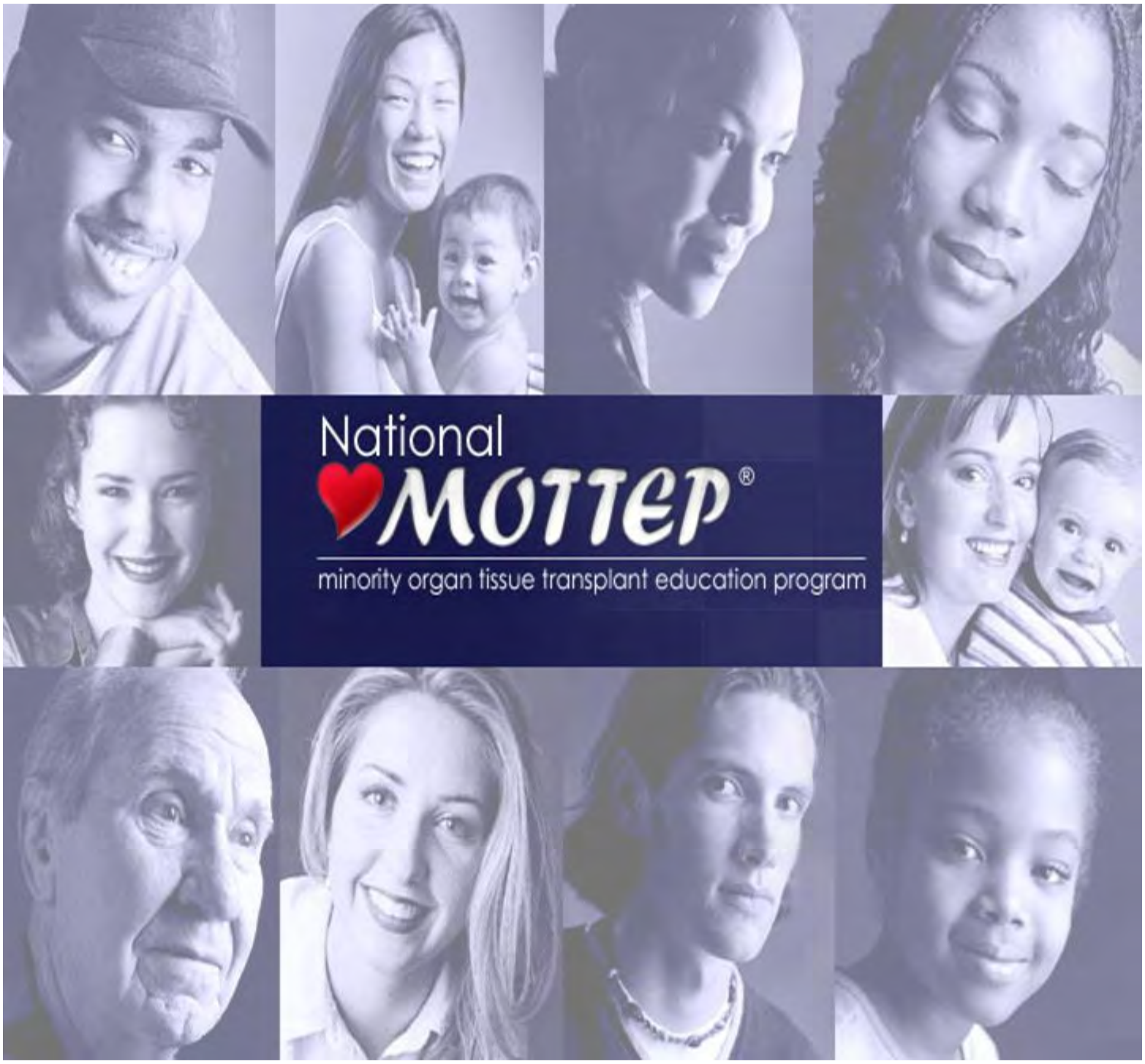

Submitted by: National Minority Organ Tissue Transplant Education Program (MOTTEP) –
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National MOTTEP – EXECUTIVE SUMMARY

The National Minority Organ Tissue Transplant Education Program (MOTTEP) was founded in 1991 by renowned transplant surgeon, Clive O. Callender, MD, FACS. National MOTTEP was conceptualized as a result of the culmination of work beginning in the late 1970’s and the methodology of the D.C. Organ Donor Program and the Dow Chemical Company Take Initiative Program. Significant strides were made between 1982 and 1992. Significant accomplishments of those efforts include African American donor card signings increased from 20/month to 750/month and Black organ donations doubled.

National MOTTEP’s mission is to reduce the rate and number of ethnic minorities needing organ and tissue transplants. National MOTTEP was the first program of its kind to include a two-fold strategy: 1) increase the number of persons becoming organ/tissue donors and 2) increase awareness of the diseases and behaviors that lead to the need for transplantation in the first place. In 2000, National MOTTEP created the campaign, “Love Yourself, Take Care of Yourself,” that promotes disease prevention. In 2006, it developed the Triple-A Effect promoting Awareness, Action and Accountability amongst community individuals.

National MOTTEP began with three cities in 1993 and expanded to 16 by 1995. Its community grass roots, face to face efforts reached an average of 1 million persons each year with its life saving message of prevention and intervention. It is important to emphasize the critical need for National MOTTEP to have sufficient funding to fund the current 7 MOTTEP sites and expand to at least 13 sites total. Lack of funding remains National MOTTEP’s number one inability to continue its work in increasing donation rates among all populations.

The great news is that while the minority donation rate began at 15%, it doubled to 30.9% in 2008. As of 2010, African American organ donors per million is 35.36. This moves African Americans from the bottom to the top by placing it as the number one ethnic group when it was initially thought that African Americans would <u>not</u> donate.

INTRODUCTION

Since its founding in 1991, the National Minority Organ Tissue Transplant Education Program (MOTTEP) has been actively promoting organ and tissue donation and transplantation especially within ethnic minority communities. The mission of National MOTTEP is to reduce the rate and number of ethnic minority Americans needing organ and tissue transplants.

National MOTTEP was founded as a result of Dr. Clive Callender's previous work within the African American community dating back to 1978. The methodology that National MOTTEP still utilizes is based upon the successful local grass roots efforts of the D.C. Organ Donor Program (1982-1988) and the Dow Take Initiative Program (1986-1992) that focused on increasing donation rates among African Americans (A.A.). Between 1982 and 1988, A.A. donor card signings increased from 20/month to 750/month and Black donations doubled. A review of the compendium of data including face to face grass roots presentations combined with a nationwide Black donor media campaign was conducted. Gallup Polls in 1985 and 1990 indicated a tripling of Blacks awareness of transplantation and the number of Blacks signing donor cards.

In 1995, National MOTTEP expanded its efforts to include a two-fold solution of promoting organ/tissue donation while simultaneously promoting disease prevention on behaviors and diseases that lead to the need for transplantation in the first place, (i.e., intervention and prevention). Specifically, the disease prevention component targets hypertension, diabetes, nutrition and physical activity. The disease prevention component led to the development of the "Love Yourself, Take Care of Yourself" campaign in 2001 and is still being promoted today.

National MOTTEP has provided overall strategic planning leadership, developed and provided educational materials, and pursued viable partnerships. All of the MOTTEP cities perform on a grass roots, face-to-face level while continuing to meet National MOTTEP's mission and community needs with creative programs such as Healthy Hair targeting beauty salons and promoting donation and wellness; hosting community symposiums such as the Kountz/Callender/Drew Symposium honoring the memory of Dr. Samuel Kountz (first African

American Transplant Surgeon), the pioneering efforts of Dr. Clive Callender and the memory of Dr. Charles Drew.

NATIONAL MOTTEP'S MISSION

The mission of National MOTTEP is to decrease the number of ethnic minority Americans needing organ and tissue transplants. National MOTTEP has used surveys in past years to evaluate the effectiveness of its successful methodology as indicated below (Table 1):

Figure 1: Specific Goals

Goals	**Tracking Methods Used**
1) Increase the number of individuals, especially ethnic minorities who are knowledgeable about organ/tissue donation and transplantation.	Pre- and post-knowledge and attitude surveys
2) Increase the number of ethnic minorities who have family discussions about donation.	Pre and post surveys
3) Increase the number of ethnic minorities willing to donate organs and tissues.	Actual number of individuals donating organs and tissues
4) Increase the number of ethnic minorities who are willing to adopt healthier life styles and behavior patterns resulting in a decreased need for transplantation.	Actual number of individuals participating in disease prevention activities hosted by MOTTEP sites

Results of Telephone Interviews Pre- versus Post Intervention Surveys (Table 1)

Metric	Signed Donor Cards (%)	Held Family Discussions (%)	Willingness to Donate (%)
Follow-up	56.8	62.0	81.0
Post Survey	83.0	82.0 (will hold)	82.0
Pre Survey	37.3	37.0	68.0

While the incorporation of technology is so important today and is being incorporated into National MOTTEP's strategic plan, the organization will continue to utilize the same successful approaches it has used since its inception. The strategies are listed in the chart below:

Approach	**Brief Description**
Community Participation and Direction	Because every community is different, the program involves diverse community persons in varied levels in the planning and implementation of their own community-based activities designed to meet MOTTEP's mission and goals.
Face-to-Face Presentations	MOTTEP makes presentations at social, civic, and faith-based events, especially to smaller audiences where there are more opportunities for discussion. More than 9 million people have been reached through community events and educational activities.
Collaboration and Partnerships	Collaborating with religious, social, civic, and other local organizations to promote the program's mission and goals while encouraging viable partnerships is extremely important and productive. MOTTEP has collaborated with more than 350 organizations since 1995.
Media Promotion	The media (radio, television and print) play a critical role in the promotion of MOTTEP's message. MOTTEP has generated more than **10 billion** media impressions since 1995.
Information Dissemination	MOTTEP has developed culturally sensitive and informative brochures, videos, PSAs, flyers, fact sheets, and other information for community dissemination.

Evaluation	6	MOTTEP has developed comprehensive quantitative and qualitative surveys to gauge the effectiveness of its programs. National MOTTEP collected more than 10,000 matched data sets from formal educational presentations.

THE NEED AND SIGNIFICANCE OF THE NATIONAL MOTTEP

The demand for organs, especially kidneys, is still in great demand. In 2015, the waiting list exceeds 123,000 while only 30,000 transplants occur annually and 20 people die per day awaiting a transplant. That is why the problem needs to be addressed from an intervention and disease prevention perspective. Intervention involves getting individuals to commit to donating organs and tissues. Disease prevention involves not only educating communities on the health behaviors and diseases that lead to the need for transplantation, but also holding individuals accountable for making sure they understand their role in preventing high blood pressure or keeping their blood pressure under control, eating nutritious meals, exercising daily/weekly, and preventing or keeping their diabetes under control.

The goal of National MOTTEP is to reduce the demand for organs especially kidneys. Minorities suffer disproportionately with uncontrolled high blood pressure and diabetes – the two leading causes of kidney failure.

National MOTTEP's role in the increase of organ/tissue donors has been tremendous. While the number of minority donors has more than doubled from 15% to 30.9%, the demand for organs remains. The data in Table 2 indicates that a higher donation rate in OPO service areas with a MOTTEP presence versus those areas without a MOTTEP presence. National MOTTEP sites will continue to mobilize communities, engage the community at time of planning and implementation and encourage aggressive involvement in community-based activities designed to help improve health behaviors.

MOTTEP Versus Non MOTTEP Cities

Cadaveric Donors per 1,000 Evaluable Deaths and Number of Donors by Ethnicity and OPO's, 1995-1998 (Table 2)

	MOTTEP		Non MOTTEP		
Ethnicity	**Donation Rate**	**Donors**	**Donation Rate**	**Donors**	**p-value**
White, Non Hispanic	**59.3**	**4,928**	**59.2**	**11,279**	**0.02**
White, Hispanic	**106.9**	**1,055**	**47.4**	**886**	**<.01**
Black	**43.4**	**1,263**	**32.9**	**1,286**	**<.01**
Other	**50.7**	**228**	**42.4**	**272**	**<.01**

Increase in Minority Donation Rates, Organ Donors Per Million and Percentages

Source: UNOS/OPTN Database – January 2009 (Table 3)

	No. of	**Donors**		**Organ**	**Donors**		**Donation**	**Percentages**
				Per	**Million**			
Ethnicity	**1990**	**2008**		**1990**	**2008**		**2000**	**2008**
Black	659	2007		22.4	53		11.2%	14%
Hispanic/Latino	518	1957		22.9	50		11.2%	14%
Asian	73	424		10.3	35.3		2.7%	2.9%
Total Minority Donors	1,250	4,988		55.6	138.3		25.1%	30.9%

Between 1990 and 2008 minority donations percentages doubled (15%-30%). African American organ donors per million (O.D.M.) quadrupled from 8 O.D.M. – 53 O.D.M between 1982 and

2008. Table 3 quantifies the success of the only national minority public education program of its kind in the world!

National MOTTEP's role in the donation increase can be attributed to the fact that its MOTTEP sites are aggressive in its approach to increasing donation awareness and donor registrations. The impact of several MOTTEP sites is described below.

Honolulu, Hawaii - Since implementation in 1995, MOTTEP of Honolulu primarily targeted the Filipino community. Within the first 3-4 years, the program's success is documented through an increase in the Filipino donor consent from 3% to 27%. Over the past several years, organ donation consent rates among Filipinos have steadily increased: **40% in 2004, 67% in 2005, and 71% in 2006**. The result of this successful program is evidenced in increased donor consent in the Filipino community from 3% to 71%.

Chicago, IL/NW Indiana - Rev. Franklin Burns initially was identified as the Local Program Coordinator of this MOTTEP site. Rev. Burns was a kidney recipient and pastor in Gary, IN. He was personally responsible for at least **25** donations directly linked to his local MOTTEP presentations about organ/tissue donation and transplantation as reported by the Chicago Organ Procurement Organization – Regional Organ Bank of Illinois (now Gift of Hope).

Detroit, MI - MOTTEP of Detroit participates in more than 400 community based activities each year and has tripled donation rates within the Detroit area from **5%** when MOTTEP first began activities. MOTTEP of Detroit is one of several sites to utilize technology to increase the number of potential donors through the statewide registry. The African American consent rates are as follow for the period 2008-2010:

2008: 40.91%

2009: 54.11%

2010: 64.79%

New York, NY - The most effective outreach strategy for MOTTEP of New York has been its partnership with Voter Registration.

When New York became a MOTTEP site, the donation rate was below 50%. As of 2015, the donation rate is 61%. An average of more than 100 new persons has registered to be donors each week over the last year. The voter registration campaign has made this MOTTEP of New York's greatest accomplishment as it has registered thousands of New Yorkers as voters and organ donors.

In addition to all the community work on the ground in the local sites, National MOTTEP has published manuscripts in nearly 50 publications since 1991. National MOTTEP actively seeks to publish research findings, data and community strategies. The overall goal is to publish the effectiveness of community outreach and education as a modus operandi to effectively reach the community at a grass roots level and assist the community in becoming "change-agents" who can help solve the number one problem in transplantation – the shortage of donors while simultaneously decreasing the high incidence of renal disease.

RESEARCH AND DESIGN

The National MOTTEP model has been successful because it takes its education program directly to the targeted audiences. MOTTEP seeks to utilize natural communication systems that exist within each targeted minority group's community to disseminate information about organ donation and transplantation and to educate audiences regarding the need to hold family discussions not only about organ/tissue donation, but about family medical history health practices in general.

As has been previously stated the ultimate goal is to SAVE LIVES. Whether it's through donation education or disease prevention activities, saving lives is the priority. Information is only power if the information is applied. Once information is provided, it is then up to the individual to become accountable. Therefore, National MOTTEP has begun to implement its MOTTEP Triple-A Effect: Moving Communities from Awareness to Action and Accountability. Via its previously funded Telehealth programs in Hypertension and Diabetes, National MOTTEP was able to gauge the Action and Accountability factors among its participants. In addition, the number of minority donors is also monitored by the UNOS/OPTN data that is collected. The accountability challenge continues, but National MOTTEP has overcome many challenges since its inception and will confidently handle this challenge.

SIGNIFICANT RESULTS IN ORGAN DONATION

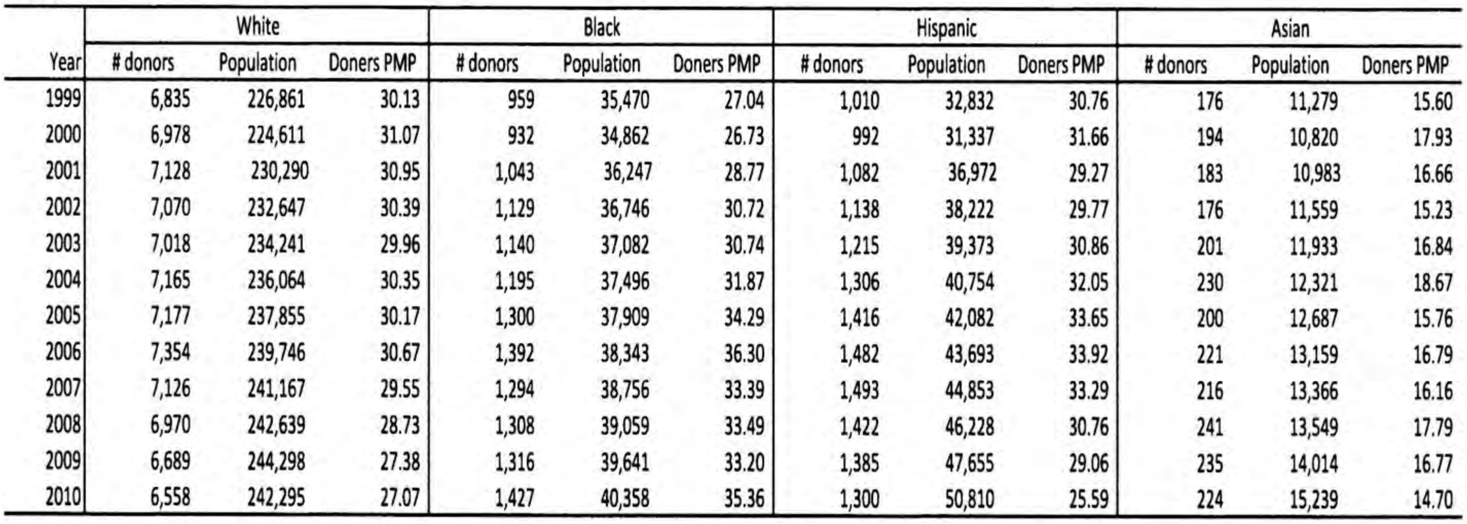
In 1982, minorities represented more than 50% of the national transplant waiting list, but represented only 3% of the donor population. Previously minorities, especially Blacks, were thought not likely to donate. As a result of the D.C. Take Initiative Program, the Dow Take Initiative Program and the work of National MOTTEP, significant progress has been made within the African American population.

Nationally, total ethnic minority organ donors per million (O.D.M.) increased from 8-10 O.D.M. (1982) to 35 O.D.M. (A.A. and Latino/Hispanics) in 2002. National minority donor percentages increased from 15% to 28.5% of donors in 2002 (minorities comprised 25% of the USA population in 2000). In 1995, organ donors per million were represented as Whites (34.2), Black (33.1), Hispanic (31.5), Asian (17.9). In 2010, Black organ donors per million totaled 35.36 versus Whites (27.07), Hispanic (25.59) and Asian (14.70). Blacks now represent 17% of the donor population (deceased and living), while representing 13% of the total U.S. population.

Based upon the data retrieved from the United Network for Organ Sharing in 2010, Blacks were ranked above Whites and other ethnic minority populations as the number one ethnic group of organ donors per million within the U.S. indicating that when a campaign combined with grass roots face to face presentations and interactions along with media reinforcement is applied, donation rates can be increased and sustained. (See Table 4 below)

Organ Donation Per Millions per Ethnicity (1999 – 2010) (Table 4)

Table 5



	White			Black			Hispanic			Asian		
Year	# donors	Population	Doners PMP	# donors	Population	Doners PMP	# donors	Population	Doners PMP	# donors	Population	Doners PMP
1999	6,835	226,861	30.13	959	35,470	27.04	1,010	32,832	30.76	176	11,279	15.60
2000	6,978	224,611	31.07	932	34,862	26.73	992	31,337	31.66	194	10,820	17.93
2001	7,128	230,290	30.95	1,043	36,247	28.77	1,082	36,972	29.27	183	10,983	16.66
2002	7,070	232,647	30.39	1,129	36,746	30.72	1,138	38,222	29.77	176	11,559	15.23
2003	7,018	234,241	29.96	1,140	37,082	30.74	1,215	39,373	30.86	201	11,933	16.84
2004	7,165	236,064	30.35	1,195	37,496	31.87	1,306	40,754	32.05	230	12,321	18.67
2005	7,177	237,855	30.17	1,300	37,909	34.29	1,416	42,082	33.65	200	12,687	15.76
2006	7,354	239,746	30.67	1,392	38,343	36.30	1,482	43,693	33.92	221	13,159	16.79
2007	7,126	241,167	29.55	1,294	38,756	33.39	1,493	44,853	33.29	216	13,366	16.16
2008	6,970	242,639	28.73	1,308	39,059	33.49	1,422	46,228	30.76	241	13,549	17.79
2009	6,689	244,298	27.38	1,316	39,641	33.20	1,385	47,655	29.06	235	14,014	16.77
2010	6,558	242,295	27.07	1,427	40,358	35.36	1,300	50,810	25.59	224	15,239	14.70

MOTTEP: Expanding the Journey (2016 and Beyond)

As MOTTEP looks to 2016 and beyond, the following areas of focus will help shape our vision for 2016 and beyond:

1- Our forte has been "community education and empowerment" by many modalities but most importantly the grass roots "Face to Face" methodology (while others primarily emphasize social media which we utilize as well). Our "niche" remains the Grass Roots approach.

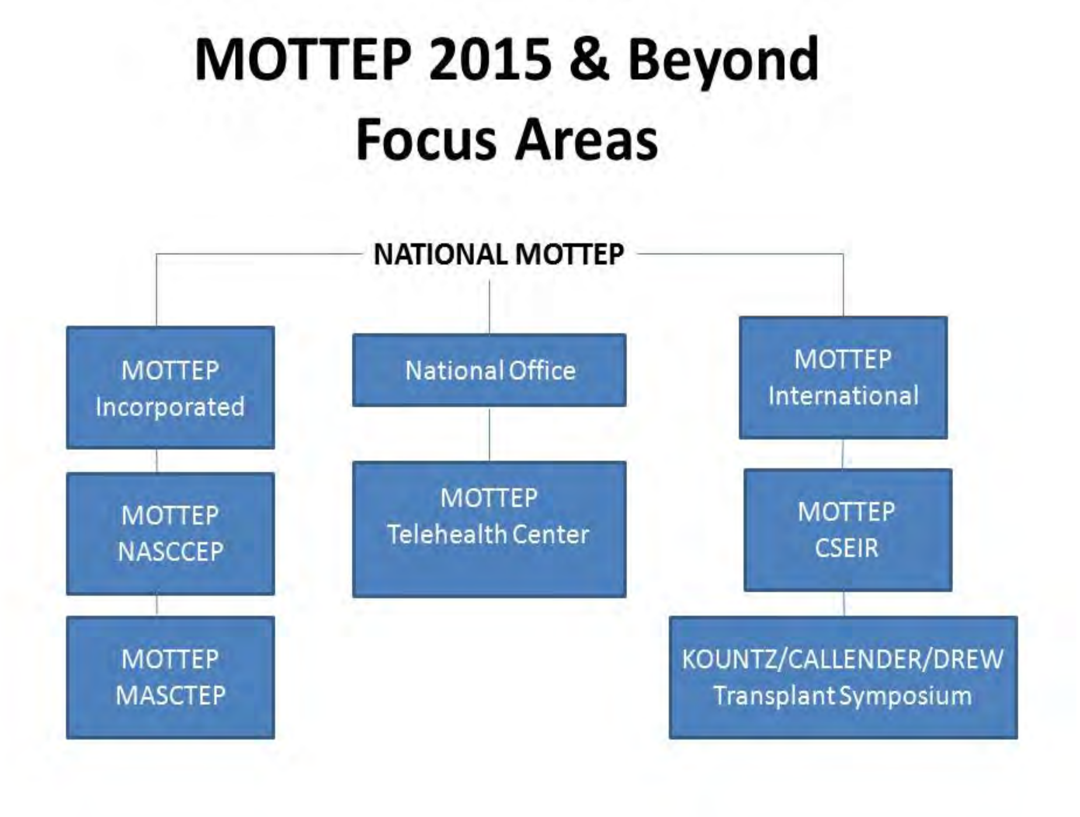
2- Emphasize objective end points:
   a). A 10-20% increase in minority registrations

- b). A 10-20% increase in family discussions
- c). An increase in minority organ donations from 30-35% by 2016
- d). Quantify and increase minority transplant tissue donations by 10% - eye, bone marrow, blood, and other tissue donations such as skin, musculoskeletal, auditory ossicles and heart valves
- e). Increase living minority organ donations by 10%
- f). Increase deceased minority organ donations by 10%

3- Heighten the wellness emphasis focusing on lifestyle changes which can:
- a). Decrease the End Stage Renal Disease (ESRD) incidence by 5% by 2017
- b). Increase education on <u>proper nutrition</u>
- c). Increase education on <u>stress reduction</u> (The Be Blessed Model)
- d). Increase the number of minorities exercising <u>150 minutes/week</u>

4- MOTTEP Areas of Focus:
- a). MOTTEP International
- b). MOTTEP Telehealth Component
- c). MOTTEP Stem Cell Education Program
- d). Center for the Study of the Elimination of Institutionalized Racism MOTTEP (CSEIR)
- e). Operation Diabetes (collaborating with the Latino/Hispanic population)

5- Getting appropriate funding for current 7 MOTTEP sites and expanding their scope and adding 7 additional sites as detailed ( ) while targeting all ethnic groups. (Thus expanding our journey to save more lives.)



BENEFITS TO PROPOSED FUNDERS AND SUPPORTERS

No activity is ever implemented or conducted if there is no way to evaluate the effectiveness. While National MOTTEP is holding the community accountable, the organization is much more accountable to its funders and sponsors. Therefore, National MOTTEP will continue to acknowledge the sponsor of its program activities in all ways possible. National MOTTEP recognizes that while the organization will forge in a manner of accountability with the community, it must be accountable to its sponsors and supporters. Therefore, acknowledgement will be made by name and/or logo on all printed materials, media recognition, website, e-newsletters, publications, videos and other educational materials for which sponsorship funds are utilized.

BUDGET
(See Attached)

The proposed budget represents the total costs needed to expand and implement programs within all populations in 25 target areas across the U.S. as illustrated on the attached. The need is critical and immediate for National MOTTEP to fund its current programs in 7 cities. The attached 5 year proposed budget provides the amount of funding needed now as well as what is needed to expand to additional sites in 2018. In order to address the number one problem in transplantation today, more programs are needed to increase the number of organ donors and decrease the number of persons being added to the waiting list. National MOTTEP believes that aggressive community outreach using its grass roots and face to face strategy along with media and social media is the answer*.

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ADDENDUM

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Biographical Sketch of

Clive O. Callender, M.D., F.A.C.S.

Dr. Clive O. Callender, the Professor of Surgery, Howard University College of Medicine, is a native of New York and was educated in their public schools and colleges- 1) P.S. 113, 2) P.S. 68, 3) Edward W. Stitt Jr. H.S., 4) Commerce H.S. and 5) Hunter College. After completing Meharry Medical College in 1963 as the top ranking medical student and his surgical training at Freedmen's Hospital in 1969, he received his transplant surgical training at the University of Minnesota, under Dr. John S. Najarian (Kidney) 1971-1973 and at the University of Pittsburgh under Dr. Thomas E. Starzl (Liver) 1986-1987. These are two of the premier transplant training programs in the U.S. Since returning to Howard University Hospital (HUH)-(formerly Freedmen's Hospital) in 1973, Dr. Callender helped develop the first minority directed dialysis and transplant center and histocompatibility and immunogenetic laboratory in this country.

Prior to receiving his transplant training, Dr. Callender pursued his goal in life to become a medical missionary by volunteering in Africa between 1970 and 1971.

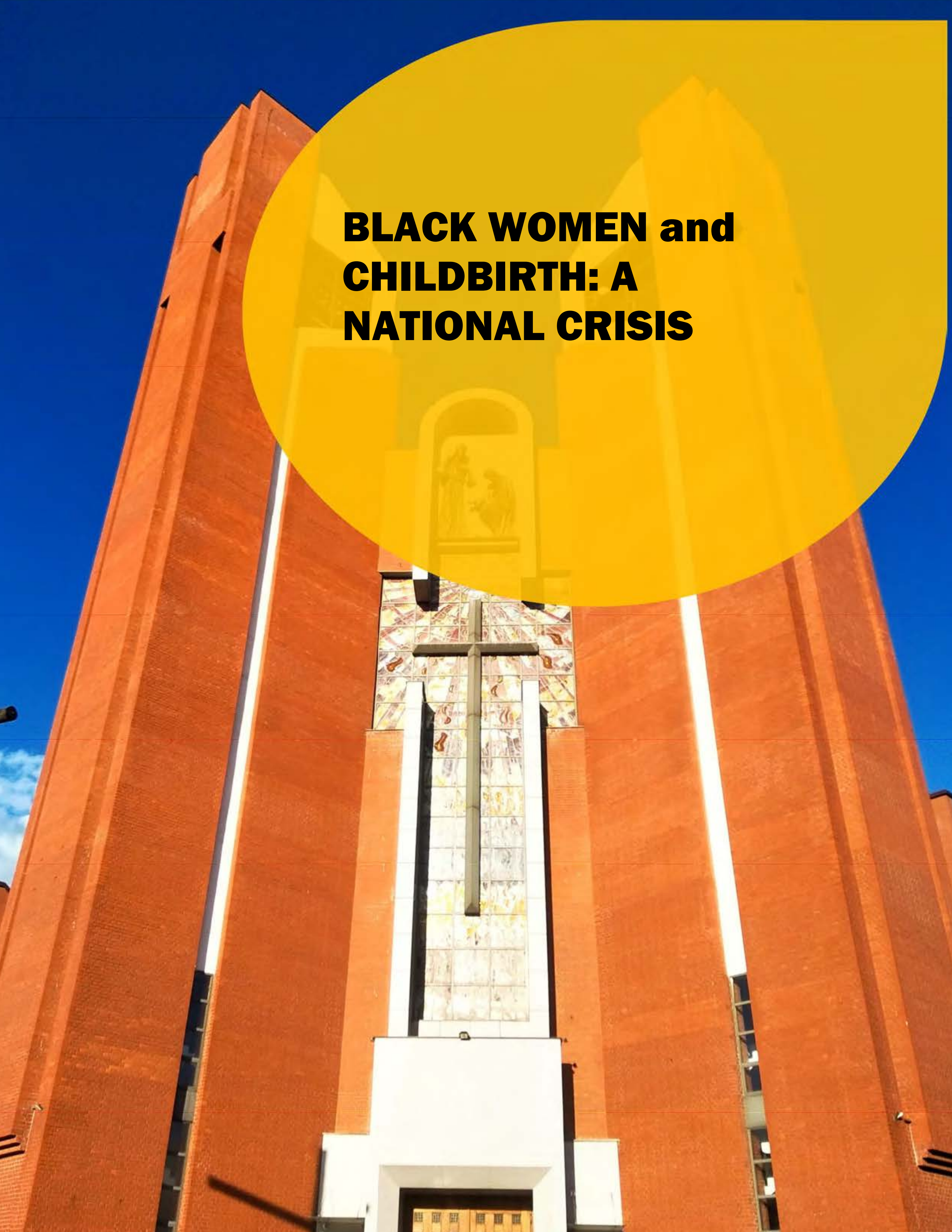
On August 8, 1991, the New England Journal of Medicine, the U.S.A's premier medical journal, chronicled the 10 year experience of the first National Organ/Tissue Donor Program in America. (Originated by Dr. Callender at HUH, the National Kidney Foundation of the National Capital Area (1982-88) and the DOW Chemical Company (1986-92)). This article referred to National Gallup Polls which were conducted in 1985 and 1990 and demonstrated a tripling of both the number of Blacks signing donor cards and the number of Blacks aware of the highly successful nature of transplantation. In 1991, Dr. Callender conceptualized and founded the National Minority Organ/Tissue Transplant Education Program (MOTTEP) utilizing the successful joint HUH and Dow Chemical Company efforts that targeted the Black community and applying the methodologies to all ethnic minority populations.

National MOTTEP is the first national organization to identify a two-fold solution to the donor shortage – disease prevention and increasing donation rates. Since its inception, National MOTTEP has been awarded total funding in the amount of $16 million from the Office of Research on Minority Health (now known as the NIH-Institute for Minority Health and Health Disparities) and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) for program expansion. National MOTTEP's methodology has contributed to the national increase in minority donation rates from 15% in 1990 to 30% in 2008. In addition, a review of the United Network for Organ Sharing database between 1990 and 2010 concluded that as of 2010, Blacks have risen from the bottom to the top exceeding Whites and other ethnic minority populations, in reference to organ donors per million - from 8% in 1982 to 35.36 in 2010.

National MOTTEP also established a MOTTEP-Export Research Center of Excellence that focused on eliminating minority renal health disparities via Telehealth programs in Hypertension and Diabetes. The Research Center also examined psycho-neuro-immunological issues that led to renal disease as well as the development of the "Be Blessed Model" – a model for overcoming the devastating effect of institutionalized and environmental racism in End Stage Renal Disease. In 2016, National MOTTEP will celebrate 25 years of educating communities and saving lives through organ/tissue donation and transplantation.

From 1995 until 2008, Dr. Callender served as the Chairman of the Department of Surgery. In February 1996, he was appointed as the first LaSalle D. Leffall, Jr. Professor of Surgery at the Howard University College of Medicine. He has received Honorary Doctor of Science degrees from Hunter College in 1994, Meharry Medical College in 2008, and Howard University in 2014.

As the senior African American transplant surgeon and expert. Dr. Callender's media appearances have included: The Oprah Show, CNN News, the CBS Evening News and hundreds more. He has spoken to both professional and lay audiences at more than 1,000 meetings/forums and has authored over 140 scientific publications on this subject. He is a member of numerous professional societies, and serves as referee for various scientific journals. Dr. Callender serves as a member or advisor of numerous boards, committees and task forces involved with transplantation issues. Dr. Callender has received many honors and awards in recognition of his significant contributions, but it is his dream that he be remembered as a God fearing surgeon who reached the "unreachable stars".



BLACK WOMEN and CHILDBIRTH: A NATIONAL CRISIS

Original Investigation

July 3, 2023

Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States

Laura G. Fleszar, MPH[1]; Allison S. Bryant, MD, MPH[2]; Catherine O. Johnson, PhD, MPH[1]; et al

Author Affiliations

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Key Points

Question How does maternal mortality vary by state and race and ethnicity over time in the US?

Findings Long-term trends in maternal mortality ratios from vital registration and census data were estimated. Increases in maternal mortality ratios in specific states were identified and showed previously unmeasured inequities for specific subpopulations.

Meaning Previous research has focused on trends at the national level or in selected states. Comprehensive reporting of disparities in maternal mortality provides evidence to guide intervention policies and benchmark progress for the prevention of maternal deaths.

Abstract

Importance Evidence suggests that maternal mortality has been increasing in the US. Comprehensive estimates do not exist. Long-term trends in maternal mortality ratios (MMRs) for all states by racial and ethnic groups were estimated.

Objective To quantify trends in MMRs (maternal deaths per 100 000 live births) by state for 5 mutually exclusive racial and ethnic groups using a bayesian extension of the generalized linear model network.

Design, Setting, and Participants Observational study using vital registration and census data from 1999 to 2019 in the US. Pregnant or recently pregnant individuals aged 10 to 54 years were included.

Main Outcomes and Measures MMRs.

Results In 2019, MMRs in most states were higher among American Indian and Alaska Native and Black populations than among Asian, Native Hawaiian, or Other Pacific Islander; Hispanic; and White populations.

Between 1999 and 2019, observed median state MMRs increased from 14.0 (IQR, 5.7-23.9) to 49.2 (IQR, 14.4-88.0) among the American Indian and Alaska Native population, 26.7 (IQR, 18.3-32.9) to 55.4 (IQR, 31.6-74.5) among the Black population, 9.6 (IQR, 5.7-12.6) to 20.9 (IQR, 12.1-32.8) among the Asian, Native Hawaiian, or Other Pacific Islander population, 9.6 (IQR, 6.9-11.6) to 19.1 (IQR, 11.6-24.9) among the Hispanic population, and 9.4 (IQR, 7.4-11.4) to 26.3 (IQR, 20.3-33.3) among the White population. In each year between 1999 and 2019, the Black population had the highest median state MMR. The American Indian and Alaska Native population had the largest increases in median state MMRs between 1999 and 2019. Since 1999, the median of state MMRs has increased for all racial and ethnic groups in the US and the American Indian and Alaska Native; Asian, Native Hawaiian, or Other Pacific Islander; and Black populations each observed their highest median state MMRs in 2019.

Conclusion and Relevance While maternal mortality remains unacceptably high among all racial and ethnic groups in the US, American Indian and Alaska Native and Black individuals are at increased risk, particularly in several states where these inequities had not been previously highlighted. Median state MMRs for the American Indian and Alaska Native and Asian, Native Hawaiian, or Other Pacific Islander populations continue to increase, even after the adoption of a pregnancy checkbox on death certificates. Median state MMR for the Black population remains the highest in the US. Comprehensive mortality surveillance for all states via vital registration identifies states and racial and ethnic groups with the greatest potential to improve maternal mortality. Maternal mortality persists as a source of worsening disparities in many US states and prevention efforts during this study period appear to have had a limited impact in addressing this health crisis.

HEALTH

Maternal deaths in the US more than doubled over two decades. Black mothers died at the highest rate

FILE - Ansonia Lyons carries her son, Adrien Lyons, as she takes him for a diaper change in Birmingham, Ala., on Saturday, Feb. 5, 2022. After two miscarriages, Ansonia became pregnant in 2020, and it was difficult. Doctors initially told her she was suffering from regular morning sickness, though she was vomiting blood. Ultimately, she was diagnosed with an excessive vomiting disorder. A study published Monday, July 3, 2023, in the Journal of the American Medical Association shows maternal mortality rates in the U.S. doubled between 1999 and 2019, that Native American and Alaskan Native populations had the largest rate increase and that, overall, Black maternal mortality rates were the highest. (AP Photo/Wong Maye-E, File)

ASSOCIATED PRESS

LAURA UNGAR

Maternal deaths across the U.S. more than doubled over the course of two decades, and the tragedy unfolded unequally.

Black mothers died at the nation's highest rates, while the largest increases in deaths were found in American Indian and Native Alaskan mothers. And some states — and racial or ethnic groups within them – fared worse than others.

The findings were laid out in a new study published Monday in the Journal of the American Medical Association. Researchers looked at maternal deaths between 1999 and 2019 — but not the pandemic spike — for every state and five racial and ethnic groups.

"It's a call to action to all of us to understand the root causes — to understand that some of it is about health care and access to health care, but a lot of it is about structural racism and the policies and procedures and things that we have in place that may keep people from being healthy," said Dr. Allison Bryant, one of the study's authors and a senior medical director for health equity at Mass General Brigham.

Among wealthy nations, the U.S. has the highest rate of maternal mortality, which is defined as a death during pregnancy or up to a year afterward. Common causes include excessive bleeding, infection, heart disease, suicide and drug overdose.

Bryant and her colleagues at Mass General Brigham and the Institute for Health Metrics and Evaluation at the University of Washington started with national vital statistics data on deaths and live births. They then used a modeling process to estimate maternal mortality out of every 100,000 live births.

Overall, they found rampant, widening disparities. The study showed high rates of maternal mortality aren't confined to the South but also extend to regions like the Midwest and states such as Wyoming and Montana, which had high rates for multiple racial and ethnic groups in 2019.

Researchers also found dramatic jumps when they compared maternal mortality in the first decade of the study to the second, and identified the five states with the largest increases between those decades. Those increases exceeded:

— 162% for American Indian and Alaska Native mothers in Florida, Illinois, Kansas, Rhode Island and Wisconsin;

— 135% for white mothers in Georgia, Indiana, Louisiana, Missouri and Tennessee;

— 105% for Hispanic mothers in Georgia, Illinois, Indiana, Minnesota and Tennessee;

— 93% for Black mothers in Arkansas, Georgia, Louisiana, New Jersey and Texas;

— 83% for Asian and Pacific Islander mothers in Georgia, Illinois, Kansas, Michigan and Missouri.

"I hate to say it, but I was not surprised by the findings. We've certainly seen enough anecdotal evidence in a single state or a group of states to suggest that maternal mortality is rising," said Dr. Karen Joynt Maddox, a health services and policy researcher at Washington University School of Medicine in St. Louis who wasn't involved in the study. "It's certainly alarming, and just more evidence we have got to figure out what's going on and try to find ways to do something about this."

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Here's the latest for Monday July 3rd: Baltimore police search for mass shooting suspects; France deploys thousands of police to stop violent protests; Massive downpour in Chicago; Hotel worker strike in Southern California.

Maddox pointed to how, compared with other wealthy nations, the U.S. underinvests in things like social services, primary care and mental health. She also said Missouri hasn't funded public health adequately and, during the years of the study, hadn't expanded Medicaid.

They've since expanded Medicaid — and lawmakers passed a bill giving new mothers a full year of Medicaid health coverage. Last week, Missouri Gov. Mike Parson signed budget bills that included $4.4 million for a maternal mortality prevention plan

In neighboring Arkansas, Black women are twice as likely to have pregnancy-associated deaths as white women, according to a 2021 state report.

Dr. William Greenfield, the medical director for family health at the Arkansas Department of Health, said the disparity is significant and has "persisted over time," and that it's hard to pinpoint exactly why there was an increase in the state's maternal mortality rate for Black mothers.

Rates among Black women have long been the worst in the nation, and the problem affects people of all socioeconomic backgrounds. For example, U.S. Olympic champion sprinter Tori Bowie, 32, died from complications of childbirth in May.

The pandemic likely exacerbated all of the demographic and geographic trends, Bryant said, and "that's absolutely an area for future study." According to preliminary federal data, maternal mortality fell in 2022 after rising to a six-decade high in 2021 — a spike experts attributed mainly to COVID-19.

Officials said the final 2022 rate is on track to get close to the pre-pandemic level, which was still the highest in decades.

Bryant said it's crucial to understand more about these disparities to help focus on community-based solutions and understand what resources are needed to tackle the problem.

Arkansas already is using telemedicine and is working on several other ways to increase access to care, said Greenfield, who is also a professor of obstetrics and gynecology at the University of Arkansas Medical Center in Little Rock and was not involved in the study.

The state also has a "perinatal quality collaborative," a network to help health care providers understand best practices for things like reducing cesarean sections, managing complications with hypertensive disorders and curbing injuries or severe complications related to childbirth.

"Most of the deaths we reviewed and other places have reviewed … were preventable," Greenfield said.

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AP Public Health Collaborations Editor Erica Hunzinger contributed to this report

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ARKANSAS ◆ ADVOCATE

CHILDREN + FAMILIES HEALTH CARE MATERNAL HEALTH

Black maternal mortality in Arkansas rose 110% in two decades, study shows

“Perfect storm” of contributing factors include systemic racism, shortage of care providers in rural areas, experts say

BY: **TESS VRBIN** - JULY 3, 2023 10:00 AM

(Getty Images)

The rate at which Black women in Arkansas die during childbirth or within a year of giving birth rose 110% from 1999 to 2019, according to a study published Monday in the Journal of the American Medical Association.

Nationally, “maternal mortality remains unacceptably high among all racial and ethnic groups,” but American Indian, Alaska Native and Black “individuals are at increased risk, particularly in several states where these inequities had not been previously highlighted,” the study noted.

Researchers at the University of Washington in Seattle gathered data by state and racial group and determined how many of these deaths occurred per 100,000 live births.

“Maternal mortality persists as a source of worsening disparities in many U.S. states, and prevention efforts during this study period appear to have had a limited impact in addressing this health crisis,” the report states.

The collection of data for the study concluded before the onset of COVID-19. The pandemic “hindered some prevention efforts to decrease the deaths of Black women,” and national data has shown that maternal mortality increased in 2020 and 2021, the report states.

Arkansas already has the nation’s highest maternal mortality rate regardless of race, according to the Arkansas Center for Health Improvement.

In 1999, the state saw 42 Black maternal deaths per 100,000 live births. That number stayed above 60 from 2009 onward and reached 89 in 2019, according to the University of Washington study.

Dr. Gloria Richard-Davis (Courtesy UAMS)

A wide range of factors, including systemic racism, create a “perfect storm” for Black Arkansans seeking prenatal and postpartum medical care, said Dr. Gloria Richard-Davis, a reproductive endocrinology professor at the University of Arkansas for Medical Sciences.

Those factors also include a shortage of labor and delivery units in Arkansas hospitals, which requires people in rural areas to travel long distances for care, something that is not always possible due to a lack of transportation or the ability to take time off work, according to medical professionals and advocates for pregnant Black Arkansans.

Arkansas remains one of the few states that have not taken advantage of the option to extend postpartum Medicaid coverage, which currently ends 60 days after birth.

Additionally, Black women might not trust the medical community or see themselves in their care providers, said Nicolle Fletcher, co-founder of the Ujima Maternity Network, a Conway-based nonprofit that seeks to create support systems for Black mothers in Arkansas.

“Those are the cries, if you will, that we’re hearing in the community,” said Fletcher, who has been a doula since 2009. “Mothers are trying to be proactive, but their hands are tied as far as solutions are concerned.”

Issues facing Black women

More than 80% of pregnancy-related deaths are preventable, according to the U.S. Centers for Disease Control and Prevention.

Richard-Davis said the medical field does not listen to Black women in particular when they raise concerns about their pregnancies.

“Many women tell their physicians or providers that they are having problems, but their voices are silenced, so trying to raise sensitivity and awareness among our providers in the obstetrical world is also critical,” said Richard-Davis, who is UAMS’ Executive Director of Diversity, Equity, and Inclusion, as well as a member of the state’s maternal mortality review committee.

Fletcher said Ujima’s focus is “collective work and responsibility” to support Black women during and after pregnancy.

Dr. Zenobia Harris (Courtesy Arkansas Birthing Project)

The Arkansas Birthing Project also tries to meet Black mothers where they are and provide whatever support they need, director Dr. Zenobia Harris said.

“Women of color need to be respected, believed, seen and heard,” Harris said. “They need to have the choice to decide when interventions are going to be done to them. They need to have a voice in whether they agree or not with what is happening to them.”

Black Americans’ distrust of the medical community dates back centuries. When COVID-19 vaccines became available in 2021, some members of the Black community were hesitant to get a shot promoted by government officials because of experiments conducted on Black people in the past.

Richard-Davis said vaccine hesitancy or refusal contributed to maternal mortality regardless of race.

“It was very difficult to get women to understand that they were putting their babies at risk by not getting vaccinated,” she said.

Some health conditions disproportionately affect Black women during pregnancy, including high blood pressure, cardiovascular issues and preeclampsia. Black women are also more likely to give birth via Cesarean section, which can increase the risk of postpartum complications, Fletcher and Richard-Davis both said.

Arkansas has 37 hospitals that deliver babies. The Arkansas Birthing Project works primarily in Southeast Arkansas, which has a significant Black population, a high poverty level and long distances between hospitals, Harris said.

The combination of racial and economic inequality plays a role in “the ravages of unequal care” for pregnant Black women, Harris said.

“There’s a belief or a perception that maybe those people don’t work as hard and don’t deserve as much as others, and I think we need to reexamine that as a society,” she said.

More than half of all Arkansas pregnancies are covered by Medicaid. A bill to expand postpartum Medicaid coverage from 60 days to a full year after giving birth did not advance in the Arkansas Legislature earlier this year.

Richard-Davis said the coverage limit does a disservice to pregnant Arkansans on Medicaid

“These patients are generally resource-challenged, so they are a lot more hands-on and need more attention and are higher-risk,” she said.

Relief efforts
The Arkansas Birthing Project is a volunteer-based mentorship program that does not require a college degree, Harris said. The nonprofit is made up of “local women in a community that want to make a difference” and has partnered with doulas in Southeast Arkansas, she said.

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Meanwhile, Fletcher is studying to become a certified professional midwife, which will qualify her as a medical professional who can assist with births outside a hospital setting, she said.

The Ujima Maternity Network received a grant to create a training program for doulas across Arkansas, primarily aimed at regions with high populations of Black people and without enough health care providers, Fletcher said. Doulas are non-medical professionals and patient advocates who provide “physical, emotional and informational support throughout the different stages of pregnancy and postpartum,” she said.

Richard-Davis said she hopes the federal government will take on an active role in reducing Black maternal mortality nationwide.

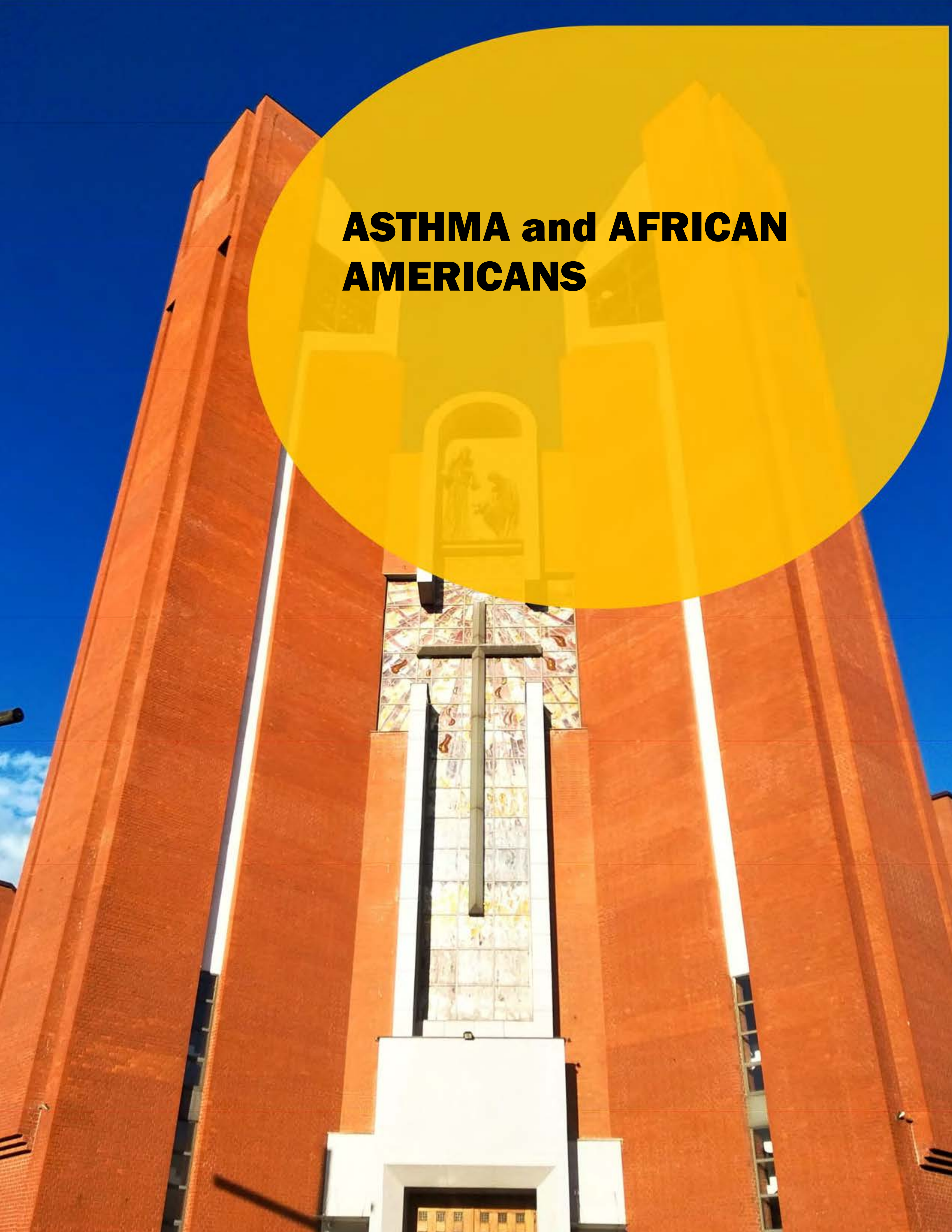
“If we are going to make any dent in maternal mortality, we have to take a look at some sort of model, and it’s going to be a money loser for the hospital,” she said. “If it’s going to be a money loser, [hospitals] can’t stay open unless they’re subsidized. What is one mom’s life worth? We’re going to have to reflect on that and make some really hard decisions.”

REPUBLISH

TESS VRBIN

Tess Vrbin came to the Advocate from the Arkansas Democrat-Gazette, where she reported on low-income housing and tenants' rights, and won awards for her coverage of 2021 flooding and tornado damage in rural Arkansas. She previously covered local government for The Commercial Dispatch in Mississippi and state government for the Columbia Daily Tribune in Missouri.

ASTHMA and AFRICAN AMERICANS



Asthma and African Americans

What is Asthma?

According to the Centers for Disease Control and Prevention (CDC), asthma is a disease that affects your lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medicine and avoiding the triggers that can cause an attack. You must also remove the triggers in your environment that can make your asthma worse.

How Does Asthma Affect African American Populations?

- From 2018-2020, 4.0 million non-Hispanic blacks (adults and children) reported that they currently have asthma.
- Non-Hispanic African Americans were 30 percent more likely to have asthma than non-Hispanic whites, in 2019.
- In 2020, non-Hispanic blacks were almost three times more likely to die from asthma related causes than the non-Hispanic white population.
- In 2020, non-Hispanic black children had a death rate 7.6 times that of non-Hispanic white children.
- Non-Hispanic black children were 4.5 times more likely to be admitted to the hospital for asthma, as compared to non-Hispanic white children, in 2019.
- While all the causes of asthma remain unclear, children exposed to secondhand tobacco smoke exposure are at increased risk for acute lower respiratory tract infections, such as bronchitis. Children living below or near the poverty level are more likely to have high levels of blood cotinine, a breakdown product of nicotine, than children living in higher income families.[1]

Diagnosed

Current asthma prevalence percentage, adults ages 18 and over, 2019

	Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
Men	8.6	5.8	1.5
Women	11.9	10.2	1.2
Both Sexes	10.4	8.0	1.3

Source: CDC 2022. National Health Interview Survey Data 2019. Table 4-1. https://www.cdc.gov/asthma/nhis/2019/table4-1.htm

Percentage of asthma among adults 18 years of age and over, ever being told they had asthma, 2018-2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
10.3	8.1	1.3

Source: CDC 2022. 2018-2020 National Health Interview Survey (NHIS). https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm

Percentage of adults 18 years of age and over, who currently have asthma, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
10.6	8.2	1.3

Source: National Center for Health Statistics. Percentage of current asthma for adults aged 18 and over, United States, 2022. National Health Interview Survey. Generated interactively: Nov 29, 2022. https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html

Death Rate

Deaths per 1,000,000, adults 18 years and over with asthma as the underlying cause, National Vital Statistics System, 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
34.9	13.0	2.7

Source: CDC 2022. Division of Vital Statistics CDC WONDER. https://wonder.cdc.gov/ucd-icd10.html [Accessed 11/29/22]

Treatment

Estimated rate of emergency department/urgent care center visits in the past 12 months with asthma as the first listed diagnosis per 10,000 population (Adults aged =18 years), 2016-2018		
Non-Hispanic Black	**Non-Hispanic White**	**African American / White Ratio**
15.1	7.9	1.9

Source: CDC 2022. Asthma Surveillance – United States, 2006-2018. Supplementary Table 13. https://stacks.cdc.gov/view/cdc/109086

Hospital admissions rate per 100,000 for asthma, adults age 18 to 39, 2019		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
82.3	22.1	3.7

Source: National Healthcare Quality and Disparities Reports. Data Query. [Accessed 11/29/2022] https://datatools.ahrq.gov/nhqdr

Percentage of people with current asthma who are taking preventive medicine daily or almost daily, 2019		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
32.7	32.6	1.0

Source: National Healthcare Quality and Disparities Reports. Data Query. [Accessed 11/29/2022] https://datatools.ahrq.gov/nhqdr?tab=nhqdrdaqu&type=tab

Children

Age-adjusted percentage for children under 18 years of age, ever being told they had asthma, 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
12.3	5.5	2.2

Source: CDC 2022. 2018-2020 National Health Interview Survey (NHIS).

http://www.cdc.gov/asthma/most_recent_national_asthma_data.htm

Age-adjusted percentage for children under 18 years of age who currently have asthma, 2018		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
14.2	5.6	2.5

Source: CDC 2022. Summary Health Statistics: National Health Interview Survey: 2018. Table C-1a. http://www.cdc.gov/nchs/nhis/shs/tables.htm

Current asthma prevalence percentage, children under 18 years, 2021			
	Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
Both Sexes	12.5	5.7	2.2

Source: CDC 2022. National Health Interview Survey (NHIS). https://wwwn.cdc.gov/NHISDataQueryTool/SHS_child/index.html

Estimated rate of emergency department/urgent care center visits in the past 12 months with asthma as the first listed diagnosis per 10,000 population (Children aged 0–17 years) 2016-2018		
Non-Hispanic Black	Non-Hispanic White	African American / White Ratio
26.6	12.1	2.2

Source: CDC 2022. Asthma Surveillance – United States, 2006-2018. Supplementary Table 13. https://stacks.cdc.gov/view/cdc/109086

Hospital admissions rate per 100,000 for asthma, children ages 2-17, 2019		
Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
172.1	38.0	4.5

Source: AHRQ 2022.National Healthcare Quality and Disparities Reports. Data Query. https://datatools.ahrq.gov/nhqdr [Accessed 11/29/2022]

Death rate for children 0-17 years of age, 2020 (deaths per 1,000,000)		
Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
10.7	1.4	7.6

Source: CDC 2022. Data, Statistics, and Surveillance. Most Recent National Asthma Data. https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm

Death rate for children 0-14 years of age, 2019 (deaths per 100,000)		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
0.8	0.1	8.0

Source: CDC 2022. CDC WONDER Online Database.
https://wonder.cdc.gov/ [Accessed 11/29/2022]

People with current asthma who received written asthma management plans from their healthcare provider (percent), 2018		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
42.9	33.8	1.3

Source: AHRQ 2022.National Healthcare Quality and Disparities Reports. Data Query. https://datatools.ahrq.gov/nhqdr [Accessed 11/29/2022]