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Response to Dr Robert E. Fullilove's Editorial Letter: "Race and Sexually Transmitted Diseases… Again?"

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We appreciate Dr Fullilove continuing the work that his father started in the 1940s to bring attention to the limitations of using reported race and Hispanic ethnicity to identify the risk for sexually transmitted diseases (STDs).[1] We agree that race and Hispanic ethnicity are social attributes of groups of people, not biological attributes of individuals in those social groups; therefore, the observed disparities in gonorrhea case rates by race and Hispanic ethnicity are unlikely to be caused by biological differences linked to race or Hispanic ethnicity. Those disparities are associated with a range of other social factors, including differential access to quality sexual health care and prevalence of disease in sexual networks. Measuring disparities in STDs can help direct limited prevention resources toward populations at greatest need. However, when reporting disparities in STDs, it is important to ensure that the underlying drivers of observed disparities are identified to avoid stigmatizing the affected groups and to inform the design and implementation of effective interventions to reduce or eliminate disparities.

We also agree with Dr Fullilove that our investigation of race and Hispanic ethnicity classification strategies will not, in and of itself, reduce disparities; however, our work draws attention to some of the challenges in monitoring trends in observed disparities in rates of reported gonorrhea.[2] Because Hispanics may be of any race, our goal was to determine whether important disparities in the rates of reported gonorrhea were being masked when using the current classification of all Hispanics into a single Hispanic ethnicity category. We found that the categorization strategy had a minimal impact on trends in disparities over time; however, the magnitude of the disparity each year was affected by the classification approach. In addition, we found that race and Hispanic ethnicity were missing for approximately 1 in 5 gonorrhea cases. If these data are not missing at random,

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estimates of disparities will be biased. Metrics used to evaluate interventions to reduce STDs in populations most affected will need to consider these limitations.

Finally, we agree and support Dr Fullilove's call for additional research to understand how to address the underlying drivers for proxy factors, such as race or Hispanic ethnicity, when implementing programs, policies, and interventions to minimize the impact of STDs. We would add a call to strengthen surveillance efforts to ensure systems are in place to adequately capture important contextual factors. Sentinel surveillance systems, such as the STD Surveillance Network,[3] which conducts enhanced patient and provider investigations on a representative sample of gonorrhea cases, could be further leveraged to monitor trends in the underlying factors that may increase the risk for STDs.

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