NASTAD
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Integrating Viral Hepatitis into HIV/AIDS/STD Programs

The Challenges and Opportunities Ahead

> **Integrated:** combining or coordinating separate elements so as to provide a harmonious, interrelated whole; organized or structured so that constituent units function cooperatively.

Who can argue with integrated services? Programs that are "combined or coordinated so as to provide" harmonious interrelationships are the goal of many public health programs, from holistically oriented alternative approaches to "continuity of care" provisions within the framework of traditional medicine

And in the case of HIV/AIDS, STD and viral hepatitis programs, the rationale for services "organized or structured so that they function cooperatively" is particularly compelling. HIV, STDs, and viral hepatitis (i.e., a family of viruses including, most notably, hepatitis A, B, and C) are all microbes generally transmitted through sexual or blood-to-blood contact that impact many of the same populations and pose a serious health threat both separately and in interaction with one another. Of course, program integration is always easier said than done. Below, we detail three of the major rationales for integration, as well as three of the major challenges posed by integration.

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NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS
444 North Capitol Street, NW, Suite 339 Washington, DC 20001-1512 FAX 202-434-8092 PHONE: 202-434-8090 www.nastad.org

Three Major Rationales for Integration

Reaching those at highest risk: Many of the people at highest behavioral risk of viral hepatitis infection are also those at highest risk for HIV, including injection drug users, health care workers, blood transfusions recipients, and those with multiple sex partners, especially men who have sex with men. Greater integration of service is essential, since it is a disservice to clients who may have multiple risks and/or multiple morbidities to focus on only a single disease rather than to view clients as whole human beings.

Avoiding unnecessary duplication of services: Since modes of transmission and impacted populations overlap, HIV and STD prevention messages can often be readily expanded to incorporate viral hepatitis messages. Similarly, once individuals have entered into an HIV or STD counseling and testing site, it makes sense to also screen and test for viral hepatitis. Integration of programs can avoid duplicative or overlapping services.

Maximizing existing infrastructure: An extensive network of HIV counseling and testing sites is already in place throughout the country, as are surveillance systems, referral mechanisms, outreach programs, and other services required by the viral hepatitis co-epidemics. Re-creating such existing infrastructures for hepatitis would represent an inefficient use of resources.

Three Major Challenges Posed by Integration

Developing capacity: Although HIV, STDs, and viral hepatitis have many similarities, they are not identical. Integration of services thus requires new training and ongoing education to broaden staff expertise. Of course, adding new services usually necessitates increasing staff size as well as new resources to build lab capacity to handle the increased testing demand.

***Securing funding*:** Although awareness about viral hepatitis is growing, it remains an unevenly and sometimes inadequately funded area. Further, categorical funding streams mean that monies earmarked for HIV, STD, or viral hepatitis sometimes cannot be readily applied in an integrated setting.

Overcoming organizational obstacles: Public health responsibility for viral hepatitis is widely dispersed across multiple programs, including but not limited to infectious disease, HIV/AIDS, STDs, immunization programs, and even environmental health. Integration of services will require cooperation and reconfiguration of program responsibilities, perhaps sparking "turf wars."

Despite these and other challenges, HIV/AIDS programs throughout the nation have begun to effectively integrate viral hepatitis into their work. This issue of the *HIV Prevention Bulletin* includes several examples of programs already underway, an overview of key challenges and first steps for integration, the views of AIDS directors on the question of viral hepatitis, and more.

For additional background information on viral hepatitis, see the February 2001 NASTAD HIV Prevention Bulletin, which can be accessed by going to:
http://www.nastad.org/pub_viralhep.asp?publication_category_id=4&publication_subcategory_id=1.

The Division of Viral Hepatitis at CDC

Viral Hepatitis is located within the National Center for Infectious Diseases (NCID) at CDC. NCID is one of 12 centers, institutes, and offices within CDC; its counterpart in HIV is the National Center for HIV, STD, and TB Prevention (NCHSTP). The mission of NCID is to prevent illness, disability, and death caused by infectious diseases in the United States and around the world. Viral Hepatitis was recently elevated from a Branch to a Division within NCID; it was formerly located in the Division of Viral and Rickettsial Diseases. The Division of Viral Hepatitis is now one of 12 divisions, programs, and offices housed under NCID. Visit http://www.cdc.gov/ncidod/diseases/hepatitis/ for more information on Viral Hepatitis activities at CDC.

Integration Projects in Action: Examples from States, Counties, and Cities

As the integration of viral hepatitis into HIV/AIDS/STD programs becomes a salient issue, health departments considering integration can look to several jurisdictions for guidance. Erie County, NY, Houston, TX, and Columbus, OH, are just a few of the jurisdictions that have successfully developed and implemented hepatitis education and awareness, counseling, testing, and referral into existing HIV/AIDS/STD programs. This information was shared at the Viral Hepatitis Coordinators meeting in Richmond, VA. CDC shared information on projects in Colorado and Montana that are actively working on integration. While these programs vary in scope, they all demonstrate that integration is not only feasible, but is also valued by staff and welcomed by clients.

Erie County, New York

Eight counties comprise the western New York region, and approximately two-thirds of the total population resides in Erie County. The Erie County Department of Health (ECDOH) has successfully integrated hepatitis services into an existing HIV/STD clinic, and is now taking the lead in assisting the seven surrounding rural counties in integrating hepatitis into their existing HIV/AIDS/STD programs.

In 1989 the ECDOH's STD clinic began offering hepatitis B screening and vaccine through funding from the New York State Department of Health. Hepatitis C screening was added to the clinic in 1998 and the clinic began offering hepatitis A screening the following year. Currently, the clinic offers testing to all clients at first visit for hepatitis B and C, immunization against hepatitis A and B, recombinant strip immunoblot assay (RIBA) testing (a supplemental test given to those who screen anti-HCV positive), and referral for medical evaluation if hepatitis B and C screening shows past or current infection. Additionally, the clinic has engaged in public awareness campaigns to educate the public on hepatitis and to inform them of the availability of screening and vaccinations at the clinic.

The clinic attributes the success of integration to strong clinic leadership, committed clinic providers

and other staff, an effective ad campaign, and client receptiveness to vaccination. Hepatitis screening and vaccination is now seamlessly integrated into clinic activities; while initially there was a slight increase of time spent per patient, currently staff spend as much time per patient as they did prior to integration.

Erie County's success at integration was shared with the neighboring seven rural counties through the Western New York HIV/AIDS coalition. The coalition began discussing integrating hepatitis services in their respective counties, and identified the need for a hepatitis C curriculum to educate providers. In response, ECDOH obtained funding through the National Association of County and City Health Officials (NACCHO) to develop a hepatitis C "train-the-trainer" program, which was later expanded to include hepatitis A and B. Erie County is now working with the seven rural counties to integrate hepatitis in their jurisdictions through a CDC-funded Viral Hepatitis Integration Project (VHIP). Current activities include the development of mentoring guidelines to be used to train family planning and STD clinic staff, the implementation of hepatitis screening and vaccination for community members seeking family planning and STD services, and the establishment of protocols for integration of screening for hepatitis A, B, and C, and vaccination for hepatitis A and B.

City of Houston Department of Health and Human Services

The Houston Department of Health and Human Services (HDHHS) determined that the most effective way to reach individuals at high risk of hepatitis C virus (HCV) was to utilize the STD clinics and community-based organizations that currently serve those populations. Integration of HCV counseling and testing into those settings followed a four-step process, which included: garnering the support of key stakeholders; training the appropriate staff that would be counseling, testing, and providing medical evaluations to those seeking HCV services; implementing HCV services; and evaluating the project.

After key stakeholder support was secured and staff were trained in HCV protocols, implementation of HCV counseling and testing at city STD clinics and community based organizations (CBOs) began. Currently, individuals seeking services from the participating sites are given a self-administered risk factor survey; if they report a "targeted" risk factor on the survey, they are offered HCV counseling and testing. Targeted risk factors at both sites include injection drug use, body piercing or tattooing in unsanitary conditions, blood transfusion and/or organ transplant, birth to a mother with HCV, and HIV infection. The CBO testing criteria is broadened to include those that report sexual risks such as more than fifty lifetime partners and/or having sex with an injection drug user (IDU), as well as illicit drug use other than IDU. After the individuals test, the HDHHS link the risk factor survey with the test results, which has provided a picture of those seeking testing at these sites.

Preliminary surveillance results have found 16.7% of those tested are positive for HCV. The prevalence of HCV is similar in all four STD clinics offering testing, while the prevalence is higher at the CBOs offering testing. Most of the infection has been among those over forty years of age, of which African-Americans and Hispanics make up the largest numbers infected; among those testing positive under the age of forty, whites have the highest rate of infection.

The final step of this process is evaluating the services provided (process and outcome measures are included). Some of the challenges so far have been incomplete forms, delay in transferring forms from the sites and a delay in receiving test results. Currently, the project is running at ten sites, and has been fully integrated into existing services.

Columbus, Ohio

The Columbus, Ohio Department of Health (CDH) has experienced similar success in integrating viral hepatitis into a sexual health and HIV counseling and testing site. The site serves Central Ohio and sees more than 15,000 clients per year. CDH received $20,000 in 1999 to integrate hepatitis and has maintained the program after the grant period. The steps that the clinic took to integrate involved securing staff buy-in, educating the staff on hepatitis, and developing hepatitis protocols. The responsibilities for the medical records staff, the clinicians, and the HIV prevention counselors were expanded to include viral hepatitis. In addition, the clinic employs a viral hepatitis nurse specialist who reviews the results, notifies those testing positive, trains the staff, administers a questionnaire, and sends clients post card reminders for immunizations. The clinic found that HCV education and testing was easily integrated but staff buy-in took some time. Once the staff recognized the effectiveness of the counseling and testing program they were supportive.

Colorado Department of Health

The Colorado Department of Public Health (CDPH) has been working to integrate viral hepatitis as well. In June, a Viral Hepatitis Strategic Planning meeting was held. Over thirty stakeholders came together to discuss the development of a state plan for the prevention of viral hepatitis, and to spotlight hepatitis-related issues among IDUs. CDPH has also co-sponsored, along with the Denver HIV/STD Prevention Training Center, the Texas Department of Health, and the CDC, a training course entitled, "Integrating Hepatitis C into HIV/STD Counseling and Testing."

In addition, El Paso County, which contains Colorado Springs, has integrated viral hepatitis into partner notification services, and will serve as a model for integration in other Colorado counties.

Montana Department of Health

The Montana Department of Health (MDH) held its first combined statewide HIV/Hepatitis meeting in June. Approximately 200 health professionals, patient advocates, educators, and outreach staff working in HIV and hepatitis attended the event, the theme of which was the integration of services.

Ongoing hepatitis integration activities in Yellowstone County include training staff and providing counseling, testing, and hepatitis A and B vaccine in the Montana State Women's Prison, Indian Health Clinic, substance abuse treatment centers, and mental health programs.

If you have any questions about these or other viral hepatitis integration projects, please contact NASTAD Viral Hepatitis Coordinator Laurie Schowalter at (202) 434-8090 or email at lschowalter@nastad.org.

Do you know who the hepatitis C coordinator is for your state?

Twenty-six states currently have CDC-funded hepatitis C coordinators. Hepatitis C coordinators are working to promote the integration of hepatitis C into programs such as HIV/STD, immunization, substance abuse treatment, and corrections. Please see the appendix for contact information for the hepatitis C coordinators. Get to know your state's coordinator!

Key Challenges and First Steps in the Integration of Viral Hepatitis into HIV/AIDS/STD Programs

The following is a modified version of the presentation given by NASTAD Consultant Ray Smith at the 2001 Viral Hepatitis Coordinators' Conference held in Richmond, Virginia in July.

The NASTAD Viral Hepatitis Program has as its guiding principle that HIV/AIDS/STD programs have extensive expertise in the public health management of a viral disease. Thus NASTAD's starting point is what additional or modified steps would be required for existing HIV/AIDS/STD programs to effectively address viral hepatitis issues? Below are four of the key challenges facing jurisdictions in the integration of viral hepatitis into existing infrastructures, and several questions that jurisdictions can use to begin a process of self-assessment.

Challenge 1: Determining current status of programs in the jurisdiction

Early assessments by NASTAD have made clear that the viral hepatitis components of HIV/AIDS/STD programs are in a wide variety of stages of development across the jurisdictions. Some HIV/AIDS/STD programs, such as Texas, Arizona, Florida, and Rhode Island have been actively engaged with viral hepatitis issues for some time. In other jurisdictions there are well developed viral hepatitis programs with only minimal contact with the HIV/AIDS/STD program and still other jurisdictions have only begun to grapple with viral hepatitis. Thus, as a very first step if necessary, we would recommend asking the following very basic questions:

Do programs exist? Are they well developed? Partial? Informal?

Viral hepatitis programs exist to varying degrees in different jurisdictions, but their level of integration into HIV/AIDS/STD programs varies dramatically. An inventory of existing programs can help to reveal gaps, and perhaps overlaps, in program areas.

Are programs funded? Are they funded adequately?

Some programs have specifically earmarked funding; others have general, flexible funding streams; some have received no additional funds. Clearly, unfunded programs will face serious limitations and expanding such programs can only come at the expense of other program areas.

Do programs have specific legislative mandates or requirements?

Some jurisdictions have specifically passed legislation regarding viral hepatitis. Such legislation may largely determine how programs are developed. In other jurisdictions, programs may be governed by established public health regulations, while in other places there may be few legal or regulatory guidelines in place.

Challenge 2: Determining where current programs are situated organizationally

Public health responsibility for viral hepatitis programs appear to be unusually dispersed organizationally. Components of such programs can be found in areas as widely dispersed as

childhood immunizations, infectious disease, HIV/AIDS/STD, maternal and child health, substance abuse, and even food and water safety and immigrant services. This is in part because of differences among the five main types of viral hepatitis (i.e., hepatitis A, B, C, D, and E), and also because the different viruses have emerged as public health issues at different times. Any attempt to integrate viral hepatitis into HIV/AIDS/STD settings should therefore include the following questions:

Where are viral hepatitis programs located relative to the HIV/AIDS program?

HIV/AIDS programs and STD programs exist within many different organizational schemes in different jurisdictions. Assessing how these programs are placed relative to viral hepatitis programs is a crucial early step.

What is the lowest level at which there is a shared organizational superior (e.g., program manager, division head, health commissioner, governor)?

As a simple practical matter, different organizational arrangements can facilitate or block effective interaction. The lower the level at which HIV/AIDS/STD programs share an organizational superior, the easier it may be to facilitate integration.

What is the history of collaboration between the HIV/AIDS program and the viral hepatitis program?

There is no reason not to build upon successful precedents for collaboration if such precedents exist. Something as small as membership on a joint committee, or prior co-sponsoring of public outreach can serve as a basis for further collaboration. Similarly, preexisting personal or professional relationships among program staff can be leveraged into closer collaboration.

Challenge 3: Assessment of current viral hepatitis programs, if any, in the jurisdiction.

Once the existence of viral hepatitis programs and their connections to the HIV/AIDS/STD infrastructure has been determined, it may be appropriate to begin an assessment of these programs to see how well they are meeting public health needs. Crucial questions in such an assessment would include the following:

Are current programs comprehensive, partial or ad hoc?

Viral hepatitis programs, especially newer hepatitis C programs, may have grown up without a specific predetermined plan. The extent of existing programs will help to determine the ways in which they may need to grow.

Do programs consider the full range of special populations (e.g., youth, immigrants, the incarcer - ated, MSM, pregnant women, those co-infected with HIV)?

As with HIV/AIDS, needs may vary greatly according to subpopulations organized along lines of age, race/ethnicity, gender, HIV status, etc. While the needs of the "general population" must always be considered, so too must those of particularly heavily impacted subpopulations.

Do the programs have evidence of effectiveness?

Science-based approaches with evidence of effectiveness have proven to be increasingly essential in the realm of HIV/AIDS. How can the best of HIV/AIDS/STD practices be brought to bear in the area of viral hepatitis as well?

Challenge 4: Determining new resources needed.

As with any new undertaking adequate resources are essential. While resources ultimately relate to funding levels, they more specifically relate to staffing, expertise, operational authority, and technical capacity. Making a determination of what new or augmented resources may be needed should include the following questions:

Is program staff size adequate?

Staff members may be "borrowed" from other programs or may be "dedicated" to viral hepatitis. Either arrangement can be workable, but the total availability of staff time must be sufficient.

Do program staffs have adequate expertise and training opportunities?

Viral hepatitis is similar to HIV in many ways, but there are crucial distinctions. While HIV/AIDS/STD program staff should build upon their preexisting expertise, the must also be wary of carrying over too many assumptions from one field to another. Thorough and ongoing training can remedy such problems.

Do programs have sufficient authority to operate in the viral hepatitis field?

Regulations or legislation may identify where authority for viral hepatitis work resides. If regulations or legislation limit the operational authority of HIV/AIDS/STD programs to function in the area of viral hepatitis, then areas of flexibility must be identified or such regulations or legislation should be amended.

Offer for a Free Vaccine Training Kit

The Immunization Action Coalition (IAC) is offering a free training kit titled "How to Provide Immunization Services: Focus on Hepatitis Prevention" to any STD/HIV clinic wishing to learn more about how to become a vaccination service provider.

This packet of information is being developed under a cooperative agreement with the Division of Viral Hepatitis at the Centers for Disease Control and Prevention. The focus of the training materials packet is primarily hepatitis B and hepatitis A vaccine delivery, but much of the information can be used when providing other vaccines such as MMR, varicella, and meningococcal.

IAC is currently compiling a list of clinics desiring the free training kit so that it can determine how many it will need to make. IAC anticipates that the training kit will be complete and ready to mail by the end of September 2001.

Order your free kit on the Internet by visiting http://www.hepprograms.org/freekit. If you have any questions, call (651) 647-9009.

Is there adequate lab capacity for expanded viral hepatitis programs?

Simply put, expanded testing requires expanded capacity. It is unproductive for counseling and testing programs to outstrip the capacity of labs to process tests. Thus, enhanced outreach and education must be matched by enhanced lab capacity.

Do programs need additional funding in any of these areas? If so, how much?

The ability to clearly document unmet need is often the first step towards garnering additional funding. Some jurisdictions have conducted extensive assessments, developed work groups, and drafted white papers and/or strategic plans to outline the public health response and to document the need for funding. The NASTAD viral hepatitis program will soon be providing guidance to jurisdictions on these and other approaches.

What do AIDS Directors Have to Say About the Challenge of Integrating HIV and Viral Hepatitis Programs?

When NASTAD launched its work in viral hepatitis in the fall of 2000, a focus group was held with a group of AIDS directors from various states. Below are excerpts from the transcript highlighting some of the challenges to integrating HIV and viral hepatitis programs.

On coalition building: We have a very strong lobby for hepatitis C that's going on with our state legislature... We're doing a lot of collaborating with our state department of rehab and corrections and some other entities to build a program and to at least ask the question. But the bottom line is, if we can get some extra dollars for support and testing to support the lab piece, the counseling and testing sites will be [expanding to include viral hepatitis].

On organizational hurdles: One of the concerns when you do [integration is that] you don't want to erode or divert your ... resources to do the work. We had the resources to build up staff at sites so they have the opportunity to hire or pay for some time...because you're going to be delivering a lot more positive results, taking a lot more time. The other sort of dynamic we see is this tendency to split hepatitis C out from other viral hepatides.

On vaccination and treatment: For example, in our STD clinic, we're only able to pull money that would in fact vaccinate 19 [year-olds] and under. Adults are left totally on their own...they're [simply] given information. If they want to be tested, they can go get tested...But even if we get the testing done, then what?

On counseling and testing: My state demonstrates how far some places have to go. Hepatitis C is a communicable disease, so its connected [with HIV/STD]. But HIV/STD has relatively little contact. We sit on a little ad hoc coordinating committee. In the meantime, what we have done in HIV has been training our counseling and testing sites in our counties to advise individuals who are coming in who have risk factors for hepatitis C that testing is available, but they have to [get a hepatitis test] in the context of their health care provider.

On working with injecting drug users: A major problem is that many of the people [at risk] are still active injection drug users. No clinic or provider is going to [serve them]. They won't [serve] them until they've been clean for several years.

On categorical funding: There's a real wisdom in what's happening [but you have to wonder] whether it will be implementable, because you still

have categorical funding that is disease directed. We've been stymied by what to do with it, because it's come to this paradox that we've got money that's disease driven.

On adult immunization programs: [Integration] is important because not too far down the line, there will be vaccine-based strategies for STD which could potentially exist within five years and [perhaps for] HIV. So we've got to set this up now so that immunization is linked to the programs that are doing behavioral prevention ...Part of the issue, you're going to get into is that they're all childhood immunization programs. And we're talking about adult immunization.

On counseling: [It's a problem] to add any more [work] to HIV counselors that are already feeling burdened. Serious counseling takes time; [especially] to refer individuals into early care if they are positive.

On client demand: We talked to counselors who were reaching a lot of injection drug users. They want to do this; they want to offer testing, because their clients are saying: Can you give me a hepatitis test? The word is out; it's on the street. They know hepatitis C is out there. They want to get tested for it.

Quick Links to Viral Hepatitis Information

Even the most experienced Web surfer can find it a challenge to navigate the ever increasing universe of Websites. So NASTAD has gone ahead and created a list of "quick links" that will bring you directly to some of the more frequently sought types of information about HIV and viral hepatitis. You can type in the links listed below, or access live links on the NASTAD Website by visiting http://www.nastad.org/pro_viral_hepatitis.asp?menu=pro and by scrolling down to and then clicking on Links for Frequently Sought Information regarding Viral Hepatitis.

For the **latest news on viral hepatitis and HIV co-infection**:

- http://www.hivandhepatitis.com

For **frequently asked questions and answers** on viral hepatitis and HIV **co-infection**:

- http://www.cdc.gov/hiv/pubs/facts/HIV-HCV_coinfection.htm

For **conference reports** on viral hepatitis and HIV co-infection:
Summaries:

- http://www.hivandhepatitis.com/int_conf_rpt.html

Full text:

- http://www.hivandhepatitis.com/teleconf.html

For a report on state-of-the-art **treatments** for hepatitis:

- http://www.hepb.org/drugwatch.html

For information on **liver health**:
- http://www.liverfoundation.org/html/livheal.dir livheal.htm

For **medical news** and information on hepatitis:
- http://www.docguide.com/news/content.nsf /PatientResAllcateg/Hepatitis?Opendocument

For information on **HIV, HBV, and HCV clinical trials:**
- http://www.veritasmedicine.com/

For information on **hepatitis clinical trials:**
- http://www.centerwatch.com/studies/cat79.htm

For the **National Hepatitis C Prevention Strategy**:
- http://www.cdc.gov/ncidod/diseases/ hepatitis/c/plan/index.htm

For the Texas Department of Health's **Hepatitis C Prevention Counseling Training**:
- http://www.tdh.state.tx.us/hivstd /educate/hepc/default.htm

For **Model Programs** for Hepatitis A, B, & C Prevention:
- http://www.hepprograms.org

For information on Hepatitis C **disease management:**
- http://www.niddk.nih.gov/health/digest/pubs/ chrnhepc/chrnhepc.htm

For information about Hepatitis A and B **vaccinations:**
- http://www.niddk.nih.gov/health/digest/pubs/ vacc4hep/vacc4hep.htm

For **state-by-state laws** regarding Hepatitis B vaccinations:
- http://www.immunize.org/laws/hepb.htm

For information about Hepatitis B **vaccinations among health care workers:**
- http://www.immunize.org/catg.d/2109hcw.htm

For state-by-state listings of hepatitis **support groups:**
- http://www.hepfi.org/US-Cities.htm#MN

For information about **pediatric** viral hepatitis:
- http://www.pkids.org/hepatitis.htm

For publications on health care in **prisons**:
- http://www.ncchc.org/publication.html#pubs

For information about viral hepatitis among **Asians and Pacific Islanders:**
- http://www.aapihp.com/hepbtf/default.asp

Para informacion en **Español:**
Sobre la Hepatitis A:
- http://www.niddk.nih.gov/health/digest/pubs /hep/hepaspn/index.htm

Sobre la Hepatitis B:
- http://www.niddk.nih.gov/health/digest/pubs /hep/hepbspn/index.htm

Sobre la Hepatitis C:
- http://www.niddk.nih.gov/health/digest/pubs /hep/hepcspn/index.htm

For information about the **international work of the Viral Hepatitis Prevention Board:**
- http://www.vhpb.org/

For an **on-line CDC training** on hepatitis C:
- http://www.cdc.gov/ncidod/diseases /hepatitis/C_Training/edu/default.htm

For **CDC's Morbidity and Mortality Weekly Report (MMWR)** articles on viral hepatitis:

- http://www.cdc.gov/ncidod/diseases/hepatitis/resource/pubs.htm

For **CDC slide sets** on viral hepatitis:

- http://www.cdc.gov/ncidod/diseases/hepatitis/slideset/

For **brochures** on viral hepatitis:

- http://www.cdc.gov/ncidod/diseases/hepatitis/resource/brochures.htm

OR

- http://www.hepfi.org/infomenu.htm

OR

- http://www.immunize.org/catg.d/free.htm

OR

- http://www.liverfoundation.org/html/livheal.dir/livheal.htm

For information about **NIH research** on viral hepatitis:

- http://www.niaid.nih.gov/dir/labs/lid/purcell.htm

For information about the **city and county health response** to viral hepatitis:

- http://www.naccho.org/project41.cfm

For **California's Hepatitis C Strategic Plan**:

- http://www.dhs.ca.gov/ps/dcdc/pdf/Hepatitis%20C%20Strategic%20Plan%20-%202001.pdf

For **Maine's Hepatitis C needs assessment,** "At the Crossroads: Hepatitis C Infection in Maine":

- http://janus.state.me.us/dhs/boh/ddc/hepcfull.doc

The Manager:

Coping with Stress, Part I

As the economy cools down, financial concerns are hitting the profit sector, with the non-profit and governmental sectors not far behind. The HIV/AIDS epidemic continues to shift and present new challenges, making the work of HIV programs a constant struggle for re-adjustment. And new technologies like cell phones, fax machines, and e-mail seem to end up not saving labor but requiring ever more of it. For these and many other reasons, the workplace is becoming ever more stressful for many. So with this edition of The Manager, we begin a three-part series on stress: how to identify it, how to minimize it in the short term, and how to manage it in the long term.

The physical and psychological reasons that stress needs to be managed are many, and familiar to most of us: long-term, stress can lead to unmanageable emotions, feelings of being overburdened and burnt-out. It can also contribute to physical ailments such as high blood pressure, back pain, substance abuse, and heart disease. For all these reasons, stress specialist Barbara Bailey Reinhold coined the term "toxic work" (Toxic Work: How to Overcome Stress, Overload, and Burnout and Revitalize your Career, Plume 1997).

Identifying Stress

We speak of "stress" as a single concept, but according to Reinhold it actually is multidimensional, consisting of several different components. To identify your level of stress in the workplace, consider the following:

***Anxiety*:** Do you have excessive or unrealistic worries about money, losing your job, having to learn new skills, or possible failure?

Anger: Do you find yourself angry while you are at work, while interacting with colleagues, or even away from work?

Lack of Control: Do you feel that you have too little input into how your work is done, how decisions are made, whether you will take on new challenges, or how much work you have?

Lack of Confidence: Are you excessively concerned about the quality of your work, your co-workers' opinion of you, your ability of keep up, or your basic capabilities?

Shut-Down Feelings: Do you feel disconnected from your emotions, worried about expressing your feelings, or alienated from colleagues?

***Diminished Relationships*:** Are you spending less time with family and friends, do you have trouble getting close to people, or do you have too little energy for relationships?

Identifying Stressors

If you can identify with many or most of these signs and symptoms, you may well be experiencing serious stress levels. To help pinpoint the exact source of your work-related stress, review the following list of stressors, derived from both outside and inside organizations, to see which may be affecting you. (This list of stressors is adapted from Controlling Work Stress: Effective Human Resource and Management Strategies by Michael T. Matteson and John M. Ivancevich, Jossey-Bass Publishers 1987.

Extra-organizational Stressors:

The Family: Family or relationship problems are often brought into the workplace.

Relocation: A recent move can lead to disorientation and trouble adapting or adjusting.

***Economic and Financial Stressors*:** Perceived or actual financial problems can lead to worry and/or the stress of taking on extra jobs.

Residential Stressors: Home and neighborhood environments can have a great impact on personal satisfaction.

Organizational Stressors:

Job Design*:* Some jobs are not designed in way that provides a range of activities that offer personal fulfillment.

Conflict*:* Many people report to more than one supervisor or are required to carry out their work roles in a way that clashes with regulations.

Role Ambiguity*:* A lack of clarity about the scope and responsibilities of a job can provoke anxiety.

Work Overload*:* Excessive amounts of work on a chronic and extensive basis can diminish job performance.

Inadequate Career Development Opportunities*:* It can become easy to feel caught in a "dead-end" job.

Organizational Culture: Some organizations reinforce "toxic work" as the norm.

Leader Relationships: Unreasonable or erratic leadership diminishes morale.

Lack of Performance Feedback: Working in a "vacuum" leaves workers unable to distinguish work done well from work done poorly.

The bad news is that virtually everyone will probably relate to some of the symptoms of stress at least some of the time - and that's not necessarily a bad thing, given that a reasonable degree of stress can keep performance high. Similarly, some of the stressors above may be able to be modified. But, of course, if they were very easily modified, you would probably have already done so.

The good news is that there are techniques, both cognitive (i.e., relating to cognition or patterns of thinking) and behavioral (i.e., relating to how work is done), for minimizing the damaging effects of toxic work and for reshaping work life over the longer run to achieve greater satisfaction. These will be the topics of the next two editions of The Manager.

Recognizing the need to support HIV/AIDS program staff members in their management challenges, the NASTAD HIV Prevention Bulletin periodically offers "The Manager" to bring to our readers' attention key works by professionals in the field of management as well as the practical experience of hands-on managers. "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 STE. 339, Washington DC 20001.

Adolescent and School-Based Health:

Youth Involvement in HIV Vaccine Trials

To help control the HIV/AIDS pandemic, the search for a safe, effective HIV vaccine is currently underway. This HIV vaccine would serve to complement existing HIV prevention strategies. Youth participation in these trials has been a controversial issue. Below is an article written by Erin Connor at Advocates for Youth on youth involvement in vaccine trials.

For more information on adolescent health research, please see the Society for Adolescent Health's Guidelines for Adolescent Health Research at: http://www.adolescenthealth.org/html/adolescent_health.html or "Guidelines for Adolescent Health Research: A Position Paper of the Society for Adolescent Medicine" in the Journal of Adolescent Health: 1995; 17:270-276.

A Promise for the Future: Youth Involved in HIV Vaccine Trials

By Erin Connor, MPH
Advocates for Youth

Today, young people contract HIV in great numbers. In fact, it is believed that one half of new HIV cases in the United States are among people under the age of 25. Many prevention and treatment efforts targeted toward youth have been sucessful, however, there is a consensus that

prevention and treatment alone are not sufficient to combat this ever-increasing epidemic. Many believe that an HIV vaccine is the only way to truly put a dent in this disease.

There are great strides being made in the field of HIV vaccine research. Currently, there are both publicly and privately funded clinical trials underway. VaxGen, a private company, has begun Phase III trials of a vaccine candidate- the final phase before application to the FDA. The National Institutes of Health (NIH) fund a network of 10 trial sites, the HIV Vaccine Trials Network (HVTN). This network is currently conducting trials for a variety of candidate vaccines in 10 communities, both domestically and internationally.

Traditionally, vaccine research begins with trials in adults followed by years of post-testing to determine its effectiveness and impact on young people in early adolescence. Additional years are then necessary to actually distribute the vaccine. In order for an HIV vaccine to be effective, it needs to be administered before people engage in behaviors which would put them at risk for HIV. With 65% of American teens becoming sexually active by the 12th grade, it is evident that the vaccine would need to be administered in early adolescence, before they become sexually active. The only surefire way to know if a vaccine is effective for young people is to involve young people in the trials. Of the 5,000 trial participants involved in the VaxGen study, not one participant is under the age of 18. Of the 3,200 trial participants involved in several government-sponsored trials, only one has been under the age of 18.

Community involvement is an important aspect of HIV vaccine trials. Community Advisory Boards (CABs) are formed to advise scientists, researchers and those who actually administer the vaccine on the issues that are important to them. CABs are the voice of the community. They bring forth concerns around HIV vaccine trials, such as recruitment of new volunteers, retention of current volunteers, the manner in which trials are conducted, and provide input from those community members most at risk for and affected by HIV. Because youth are so greatly affected by HIV, young people need to be involved not only in trials themselves, but at all levels of the process, including CABs.

The idea of the CAB is based on the same premise as HIV prevention community planning; the concept of community members working together to better the group. Just like in CABs, members of community planning groups (CPGs), work together to form a plan. Many CPGs throughout the U.S. and the Territories have recognized the need for youth involvement on the CPG. They have come to realize that young people have a lot to offer in the development of prevention activities for their peers. Adolescents and young adults offer expertise on youth issues and provide insight on the risk factors particular to young people. With youth and adults working together in partnership, the young person becomes part of the solution, rather than simply a part of the problem. The youth-adult partnership model in community planning has been implemented by various jurisdictions, including Minnesota, Hawaii, Pennsylvania, Rhode Island, and Alabama. The same model used to achieve meaningful representation of young people in the CPG process could be easily replicated in HIV vaccine trial CABs.

Advocates for Youth has a long history of working to involve youth in HIV prevention activities. Recently, Advocates has joined forces with the AIDS Vaccine Advocacy Coalition (AVAC), a non-profit organization based in Washington, D.C. to ensure the meaningful involvement of young people at all levels of HIV vaccine trials. The two organizations combined their expertise and put forth a call to action to the NIH and the HIV Vaccine Network (HVTN) to identify any scientific, legal, or procedural barriers to youth participation in trials and will work with the experts to overcome these

barriers. Advocates and AVAC understand the gravity of the epidemic within our nation's young people. They believe that young people need to take responsibility for their own sexual health, yet they need to be given the proper information and need to be included in the scientific research that will affect their health.

Vaccine research represents our only real hope for ending the AIDS pandemic. Without full participation from community members who are infected and affected by HIV, we have no real hope for a future without AIDS.

For more information, please contact Advocates for Youth at (202) 347-5700 or see: http://www.advocatesforyouth.org.

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.

September 24-25, 2001
" 2001 Regional Meetings on MSM and HIV Prevention - Southern Regional Meeting" New Orleans, LA . Sponsored by CDC For information, contact Cathy Motamed (202) 884-8000 or at cmotamed@aed.org

September 30-October 2, 2001
"14th Annual Women's Issues Conference," Tucson, AZ. Sponsored by the Alcohol & Drug Problems Association of North America. The conference will disseminate up-to-date programmatic and research information pertinent to women's services in the treatment and prevention of alcohol and drug abuse. For additional information, contact Janet Woodburn at (636) 940-2283 or jwoodburn@bridgewaycounseling.com.

October 4-5, 2001
"Growing Up with HIV/AIDS: Issues in Prevention and Quality of Life," Memphis, TN. Sponsored by St. Jude Children's Research Hospital and the University of Tennessee Boiling Center for Developmental Disabilities. For more information, call (901) 448-2660 or visit http://www.utmem.edu/bcdd.

October 5-7, 2001
"Pa'Fuera, Pa'Lante!"-Stepping Out and Moving Forward, Boston, MA. This conference will highlight the issues affecting the Latino LGBT communities in the Northeast region. For more information please contact Maria Cristina Vlassidis, Chair of the Planning Committee, at (617) 204-3882 , mcv59@yahoo.com or visit http://www.pafuera-palante.org.

October 21-25
American Public Health Association 129th Annual Meeting and Exposition, Atlanta, GA. For more information, visit: http://www.apha.org, or call (514) 338-3009.

October 22-26, 2001
CDC External Review. Atlanta, GA.

October 30-31, 2001
"2001 Regional Meetings on MSM and HIV Prevention - Midwestern Region Meeting" Chicago, IL Sponsored by CDC For information, contact Cathy Motamed (202) 884-8000 or at cmotamed@aed.org

November 26 - 27, 2001
"2001 Regional Meetings on MSM and HIV Prevention - Western Regional Meeting" Los Angeles, CA . Sponsored by CDC For information, contact Cathy Motamed (202) 884-8000 or at cmotamed@aed.org

November 27-29, 2001
"Transcending Boundaries: Science and Society," 10th Annual HIV/STD Conference, Springfield, IL.

December 2-4, 2001
"Rights, Respect, Responsibility: A Bold New Paradigm for Health Adolescent Sexuality," Washington, D.C. Sponsored by Advocates for Youth. For more information, contact Advocates for Youth at .conf@advocatesforyouth.com or visit http://www.advocatesforyouth.org.

December 2-5, 2001
The 2001 North American AIDS Treatment Action Forum (NATAF), Vancouver, Canada. Sponsored by NMAC. For more info, visit:
http://www.nmac.org/nataf/2001/welcome.htm.

December 11-12 2001
"2001 Regional Meetings on MSM and HIV Prevention - Eastern Regional Meeting" Brooklyn, NYC . Sponsored by CDC For information, contact Cathy Motamed (202) 884-8000 or at cmotamed@aed.org

February 7, 2001
Second National Black HIV/AIDS Awareness and Information Day. Coordinated by the Community Capacity Building Coalition (CCBC), comprised of five national organizations funded by the Centers for Disease Control and Prevention (CDC) through the Minority AIDS Initiative. For more information, contact Steven J. Davis, CDC, NCHSTP, DHAP - Capacity Building Branch, at: (404) 639-5227, or sjd1@cdc.gov.

February 20-24, 2002
The American College of Preventive Medicine's annual meeting, San Antonio Texas. For more information on the program tracks and how to submit your abstract, (abstract due Sept.26) visit: http://www.PreventiveMedicine2002.org or contact Maureen Crane, ACPM Meetings Manager, at (202) 466-2044, ext. 103 or mkc@acpm.org with any questions.

March 4 -7, 2002
National STD Prevention Conference, San Diego, CA Sponsored by CDC. For more information, visit http://www.stdconference.org

March 6-9, 2002
Community Planning Leadership Summit for HIV Prevention, Chicago, IL. Sponsored by the Academy for Educational Development, CDC, NASTAD, and the National Minority AIDS Council. Abstracts due October 12, 2001. For more information, visit the NMAC website and click on CPLS.

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

If you have an idea or program relative to any of these topics which you would like to include in the Bulletin, please contact Lynne Greabell (e-mail: lgreabell@nastad.org, phone: (202) (434-8090).

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NASTAD
HIV PREVENTION
BULLETIN

ENCLOSURE
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Hepatitis C Coordinators, 8/13/01

State/City	Coordinator	Other Contact	E-mail	Phone
Arizona	Lee Connelly		lconnel@hs.state.az.us	602-230-5819
California	Lori Fries		lfries@dhs.ca.gov	510-540-2022
Chicago	pending	Sue Gerber	gerber_sue@cdph.org	312-746-5992
Colorado	Mauricio Palacio		mauricio.palacio@state.co.us	303-692-2674
Connecticut	pending	Aaron Roome	aaron.roome@po.state.ct.us	860-509-7900
Delaware	Kathleen O'Connor Watson		ko'connor-w@state.de.us	302-739-4745
DC	pending	Martin Levy	martinlevy@hotmail.com	202-442-5899
Florida	Sandy Roush		Sandra_Roush@doh.state.fl.us	850-245-4426
Hawaii	Jennifer Hagen		jmhagen@mail.health.state.hi.us	808-586-8338
Louisiana	pending	Karen Kelso	kkelso@dhh.state.la.us	504-564-5005
Maine	Mary Kate Appicelli		mary-kate.appicelli@state.me.us	207-287-3817
Massachusetts	Dan Church		daniel.church@state.ma.us	617-983-6830
Michigan	Kim Kirkey		kirkeyk@state.mi.us	517-335-8165
Missouri	Thomas Ray		rayt@mail.health.state.mo.us	573-751-6113
Montana	Elton Mosher		emosher@state.mt.us	406-444-6736
New Mexico	pending	Reena Anthony	reenaa@doh.state.nm.us	505-827-2507
New York City	Karen Schlanger		kschlang@health.nyc.gov	212-788-4714
Ohio	pending	Barbara Bradley	bbradley@gw.odh.state.oh.us	614-728-0880
Oklahoma	Angela Horning		angelang@health.state.ok.us	405-271-4636
Philadelphia	Caroline Johnson		caroline.johnson@phila.gov	215-685-6740
Rhode Island	Lorraine Moynihan		LorraineM@doh.state.ri.us	401-222-7541
South Carolina	Robert Ball		ballrt@columb60.dhec.state.sc.us	803-898-0861
Tennessee	pending	Mary Ellen Chesser	mchesser@mail.state.tn.us	615-532-8486
Texas	pending	Gary Heseltine	gary.heseltine@tdh.tx.us	512-458-7676
West Virginia	pending	Danae Bixler	DanaeBixler@wvdhhr.org	304-558-5358
Wisconsin	Marjorie Hurie		huriemb@dhfs.state.wi.us	608-266-5819