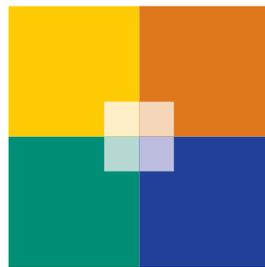


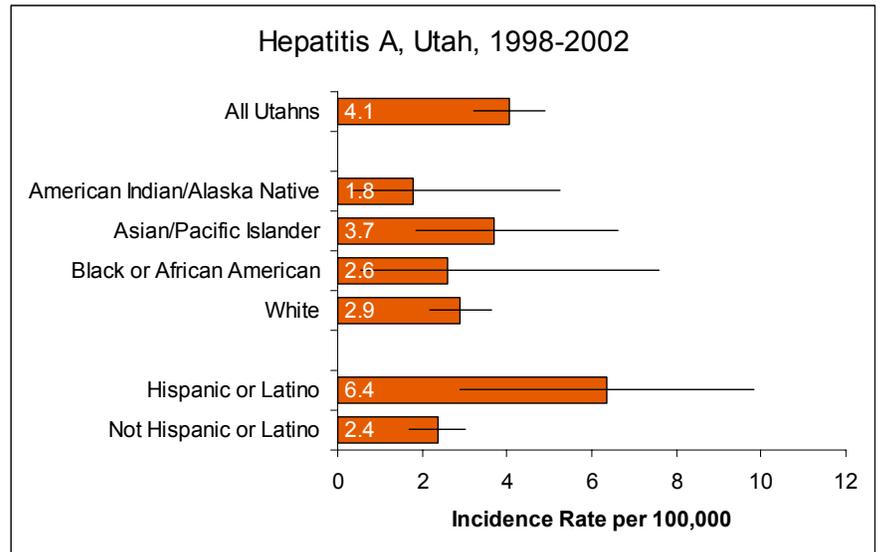
I N F E C T I O U S
D I S E A S E S



Hepatitis A

Why Is It Important?

Hepatitis A is the most common type of hepatitis reported in the U.S. Utah was identified as 1 of 11 states with average annual disease rates at least twice the national average during the 1987–1997 time period. Hepatitis A may be spread by food prepared or handled by an infected person who does not wash his or her hands carefully. Hepatitis A may be spread by water contaminated with human feces. It may also be spread by close intimate contact (household or sexual) and by diaper changing.



How Are We Doing?

- The number of hepatitis A infections reported annually has decreased significantly since 1997, and was 4.1 per 100,000 persons between 1998 and 2002.
- The hepatitis A incidence rates for non-Hispanic/Latino and White Utahns were lower than the overall state rate.

How Can We Improve?

Although it is not clear why racial and ethnic disparities exist for hepatitis A incidence, potential explanations include miscoding of communicable disease case reports and differences in exposure from travel to high-risk areas such as Mexico.

Prevention of hepatitis A is possible through vaccination and avoiding contaminated food and drink. The best way to prevent hepatitis A is through ensuring access to vaccine and providing education about risk factors and ways to prevent disease. At this time, efforts to prevent hepatitis A in Utah have been global and have not targeted specific racial or ethnic groups. Information and vaccine programs

have targeted schools and workplaces to ensure comprehensive prevention of hepatitis A in Utah. However, prevention strategies are developed based on identified needs and may change as more data become available.

Utah Hepatitis A Incidence, 1998-2002

Race/Ethnicity	Avg Annual # of Cases	Total Population	Crude Rate per 100,000 (95% CI Range)	Sig.*
All Utahns	91	2,233,169	4.1 (3.2 - 4.9)	n/a
American Indian/Alaska Native	1	33,733	1.8 (0.4 - 5.3)	
Asian/Pacific Islander	2	59,348	3.7 (1.9 - 6.6)	
Black or African American	1	23,063	2.6 (0.5 - 7.6)	
White	61	2,117,025	2.9 (2.2 - 3.6)	↓
Hispanic or Latino	13	201,559	6.4 (2.9 - 9.8)	
Not Hispanic or Latino	48	2,031,610	2.4 (1.7 - 3.0)	↓

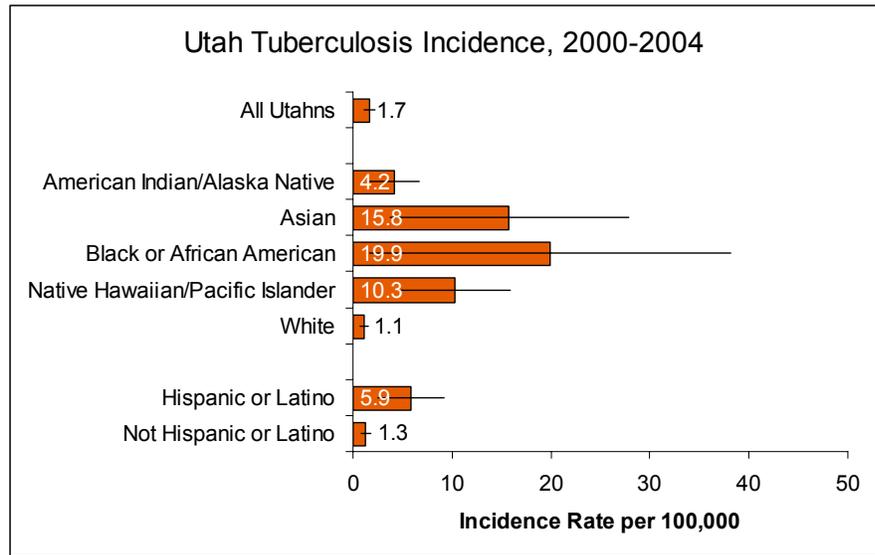
Source: UDOH, Bureau of Epidemiology

* The rate for each race/ethnic population has been noted when it was significantly higher (↑) or lower (↓) than the state rate.

Tuberculosis

Why Is It Important?

Tuberculosis (TB) is caused by bacteria called *Mycobacterium tuberculosis* that usually attack the lungs but may attack any part of the body. TB is typically spread through the air when a person with TB disease of the lungs or throat expels tiny airborne particles. People nearby may breathe in these particles and become infected. People who have latent TB infection do not feel sick, do not have any symptoms, and cannot spread TB. But they may develop active TB disease at some time in the future. One third of the world's population is currently infected with the TB bacillus.



Early detection and treatment of TB are essential to control the spread of the disease. Treatment for TB is at least six months for most patients. In Utah, all patients with active TB disease are placed on directly observed therapy (DOT), where a health care worker watches the patient swallow each dose of TB medication.

How Are We Doing?

- Between 2000–2004, the average tuberculosis incidence rate among all Utahns was 1.7 per 100,000 population. TB incidence has been decreasing nationally, and the Utah case rate has also been decreasing over the last decade. Utah's rate is about one-third the national rate.
- Tuberculosis incidence was higher among Black/African American, Asian, Native Hawaiian/Pacific Islander, and Hispanic/Latino Utahns.

How Can We Improve?

From 2000–2004, an average of 65% of the persons diagnosed with TB in Utah were born outside the U.S. To address the high rates among foreign-born persons, the Utah TB Control Program has implemented TB control initiatives among recent international arrivals to our state.

Utah Tuberculosis Incidence, 2000-2004

Race/Ethnicity	Avg Annual # of Cases	Total Population	Crude Rate per 100,000 (95% CI Range)	Sig.*
All Utahns	38	2,233,169	1.7 (1.2 - 2.2)	n/a
American Indian/Alaska Native	1	33,733	4.2 (1.7 - 8.7)	
Asian	7	41,866	15.8 (3.7 - 27.8)	↑
Black or African American	5	23,063	19.9 (1.7 - 38.2)	↑↑
Native Hawaiian/Pacific Islander	2	17,482	10.3 (4.7 - 19.6)	↑↑
White	24	2,117,025	1.1 (0.7 - 1.6)	↓
Hispanic or Latino	12	201,559	5.9 (2.5 - 9.2)	↑
Not Hispanic or Latino	26	2,031,610	1.3 (0.8 - 1.8)	

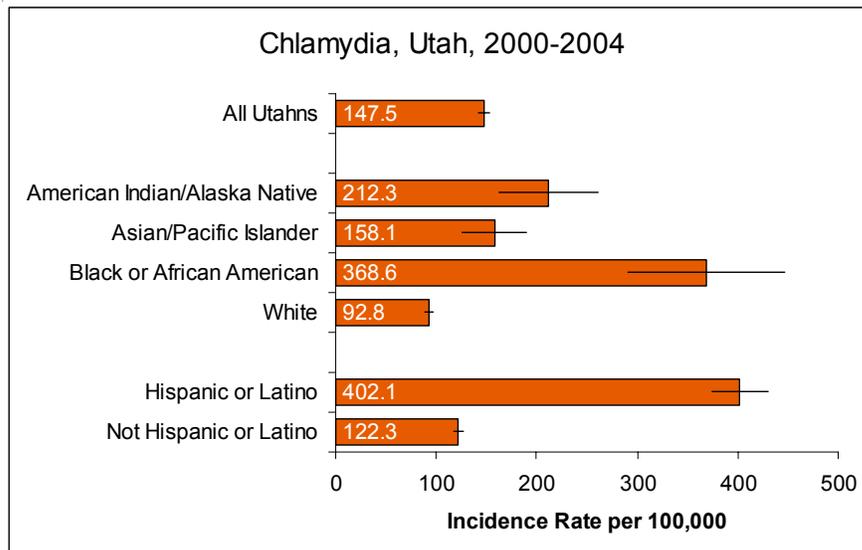
Source: UDOH, Bureau of Communicable Disease Control

* The rate for each race/ethnic population has been noted when it was significantly higher (↑) or lower (↓) than the state rate.

Chlamydia

Why Is It Important?

Chlamydia is the most frequently reported notifiable disease in the U.S., with 877,478 cases being reported in 2003, over two-thirds of which occurred among persons aged 15 to 24. Chlamydia infections in both men and women commonly show no symptoms. Untreated infections can lead to infertility. As with other STDs, pregnant women with chlamydia can pass the infection to their infant during delivery, potentially resulting in ophthalmia.



How Are We Doing?

- Chlamydia rates in Utah and in the U.S. have increased over the last ten years, at least partially due to improved screening, detection, and reporting.
- From 2000–2004, Utah reported a chlamydia rate of 147.5 cases per 100,000 persons.
- The chlamydia rate was higher among Utah’s Hispanic/Latino, Black/African American, and American Indian/Alaska Native populations.

How Can We Improve?

A 2003 CDC publication suggests that differences in rates may be biased due to minority populations’ higher use of public clinics. In Utah in an attempt to provide more culturally appropriate health care services to non-English speaking, at-risk populations, the TB Control/Refugee Health Program and the STD Control Program collaborated on bringing a Medical Interpreter Training project “Bridging the Gap,” course to Utah. Courses have been conducted since inception in 2001. The Cross Cultural Health Care Program (CCHCP) of Seattle developed the course, which includes a five-day, 40-hour course for medical interpreters speaking multiple languages. The content of the course focuses on professional interpreting skills, knowledge of the health care field, medical vocabulary, cultural knowledge and sensitivity, and communication skills for appropriate advocacy. Participants come from community-based organizations, local health departments, nonprofit interpreting agencies, and local school district interpreters. Languages that have been represented by interpreters included Spanish, Bosnian, Arabic, Farsi, Korean, Somali, Malaysian, Vietnamese, Samoan, and French.

Utah Chlamydia Incidence, 2000-2004

Race/Ethnicity	Avg Annual # of Cases	Total Population	Crude Rate per 100,000 (95% CI Range)	Sig.*
All Utahns	3,294	2,233,169	147.5 (142.5 - 152.5)	n/a
American Indian/Alaska Native	72	33,733	212.3 (163.1 - 261.4)	↑
Asian/Pacific Islander	94	59,348	158.1 (126.1 - 190.0)	
Black or African American	85	23,063	368.6 (290.3 - 446.8)	↑↑
White	1,964	2,117,025	92.8 (88.7 - 96.9)	↓↓
Hispanic or Latino	810	201,559	402.1 (374.4 - 429.7)	↑↑
Not Hispanic or Latino	2,484	2,031,610	122.3 (117.5 - 127.1)	↓↓

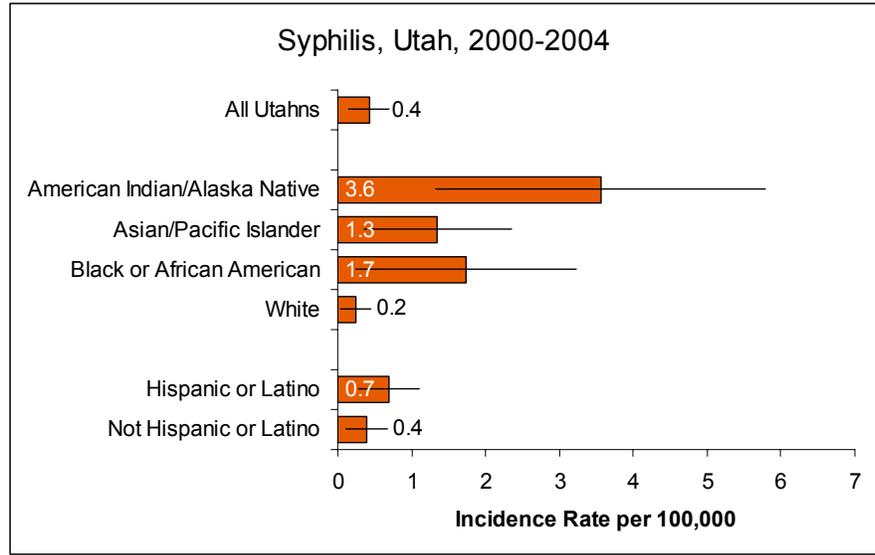
Source: UDOH, Bureau of Communicable Disease Control

* The rate for each race/ethnic population has been noted when it was significantly higher (↑) or lower (↓) than the state rate.

Syphilis

Why Is It Important?

Syphilis is a complex sexually transmitted disease (STD) caused by the bacterium *Treponema pallidum* (spp. *pallidum*). Syphilis is passed from person to person through direct contact, and can be passed from mother to fetus. Sexual transmission can also occur during the secondary stage of syphilis. In later stages of the disease, the bacteria move throughout the body, damaging many organs over time. Susceptibility to more serious infections also increases when an individual is infected with an STD. The open nature of the syphilitic sores makes it easier to acquire HIV, if exposed, or to transmit the virus, if infected. Public health intervention and education measures are crucial in eliminating syphilis.



How Are We Doing?

- From 2000 through 2004, 47 primary and secondary (P&S) syphilis cases were reported in Utah.
- Although case rates are low, Utah’s American Indian/Alaska Native population had a statistically significantly higher rate of syphilis than the overall state rate.

How Can We Improve?

A 2003 CDC publication states that differences in rates may be biased due to minority populations’ higher use of public clinics whose doctors may be more likely to comply with disease notification requirements. In Utah in an attempt to provide more culturally appropriate health care services to non-English speaking, at-risk populations, a Medical Interpreter Training project, “Bridging the Gap,” course was brought to Utah. It is anticipated that with better medical interpretation, non-English speaking individuals will have the vital information needed to protect themselves against acquiring or reacquiring sexually transmitted diseases.

Utah Syphilis Incidence, 2000-2004

Race/Ethnicity	Avg Annual # of Cases	Total Population	Crude Rate per 100,000 (95% CI Range)	Sig.*
All Utahns	9	2,233,169	0.4 (0.2 - 0.7)	n/a
American Indian/Alaska Native	1	33,733	3.6 (1.3 - 7.8)	↑
Asian/Pacific Islander	1	59,348	1.3 (0.4 - 3.3)	
Black or African American	<1	23,063	1.7 (0.2 - 6.1)	
White	5	2,117,025	0.2 (0.0 - 0.5)	
Hispanic or Latino	1	201,559	0.7 (0.3 - 1.4)	
Not Hispanic or Latino	8	2,031,610	0.4 (0.1 - 0.7)	

Source: UDOH, Bureau of Communicable Disease Control

* The rate for each race/ethnic population has been noted when it was significantly higher (↑) or lower (↓) than the state rate.

Gonorrhea

Why Is It Important?

Although much less common than chlamydia infections, gonorrhea, caused by *Neisseria gonorrhoeae*, is a priority public health concern in Utah. Long-term consequences similar to those of chlamydia result in negative health outcomes. Untreated gonorrhea infections can damage the reproductive systems of both males and females, leading to infertility. Gonorrhea can spread to joints and become systemic (disseminated gonorrhea). In addition to the cervix and urethra, the rectum and pharynx are also important sites of gonococcal infection.

How Are We Doing?

- Gonorrhea infection in Utah occurred at the rate of 16.5 per 100,000 population from 2000–2004.
- Incidence of gonorrhea infection was higher among Utah’s Black/African American and Hispanic/Latino populations.

How Can We Improve?

From the Centers for Disease Control and Prevention STD Surveillance 2003:

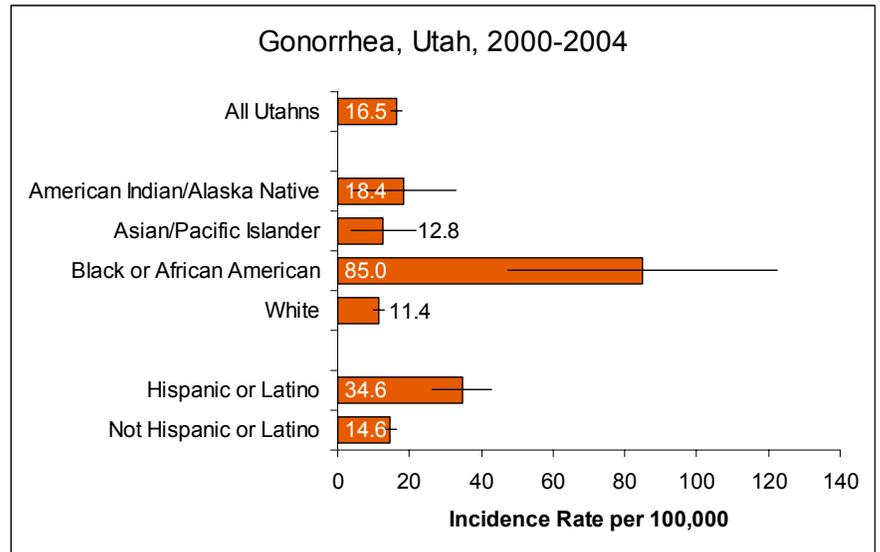
“... data show higher rates of reported STDs among some minority racial or ethnic groups when compared with rates among whites. Race and ethnicity in the United States are risk markers that correlate with other more fundamental determinants of health status such as poverty, access to quality health care, health care seeking behavior, illicit drug use, and living in communities with high prevalence of STDs. In many areas, reporting from public sources, (for example, STD clinics) is more complete than reporting from private sources. Since minority populations may utilize public clinics more than whites, differences in rates between minorities and whites may be increased by this reporting bias.”

Utah Gonorrhea Incidence, 2000-2004

Race/Ethnicity	Avg Annual # of Cases	Total Population	Crude Rate per 100,000 (95% CI Range)	Sig.*
All Utahns	367	2,233,169	16.5 (14.8 - 18.1)	n/a
American Indian/Alaska Native	6	33,733	18.4 (3.9 - 32.8)	
Asian/Pacific Islander	8	59,348	12.8 (3.7 - 21.9)	
Black or African American	20	23,063	85.0 (47.4 - 122.6)	↑
White	241	2,117,025	11.4 (10.0 - 12.8)	↓
Hispanic or Latino	70	201,559	34.6 (26.5 - 42.8)	↑
Not Hispanic or Latino	298	2,031,610	14.6 (13.0 - 16.3)	↓

Source: UDOH, Bureau of Communicable Disease Control

* The rate for each race/ethnic population has been noted when it was significantly higher (↑) or lower (↓) than the state rate.

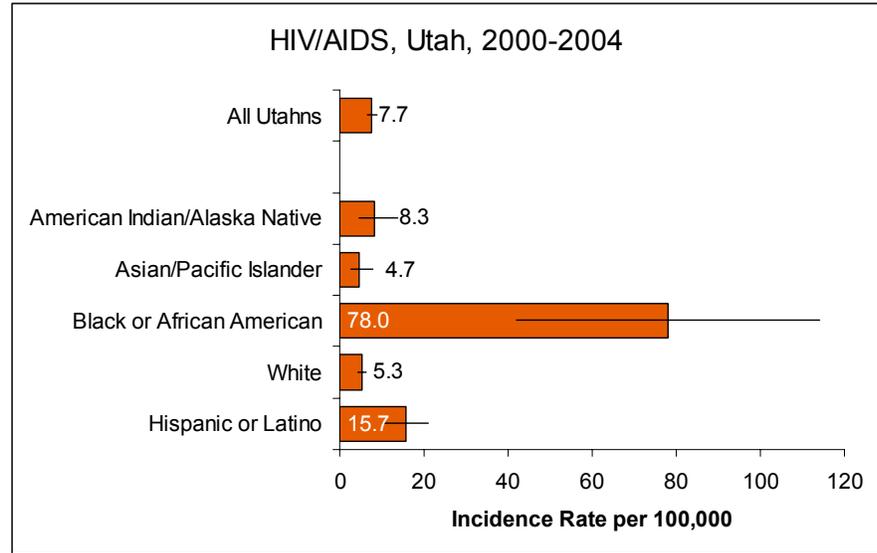


In Utah in an attempt to provide more culturally appropriate health care services to non-English speaking, at-risk populations, a Medical Interpreter Training project, “Bridging the Gap,” course was brought to Utah. It is anticipated that with better medical interpretation, minorities will gain information needed to protect themselves against STDs.

HIV/AIDS

Why Is It Important?

HIV (human immunodeficiency virus) is a blood-borne virus. Transmission occurs primarily through sexual contact with an infected person, sharing needles for the injection of drugs, or before, during, or after the birth of children of HIV-infected mothers. The Bureau of Communicable Disease Control and the HIV/AIDS Surveillance Program has the responsibility for tracking cases of HIV/AIDS in order to monitor trends in the disease and whenever possible to interrupt the transmission of HIV. This is done by collecting pertinent demographic information on reported AIDS cases and HIV-positive individuals and by conducting follow-up on newly diagnosed individuals and their partners. No treatment is available to cure AIDS, although antimicrobial and antiretroviral treatments now available extend survival among those who are infected with HIV.



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How Are We Doing?

- Each year from 2000 through 2004, 172 Utahns were newly diagnosed with HIV or AIDS, for an annual incidence rate of 7.7 per 100,000.
- Incidence of HIV/AIDS was significantly higher among Utah's Black/African American and Hispanic/Latino citizens.

How Can We Improve?

Community-based prevention efforts include:

- Encouraging safer sexual practices.
- Encouraging drug users to get treatment to stop using drugs and teach them harm reduction.
- Encouraging pregnant women or women considering pregnancy to be tested for HIV.

Utah HIV/AIDS Incidence, 2000-2004

Primary Race/Ethnicity	Avg Annual # of Cases	Total Population	Crude Rate per 100,000 (95% CI Range)	Sig.*
All Utahns	172	2,233,169	7.7 (6.5 - 8.8)	n/a
American Indian/Alaska Native	3	33,733	8.3 (4.5 - 13.9)	
Asian/Pacific Islander	3	59,348	4.7 (2.6 - 7.9)	
Black or African American	18	23,063	78.0 (42.0 - 114.1)	↑
White	112	2,117,025	5.3 (4.3 - 6.3)	↓
Hispanic or Latino	32	201,559	15.7 (10.2 - 21.1)	↑

Source: UDOH, HIV/AIDS Surveillance Program, Office of Communicable Disease Control

Note: Individuals were classified into only one race/ethnic category.

* The rate for each race/ethnic population has been noted when it was significantly higher (↑) or lower (↓) than the state rate.