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Integrating HIV and STD services is essential to effective prevention programs. An increasing number of public health agencies are adopting this comprehensive approach, including the integration of viral hepatitis services as discussed in the February edition of the [NASTAD HIV Prevention Bulletin](#). Populations at risk for HIV and sexually transmitted diseases (STDs) often overlap given that HIV and STDs share many of the same risk factors. Studies have also demonstrated that the presence of STDs can increase HIV transmission risk.

In a recently updated CDC fact sheet on [Syphilis and MSM](#), the rate of HIV and syphilis co-infection is discussed. According to CDC, recent syphilis outbreaks in cities such as New York, Chicago, San Francisco and Miami have documented rates of HIV co-infection ranging from 20 to 70%.¹ CDC's Division of STD Prevention provided funding to 8 cities for pilot projects to address the syphilis outbreaks and associated risk behaviors among MSM. Promising interventions included using the internet to encourage gay men to get tested for HIV and STDs and using the internet to conduct partner counseling and referral services. While noting that it is not known whether HIV is also being transmitted among MSM where the syphilis outbreaks are occurring, CDC acknowledges that HIV and STD stakeholders need to work together.

The alarming number of syphilis outbreaks occurring within the past few years among men who have sex with men (MSM) have prompted many federal, state and local health agencies to explore integrated approaches to identifying HIV and STDs cases, particularly among those who are co-infected. These integrated approaches have led to the development of behavioral interventions targeting those at risk for both HIV and STDs.

In 2002, NASTAD and the National Coalition of STD Directors (NCSD) developed an issue brief on [STD/HIV Prevention Integration](#), which outlined the critical need for integrated HIV and STD services. An assessment of state and local health jurisdictions already using an integrated HIV and STD approach revealed that integration allows for "increased flexibility in offering STD screening alongside HIV testing", "more efficient data collection, standardization and integration of data... for improved prediction of transmission and outbreaks" and "better cross-training and utilization of staff and administrative time."

This month's *Bulletin* highlights health departments who have implemented an integrated approach to HIV and STD prevention. HIV/STD program collaboration around partner counseling and referral services (PCRS) is also discussed. As well as a CDC "Dear Colleague" letter calling for the implementation of the 2002 STD Treatment Guidelines. Rounding out this month's *Bulletin* is a report-back on the 2004 National STD Prevention Conference held in Philadelphia, PA, which focused on various youth issues. The conference was sponsored by the American Social Health Association (ASHA), the American Sexually Transmitted Diseases Association, and the National Coalition of STD Directors (NCSD).

¹ Centers for Disease Control and Prevention (CDC). Fact Sheet, Syphilis and MSM (Technical Update: January 9, 2004).

Michigan and South Carolina: Integrated Approaches to HIV/STD Prevention

The following excerpts are from interviews with Mark Miller, Director of STD Prevention in the Michigan Division of HIV/AIDS and STD and Lynda Kettinger, Division Director of South Carolina's STD/HIV Division. Both interviews highlight some of the advantages and challenges these state agencies faced as they integrated their HIV and STD programs.

What was the rationale behind integrating the HIV and STD programs?

MI: When Loretta Davis-Satterla joined the program in 1999 as the Director of the Division of HIV/AIDS-STD, she made integration one of her priorities.

Efficiency may be the greatest rationale for integrating the two programs. In addition there is a lot of overlap in the areas in that both programs do partner counseling and referral services (PCRS), education and lab services. We've also completely integrated the training unit. Our HIV training was much more developed and adding STD to the structure was not difficult. From a clinical viewpoint, if patients are at risk for HIV, they're also at risk for STDs. It shows consideration on our part if we only make the patients go through one clinic. Also, since STDs increase the risk of HIV transmission anywhere from 2 to 5 times, a strong STD program is an excellent way to prevent new HIV cases.

It makes a lot of sense to integrate especially in these times of tight budgets; we get more bang for our buck.

SC: When we integrated our HIV and STD programs back in 1995 it was part of a larger reorganization in our state office. Our surveillance staff were already integrated. The idea was to "down-size" the number of management positions and to integrate areas for increased efficiency and cost savings. Practically speaking, the work that was being done at the local health department level was already integrated in most areas (such as partner notification). Many local staff were split-funded on HIV and STD funds. At the state office level we worked very closely with the STD program staff around surveillance functions, joint trainings, and purchasing condoms and educational materials (HIV resources helped the traditionally under-funded STD program).

Can you briefly describe how this integrated program functions and the topical areas it encompasses (HIV, STDs, hepatitis, etc.)?

MI: STD and HIV programs in many local health departments are integrated. We're working to routinize HIV testing in our largest STD clinic. Partner counseling and referral services (PCRS) is integrated into the STD program in our largest health department. Steps have been taken to smooth the transition between PCRS and case management. We also have a condom distribution program that is run jointly with HIV, family planning and STD.

We had integrated hepatitis B with STD/family planning/adolescent health from 1999-2002. We are looking to integrate hepatitis C with STD and HIV. What we're lacking is funding. A pilot project to provide hepatitis C testing and education has been conducted at a couple of sites.

SC: Our Division encompasses all STD and HIV prevention and care services. We are organizationally in the Bureau of Disease Control which also includes the STD/HIV surveillance program, TB program and hepatitis program, and we work very closely with these staff. Recently we have received some funding for hepatitis C training and screening through our contract with the state Department of Alcohol and Other Drug Abuse Services (DAODAS). We collaborate with our Bureau's Hepatitis Coordinator and pool resources to cover total screening costs, develop screening policies, and conduct local health department staff trainings as the screening and counseling is provided by STD/HIV staff. The integrated surveillance unit utilizes STD*MIS and HARS which allows for more complete data access such as HIV risk exposure information obtained from the STD partner notification records.

Since the initial reorganization in 1995, we have also worked to integrate STD/HIV and family planning services at the local level to create "one-stop shopping" for women. In partnership with our family planning program, our Division conducts an integrated preventive health training program for family planning and STD/HIV clinical staff in local health departments. This allows for more clients to receive these services given that staff are cross-trained. This is most beneficial in the smaller counties where there are fewer nursing staff available. Due to this collaborative environment, we have been able to receive additional HIV counseling and testing funds in high prevalence areas through the Office of Population Affairs. These grants focus on screening women in family planning settings.

What have been some of the specific benefits of an integrated program?

MI: Efficiency. We have a large yearly STD/HIV conference that has been held for almost 10 years. It is cost efficient in that we conduct one meeting instead of two. Because most of the local health department staff would have to attend a HIV and STD meeting, we save considerable expense by condensing the two meetings into one. By combining the two meetings there is also greater diversity of workshops at the meeting, and it gives individuals a chance to be cross-trained.

SC: In addition to creating opportunities for receiving other funds, the primary benefit is that we are able to utilize staff more fully to meet the needs of our epidemic by cross-training staff. Having cross-trained staff to provide more services enables staff in rural areas to see more clients and promotes coordinated case management/care provision. All newly diagnosed persons with HIV receive RPR (rapid plasma reagin) screening for syphilis, PPD skin testing for tuberculosis, immunizations, and initial CD4 and viral load tests. STD clients receive HIV counseling and testing, family planning and immunizations. In most areas, a client will have the same provider for all of these clinical services, promoting continuity of care and enhanced rapport.

We are also able to share or leverage resources for conducting several program and training activities. We use syphilis elimination and HIV funds to support community outreach and screening services for syphilis and HIV through a mobile van unit and through contracts with CBO's that were funded initially with HIV prevention funds. When we conduct outbreak response initiatives for syphilis elimination, cross trained staff also screen for HIV in populations at very high risk for both syphilis and HIV, e.g. commercial sex workers, substance users, MSM. We have used syphilis elimination and HIV resources to fund radio spots and live remotes when we do testing in the field. We also use combined resources for purchasing condoms and educational materials for STD and HIV prevention. Our program policies are integrated ensuring consistent procedures, quality assurance and technical assistance. Finally, having an integrated program also gives us more flexibility in using state resources for required federal matching.

What have been some of the challenges in integrating the HIV and STD programs?

MI: The focus of the programs was one challenge we had to overcome. The STD program has been a traditional communicable disease program and was run mostly out of local health departments. STD had relatively little experience with CBOs until a few years ago. At first this lack of experience was a challenge. However, integration with the HIV program brought the experience and credibility necessary to develop relationships with CBOs. In the case of syphilis we were able to piggy back our efforts on those already established through the HIV program. In many cases all we had to do was amend our HIV contracts to include syphilis.

The collection of behavioral risk data also presented a challenge. Most HIV programs collect behavioral and demographic data while many STD programs have traditionally not collected this information. Michigan now collects this information for syphilis and also collects some of the same information for gonorrhea. Collection of this data has helped us to better target our efforts.

While the goals and objectives were similar for both programs; what we discovered was that as an integrated division we didn't have any overall goals and objectives. To respond to the lack of goals and objectives we established a strategic planning committee. The process took a long time. The committee was fully integrated and for the most part everyone in the division was involved. While there were many challenges, we came out of the process with a good plan.

SC: For a state of our size and disease morbidity, the integration of STD and HIV was a natural "marriage". Some staff, particularly at the state level, may have initially felt that HIV received more attention than STDs. At the local level, larger clinics may find integration more difficult due to demands to see STD patients in the same day. Also, in larger clinics due to the expertise required for HIV services there will be some staff just designated to HIV counseling and testing or HIV partner notification (and they do not typically provide STD services). While not specifically related to integration, recent local health department challenges of nursing shortages, budget cuts, etc., have resulted in other staff such as health educators, DIS and social workers being trained to provide HIV counseling and testing, which we see as a positive step to increase capacity for these services.

As with any organizational change, good planning and creating opportunities for people to share concerns/feelings and process the change is important. We had to plan for specific training needs for staff. For example, nursing staff that only did HIV counseling and testing services needed training in STD diagnosis and treatment, or vice versa.

What lessons learned or guidance would you offer to other health departments seeking to integrate their HIV and STD programs?

MI: Look more at the similarities than the differences. You'll find there are many more similarities than differences. For example, in the late 1980's the perception on the part of some STD staff of HIV staff was that HIV work was mostly done by "social worker types". At the same time, some HIV staff thought STD work was barbaric. Clearly, there was some division between the two programs. But in the end, the similarities of the work being done by each program were obvious.

SC: Integration works best if the overall organizational climate/philosophy promotes integrated services and communication. This environment helps to reduce potential programmatic barriers/issues such as shared client records, shared staff, consistent policies and standards for delivery of services, and consistent administrative policies such as billing, forms, data entry, reporting, etc. Integration also works best in smaller departments/clinics and when all staff are physically "housed" in the same location. Finally, integration also works best when staff providing basic STD/HIV services, have available consultant staff with more specific expertise for complex cases.

As evidenced by the experiences of Michigan and South Carolina, integrating HIV and STD programs can have its challenges however being able to provide coordinated and comprehensive prevention services to those at risk for HIV and STDs may also be beneficial.

For more information on HIV/STD integration in Michigan please contact [Mark Miller](#), STD Program Manager, Division of HIV/AIDS-STD, Michigan Department of

Community Health and for South Carolina, please contact [Lynda Kettinger](#), Director, STD/HIV Division, South Carolina Department of Health & Environmental Control.

HIV/STD Integration in Indiana: The OASIS Project

The Centers for Disease Control and Prevention (CDC) has funded a multi-state project to support HIV/STD integration. The *Outcomes Assessment through Systems of Integrated Surveillance* (OASIS) grants were established to "support disease prevention and program planning through the integration of management and analysis of STD and HIV/AIDS surveillance data through a blinded match."¹

In 1999, the Indiana State Department of Health (ISDH), STD and HIV/AIDS surveillance program received an OASIS grant to support ISDH's efforts in looking at an integrated system of STD and HIV surveillance. The project involved comparing HIV/AIDS Reporting System (HARS) data with Sexually Transmitted Disease Management Information System (STD*MIS) data and looking for "matches" or cases found in both the HARS and STD*MIS registries.

Prior to beginning the project, ISDH shared an outline of the proposed activities with their HIV Prevention Community Planning Group (CPG) and Stamp Out Syphilis (SOS) Coalition of Marion County. After the CPG and SOS Coalition were given detailed information on the process in which activities of the OASIS project would be carried out, both groups signed letters of support for the project. The CPG and SOS Coalition were also assured that measures would be taken such that neither HIV nor STD program personnel administering the project would be exposed to identifiable characteristics of each program's data.

HARS data from 1982-2001 and STD*MIS data from 1999-2001 were examined. A total of 253 "matches" were identified based on the analysis [74 chlamydia cases, 132 gonorrhea cases and 47 syphilis (all stages) cases]. This meant that there were a total of 253 cases that were identified in both the HARS and STD*MIS registries indicating that these individuals had received both an HIV and STD diagnosis during the timeframe in which the analysis was being conducted. Of the 253 matches identified, 80% of these co-infections involved patients who became infected with an STD after an HIV diagnosis had been reported. These results provided a strong indication that high-risk sexual behavior was occurring even after the individuals had received an HIV diagnosis. Analysis of behavioral risk data was used to design effective behavioral interventions and to determine common risk factors in areas where co-infections were more commonly occurring.

Patients in Marion County, which includes Indianapolis, accounted for 161 (64%) of the 253 matches. Additionally, 74% of the syphilis (all stages) cases reported (35 of 47) were from patients residing in Marion County. Although the syphilis results were not surprising to ISDH given ongoing syphilis outbreaks in Marion County during the timeframe of the analysis, these results did prompt the Marion County STD Program to tailor their risk assessment forms.

Although the OASIS project with ISDH concluded in 2002, the Indiana State Department of Health, STD and HIV Surveillance Programs have continued to implement this framework in order to document HIV/STD co-infection and develop targeted behavioral interventions.

For more information on the Indiana State Department of Health surveillance programs and the OASIS project, please contact [James D. Beall](#), STD Manager, Indiana State Department of Health.

¹ Indiana State Department of Health, Indiana Epidemiology Newsletter, May 2002, Vol. X, No. 4.

Integrating HIV and STD Programs in Texas

For several years the Texas Department Health (TDH) has maintained an integrated HIV/STD program. Integration of the two programs can be found in all levels of the state's activities to address both HIV and STDs. Evidence of TDH's integrated approach is reflected in the priorities of the community planning group, through the development of an HIV and STD Program Operating Procedures and Standards manual and through targeted HIV testing in STD clinics.

The community planning groups in Texas have recognized that STDs play a role in the prevention, testing and treatment of HIV. To address this issue, CPGs across the state have developed linkages between HIV planning and STD prevention, testing and treatment. The linkages included the use of the epidemiological profile which included both HIV and STD data. STD data played a critical role in the development of the plans as it was factored into decisions such as prioritization of subpopulations and the selection of behavioral-based interventions. Several of the behavioral-based interventions chosen by all CPGs address the critical link between STD infections and increased risk for acquiring HIV.

The HIV and STD Program Operating Procedures and Standards for TDH were adopted as the standards by which TDH staff and contractors of the Bureau of HIV and STD Prevention are expected to perform and fulfill prevention activities. The Bureau developed Operating Procedures and Standards into a single document to meet the needs of both HIV and STD programs. The document is comprised of 20 chapters and includes information on counseling and testing, documentation in client charts, HIV testing in STD clinics, and performance standards for all levels of staff and programs under the Bureau of HIV/STD. The [policies](#) for the Bureau of HIV/STD and a draft of the [HIV and STD Program Operating Procedures and Standards](#) are available on line at the TDH website.

In Texas, consensual HIV testing is included in the routine battery of tests performed on all clients in an STD clinic and on clients in comprehensive clinics who request STD services. Consent for HIV testing is conducted as "Opt-out"-in which the client must actively refuse the test being offered. To compare the acceptance and effectiveness of the Opt-out approach, TDH conducted an evaluation in Amarillo, Austin, Dallas, Fort Worth, Houston and Lubbock during a six month period prior to and after initiation of Opt-out testing implementation. The conclusion of the study indicated that the Opt-out approach was effective for the STD clinics in that a greater number of clients received testing, a greater number of HIV infected persons learned their status and entered treatment, and more HIV positive partners learned of their infection. Additional information regarding the rationale for Opt-out HIV testing is available in [chapter 5 of the HIV and STD Program Operating Procedures and Standards](#).

For additional information, please contact [Felipe Rocha](#) or [Jim Lee](#) at the Texas Department of Health.

Partner Counseling and Referral Services: A Key Program for HIV/STD Collaboration

CDC's *Advancing HIV Prevention* initiative emphasizes the need for individuals to learn their serostatus and receive care and prevention services fitting their needs, with a strong focus on working with HIV positive individuals and their partners. Partner counseling and referral services (PCRS), a broadly defined intervention with partner notification at its core, serves as one of the main interventions to ensure that partners of positive individuals receive counseling, HIV testing, and referrals to appropriate services based on their serostatus. Health departments have used partner notification as a key public health strategy for years in the fight against HIV, STDs and other communicable diseases. STD programs already possess a trained staff of disease intervention specialists (DIS) already familiar with some of the same communities at high risk for HIV. For these reason, PCRS has become one of the main areas of collaboration between health department HIV and STD programs.

What is PCRS?

Public health entities have used contact tracing, informing individuals of their potential exposure to a communicable disease, as a key control strategy for years. For example, to control outbreaks of tuberculosis (TB), officials attempt to locate any person that has come in contact with the infected person (referred to as the index case). Persons exposed to TB are then tested and treated as necessary to prevent anyone else from becoming exposed. For STDs, the term partner notification is used for this process, referencing the fact that individuals exposed to an STD are or were the sexual partners of the index case.

For HIV, the process of partner notification becomes more complex. Unlike most STDs, HIV is incurable, can be fatal, and requires complex medical and behavioral management for life. The stigma associated with HIV and misinformation regarding the disease in many communities also creates the need for a program broader in scope than just partner notification. To meet this challenge, public health officials expanded the concept of partner notification to become partner counseling and referral services. The change in term recognizes that HIV requires more than simply informing someone of their exposure, offering testing and subsequent treatment as necessary. Persons exposed to HIV may need a greater level of counseling and support to ensure they clearly understand what exposure and a potential diagnosis means, receive necessary testing and care, and take steps to protect their partners.

How do STD and HIV programs collaborate on PCRS?

Given that STDs and HIV often occur in the same communities, with STD outbreaks such as syphilis serving as precursors for later HIV outbreaks, it makes sense that HIV and STD programs work closely together. As noted above, STD programs already possess a trained staff of DIS (individuals trained to identify and locate partners of persons infected) that work in many of the same communities impacted by HIV. Rather than create a duplicate program, many health department HIV programs collaborated with their STD programs to offer PCRS.

Recently, NASTAD conducted a survey of health departments to better understand the structure of PCRS programs including how they work with STD programs. Forty-five state, local, and territorial health departments responded to the survey (an approximately 80% return rate). Only 27% of health departments reported that the HIV program manages PCRS. In 31% of states, the STD program administers PCRS while 42% of states report management of PCRS by a combined HIV/STD program (where the same program administration runs both HIV and STD prevention programs). Funding for programs comes from a variety of sources. In general, most health departments (91% of respondents) use CDC HIV cooperative agreement funds to support PCRS. However, another 57% use CDC STD cooperative agreement funds with one state reporting using only CDC STD cooperative agreement funds to support HIV PCRS. Other funding comes from state and local resources, with three states reporting only the use of state funds to support PCRS.

Many health departments require STD training for their DIS who do PCRS, with 47% of respondents indicating that CDC's STD course is required (with nearly 70% of states requiring CDC's STD training for DIS and other staff that offer partner counseling, some of whom may not participate in field investigations). Both state and local health departments may also require STD courses developed specifically for their jurisdiction. Up to 70% of respondents indicated that the provision of STD and/or hepatitis results was also a required part of the training for HIV PCRS staff. Over 53% of respondent reported tracking PCRS data using their STD data system, rather than a data system developed specifically for HIV PCRS.

The survey results clearly indicate a strong dependence of HIV programs on STD programs to offer PCRS. The level of collaboration varies from jurisdiction to jurisdiction. In some cases, STD programs may administer PCRS with little input from the HIV program, while in other cases, the HIV program takes a more active role. Other health department programs may also play a key role. Disease surveillance may play a part in identifying individuals who need PCRS and assisting providers in offering the services. Public health laboratories and local HIV and/or STD programs may collaborate in offering PCRS as well.

Barriers to Collaboration

Barriers to collaboration may exist in some jurisdictions, hindering the ability of AIDS and STD programs to work together on PCRS. The appropriate balance of funding between programs represents one challenge. As described above, health departments fund PCRS in a variety of ways, but determining how much each program contributes varies across jurisdictions.

Perhaps a more daunting challenge comes in addressing differences in culture between HIV and STD programs. As noted above, STD programs have used partner notifications as a key strategy for years, prior to the beginning of the AIDS epidemic in the 1980s. Traditional STD partner notification focused on notification, testing, and treatment. HIV PCRS introduced client-centered counseling concepts and the recognition that HIV positive individuals must struggle with partner issues throughout their life, creating an ongoing, long-term support role for PCRS. For DIS doing STD partner notification for years, PCRS may represent a significant cultural shift in how they perform their job. In addition, although many DIS have experience working with the same communities impacted by HIV, some communities were new to DIS, creating issues as staff attempted to learn community norms.

Aligning Partner Services and PCRS

In response to a 1997 report by the Institute of Medicine, the Division of STD at CDC began reformatting its operational guidelines for STD programs including partner notification, now referred to as partner services. The resulting guidelines more closely aligned STD partner services with HIV PCRS. The STD guidelines adopt a broader role for partner services and a common set of principles with HIV PCRS. Shared principles include the use of client centered counseling, the need to support individuals in informing their partners, and the importance of confidentiality and of providing culturally appropriate services. These principles also recognize that partner services/PCRS serves as only one component of a comprehensive system of prevention. As HIV PCRS and STD partner services become more closely aligned, they will grow as a key point of collaboration between HIV and STD programs.

For more information on integration around partner counseling and referral services (PCRS), please contact [Chris Aldridge](#), HIV/AIDS Prevention & Care Program Manager at NASTAD.

CDC Letter Encourages Implementation of the 2002 STD Treatment Guidelines

In response to rising rates of HIV and other STDs among gay men and men who have sex with men (MSM), CDC published a "Dear Colleague" letter calling for implementation of the [2002 STD Treatment Guidelines](#) recommendations for sexually active gay men/MSM. The *Guidelines* recommend the following prevention services for sexually active gay men/MSM: Testing for HIV, syphilis, gonorrhea and chlamydia, at least annually; and vaccination against both hepatitis A (HAV) and hepatitis B virus (HBV) infections. The letter encourages public health and private health care providers to work together to offer these comprehensive prevention services to gay men/MSM. The letter is signed by the Directors of CDC's Division of HIV/AIDS Prevention (DHAP), the Division of STD Prevention (DSTD), the Division of Viral Hepatitis (DVH) and the Division of Immunization Services (DIS), and also serves to help clarify and coordinate CDC's prevention efforts for gay men/MSM.

Public health officials will play a critical role in the dissemination of the letter and in the adoption of the *Guidelines* in their respective jurisdictions. The letter is designed to assist health officials in their efforts to promote access to and implementation of comprehensive HIV/STD/hepatitis services, particularly among private physicians and other medical providers treating gay men/MSM. Ensuring that private health care providers are aware of the recommendations and are consistently offering comprehensive STD services to sexually active gay men/MSM is an important component of all HIV, STD and hepatitis prevention efforts. This letter may also serve as a tool for gay men/MSM and gay, lesbian, bisexual, transgender and questioning (GLBTQ) advocacy groups to increase awareness among gay men/MSM of their risk for multiple infections, and to encourage men to talk with their providers about the recommended services and their risks.

HIV community planning groups (CPGs) and community-based organizations (CBOs) prioritizing and serving MSM should consider ways to incorporate the *STD Treatment Guidelines* into their work. CDC's *Advancing HIV Prevention* Initiative (AHP) encourages routine HIV testing in medical settings; public health can also encourage

the adoption of additional services for at-risk clients when bringing the AHP message to private settings. Similarly, AHP focuses on reaching and testing high risk clients for HIV. The behaviors that put clients at risk of HIV infection also put them at risk for hepatitis and STDs, therefore, HIV counselors should integrate multiple infection prevention education/screening into their work, when they are able. While comprehensive HIV, STD and hepatitis services are not yet a public health standard; increasingly, health departments, CBOs, HIV C&T sites and STD clinics are working together to integrate services in order to best serve the populations at risk.

If you would like additional information about CDC's Dear Colleague letter, please contact [Laurie Schowalter](#), Viral Hepatitis Program Manager at NASTAD.

National STD Conference Highlights Links between Crystal Methamphetamine Use, Internet Use and HIV/STDs among MSM

Abstracts presented at the 2004 National STD Prevention Conference add to the growing body of evidence associating crystal methamphetamine use and Internet use by men who have sex with men (MSM) to HIV and STD infections. While the majority of the research presented on methamphetamine use was from San Francisco, increases in methamphetamine use among MSM on the east coast have recently been reported¹ suggesting that methamphetamine use among MSM is widespread and should be considered in all HIV/STD prevention programs. Finding sex partners on the Internet is a practice that spans both rural and urban areas; the STD conference highlighted data both demonstrating the association between meeting partners on the Internet and STDs, and the utility of the Internet in partner notification efforts. The following are selected abstracts from the STD conference on methamphetamine use and Internet use among MSM.

Methamphetamine Use

The San Francisco Department of Public Health² reported on survey data collected from the city's municipal STD clinic, the "City Clinic", which found that men reporting methamphetamine use were more likely than non-methamphetamine users to be infected with HIV or other STDs. The researchers examined data from 1,263 MSM who visited the clinic between November 2002 and March 2003; 219 (17.4%) reported methamphetamine use during the four weeks prior to the clinic visit. Compared to non-methamphetamine users, methamphetamine users were more than twice as likely to be HIV infected, 1.7 times more likely to test positive for gonorrhea, 1.9 times more likely to test positive for chlamydia and 4.9 times more likely to be diagnosed with syphilis. Methamphetamine users also reported a median of four sexual partners over the four week period prior to clinic visit compared to two partners reported by non-methamphetamine users. This study suggests that methamphetamine use may play an important role in the transmission of HIV and STDs.

An additional study from the San Francisco Department of Public Health³ reported on the risk factors for early syphilis infection among MSM attending the San Francisco City Clinic. One-thousand three hundred and eighteen (1,318) MSM participated in a cross-sectional, self-administered survey between November 2002 and March 2003. Of the 1,318 MSM surveyed, 53 (4.0%) were diagnosed with early syphilis. Associated risk factors with early syphilis infection include: HIV-infected MSM were 4.2 times as likely to be diagnosed with syphilis than HIV-negative men; men who

used methamphetamine and Viagra were 6.1 times as likely to have syphilis than men who did not use either drug; men who met sex partners on the Internet were two times more likely to have syphilis than those who did not meet sex partners online; and men reporting a strong affiliation with the gay community were 2.9 times more likely to be infected with syphilis than those reporting a weak affiliation. These data indicate that HIV infection and drug use are associated with syphilis infection among MSM, and suggest that prevention efforts should target HIV-infected persons and those who meet partners online.

Researchers⁴ also reported on data from San Francisco which found that of a diverse, cross-sectional sample of 388 MSM, sixteen percent reported methamphetamine use during their last anal sex encounter and six percent reported Viagra use. Viagra use was associated with unprotected insertive anal intercourse and methamphetamine use was associated with unprotected receptive anal intercourse, suggesting that MSM who use methamphetamine and Viagra should be targeted for HIV and STD prevention efforts.

Internet Use

Researchers from Los Angeles⁵ shared findings on MSM diagnosed with early syphilis who reported meeting sex partners over the Internet. Of 587 MSM who were diagnosed with early-stage syphilis, 132 (22%) reported meeting one or more of their sexual partners through the Internet during the period when syphilis infection likely occurred. Sixty-seven percent of these men were also HIV-infected. Overall, the researchers found that the men who met partners over the Internet were 1.2 times more likely to be HIV-positive, 3.5 times more likely to have anonymous sex, and twice as likely to inject drugs than non-Internet users, indicating that HIV/STD prevention efforts should focus on reaching individuals accessing the Internet for sex partners.

Research presented from the Minnesota Department of Health⁶ (MDH) highlighted the effectiveness of utilizing the Internet for partner notification. MDH identified 176 individuals who were infected with or at risk for HIV, syphilis, gonorrhea and/or chlamydia, and found that 108 (61%) used the Internet to meet sex partners. Of the 108, 50 (46.3%) could be located by e-mail addresses or screen names, and these fifty were sent an e-mail asking them to respond to the sender regarding important health-related information. Thirty of the 50 (60%) responded to online partner notification efforts, 13 (26%) did not respond, and 7 (14%) were sent to other state health departments for follow up. These data indicate that Internet partner notification efforts can serve as a cost-effective tool in health departments' partner notification efforts.

¹ Jacobs, A. (2004, January 12). The Beast in the Bathhouse. *New York Times*, p. B1.

² Mitchell, SJ et al. (2004) Methamphetamine Use, Sexual Behavior, and Sexually Transmitted Diseases Among Men Who Have Sex with Men Seen in an STD Clinic, San Francisco 2002-2003 [Abstract D04C]. *2004 National STD Prevention Conference*, p. A.71.

³ Wong, W et al. Risk Factors for Early Syphilis Among Men Who Have Sex With Men Seen in an STD Clinic, San Francisco 2002-03. [Abstract C02B]. *2004 National STD Prevention Conference*, p. A.46.

⁴ Mansergh, G et al. Crystal Use, Viagra Use, and Specific Sexual Risk Behaviors of Men who Have Sex with Men (MSM) during a Recent Anal Sex Encounter. [Abstract D04B]. *2004 National STD Prevention Conference*, p. A.71.

⁵ Aynalem, G. The Internet: Emerging Venue for Syphilis Epidemics Among Men Who Have Sex With Men in Los Angeles. [Abstract C05D]. *2004 National STD Prevention Conference*, p.A.55.

⁶ Constant, P. Utilizing the Internet for Partner Notification. [Abstract B09E]. *2004 National STD Prevention Conference*, p.A.44.

Youth and STDs

The *2004 National STD Prevention Conference* focused on sharing successes and strategies during an era of uncertainty. The conference included several youth-focused sessions including a mini plenary session on new perspectives and approaches on STD prevention in adolescents, a symposium on adolescent STD clinic clients with repeat bacterial STDs, a roundtable on integrating STDs into existing HIV and pregnancy prevention programs for school-aged youth, oral presentations on current issues related to youth and STD prevention, and numerous posters. Most of these information sessions centered on new and innovative research in the field of youth STD prevention. Research in youth STD prevention is related to HIV prevention because the risk behaviors for HIV and STDs are the same and because STDs increase the risk of transmitting HIV. Therefore, information resulting from the *2004 STD Conference* is relevant to HIV prevention.

Peter Bearman, Director of the Institute for Social and Economic Research and Policy at Columbia University, presented emerging research at the mini plenary session "*Contextual View of STD Prevention in Adolescents: New Perspectives, New Approaches*" suggesting that the context of adolescent risk for STDs is different than for adults. According to Bearman, "social and sexual networks differ in their structure and environment, sexual relationships differ in their structure and in the associated contraceptive behavior, and other relationships (e.g. those with parents and peers) have differential impact on risk than they do for adults". Bearman stressed that these factors must be considered when developing youth STD prevention programs.¹

Bearman presented findings from a study he and Hannah Bruckner of Yale University, co-authored. They used data from the National Longitudinal Study of Adolescent Health, which is funded by the National Institute of Child Health and Human Development and the Centers for Disease Control and Prevention (CDC) to study the differences in sexual risk behaviors and STD infection amongst teens who take virginity pledges compared to those who do not take virginity pledges. The study was of a nationally representative sample of 12,000 teenagers who entered the study when they were between the ages of 12 and 18. These teenagers were asked whether they had taken a virginity pledge, if they had engaged in sexual intercourse and then were tested for three common STDs (chlamydia, gonorrhea, and trichomoniasis). Findings show that:

- About 88% of teens who had pledged to remain virgins until marriage had reported having sexual intercourse before marriage
- 2.8% of white teens who made a virginity pledge tested positive for STDs compared to 3.5% of white teen non-pledgers*
- 18.1% of black teens who made a virginity pledge tested positive for STDs compared to 20.3% of black teen non-pledgers*
- 6.7% of Hispanic teens who pledged virginity tested positive for STDs compared 8.6% of Hispanic teen non-pledgers*
- It is important to note that the differences between STD rates of pledgers and non-pledgers was not statistically significant
- 40% of male teens who took a pledge reported having used a condom in the past year compared to 59% of male teens who did not take the pledge
- 47% of female teens who took a pledge reported having used a condom in the past year compared to 55% of female teens who did not take the pledge

In addition, according to Bearman and Bruckner, teens who took the virginity pledge were less likely than other teens to have gotten STD testing or to know their STD status. Bearman contended that "telling teens to 'just say no, without understanding risk or how to protect oneself from risk, turns out to create greater risk' and [stated] that it is 'difficult to simultaneously prepare for sex and say you're not going to have sex' adding that 'it is the combination of hidden sex and unsafe sex that creates a world where people underestimate the risk of STDs.'"² The [Kaiser Foundation Daily Reproductive Health Report](#) reported on Bearman's presentation at the conference.²

The *2004 STD Conference* also had a symposium on repeat adolescent STD clinic clients where the discussion focused on the range of psychosocial and contextual factors that underlie STD infection among youth with repeat STDs. Of interest was a presentation by Cheryl McGhan from the University of Florida - College of Nursing in Gainesville, FL who presented three case studies of adolescent STD repeaters. In depth interviews were done with the teens and a qualitative analysis was done to find common themes among the adolescents that participated. It was demonstrated that while there were similarities between some of the youth there were also significant differences in these teen's lives that led to repeat STD infection, indicating that interventions would need to be individualized.³ Other presenters felt that adolescent networks were a more determinative factor of STD infection (including repeat infection) and that interventions must link into the "network" of core transmitters to break the link and spread of STDs amongst adolescents in order to be effective.

For more information on the 2004 National STD Prevention Conference please visit their [website](#). To read the Kaiser Family Foundation Daily Reproductive Health Report please visit their [website](#).

For more information on youth HIV and STD prevention please contact [Elena Soler](#), Youth HIV/STD Program Manager at NASTAD.

References:

¹ Bearman, Peter. "Rules, Behaviors, and Networks that Influence STD Prevention among Adolescents" Presented at the 2004 National STD Prevention Conference. March 8-11, 2004, Philadelphia, PA.

² [The Kaiser Foundation Daily Reproductive Health Report](#), 3/10/04. "Public Health and Education: Teenagers Who Take 'Virginity Pledges,' Other Teens Have Similar STD Rates, Study Says"

³ McGhan, Cheryl. "Life Story Narratives: Similarities and Differences in Adolescents Who Acquire Repeat STDs" Presented at the 2004 National STD Prevention Conference. March 8-11, 2004, Philadelphia, PA.

Adolescent and School-Based Health:

Integrating Efforts to Prevent HIV, STDs and Teen Pregnancy in School Aged-Youth

The *2004 National STD Prevention Conference*, co-sponsored by the American Social Health Association, the American Sexually Transmitted Diseases Association, and the National Coalition of STD Directors, was held from March 8 – 11, 2004 in Philadelphia, PA. At the conference, Jennifer Galbraith, Tim Hack and Sue Shaw from the Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC-DASH) convened a roundtable on integrating school efforts to prevent HIV, other STDs, and pregnancy. The roundtable highlighted reasons to integrate school efforts and encouraged participant discussion on technical assistance needs to facilitate integration of school efforts at the state level.

In addition to integration being a part of the *CDC HIV Prevention Strategic Plan* (Goal 1, Objective 3, Strategy 2) and to being part of *Healthy People 2010* (Objective 25-11, Indicator 5), DASH supports integration of school efforts to prevent HIV, STDs and teen pregnancy because:

- Youth should know how to prevent HIV, STDs and pregnancy
- Integration allows for an efficiency of approach
- The issues are related
- There is potential to increase effectiveness
- Integration promotes collaboration among those involved
- Many of the risk and protective factors are shared

DASH also outlined three critical steps that may be taken to integrate school efforts to prevent HIV, STDs, and teen pregnancy. The first step is to hold meetings of categorical representatives to identify issues and help chart actions. The second step is to outline broad content to be considered at elementary, middle/junior high, and senior high school levels. And finally, the third step DASH outlined is to augment support for state and large city education agencies to implement integrated programs.

During the last half of the roundtable, participants were given an opportunity to interact with each other and with DASH staff to provide feedback on types of technical assistance states needed in order to integrate efforts to prevent HIV, STD, and teen pregnancy. Below is a list of some of the many suggestions discussed:

- Post available curriculums on the DASH website
- Develop guidelines (or a set of standards, a licensing, certification) for HIV Educators
- Require that funding include letters of concurrence from the Departments of Health and Education on whether they agree with what the other is doing
- Require letters of support from Departments of Health (DOH) for Abstinence Only Funding Programs
- Fund Departments of Education (DOE) to train teachers
- Provide information on different funding streams and the requirements for the projects receiving those funds
- Provide information on funding recipients so that staff in other organizations can make connections with those funded to do similar projects
- When testing for STDs in a school setting be sure to counsel both the positives and the negatives
- Improve Teacher Trainings (regular updates on policy and health issues, provide materials, staff development, etc)
- Provide Train the Trainers programs
- Fund the DOH and the DOE to each hire a staff person so they can work together and act as the department youth liaison
- Provide TA for the implementation process (for e.g. help bridge knowledge of curriculum with actual practice based skills)
- Develop integrated curricula
- Develop shorter curricula that fit into the timeframes allotted to teachers for teaching these subjects
- Increase collaboration between community based organizations and schools
- Involve youth and parents in the integration process

Integration to prevent HIV, STDs and pregnancy in school aged youth is an ongoing effort at CDC DASH. NASTAD has been funded by DASH to help integrate HIV with STD and teen pregnancy prevention. For more information on DASH integration efforts please contact [Tim Hack](#) or via phone at (770) 488-6147.

For more information on NASTAD's youth integration efforts please contact [Elena Soler](#) or via phone at (202) 434-8090.

Resources:

Rural Center for AIDS/STD Prevention

The Rural Center for AIDS/STD Prevention (RCAP), a project in conjunction with Indiana University, Purdue University and the University of Colorado, provides various resources on HIV/STD integration in rural communities.

Resources available through RCAP include:

- Monograph published in 2003 focusing on HIV/STD prevention and research for rural communities
- Proceedings from the third RCAP national conference on "HIV/STD Prevention in Rural Communities: Sharing Successful Strategies III"
- Standards for STD/HIV Prevention Curricula in Secondary Schools

RCAP has also established a national coalition, "The National Network of Rural HIV/STD Prevention Specialist" or "The Rural Network", in order to provide information and support to individuals working in HIV/STD prevention. Membership is free. For more information, please visit the [RCAP website](#).

For more information on the many resources available through the Rural Center for AIDS/STD Prevention or for information on how to become a part of their mailing list, please visit the [RCAP website](#).

U.S. Conference of Mayors Offers HIV/AIDS Prevention Grants

The United States Conference of Mayors (USCM), in cooperation with the Centers for Disease Control and Prevention (CDC), National Center for HIV, STD and TB Prevention (NCHSTP), is accepting proposals to fund programs that seek to strengthen local capacity around effective HIV/AIDS prevention activities.

Proposals will be accepted for two tracks: implementation of HIV/AIDS prevention services targeting Native Americans and implementation of HIV/AIDS prevention services targeting gay/bisexual men of color.

A total of \$530,000 in funding is to be awarded to local health departments, non-profit community-based organizations (CBOs) and Native American tribes/nations. For more information on the U.S. Conference of Mayors HIV/AIDS prevention grants program, please visit the [USCM website](#).

CDC Releases Asian Language HIV/AIDS and STD Materials

CDC's National Prevention Information Network (NPIN) recently released several HIV/AIDS and STD publications in a wide range of Asian Languages. Below is a list of the publications currently available:

- "Living with HIV/AIDS"
- "HIV and AIDS: Are You at Risk?"
- "HIV and Pregnancy: Ten Things You Should Know: For You and Your Baby"
- "Teens and HIV and Other STDs: At Risk? Get Tested!"
- "Learn About HIV Testing"

These documents can be ordered through the online [NPIN publication page](#).

Capacity Building Assistance Training Calendar

CDC sponsored Capacity Building Assistance Trainings for [April through May](#) are now available.

Community Planning Calendar

The Community Planning Calendar is a listing of meetings, conferences and other key dates that may be of interest to those working on HIV prevention or community planning. Their inclusion does not necessarily indicate endorsement by NASTAD; please see contact information for additional details about each activity.

April 1-3, 2004

Breaking the Chains: Communities of Color and the War on Drugs, Houston, TX. For more information, visit the [Breaking the Chains](#) conference website.

April 16, 2004

The Fourth Annual CAPS Conference, "Broadening the HIV Prevention Landscape", San Francisco, CA. Sponsored by the Center for AIDS Prevention Studies (CAPS), University of California, San Francisco. For more information, visit the [RDL Enterprises](#) website.

April 29, 2004

Racial/Ethnic and Socioeconomic Disparities in Health: Implications for Action. Sponsored by the MacArthur Network on SES and Health and the Center for the Advancement of Health. For more information, visit the [Center for the Advancement of Health](#) website.

May 27-30, 2004

The Sixteenth Annual National Conference on Social Work and HIV/AIDS, Washington, DC. Sponsored by the Boston College Graduate School of Social Work. For more information, contact Dr. Vincent J. Lynch via [e-mail](#) or at 617-552-4038.

June 16-19, 2004

2004 HIV Prevention Leadership Summit, Atlanta, GA. Sponsored by the Centers for Disease Control and Prevention (CDC), National Minority AIDS Council (NMAC), National Alliance of State and Territorial AIDS Directors (NASTAD) and the Academy for Educational Development (AED). For more information, please visit the [NMAC](#) website.

August 12-15, 2004

2004 Minority Women's Health Summit, "Women of Color, Taking Action for a Healthier Life: Progress, Partnerships and Possibilities", Washington, DC. For more information, call toll free at 800-994-WOMAN or visit the [conference website](#).

September 10-11, 2004

2004 African American and Hispanic Leadership Conference on HIV/AIDS, "When The Drumbeat Changes, The Dance Changes", Lexington, KY. For more information, contact [Ramonda Yocum](#) via e-mail or at 800-420-7431 or visit the [conference website](#).

October 21-23, 2004

2004 National Conference on Health Care and Domestic Violence: Health Consequences Over the Lifespan, Boston, MA. Sponsored by the Family Violence Prevention Fund, National Health Resource Center on Domestic Violence. For more information, visit the [Family Violence Prevention Fund](#) website.

October 21-24, 2004

United States Conference on AIDS (USCA), Philadelphia, PA. For more information, visit the [National Minority AIDS Council \(NMAC\)](#) website.

November 6-10, 2004

American Public Health Association, 132nd Annual Meeting and Exposition, Washington, DC. For more information, visit the [American Public Health Association \(APHA\)](#) website.

November 11-14, 2004

Fifth Annual National Harm Reduction Conference (HRC), "Working Under Fire: Drug User Health and Justice 2004", New Orleans, LA. Organized by the Harm Reduction Coalition. For more information, visit [HRC online](#).

*If you have an idea or program relative to any of these topics that you would like to include in the **Bulletin**, please contact [Nyedra Booker](#) (202/434-8090).*

The *NASTAD HIV Prevention Bulletin* is written and edited by NASTAD staff and participants of community planning and prevention efforts around the country. NASTAD's production of the *Bulletin* is made possible through funding provided by CDC's Division of HIV/AIDS Prevention (DHAP) in the National Center for HIV, STD, and TB Prevention.

LET US KNOW WHAT YOU THINK!

NASTAD welcomes feedback to issues presented in our newsletter. To submit commentary, please e-mail us at nastad@nastad.org.

Visit our [Webpage](#)! Electronic versions of the Bulletin are posted, along with other information on both NASTAD's prevention and care projects.