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Focus on MSM Issues

Just last week, CDC's *Morbidity and Mortality Weekly Report* reported that the number of primary and secondary syphilis cases among men who have sex with men (MSM) in New York City more than doubled from 2000 to 2001. According to CDC, similar syphilis outbreaks among MSM have occurred in other U.S. cities since 1997, including Seattle, Chicago, San Francisco, Los Angeles and Miami. The New York City findings suggest a resurgence of high-risk sexual behavior among MSM that "underscore[s] the importance of coordinating efforts between the MSM community, public health officials, and health care-providers to strengthen HIV prevention efforts."[1]

Gays and bisexuals continue to bear a heavy burden of the HIV/AIDS epidemic, and MSM account for the largest number of people reported with AIDS each year. This month's *HIV Prevention Bulletin* features stories on various MSM related issues. One story entitled, "Trends in HIV Infection and Risk Behaviors Among MSM: An Update from the 14th International AIDS Conference," is a detailed summary of recently published studies that document a continued need for focused attention on the HIV/STD prevention needs of gay and bisexual men.

While the need for effective interventions targeting MSM is evident, MSM programs can expect to face challenges around accountability in light of elevated HIV and STD infection rates and increasing governmental scrutiny. Such scrutiny of HIV prevention programs is creating new challenges for health departments and community-based organizations on the frontlines, particularly those that target MSM. As underscored by Joseph O'Neill, Director of the White House Office of National AIDS Policy, during the

Inside the *Bulletin:*

Focus on: MSM Issues

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opening plenary session at last month's United States Conference on AIDS (USCA), audits of HIV/AIDS programs are expected to continue. Now more than ever, HIV prevention providers must be prepared to demonstrate accountability.

MSM programs can also expect to be asked to provide evidence that their programs are effective and science-based. CDC Director Dr. Julie Gerberding has called for a renewed focus on the science of HIV prevention. All can agree that science can inform the development of strong HIV prevention programs. But this shift in attention places additional demands that MSM programs will struggle to meet. Few HIV prevention interventions targeting MSM have been scientifically evaluated. One systematic review of the HIV prevention literature found only 9 rigorous studies of HIV prevention interventions for MSM that reported behavior change outcomes, thereby demonstrating the effectiveness of the intervention.[2]

These challenges facing MSM HIV prevention providers were under discussion in a NASTAD sponsored Institute held on September 19 at USCA. Highlights of the Institute, "Challenges in Implementing Effective, Science-Based Interventions for Men Who Have Sex with Men," are summarized below. One community stakeholder who attended the daylong session offers his perspectives on the session. Jurisdiction profiles of San Francisco and New York City MSM initiatives round out this month's focus on MSM.

[1] Centers for Disease Control and Prevention. "Primary and Secondary Syphilis Among Men Who Have Sex With Men—New York City, 2001." Morbidity and Mortality Weekly Report. September 27, 2002.

[2] Johnson, Wayne D. "HIV Prevention Research for Men Who Have Sex with Men: A Systematic Review and Meta-analysis." Journal of Acquired Immune Deficiency Syndromes, 30: S118-S129. 2002.

Trends in Risk Behaviors Among MSM:

An Update from the 14th International AIDS Conference

Research presented at the 14th International AIDS Conference in Barcelona this past July emphasized an increase in risk-taking behaviors among men who have sex with men (MSM). Researchers, health departments, and community advocates in the U.S. have expressed growing concern regarding this alarming trend for some time. The Barcelona conference makes clear that this development is not simply limited to the U.S. and North America, but continues to emerge throughout the world. This trend has been well documented in Europe and Australia, although stigma continues to hamper efforts to track the epidemic among MSM in other parts of the world. The data paints an increasingly complex picture of MSM risk behaviors that will present growing challenges for programs trying to prevent the spread of HIV and STDs among MSM.

Rising Infections and Changing Behaviors

On April 20, 2001, CDC issued a call to action in response to data showing increasing infection rates among MSM in the U.S. Of particular concern was data from Valeroy (et al., 2001) that showed alarming rates of HIV infection among young MSM in seven U.S. cities. Rates were as high as 15% among Latinos and up to 30% among young African American MSM. CDC presented additional data in Barcelona that also showed this trend. Linley (et al., 2002) looked at 40,000 high-risk individuals at STD clinics in Los Angeles, Denver, Miami and Newark between 1997 and 1999. She found the rate of new HIV infections among MSM to be nine times higher than that of heterosexual men, and the rate among African American and Latino MSM was nearly twice that of white MSM. Data from Washington State, as reported by Stenger (et al., 2002), also showed an increase in STDs among MSM in that state. STD infections can increase the risk that a person exposed to HIV will become infected.

Further studies noted an increase in risk taking behaviors among MSM. A study by Chen (et al., 2002) reported increasing rates of unprotected anal intercourse among MSM in San Francisco. The increase could not be explained by trends in unprotected anal intercourse among partners of the same serostatus alone. Another study by Mercer (et al., 2002) compared interviews of MSM in Britain from the National Surveys of Sexual Attitudes and Lifestyles in 1990 and 2000. Study data found an increase in the number of men reporting having sex with other men between 1990 and 2000. In addition, MSM in 2000 were more likely to report increased incidence of anal sex and an increased number of partners. Finally, a study by Remis (et al., 2002) followed a cohort of MSM in Montreal from 1996 through 2001. The study found a significant increase in rates of unprotected anal sex with partners who were HIV positive or did not know their status.

However, other studies presented in Barcelona begin to construct an increasingly complicated picture of MSM risk behaviors. Some studies reported that even MSM who indicate the use of condoms during anal intercourse might still be engaging in behaviors that place them at risk for infection. Hoff (et al., 2002) discussed "dipping" among MSM in California. While condoms may ultimately be used for intercourse, dipping is a brief act of anal penetration during the course of sex. Men who dip generally state they are engaging in protected sex, although condoms may not have been used while dipping. Twenty-nine percent of HIV positive men in the study reported having dipped with a partner who was negative or of unknown status.

The Polaris study in Canada followed a MSM cohort who had recently seroconverted, along with an HIV negative control group. Research by Calzavara (et al., 2002) found that 46% of HIV positive MSM that reported using condoms during receptive anal intercourse noted a delayed use of condoms. One reason described for the delay was the perception that pre-ejaculate fluid was not infectious and that early penetration posed no risk due to a reduction in the trauma involved. In addition, sex under the influence of alcohol or drugs was also seen as a facilitator. Data from the same cohort also found that 33% of HIV positive MSM that reported using condoms during receptive anal sex experienced condom breakage or slippage while 23% reported removing condoms early during intercourse. Another study from Britain (Hickson, et al., 2002) further explored issues around condom breakage. The study found that nearly 12% of MSM that use condoms have issues with condom breakage. Factors included failure to use sufficient lubricant with the condom and failure to use more than one condom for an extended period of intercourse.

At the same time, a study from Australia indicated that not all reports of unprotected anal intercourse are the same. Data showed that some MSM may negotiate safety during acts of unprotected anal intercourse. Regular partners may use condoms when having sex with anyone outside their relationship, yet not use condoms with each other. As another strategy, HIV positive individuals may agree to have unprotected sex with other HIV positive individuals, but use condoms with negative partners or partners of unknown status. While such strategies do not eliminate all risk, they do allow individuals to negotiate a level of risk that is acceptable to them (Crawford, et al., 2002; Paul van de Ven, et al., 2002).

HAART Optimism

Of particular concern has been the impact of HAART on the risk that MSM may be willing to take. Referred to as HAART optimism, some MSM may perceive that HIV is not as life threatening or is easy to manage. Some MSM may also believe that HIV positive individuals on HAART will be less infectious due to their lower viral load. However, research on HAART optimism remains unclear. A Brazilian study (Kerrigan, et al., 2002) found that many HIV positive men do not understand the relationship between HAART and viral load, making it unlikely that they would perceive themselves as less infectious. While the study did find a correlation

between increases in risk behavior and use of HAART, that correlation could be explained by an increase in quality of life experienced by those on HAART. A study from Canada by Miller (et al., 2002) examined the impact HAART optimism had on sexual decision-making among young MSM. The study found that HAART had little impact. Other factors, such as childhood sexual abuse, substance abuse, and in general, issues around coming out played a much stronger role in the risks men took.

However, a study from the Netherlands (Stolte, et al., 2002) found the opposite, noting that risk taking behavior increased as MSM perceived less of a threat from HIV. The study looked at MSM who had previously reported only protected anal intercourse that began to report having unprotected intercourse. HAART was described as one of the main facilitators of this change.

An Australian study concurs. Rawstorne (et al., 2002) interviewed 207 HIV positive men who were either on HAART, had recently stopped HAART, or who had never been on HAART. Fifty-eight percent of those men reported unprotected anal intercourse in the prior six months. The study found that factors most influencing increased rates of unprotected anal intercourse were better health status, more partners, and the perception that HIV was not as serious a threat due to HAART. In addition, men on HAART were more likely to engage in risky sex than those that had ceased HAART or never been on HAART. However, as noted by Stall (2002), HAART optimism alone cannot explain the rise in risk taking sexual behavior among MSM.

Other Causes

Other reasons for the trend toward increasing risk behaviors among MSM remain varied. Data from the CDC (Stall, et al., 2002) and Miller (et al., 2002) found that factors behind risk taking behavior continue to be issues such as domestic violence, homophobia, drug use, and childhood sexual abuse. These are critical factors in influencing risk behaviors, but they have remained constants throughout the epidemic. Another issue may be AIDS burnout. After two decades of the epidemic, messages about condoms and safer sex have remained the same. Yet use of condoms was initially considered a short-term strategy. Longer-term strategies and messages have not yet been developed, although many MSM may have already begun looking beyond simple condom use as protection against HIV infection. Negotiated risk, as described in the Australian study, is one way that MSM have begun to look for new strategies to protect themselves from HIV.

Finally, research from CDC indicates that young MSM are at particularly high risk for infection. New generations of MSM are growing up in a world that has always known AIDS. Many of these young men may not have known anyone who died during the early years of the epidemic and many may have come out in the post HAART era. For these young MSM, the perceived threat of HIV may be different, and they may not have been exposed to many of the early HIV prevention messages, as were men in the early days of the epidemic. CDC data indicates that many of the young men who are HIV infected, up to three quarters, are unaware of their status. Fifty-nine percent of those young men who are infected and do not know their status also perceived themselves to be at low risk for infection. This increases the likelihood that they will continue to spread the virus (MacKellar, et al., 2002).

Conclusion

Research has painted a complex picture of MSM risk taking behaviors, and prevention programs are increasingly being challenged to find ways to prevent a new wave of the epidemic among MSM. While condoms will likely remain one of the foundations of our prevention efforts, including increasing the efficacy of MSM to use condoms, new strategies are needed that look beyond condoms to address the complex psychosocial issues that MSM face. However, developing these new strategies may be difficult in the current political environment in which many HIV

prevention programs targeting MSM are under heavy scrutiny for their sexually explicit nature and their sex positive approach. Yet such strategies will be necessary to address this growing trend among MSM throughout the world.

For more information on these studies, see the attached bibliography. Also contact Chris Aldridge, HIV/AIDS Prevention and Care Program Specialist, at caldridge@nastad.org.

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Challenges in Implementing Effective, Science-Based Interventions for Men Who Have Sex with Men

Anticipating the changing environment in which HIV prevention providers now function, NASTAD coordinated a day-long Institute at USCA entitled "Challenges in Implementing Effective, Science-Based Interventions for Men who Have Sex with Men (MSM)." The Institute consisted of three panel presentations with discussion:

- Translating Research on Effective Interventions into Practice
- Current Challenges in Implementing HIV Prevention for Gay and Bisexual Men
- Implementing Effective Interventions in Community Based Settings

Translating Research on Effective Interventions into Practice

The first panel included presenters Roger Myrick of the University-wide AIDS Research Program (UARP) at the University of California; George Ayala, AIDS Project Los Angeles; Greg Rebchock, Center for AIDS Prevention Studies, UCSF; and Pete Gregson, Alaskan AIDS Assistance Association. Dr. Myrick opened with an overview of issues in translation research. By highlighting a recent RFP, Dr. Myrick summarized steps that the UARP has taken to stimulate collaborations between researchers and community-based providers to put scientific interventions into practice. Stakeholders who are interested in translation research should look to the UARP approach as a potential model. Dr. Greg Rebchcok discussed efforts to translate "Mpowerment," a community level intervention for young gay and bisexual men that is based on theories about community and personal empowerment, community organizing and diffusion of innovation. The project's goal is to create an empowered community in which young gay men encourage each other to practice safer sex and where safer sex is a mutually understood norm.[1] His co-presenter, Pete Gregson, talked about challenges his agency faced when trying to implement Mpowerment. Mr. Gregson emphasized the rationale of relying on interventions that are proven to be scientifically effective. Since many CBOs do not have the capacity (resources, technical expertise) to conduct outcome evaluations of the interventions they choose to implement, implementing an intervention that has been scientifically evaluated serves as a proxy for knowing that a CBO's interventions are effective. Dr. Ayala noted that scientifically evaluated interventions still need to be tailored to specific communities. They can be used as templates with appropriate elements being implemented to address pressing HIV prevention needs.

Current Challenges in Implementing HIV Prevention for Gay and Bisexual Men

The second panel featured Darlene Weide, Executive Director of STOP AIDS, San Francisco; Ron Simmons, Executive Director of Us Helping Us, Washington, DC; and Javier Salazar, Director of Federal Affairs of the National Minority AIDS Council. Leo Rennie of NASTAD opened the discussion by noting that HHS Office of the Inspector General audits of CBOs are raising grave concerns across the country. Executive Directors of two CBOs that are undergoing HHS OIG audits were invited to discuss their experiences. The STOP AIDS audit initially focused on compliance

Jurisdiction Profile:

New York City Non-Gay Identified MSM Needs Assessment

Across the country health departments and community-based organizations are continuously being challenged to develop HIV prevention programs targeted to specific sub-populations of MSM. One group that has received significant attention in the past year is men who have sex with men, but who do not identify as gay or bisexual. Such terms as "down low," "non-gay identified," and "sexual beings" have been used to describe these men. How do prevention providers reach these men? What types of interventions work for them?

To begin to answer these questions, the New York City Department of Health and Mental Hygiene and the MSM work group of the New York City Prevention Planning Group (NYCPPG) commissioned consultant Dr. Darrell Wheeler to conduct a needs assessment on "non-gay" identified MSM. This first phase of the needs assessment initiated a report titled *"'Non-gay' Identified Men Who Have Sex with Men in NYC: Who Are They and What are Their HIV/AIDS Prevention Needs?"* [1] In November 2000, three focus groups comprised of "non-gay" identified men who have sex with men were held. Twenty-five men participated in one of three focus groups. They discussed their sexual identities, sexual experiences and behaviors related to HIV transmission based on their personal experiences. They also shared ideas about future department of health prevention efforts within 'non-gay' identified MSM groups. Four major themes resonated from these focus groups:

- Men expressed the need to develop interventions that require the least amount of self-disclosure. Specifically, the men expressed concerns about services that would perceive them as gay to the community or family members.
- Participants expressed their viewpoints and practices related to their sexuality. Such beliefs need to be incorporated into any prevention intervention strategy.
- Men expressed the importance of revealing their sexual practices in a safe space.
- HIV prevention programs need to include "indigenous expertise among 'non-gay' identified MSM's." when developing and staffing these programs.

In the report, Dr. Wheeler expressed the need to develop a more comprehensive needs assessment that utilizes multiple data sources, e.g., current census data and HIV/AIDS and STD surveillance data. Information from past strategies used by the department of health can be included. Individual interviews to enhance the information generated from the focus groups will also be used in the next phase. The New York City Department of Health and Mental Hygiene Prevention Planning Unit has funded the second phase of this project. Upon completion, NASTAD plans to highlight key findings in a future *HIV Prevention Bulletin*.

[1] Wheeler, Darrell. "'Non-Gay' Identified Men Who Have Sex with Men in NYC: Who Are They and What Are Their HIV/AIDS Prevention Needs?" December 2000.

with federal material review requirements. Later, CDC inquiries began to focus on assessing the scientific basis of STOP AIDS's programs. The Us Helping Us audit is considered a pilot and may serve as template for future HHS investigations.

Weide and Simmons presented their experiences and challenges faced during the highly publicized audits of their MSM prevention programs. They also provided participants with tools, information and examples on how to develop effective program review panels and sound fiscal management. Javier Salazar followed by presenting and initiating a discussion on current national policy issues that shape the context in which HIV prevention work is being conducted. He discussed ongoing meetings of national AIDS policy organizations and larger local and regional CBOs who are working together to share information about these issues and to develop a strategy to support HIV prevention providers working on the front lines.

Weide offered concrete advice to CBOs if they are audited. Most importantly, she advised cooperation with the investigation, but also to make sure that investigators remain within the scope of the audit. She emphasized the importance of ensuring that program review panels are in place and that documentation that materials have been reviewed and approved is available. Both Simmons and Weide emphasized the importance of good record keeping with respect to all aspects of management of CDC cooperative agreements.

Implementing Effective Interventions in Community-Based Settings

The CDC *Compendium of Interventions with Evidence of Effectiveness* was developed to help move evidence-based interventions into the community. All interventions selected for the *Compendium* came from behavioral or social studies that had both intervention and control/comparison groups and positive results for behavioral or health outcomes. Because of the rigorous criteria, of the twenty-eight interventions included in the compendium, only five were developed for MSM. During the final panel presentation, CDC's Charles Collins discussed steps that CDC is taking to further help CBOs implement evidence-based interventions.

Packaged resources and tools to facilitate the implementation of interventions listed in the *Compendium* are in development, and will be released soon. Recognizing the length of time necessary for an HIV prevention intervention to be scientifically evaluated and included in the *Compendium*, other strategies for disseminating information about what works are being implemented. Under a fast track process, CDC will identify programs with strong reputations-those programs identified by project officers, health departments and CBOs that appear to be effective. To be considered "reputationally" strong, a program will need to be theory based, and have undergone some degree of evaluation (process, outcome monitoring or outcome evaluation).

Presenters Maureen Scahill of the Center for HIV Behavioral Training, Rochester, NY (http://www.urmc.rochester.edu/chbt/) and Michael Robinson of People of Color In Crisis, Brooklyn, New York (http://www.pocc.org) discussed their adaptation of the popular opinion leader model to address the HIV prevention needs of Black MSM. Cultural issues (coping with racism and homophobia) and STDs were incorporated into the model to make it more culturally salient.

[1] Kegeles, Susan M. et. al. "From Science to Application: The Development of an Intervention Package," AIDS Education and Prevention, 12, Supplement A, 62-74, 2000.

For more information about any of the topics discussed above, please contact Leo Rennie, Associate Director of Prevention Programs at lrennie@nastad.org or Alberto Santana, Technical Assistance Coordinator at asantana@nastad.org.

Compendium of Interventions with Evidence of Effectiveness
Website: www.cdc.gov/hiv/pubs/hivcompendium/toc.htm

Stakeholder Reaction to the USCA MSM Institute

Invited guest writer to this month's HIV Prevention Bulletin *Colin Robinson, Executive Director, New York State Black Gay Network, shared his thoughts about the Institute.*

This year's USCA Institute showed an impressive development in quality and focus. Though not as well marketed in pre-conference materials as deserved, NASTAD's offering that focused on prevention interventions for men who have sex with men, was timely, topical and well organized. It divided itself neatly into three modules, each focused on a topic of significant interest and relevance and was populated by interesting speakers. In manageable chunks of 90-120 minutes, attendees who stayed the whole day got to focus on translating theory into programs, on politics and policy, and on a specific community-based intervention.

The Institute engaged squarely with the increasing challenges around accountability MSM programs face in light of elevated infection rates and increasing government scrutiny, although it didn't live up to its promise of framing a comprehensive sexual health agenda. The Institute had both researchers and CBO staff talk interactively with participants about real practices involved in converting documented effective interventions into programs on the ground. It offered a political context for and frontline reports from the new wave of program and management audits of CDC-funded programs, addressing many burning

questions. And it paired the perspectives of research and community-based institutions jointly implementing a specific intervention.

The Institute adhered to its stated timeframes and there was a reliable written guide to the day, so those interested in just one or two specific areas could also manage their participation. Facilitators were flexible enough to abandon their scripts when they did not work. All nine panelists were well disciplined, allowing for rich audience discussion; useful handouts accompanied each unit; and all the panels were reasonably diverse, although the voice of government (local, state or federal) was not well integrated or helpful. I think the structure of this year's Institute offers a good model for future learning and exchange opportunities at USCA. Colin Robison can be reached at nysbgn@aol.com.

StopHep in San Francisco:
Reaching MSM with Viral Hepatitis Prevention

Rates of vaccination against hepatitis A (HAV) and hepatitis B virus (HBV) infection among men who have sex with men (MSM) remain low, despite years of awareness that MSM are at increased risk for infection. The young men's survey[1] found that 77% of the men surveyed were susceptible to HBV infection and only 9% were immunized against HBV. Further, one in five young MSM acquired HBV infection by the age of 22. These data illustrate the importance of increasing awareness among MSM about the risks of HAV and HBV infection and providing them with prevention education and immunization opportunities.

The San Francisco Department of Public Health, Communicable Disease Prevention Unit (SFDPH, CDPU), which focuses on vaccine-preventable diseases, suspected that San Francisco was similar to the rest of the country and had low rates of HAV and HBV immunization among MSM. They determined that they should focus on increasing HAV and HBV vaccination among MSM, and although they had no special funding or staff to support a new project, they had vaccine they could deliver. In order to develop appropriate outreach initiatives and vaccination programs tailored towards MSM, they collaborated with the Gay and Lesbian Medical Association (GLMA), Castroguys (a local gay men's health project focused on MSM wellness issues) and several HIV prevention agencies. Castroguys served in an advisory role assisting in identifying strategies to effectively reach the MSM community.

Data have shown that the majority of self-identified MSM have health insurance, and most health insurance companies reimburse for vaccine. In San Francisco, as elsewhere, time and convenience were seen as major barriers to HAV and HBV vaccination among MSM. To address these barriers, SFDPH decided to create a 6-month pilot project offering low cost vaccine at a convenient location in the Castro District (San Francisco's predominately gay neighborhood). Gold's Gym agreed to serve as a vaccination site and GlaxoSmithKline agreed to underwrite the cost of outreach and marketing.

In May of 2002, SFDPH launched the StopHep pilot program with a widely attended press conference. The vaccination component of the program will end in late November. Until then, vaccination is available two evenings a week, from 4 pm to 7 pm, and is offered at "community" prices: one dose of HAV vaccine is $15, one dose of HBV vaccine is $20, and one dose of Twinrix (the combined HAV and HBV vaccine) is $30. One nurse and one receptionist are onsite to administer the vaccine and paperwork required. StopHep has also conducted extensive outreach within the community to inform eligible MSM about the services available (although MSM are the primary target population, anyone 18 or older is welcome to come in for shots). Payment is cash only. Referral information is provided for those individuals who will not be able to complete the series before the end of November, along with the mailing of reminder postcards.

Currently, the Gold's Gym site is administering an average of 18 (one every 20 minutes) shots per week. Approximately 60% of persons accessing the program opt for the combined HAV and HBV vaccine Twinrix. Those choosing a monovalent vaccine have either already been vaccinated against one of the viruses or have been previously infected with HAV or HBV.

StopHep is also engaging in ongoing community outreach efforts to ensure that MSM in the community are aware of the need for vaccination and that they can get vaccinated at Gold's Gym. They are working to increase the awareness of medical providers as well, focusing on risk factors, reimbursement issues and creating simplified materials such as low cost testing and vaccination referrals, and identifying patients with a risk factor. Many have begun referring their uninsured patients to Gold's Gym. The SFDPH Disease Prevention Unit is also collaborating with other divisions in the San Francisco Health Department to improve vaccination rates among MSM. The STD clinic, which primarily offers vaccine to men 30 years and younger, agreed to vaccinate clients who began their vaccine series at Gold's Gym but who were unable to finish the series there. In addition, SFDPH provides hepatitis vaccine to numerous nonprofit health care and research sites serving high-risk clients. San Francisco's confidential and anonymous HIV counseling and testing sites are partnering with the Disease Prevention Unit by sharing the data they collect on hepatitis vaccination rates among the MSM accessing their services. The data to date is disturbing—of 3600 self-identified MSM (3/2001-12/2001) less than 16% report vaccination against HAV and less that 20% report vaccination against HBV.

SFDPH collaborated in the creation of a 30-second public service announcement (PSA) emphasizing the importance of getting vaccinated against HAV and HBV. The PSA was created without specific local contact information so it can be shown anywhere in the country. The PSA can be viewed on the newly created website, www.stophep.com, which serves as a portal and link to basic information on HAV, HBV and HCV. The site is available for links to local jurisdictions to tell people where they can get vaccinated against HAV and HBV in their own community. An information phone line and email address are available to the public with a 24-hour turnaround response time.

For more information about the StopHep program, or if you are interested in having your local program linked on stophep.com, contact Janet Zola at (415) 554-2790 or email her at janet.zola@sfdph.org.

[1] Mackellar, Duncan A.; Valleroy, Linda A.; Secura, Gina M.; et al. (2001) Two Decades After Vaccine License: Hepatitis B Immunization and Infection Among Young Men Who Have Sex With Men. *American Journal of Public Health*, Vol. 91, No. 6, pp. 965-971.

Adolescent and School-Based Health:

New Program Announcement for School-Based Health Programs

The CDC DASH Program Announcement 03004, *Improving the Health, Education, and Well-Being of Young People Through Coordinated School Health Programs* was published in the Federal Register on September 17, 2002. This announcement provides new five-year cooperative agreements to support school health programs and continue HIV prevention in state and local education agencies.

Eligible state education agencies (SEAs) and local education agencies (LEAs) may apply for funding in one of four categories, one of which is HIV Prevention for School-Aged Youth. Other priority areas for SEAs include: the Youth Risk Behavior Survey (YRBS); coordinated school health programs/reduction of chronic disease risks; state demonstration efforts around asthma and food borne illness; and national professional development. Other priority areas for the LEAs

include: the YRBS; local demonstration efforts for asthma; and national professional development. Education agencies may choose not to apply for funding in any of the four major categories.

In the program announcement, SEAs/LEAs are required to "develop and implement a plan that builds on the broader state and community plans for strengthening HIV prevention in schools," which should be developed in collaboration with health departments, community planning groups and other entities. This plan should complement priorities in the jurisdiction's comprehensive HIV prevention plan(s). SEAs/LEAs are encouraged to take opportunities to implement programs that cross departments of education and health, including joint planning and funding of school-health programs.

Approximately $12 million is available for the HIV prevention awards to SEAs and approximately $5 million is available for the HIV prevention awards to LEAs. DASH is asking for Letters of Intent by October 7. **The deadline for submission of the applications is November 1**.

Program Announcement 03004 is available in the Federal Register (Vol. 67, No. 180 , Pages 58610 – 58624) and can be accessed on the Internet at: http://www.access.gpo.gov/su_docs/fedreg/frcont02.html. State health departments and CPGs may want to contact the HIV educator in the state education agency to share information about the jurisdiction's comprehensive HIV prevention plan and/or offer any assistance in developing this application. Contact information is available at the DASH website: www.cdc.gov/nccdphp/dash/partners/index.htm.

The Manager

Making the Perfect Hire

The heady days of the 1990s with their record low unemployment rates and constant employee turnover sometimes seem far away. But the hiring process remains challenging, and the stakes remain high when filling a position. Getting your "first choice" to accept a job offer – or not getting them to do so – can have significant long-term consequences.

Whether or not your first choice takes the position is heavily influenced by the person who is making the hire, according to Dennis Doverspike and *Rhonda C. Teul, authors of The Difficult Hire: Seven Recruitment and Selection Principles for Hard-to-Fill Positions* (Impact Publications, 2000). Although couched in language applicable to the profit sector, their seven key principles have great relevance for the managers of HIV/AIDS programs as well. The key principles are as follows:

YOU ARE THE MOST IMPORTANT FACTOR IN FILLING THE JOB. Of course, many factors may influence whether someone wants to take a job – your program's reputation and image, the overall job market, salary, location, and hours. But the authors argue that "You are the job candidate's or potential employee's window into the soul of the company. You are the conduit by which they receive information on the job and the company… It is you who will determine how job candidates perceive the company and the job. If you are positive, they will receive a positive image. If you are negative, they will receive a negative image."

DURING ALL INTERVIEWS OR COMMUNICATIONS WITH THE CANDIDATE, YOU MUST STAY IN CONTROL. "You must control your attitude, the job candidate's perceptions, and the flow of information. If you do not, then there is high likelihood that you will lose good people and select the wrong people."

YOU MUST PUT THE JOB AND THE COMPANY ON A PEDESTAL. Although this principle may sound a bit excessive at first glance, what it really means is that "even for hard to fill positions, the best and correct attitude to take is one where the job candidate has to earn the job and the right to work for the company… The perception must be created

and exist within the candidate that this is a job worth having and that it is worth the candidate's time and effort compete for the job."

PERCEPTIONS ARE EVERYTHING AND YOU CAN CHANGE PERCEPTIONS. If a given position is hard to fill, there are likely to be reasons that this is so. But by applying the foregoing principles, you really can "accentuate the positive" and change the perceptions of job candidates.

YOU MUST CONTROL THE NEGATIVES. "The best way to do this is by concentrating on the positives and by creating a climate of achievement…The second method of dealing with negatives is to turn them into positives" such as by presenting challenges as opportunities and difficulties as chances for growth.

You must fulfill the individual's needs. In seeking to understand a person's needs, find out as much as you can about that person's past behavior and personal and professional choices; about the needs of significant others such as a partner or children; about the person's abilities and goals; and about his or her personality.

EVEN WITH HARD TO FILL JOBS, SET AND KEEP YOUR STANDARDS HIGH. If you enter a hiring process with the desire to just fill a position as quickly as possible, you are all too likely to end up with the wrong hire. "An important principle in attracting the difficult hire is to create the perception that the job is valued and important and that the person who fills the job will be valued and important. It is critical to remember, then, that just because a position is hard to fill does not mean that we should adopt an attitude that anyone can do the job. The job will actually be easier to fill if we set, maintain, and publicize high standards."

Recognizing the need to support HIV/AIDS program staff members in their management challenges, the NASTAD HIV Prevention Bulletin offers "The Manager" column to bring to our readers'attention key works by professionals in the field of management. "The Manager" encourages readers to send in ideas for topics to be covered in this column. Please e-mail suggestions to nastad@nastad.org , fax them to 202-484-8092, or mail them to "The Manager," NASTAD, 444 N. Capitol St., NW, Washington DC 20001.

Resources

Regional Healthy People 2010 Events and Priorities

Website: www.phf.org/HPtools/regions.htm

Use resource listings, event information, and contacts on this site to get involved in your region's Healthy People 2010 activities and priority area(s). Click on the map or state listings to find information for your HHS region. For each region's priority area(s), you can download, print, or search listings of action resources in Acrobat Reader. Two-page resource listings describe Healthy People 2010 companion resources, sites with evidence-based strategies, and other tools to achieve and promote relevant objectives.

Direct URLs for resource listings for regional priority areas are as follows:

Region I - Asthma
www.phf.org/HPtools/regions/Region_I.pdf

Region II - Eliminating Racial and Ethnic Health Disparities
www.phf.org/HPtools/regions/Region_II.pdf

Region III - Obesity and Lead Poisoning
www.phf.org/HPtools/regions/Region_III.pdf

Region IV - Diabetes
www.phf.org/HPtools/regions/Region_IV.pdf

Region V - Working with Community Associations with a Focus on Health Disparities
www.phf.org/HPtools/regions/Region_V.pdf

Region VI - Immunization, Infectious Diseases, and HIV/AIDS
www.phf.org/HPtools/regions/Region_VI.pdf

Eliminating Racial and Ethnic Health Disparities
www.phf.org/HPtools/regions/Region_VI-disparities.pdf

Region VII: Priority to be determined

Region VIII - Workforce Development
www.phf.org/HPtools/regions/Region_VIII.pdf

Region IX - Sexual Health and Responsible Sexual Behavior
www.phf.org/HPtools/regions/Region_IX.pdf

Region X - Injury and Violence, Suicide Prevention
www.phf.org/HPtools/regions/Region_X.pdf

Other related resources:

State Healthy People 2010 Tool Library
www.phf.org/HPtools/state.htm

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Community Planning Calendar

Following are listings 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.

October 25-28, 2002
2002 National Black Lesbian and Gay Leadership Forum (NBLGLF) Conference: "Discovery," Detroit, MI. Sponsored by the National Black Lesbian and Gay Leadership Forum. For more information, contact Chyrill Quamina, NBLGLF registrar at natblkforum@aol.com or visit: http://www.hotterthanjuly.com.

November 9-13, 2002
American Public Health Association (APHA) 130th Annual Meeting and Exposition, "Putting the Public Back Into Public Health," Philadelphia, PA. For more information, visit: http://www.apha.org.

November 15-17, 2002
First National Asian and Pacific Islander Summit on HIV/AIDS Research, Oakland, CA. For more information, visit: http://meetings.s-3.com/apishare/default.htm or call Ms. Brenda Robin at (301) 628-3536 or (800) 749-9620.

November 21, 2002
CDC Live Satellite Broadcast and Webcast: "Public-Private Partnerships: A New Model for Community Mobilization Against AIDS," 1-3 p.m. EST. The broadcast will focus on public-private partnerships and engaging the private sector as an educational resource and mobilizing agent for community-based HIV prevention. For more information on this broadcast call toll-free: (800) 458-5231 or (301) 562-1000. The TTY number is (800) 243-7012.

December 1-3, 2002
2nd International Conference on Substance Abuse and HIV, Mumbai, India. Sponsored by United Nations AIDS. For more information, contact The Hope 2002 Secretariat at info@hopeconference.org or visit: http://www.hopeconference.org/hope2002main.html.

December 1-4, 2002
4th National Harm Reduction Conference, "Taking Drug Users Seriously," Seattle, WA. For more information, visit: http://harmreduction.org/conference/4thnatlconf.html.

January 27-30, 2003
National Hepatitis Coordinator Conference, San Antonio, TX.

March 2-8, 2003
The Black Church Week of Prayer For the Healing of AIDS, sponsored by The Balm in Gilead, Inc. For more information, visit: http://www.balmingilead.org/home.asp.

March 12-15, 2003
Community Planning Leadership Summit for HIV Prevention, New York City. Sponsored by AED, CDC, NASTAD and NMAC. For more information, visit: www.nmac.org and click on the CPLS button.

March 30- April 2, 2003
15th National HIV/AIDS Update Conference (NAUC), Miami, FL. Sponsored by the American Foundation for AIDS Research (AmFAR). For more information, contact Jennifer Attonito, Conference Director at (212) 805-1631 or visit: http://www.amfar.org/cgi-bin/iowa/nauc/index.html.

April 6-10, 2003
14th International Conference on the Reduction of Drug-Related Harm, Chiang Mai, Thailand.
For more information, visit http://www.ihrc2003.net

May 21-23, 2003
Call for Abstracts: National Conference on Health Education and Health Promotion, San Diego, CA. Sponsored by The Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE). For more information on abstract submission, contact Sara Riedal at (202) 659-2230 x102 or sriedel@astdhpphe.org

July 27-30, 2003
2003 National HIV Prevention Conference, Atlanta, GA. Sponsored by CDC and other governmental and non-governmental partners. For more information, visit: www.2003HIVPrevConf.org

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 (e-mail: nbooker@nastad.org, phone: 202/434-8090).

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. http://www.nastad.org

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