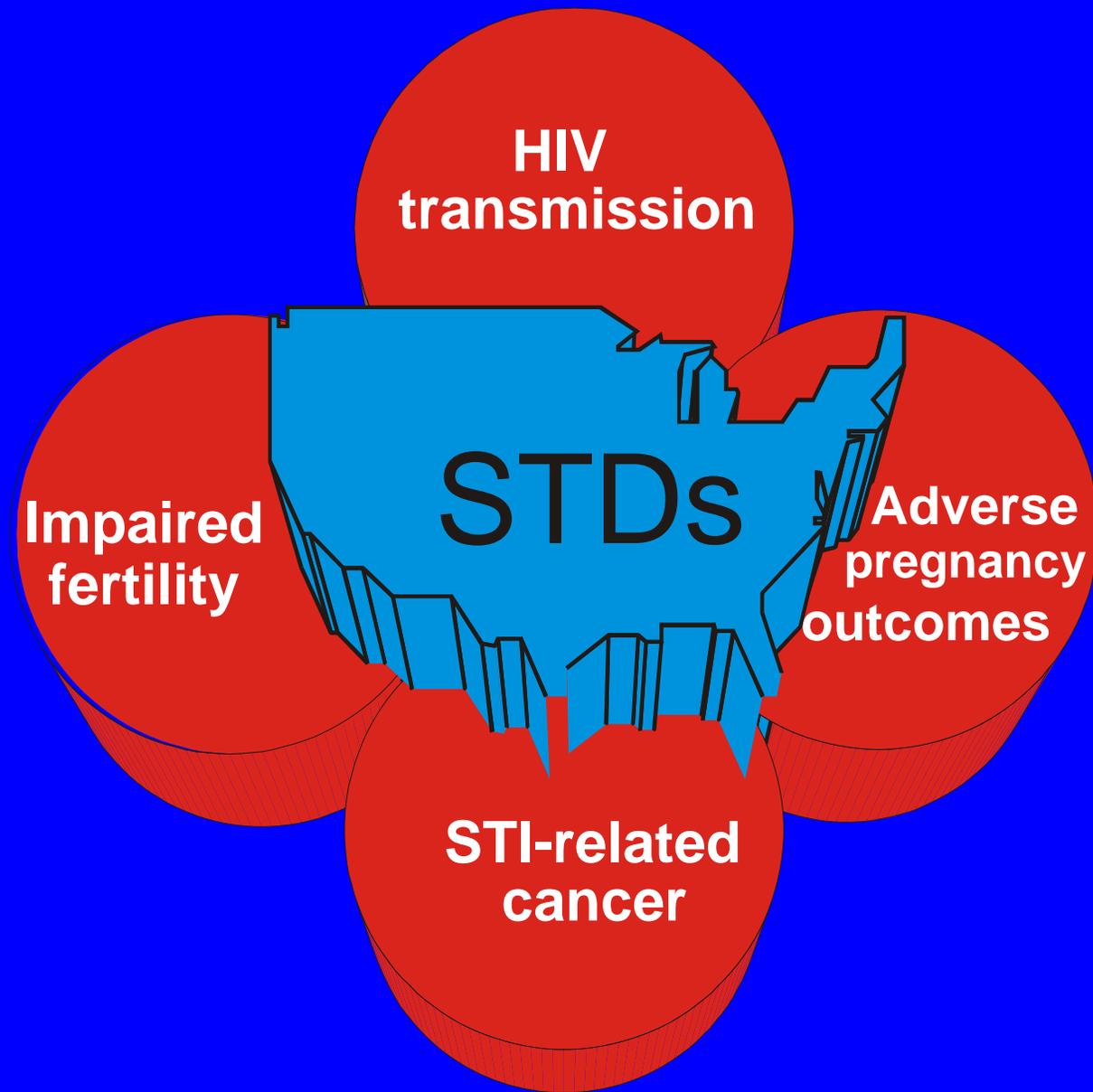


# Prevention of Viral Hepatitis in STD Programs

John M. Douglas, Jr, MD

Director

Division of STD Prevention



# **Integration of STD and Viral Hepatitis Prevention Activities within DSTDP**

- Guidelines**
- Program**
- Training**

# Integration of STD and Viral Hepatitis Prevention: Guidelines

- STD Treatment Guidelines
  - HBV recommendations since 1993
  - expanded to “Vaccine Preventable STD” 1998 (both HAV & HBV)
  - additional section on HCV 2002
- Program Operation Guidelines 2001
  - STD clinics advised to collaborate with immunization & viral hepatitis programs to provide HBV vaccine to those at risk
  - range of services should include vaccination

# Hepatitis A & B Prevention: STD Treatment Guidelines, 2006 (draft)

- HAV immunization for
  - MSM
  - Injection and non-injection drug users
  - Persons with chronic liver disease (including chronic HBV and HCV)
- HBV immunization
  - 2002
    - STD clinics: all unimmunized
    - Non-STD clinic setting: persons with history of STD; those with sex with multiple partners, IDU, MSM; those with illegal drug use; contacts of those with chronic HBV
  - 2006
    - All unimmunized persons being evaluated or treated for any STD
    - All unimmunized persons seen in substance abuse programs, HIV care clinics, correctional facilities
      - All should be offered vaccine unless reliable vaccination history or serologic evidence of immunity
      - Initiate vaccine even if completion cant be assured

# Reported cases of sexually transmitted disease by reporting source, U.S., 2004

	Non-STD Clinic	STD Clinic
<b>C. Trachomatis</b>	<b>77%</b>	<b>23%</b>
<b>N. Gonorrhoeae</b>	<b>65%</b>	<b>35%</b>
<b>Syphilis</b>		
P&S	64%	36%
EL	63%	37%
LL	68%	32%

# STD Prevention for MSM (*CDC STD Treatment Guidelines 2002*)

- STD/HIV sexual risk assessment and client-centered prevention counseling
- Annual STD screening for sexually active MSM
  - HIV and syphilis serology
  - Urethral cx or NAAT, GC/CT
  - Pharyngeal cx, GC (oro-genital)
  - Rectal cx, GC/CT (receptive anal IC)
- More frequent STD testing (3-6 months) if multiple anonymous partners, sex with drugs, partners with these characteristics
- Screening recommended regardless of condom use history
- Diagnostic testing when indicated by exposure, symptoms, exam
- Vaccination for hepatitis A and B

# March 2004 Dear Colleague Letter

Dear Colleague:

Men who have sex with men (MSM) are at increased risk for multiple sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV) infection/Acquired Immunodeficiency Syndrome (AIDS), syphilis, gonorrhea, chlamydia, ***hepatitis B virus (HBV) and hepatitis A virus (HAV)***. Numerous recent reports document a resurgence in unsafe sexual practices among MSM that appear to be associated with increased rates of STDs....

# Integration of STD and Viral Hepatitis

## Prevention in Program: 2005

### Comprehensive STD Prevention System

### Projects Grant Program Guidance

- Encourage DSTDP's grantees to:
  - Collaborate and integrate with HIV and hepatitis prevention programs to serve groups at risk for or infected with all of these diseases.
  - Encourage providers to provide HIV, Hepatitis A&B vaccination, and STD screening in high prevalence settings.
  - Integrate HIV, hepatitis and STD prevention messages into health education messages.

# Integration of HBV Prevention into STD Services (Gilbert, STD 2005)

Responses	1997	2001
Project areas (n)	(63)	(51)
--Written HBV policy	21%	33%
--VFC policy	27%	49%
--Used VFC resources	46%	67%
--Policy—all clinics should offer HBV Vx	25%	45%
--% clinics offering HBV VX	24%	65%
--All patients eligible for HBV Vx	9%	26%
Clinic managers (n)	(71)	(317)
--% clinics offering HBV Vx	61%	82%
--All patients eligible	5%	45%

# Provision of Hepatitis Immunization in STD Clinics: 2004-5 (Barrow R, preliminary data)

- Ongoing survey of services provided in US STD clinics
- Preliminary results
  - 2471 surveys sent, 1355 received to date (56%)
  - 441 clinics whose primary mission is STD services, with  $\geq 75\%$  of visits for STD services
  - Hepatitis immunization
    - 232 (53%) both HAV and HBV
    - 98 (22%) HBV only
    - 4 (1%) HAV only
    - 107 (24%) neither

# HBV Immunization in the Denver STD Clinic (Douglas, ISSTDR, 2003)

- Aug, 1999: pilot HBV immunization program using city funds for vaccine and routine clinic staff for screening, immunization, follow-up
  - Eligibility: “high-risk” (MSM, IDU, multiple partners past 4 months, hx or current STD)
- Oct, 2000: VHIP funds provide coordinating staff, improved tracking and follow-up
- Jan, 2002: VHIP funds used to provide VX for all clinic patients

Time period	Targeted patients	Follow-up procedures
#1 (8/99-6/00)	high-risk	phone calls, letters by clinic RN
#2 (7/00-4/01)	high-risk	none
#3 (5/01-1/02)	high-risk	post card for doses #2 & 3
#4 (1/02-12/02)	all	post card for doses #2 & 3

# HBV Vaccine Results by Time Period, Denver STD Clinic

Response	Time Period			
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
# targeted	7224	5701	5221	9701
% screened	26%	40%	37%	74%
% prior VX	26%	33%	42%	42%
% eligible willing	54%	55%	66%	75%
% eligible, 1 <sup>st</sup> dose	37%	30%	35%	53%
% 2 <sup>nd</sup> dose (if 1 <sup>st</sup> )	39%	29%	35%	30%
% 3 <sup>rd</sup> dose (if 1 <sup>st</sup> )	21%	22%	27%	22%

AARON  
TANNER  
HOSTS

# HOT SHOT



Meet the  
HotShot Models  
and  
Go-GO Boys!!

THURSDAY FEBRUARY 26 6-11PM  
VIEW BAR 232 8th AVE.  
**FREE**  
HEPATITIS A & B SHOTS  
HIV/STD SCREENINGS  
SMOKING CESSATION PATCHES

Music by  
DJStevieBeat



## MSM Wellness: Hot Shot Outreach Events, NYC, 11/03-5/04 (Blank. STD 2005)

Events	Attendees	Received 1+ services
9	1634	445

Syphilis testing	161 (4 new cases)
HIV testing	167 (7 new cases)
Hepatitis A Vx	226
Hepatitis B Vx	239
Influenza Vx	214
Pneumococcal Vx	12

Depression/mental health	59 8 referrals
Diabetes	73 1 referral
Hypercholesterolemia	88 all normal
Hypertension	59 2 referrals
Substance abuse	49 13 referrals
Tobacco cessation	64 50 patches

# Integration of STD and Viral Hepatitis Prevention: Training

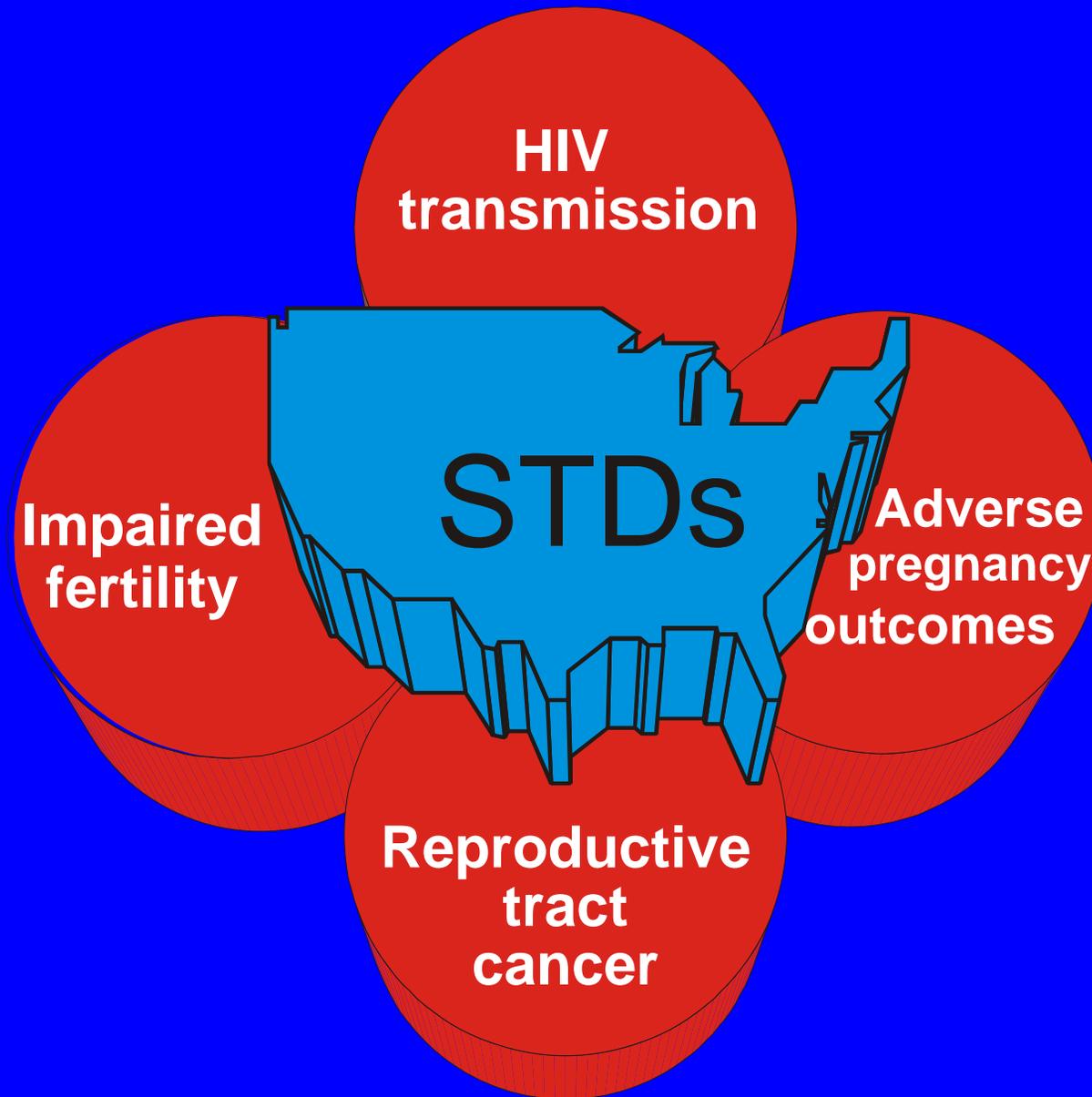
- PTCs conducted hepatitis training needs assessment leading to development of several hepatitis training courses, 2001
- PTC curriculum modules
  - “Hepatitis” 1 of 12 core curriculum modules taught in clinical training
  - Included in training for DIS & HIV prevention staff
  - also available as a home study course

# PTC Hepatitis-related Training

- Through the PTCs, over 3,000 students receive training in hepatitis-related activities annually.
- Hepatitis training has been included in a variety of courses:
  - Introduction to STD Disease Intervention
  - STD Intensive
  - STD Update
  - STD Overview for Clinicians
  - Clinical Comprehensive
  - Viral STDs
  - STD Grand Rounds: Hepatitis A
  - STD Grand Rounds: Hepatitis B
  - Integration of Hepatitis C
  - HIV/Hepatitis Update.

# Integration of STD and Viral Hepatitis Prevention: Reflections for the Future

“Integration is important because not too far down the line, there will be vaccine-based strategies for STD [eg, HPV, HSV-2] which could potentially exist within 5 yrs...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...is that they’re all childhood immunization programs. And we’re talking about adult immunization.” (NASTAD HIV Prevention Bulletin Sept 2001)



# HBV Immunization in the Denver

## STD Clinic (Douglas, ISSTDR, 2003)

- The Denver Metro Health Clinic is a free, walk-in STD clinic serving residents of the Denver metropolitan area
- In August 1999, a pilot HBV immunization program was initiated using city funds to purchase vaccine and routine STD staff to screen eligible patients, administer vaccine, and contact patients for follow-up. “High risk” patients were targeted for immunization including MSM, IDU, those with multiple sex partners in the past 4 months, and those with a history of or current STD
- In October, 2000, support from the CDC Viral Hepatitis Integration Project (VHIP) allowed improved tracking and follow-up activities
- In January 2002, VHIP funds were used to expand screening for immunization to all patients attending the clinic for a new problem (“all patients”)

# Evaluation of Adherence to National Guidelines on HIV Prevention for HIV-infected MSM

- Guidelines “Recommendations for Incorporating HIV Prevention into the Medical Care of Persons with HIV Infection” (CDC, MMWR 2003)
  - Promote prevention efforts among persons who are HIV infected to reduce HIV transmission to uninfected partners
- 9 HIV care clinics in 6 U.S. cities
  - NYC, Atlanta, Chicago, Los Angeles, San Francisco, Miami
  - Mix of public and private sector clinics
- Evaluate adherence to guidelines in providing STD and hepatitis prevention services:
  - Behavioral and sexual risk assessments
  - screening for STD and hepatitis B, C
  - treatment for STD, referrals for hepatitis
  - Hepatitis A and B immunizations
  - Counseling and risk reduction
- Understand facilitators and barriers to providing services at the clinics from patient, provider, clinic point of view
- Identify interventions to improve adherence

# Integration of STD and Viral Hepatitis Prevention: Reflections for the Future

- “Integration is important because not too far down the line, there will be vaccine-based strategies for STD [eg, HPV, HSV-2] which could potentially exist within 5 yrs...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...is that they’re all childhood immunization programs. And we’re talking about adult immunization.” (NASTAD HIV Prevention Bulletin Sept 2001)
- In an era emphasizing that “smaller government is better”, we all need to think about how to make the case for better, more efficient, more accountable, and more impactful public health programs

# Conclusions

- Overall, 47% of targeted patients were screened by clinic staff, with rates improving when all patients were eligible
- The proportion of clients claiming prior history of HBV immunization or infection B significantly increased over the study period (from 26% to 47%), among all age groups
- Overall, 44% of eligible clients received a first dose of HBV vaccine with rates improving when all patients were eligible, although 23% of all patients accepted but did not wait to receive vaccine
- Rates of completion of FU doses improved with reminders, especially dose #3, but were disappointingly low overall (32% dose #2, 23% dose #3).
- Factors associated with higher rates of receipt of follow-up doses included white race, male sex, older age, absence of an STD diagnosis at initial visit, and use of reminders
- Longer FU intervals improved rates completion of FU doses, especially among MSM

# Screening Results by Time Period

% screened (number targeted)

Time Period	Total patients	MSM
1 (high risk)	26% (7224)	38% (645)
2 (high risk)	40% (5701)	50% (580)
3 (high risk)	37% (5221)	56% (505)
4 (all)	74% (9701)	85% (879)

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Total	47% (27,847)	60% (2609)
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# Percentage with Past HBV Vaccine or Infection by Time Period

% reporting prior HBV vaccine or infection (no. screened)

Time Period	Total patients	MSM
1 (8/99-6/00)	26% (1908)	39% (260)
2 (7/00-4/01)	33% (2498)	49% (347)
3 (5/01-1/02)	42% (2150)	46% (353)
4 (1/02-12/02)	42% (8847)	50% (1065)
<hr/>		
Total	39% (15,403)	46% (2025)

# Acceptance of Immunization among those Eligible — All Patients

Time Period	No. eligible	No. (%) willing to receive vaccine	No. (%) receiving first dose
1—high risk	1405	756 (54%)	524 (37%)
2—high risk	1672	913 (55%)	508 (30%)
3—high risk	1248	817 (66%)	431 (35%)
4—high risk	5140	3856 (75%)	2718 (53%)
<hr/>			
Total	9465	6361 (67%)	4181 (44%)

# Completion of Doses #2 and #3 by Time Period — All Patients

Time Period	No. 1 <sup>st</sup> dose	No. (%) 2 <sup>nd</sup> dose*	No. (%) 3 <sup>rd</sup> dose**
1 - high risk (2 <sup>nd</sup> dose reminder by phone, letter)	524	206 (39%)	112 (21%)
2 – high risk (no reminder)	508	149 (29%)	109 (22%)
3 – high risk (reminders by postcard)	431	151 (35%)	117 (27%)
4 – all (reminders by postcard)	2718	821 (30%)	105/468 (22%)
<hr/>			
Total	4181	1327 (32%)	443/1931 (23%)

\*within 60 days of 1<sup>st</sup> dose

\*\*within 12 mos of 1<sup>st</sup> dose for those with  $\geq 1$  yr. follow-up

# Integration of STD and Viral Hepatitis Prevention: Program Examples

- TX: Hep C initiative including training for counseling, public education; State inmate HBV immunization program
- WV: HBV vx provided to adolescents in STD/public clinics statewide
- MI: HBV vx offered to adolescents in FP, STD, adolescent clinics
- CO: HBV vx offered in several STD clinics/CTS; HCV testing offered in all CTS sites
- Denver: STD, CTS, and jail screening clinic: HBV vx offered to all pts, HAV vx & HCV screening to targeted groups
- SF: HBV vx in STD clinic since 1989, HAV vx since 1998

# Current DSTDP Integration Evaluation Projects

- Evaluation of HIV-Related Service Networks and STD Service Provision within the Networks
  - Formative description of HIV prevention and care service network components and how STD services are offered in the network
  - In partnership with DHAP
- 1% and Health Disparities Evaluation – Evaluation of Adherence to National Guidelines to Provide STD and Hepatitis Services in the Public and Private Sectors to HIV-infected MSM
  - Evaluation of STD and hepatitis service delivery in 10 HIV care clinics
  - In partnership with DVH, DHAP and HRSA

# Evaluation of Adherence to National Guidelines on HIV Prevention for HIV-infected MSM

- Evaluate adherence to guidelines in providing STD and hepatitis prevention services:
  - Behavioral and sexual risk assessments
  - screening for STD and hepatitis B, C
  - treatment for STD, referrals for hepatitis
  - Hepatitis A and B immunizations
  - Counseling and risk reduction
- Understand facilitators and barriers to providing services at the clinics from patient, provider, clinic point of view
- Assess racial and ethnic disparities
- Identify interventions to improve adherence

## Data collection sources

- Medical chart abstraction— evaluate if services are provided
- Clinic protocols abstracted- evaluate clinic protocols
- Clinic administrative data- understand clinic's structure, staffing, resources, burden of disease, etc
- Surveys and in-depth interviews-
  - With clinicians to evaluate if they are providing services; if not, why not? What barriers/facilitators do they identify?
  - With patients to evaluate if they confirm receiving recommended services; if not, why not? What barriers/facilitators do they identify?
- Interview clinic director- understand director's perspective on how services are provided at the clinic
- Focus Groups
  - health care staff—understand their perspective on services
  - community leaders—understand social norms in the community and issues around access and utilization of the clinic by HIV+ MSM

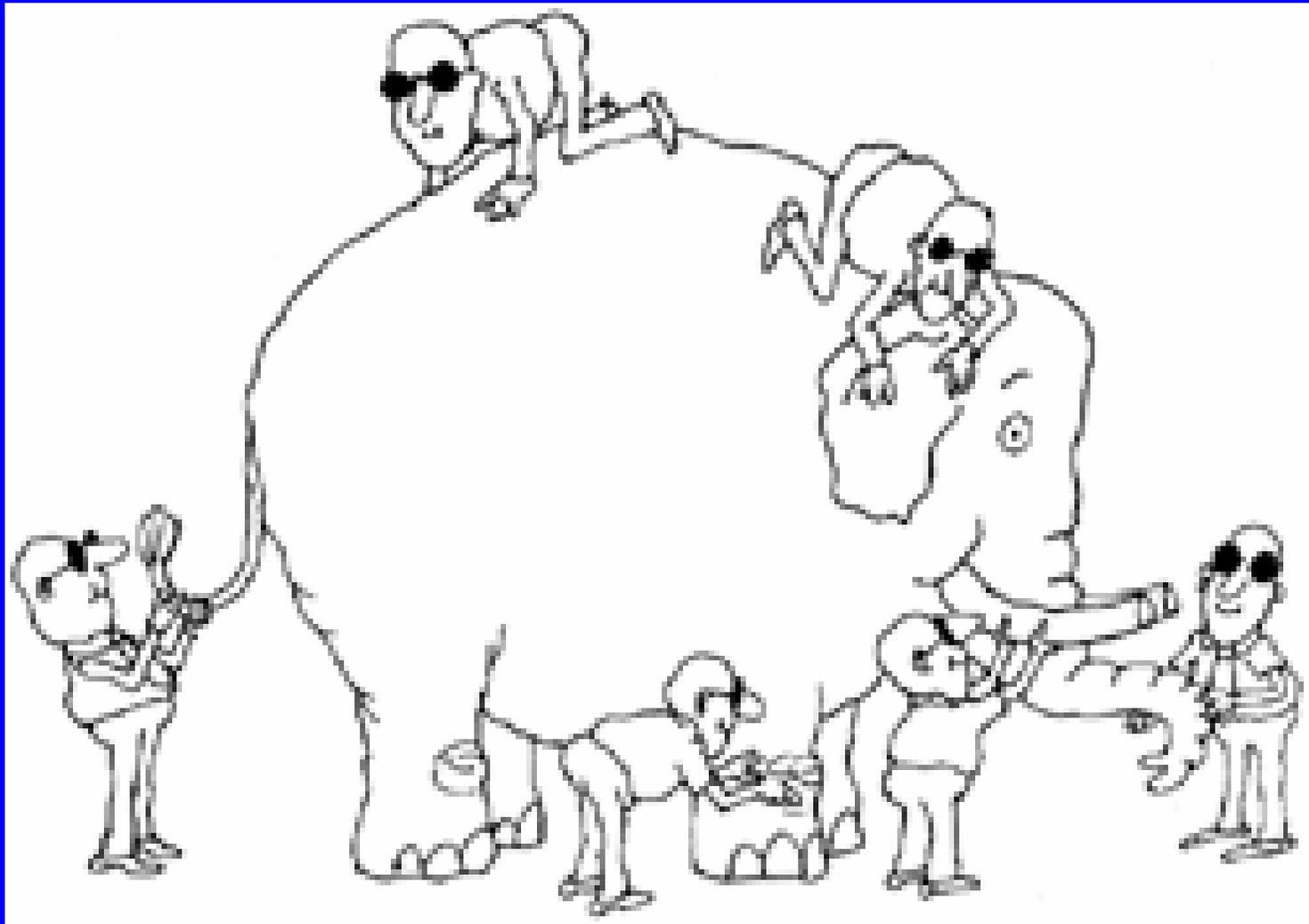
# Integration of STD and Viral Hepatitis Prevention in Program: Comprehensive STD Prevention System Projects Grant Program Guidance

- STD program managers encouraged to develop working relationships with other non-HIV public health programs...such as hepatitis B...
- As advances in diagnostic & therapeutic technologies for viral STD are made... they will demand increasing priority...Programs are strongly encouraged to work with NIP (and others...) to provide HBV vx for public & private high-risk clients...

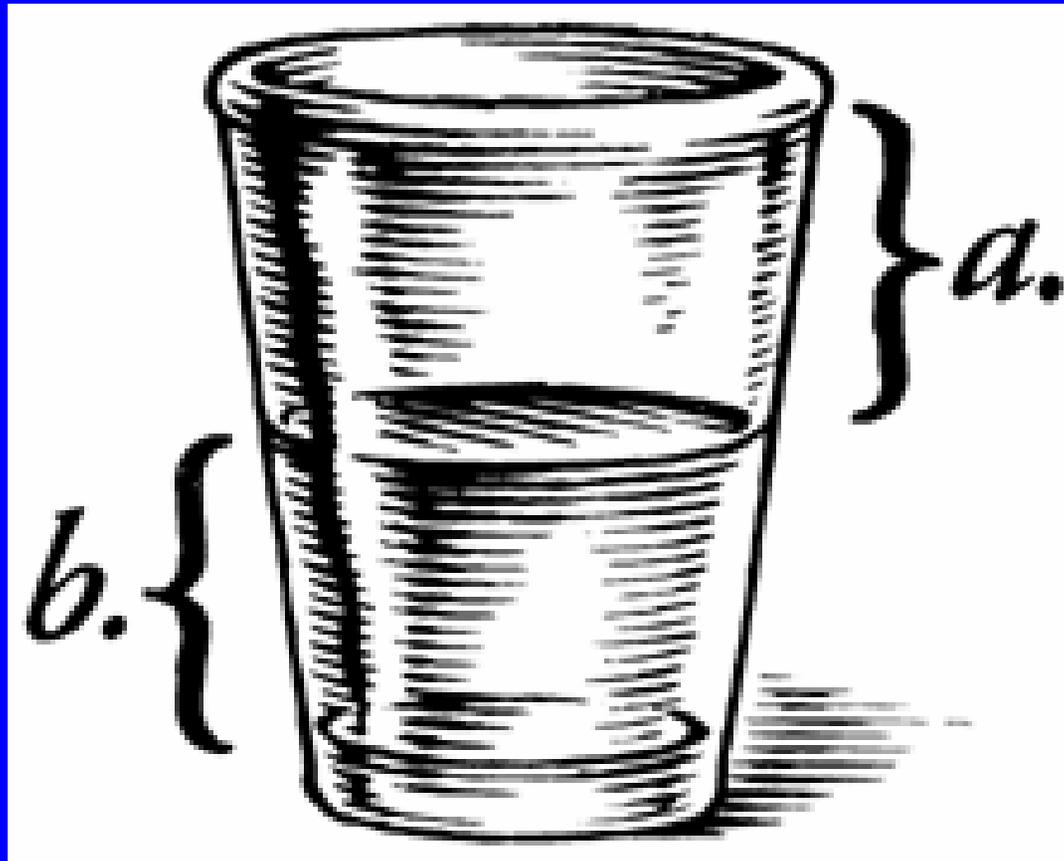
# Program Integration and DSTDP's '05 CSPS Program Announcement

- Encourage DSTDP's grantees to:
  - Collaborate and integrate with HIV and hepatitis prevention programs to serve groups at risk for or infected with all of these diseases.
  - Encourage providers to provide HIV, Hepatitis A&B vaccination, and STD screening in high prevalence settings.
  - Integrate HIV, hepatitis and STD prevention messages into health education messages.

# The Challenges of Integration



Is Integration happening?:  
It all depends on your point  
of view



# **DSTDP's efforts to enhance Integration**

- 10/03 – In response to a critical need to improve program integration activities within DSTDP
  - Developed new “lead” position within program branch.
- 4/7/04 – Recruited and hired “lead” program consultant at GS-14 level.

# DSTDP's efforts to enhance Integration (cont'd)

- Major responsibilities of this position:
  - Facilitate the integration of HIV and hepatitis in STD clinics and other non-traditional settings.
  - Identification of training needs and the provision of relevant training of PDSB program consultants specific to the integration/application of STD services within HIV and hepatitis programs.
  - Identification of state and local project area capacity to provide integrated services.
  - Participate in the monitoring, collection and evaluation of integration activities and the reporting of these data to the Director, DSTDP.
  - Serve as PDSB's representative in the development of programmatic research when indicated.

# Reasons to Integrate Viral Hepatitis, HIV/AIDS, and STD Prevention

- All major public health problems
- Routes of transmission overlap substantially & thus common prevention messages
- National programs exist for prevention of STDs and HIV/AIDS; yet most effective prevention approaches exist for viral hepatitis (eg, vaccines, screening of blood products)
- Lack of integrated prevention activities leads to ongoing transmission of all 3 (especially viral hepatitis)

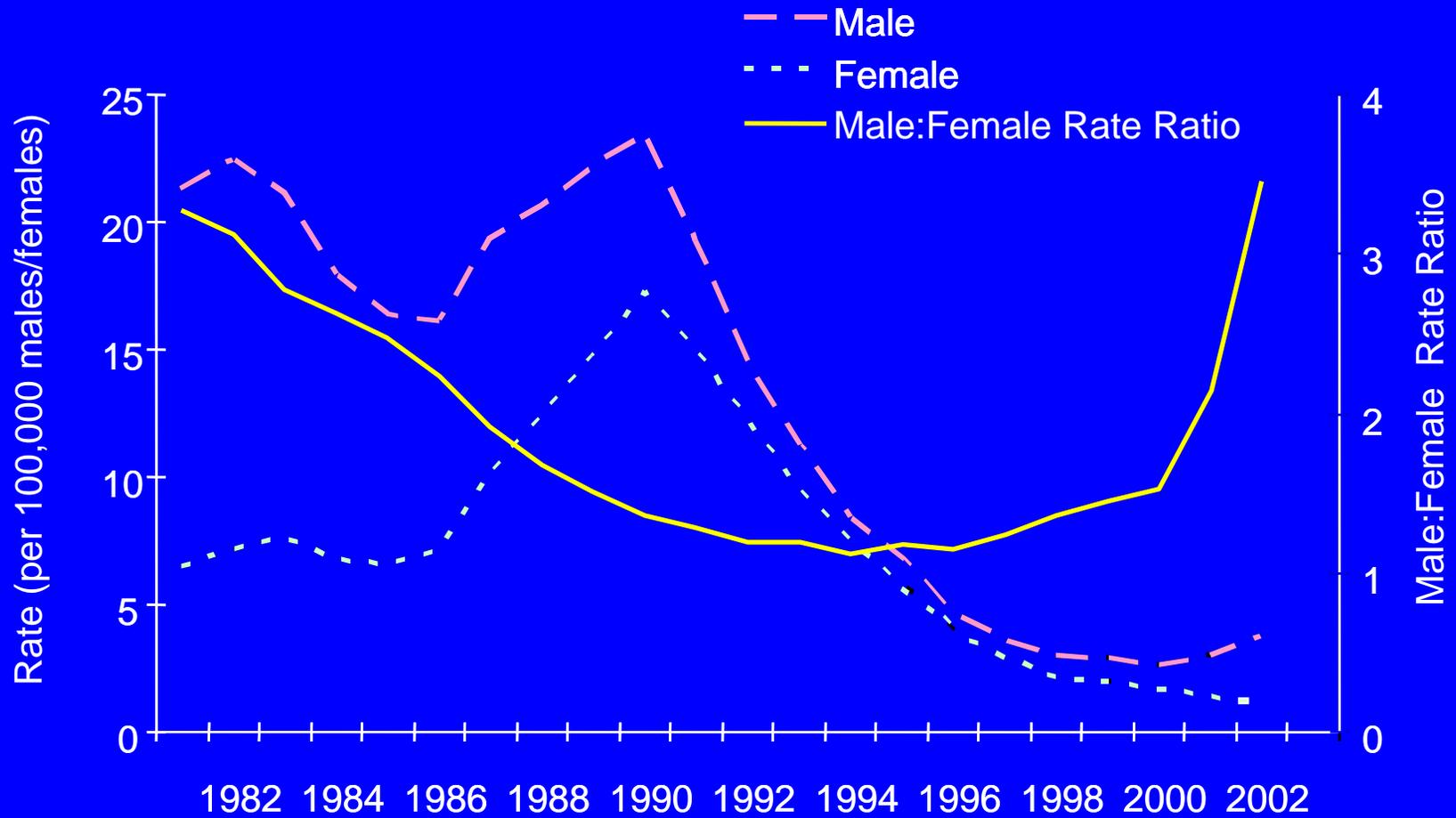
# Program Operations Guidelines (POG)

- DSTD's POG recommends that clinics collaborate with immunization programs and viral hepatitis programs to provide hepatitis B vaccinations to those at risk.
- The range of services provided by STD clinics should include basic STD prevention services emphasizing the particular needs of the at-risk populations within the community, including vaccination for viral hepatitis.

# *Comprehensive STD Prevention System Projects Grant Program*

- STD program managers should develop working relationships with other public health programs.
- Coordination and integration of STD prevention services with these programs, such as family planning, drug and alcohol, maternal and child health, **hepatitis B**, corrections, and other programs in primary care settings, should work toward assuring that funds are leveraged for appropriate STD prevention services.

# Primary/secondary syphilis, by year and sex: reported rates and male:female rate ratios United States, 1981-2002



# Findings from syphilis outbreak investigations, 2001

Characteristic	Miami	New York City	Los Angeles
No. of cases	50*	111**	171
Median age, yrs	33	34	35
Race/ethnicity			
White	27%	41%	38%
Black	10%	32%	14%
Hispanic	59%	22%	44%
Known HIV+	43%	53%	59%

\*January through June 2001 only

\*\*Primary & secondary syphilis only

## Number of Cases of Early Syphilis in MSM (% met on internet): preliminary program survey

		2001	2002	Jan-Jun 2003
<b>West Coast</b>	SF	(25%)	432 (33%)	284 (46%)
	LA	(13%)	520 (16%)	159 (25%)
	Seattle	50 (14%)	58 (18%)	38 (28%)
<b>East Coast</b>	Boston	—	95 (13%)	52 (30%)
	Miami	131 (7%)	206 (5%)	119 (9%)
	Ft Lauderdale	44 (2%)	183 (11%)	119 (18%)
	Prince George's Co., MD	—	25 (24%)	25 (16%)
	South Carolina	18 (0)	27 (11%)	31 (0%)
	Philadelphia	16 (2%)	32 (9%)	24 (0%)
<b>Midwest</b>	Columbus, OH	—	39 (0%)	42 (14%)
	Minnesota	—	—	45 (14%)
	Kansas	—	0	12 (17%)
	Illinois	—	48 (4%)	27 (13%)

# CDC's Response to Syphilis Outbreaks Among MSM

- \$4 million supplemental funding to 8 cities (FY2004)
- Internet conference (August 25-27, 2003)
- Work with NCSD/NASTAD
- Dear Colleague Letter on MSM (March 2004)
- Pro bono NPIN ads to AOL (2003-4)
- Meeting with non-traditional partners, July 2004
- Ongoing investigations in the 8 cities evaluating impact of syphilis on HIV transmission

# In 2002, the eight cities....

- Account for 30% of total P&S and 29% of early cases in 2002
- Account for 36% of male P&S and 35% of early cases
- Have M:F ratio of P&S 4 times greater than rest of the U.S. (9.2:1 compared to 2.3:1)
- Have M:F ratio of EL twice that of U.S. (3.1:1 to 1.7:1)

# Examples Integration – 7 MSM Cities

- **CHICAGO**
  - Building Community Advocacy
    - Host semi-annual Gay Men’s Health summits and an educational forum for community leaders and health care providers
- **FLORIDA (Miami, Fort Lauderdale)**
  - Recruitment of (POLs), popular opinion leaders, who are connected to establishments where as-risk sexual encounters occur to deliver individualized and small group education on bacterial STDs (with emphasis on syphilis), HIV, HPV, HSV and hepatitis
- **GEORGIA**
  - Establish a visitation program for medical providers (public and private) to heighten awareness about reporting, treatment, and partner notification services.
- **HOUSTON**
  - Expanded Testing and Treatment New mobile clinic
    - Rapid syphilis testing
    - Post-exposure treatment

# MSM Integration - 7 Cities (cont'd)

- **LOS ANGELES**

- Prevention Counseling
  - Assessing and updating risk reduction messages delivered by public health field staff, community outreach staff and STD clinic staff who screen or follow-up syphilis cases
- Training STD staff to deliver effective and consistent prevention messages.

- **NEW YORK CITY**

- Healthy Men's Night Out Project – Conducted every Thursday night in the epi-center of the syphilis outbreak
  - Coordinate on-site access to BP screening, smoking & other drug cessation services, domestic violence & depression screening, STD interventions (i.e. syphilis screening, urine-based GC/CT testing), vaccination for hepatitis A & B, hepatitis C counseling and testing, HIV counseling +/- rapid HIV testing, referrals for HIV care and understanding of partner notification services.

- **SAN FRANCISCO**

- Increased Access to Sustainable Syphilis Testing Services
- Develop testing services at community locations that are peer run and serve gay and bisexual men

# Prevalence of QRNG by sexual orientation, excluding Hawaii and California, GISP

	<b>MSM</b>	<b>Heterosexuals</b>
2001	0% (0/447)	0.03% (1/3936)
2002	1.8% (10/547)	0.2% (8/3740)
2003*	4.6% (20/438)	0.3% (11/3285)

\* Preliminary data

# Internet and STD: What we know about patient access (Rietmeijer C. STD 2003; 30:15)

- Survey of 4741 patients attending Denver STD clinic 9/00-5/01
- Internet access/experience

<u>Group</u>	<u>N</u>	<u>Internet access</u>	<u>Sex-seeking</u>	<u>Sex part.</u>	<u>Info seeking</u>
MSM	425	63%	29%	30%	42%
MSW	267	44%	4%	4%	27%
Women	1645	43%	1%	3%	25%

- Internet sex seeking more common in MSM, whites
- Internet sex partner more common in MSM
- 30% who met partners online denied using the Internet to *seek* sex

# What Internet-Based STI-Related Information Are STI Clinic Clients Seeking?

(Rietmeijer C. STD 2003; 30:15)

	Men %	Women %
General STD	66.0	62.9
HIV	36.8	34.9
HSV	22.8	32.6
Chlamydia	21.4	24.6
HPV	21.9	21.1
Gonorrhea	20.8	17.7
Syphilis	16.8	14.3
Other	9.8	8.0

# Potential Prevention Benefits of the Internet

- Potentially efficient approach to reaching large numbers of at-risk persons regarding prevention in general and disease-specific information (eg, syphilis outbreaks)
- Potentially effective approach to contact hard-to-reach populations who may not access more traditional approaches (eg, media, community forums, outreach venues)
- Supplemental approach to partner notification

# DSTDP Internet Alert

- Project initiated by CDC staff in 2000 to provide project areas information available on the Internet about sexual environment of their area. Three types of alerts now provided
  - Full Internet Alerts -- compilations of all information about bars, bathhouses, sex clubs, public sex environments, sex parties, circuit parties, and raves in a program area.
  - Alerts At-A-Glance -- brief notifications of upcoming, large-scale events in a program area.
  - The 3-Month Calendar -- a quarterly notification of all circuit parties and other large-scale social/sexual events occurring across the nation and in commonly accessed cities in Canada and Mexico.

# CDC Response to QRNG

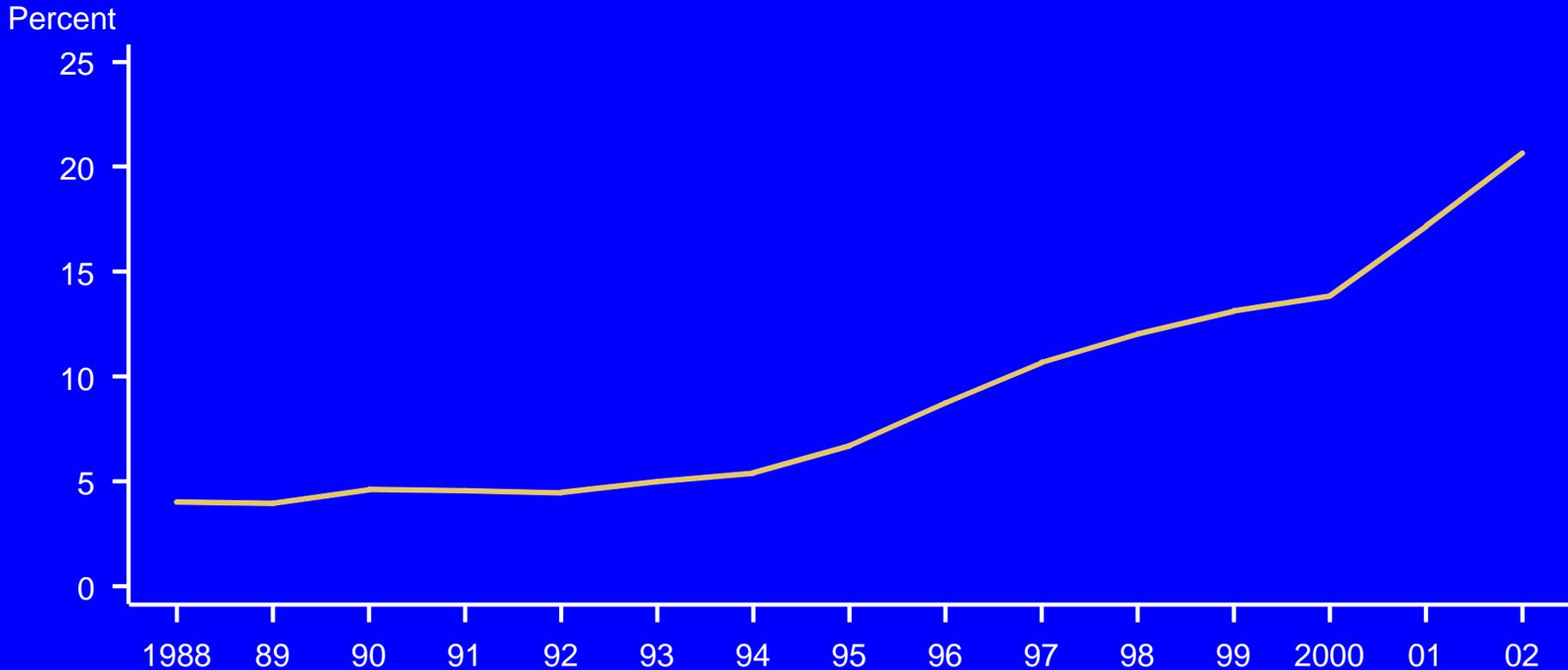
- **MMWR**
  - Fluoroquinolones should not be used in MSM
  - Clinicians should be alert to treatment failures and prepared to culture
- **Notified state and local health departments of QRNG increases (Epi-X Notice, June 2003)**
- **Added 2 new GISP sites in 2002 and 4 in 2003**
- **Funded California to evaluate cefpodoxime 400mg for treating GC**
- **Discussions with FDA to explore additional treatment options**

# When integration doesn't work so well...

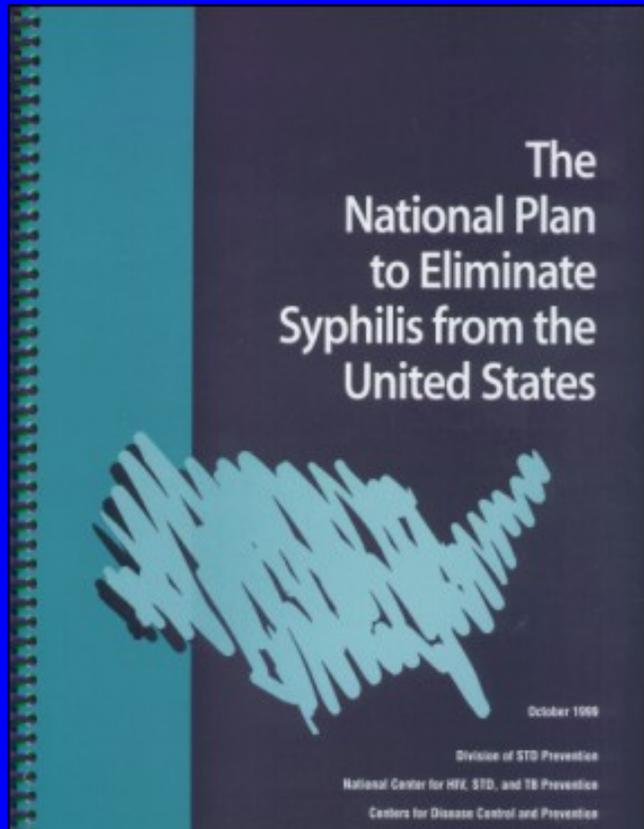
## New drugs urged for resistant gonorrhea

Spurred by an alarming rise in drug-resistant cases of gonorrhea, the government is expected to recommend this week that doctors switch to another antibiotic for treating the sexually transmitted disease, top experts say. The class of antibiotics commonly used, including Cipro, is no longer effective against certain strains of the bacteria, says Jeffrey Klausner, director of STD prevention for the San Francisco Department of Public Health. In place of Cipro, which is administered as a pill, the Centers for Disease Control and Prevention is expected to recommend the antibiotic ceftriaxone, which is less convenient because it is injected, says Klausner, who worked with the CDC on its new guidelines. Another recommended drug, cefixime, is in pill form but is no longer made in the USA. A CDC spokeswoman said the agency would announce new recommendations Thursday.

# Gonococcal Isolate Surveillance Project (GISP) — Percent of gonorrhea cases that occurred among MSM, 1988-2002



# The National Plan to Eliminate Syphilis from the United States



To reduce primary and secondary syphilis cases to 1,000 or fewer, and increase the number of syphilis free counties to 90%.

Launched October 1999

# Manifesto Purpose

- To define our (Task Force) demands, values, & vision for a healthy Gay community
- To build an HIV responsive community
- To promote ideas that will help people feel supported
- To help establish healthy Gay community norms
- To promote the idea that we should treat each other with value as human beings, instead of as objects
- To issue a call to action that "micro-organisms don't care about us, but we can care about ourselves"

# Sexual Health: Surgeon General's Call to Action (July 2001)

- Surgeon General's Call to Action (July 2001)
  - Focuses on the need to promote sexual health and responsible sexual behavior across the lifespan
  - Primary goal is stimulate respectful, thoughtful, and mature discussion in our communities and in our home about sexuality.
  - It is necessary to find common ground—balancing diversity of opinion with the best available scientific evidence—to improve the health of our nation
  - While sexuality may be difficult to discuss for *some...we cannot afford consequences of continued or selective silence*

# Integration of Prevention Programs for STD, HIV, and Viral Hepatitis

- Major public health problems with overlapping routes of transmission
- National programs exist for prevention of STDs and HIV/AIDS, with inter-programmatic collaboration and integration increasing
- Integrated prevention activities for viral hepatitis in existing public health settings now underway in STD clinics, HIV counseling sites, drug RX clinics, correctional care
- Resurgence of risk behavior in MSM is creating opportunities at all levels for integration

# Response to Increases in Syphilis Among MSM

- Mid-2002, NCHSTP formed cross-division (STD/HIV) workgroup to address increases in syphilis among MSM
- December 2002, Dr. Jaffe charged group with developing city profiles, conducting assessments and assisting areas with the greatest number of early cases among MSM
- Eight cities identified; profile instrument developed
- February 6, 2003, the eight cities were contacted
- March, site visits conducted

# **Eight U.S. Cities with >100 cases of early syphilis among MSM 2002**

- Atlanta
- Chicago
- Ft. Lauderdale
- Houston
- Los Angeles
- Miami
- New York City
- San Francisco

# 8-City Meetings-Things That Worked

- Social Marketing
- Testing and reporting
- Community advocacy
- Outreach and Partner Notification
- Collaboration

# 8-City Meetings-Barriers

- Stigma
- Physicians not discussing at-risk behaviors
- Message fatigue
- Drug use
- Funding

# STD Control and Prevention in MSM: What Can We Do?

- Public health
  - Screening (outreach settings, on-line)
  - Social marketing/targeted public awareness regarding signs/symptoms
  - New approaches to partner services (on-line contact, partner-delivered oral RX)
- Providers
  - Awareness of signs, symptoms to enhance DX, RX
  - Screening for STD/HIV, risk reduction counseling
- Community
  - Discussion of and mobilization around norms for safer sexual practices



# Integration of STD and HIV Activities within DSTDP

- Program:
  - up to 10% of local STD control activities devoted to HIV prevention (with cross-funding)
  - strong encouragement that integration of HIV & STD prevention services “is necessary and cost-effective, and should be accomplished to reduce the transmission of all STDs including HIV”

# Integration of STD and Viral Hepatitis Prevention: Reflections for the Future

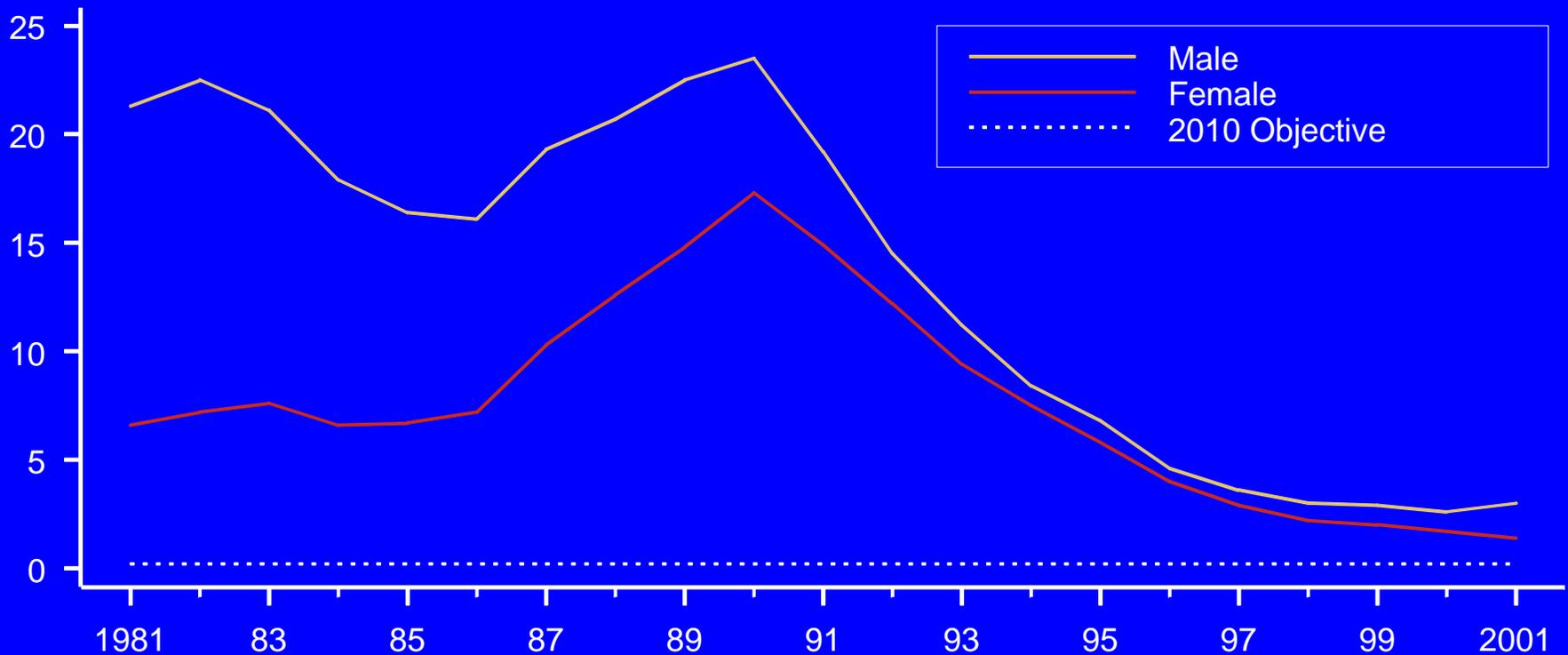
“Integration is important because not too far down the line, there will be vaccine-based strategies for STD which could potentially exist within 5 yrs...So we’ve got to set this up now so that immunization is linked to the programs that are doing behavioral prevention...Part of the issue...is that they’re all childhood immunization programs. And we’re talking about adult immunization.” (NASTAD HIV Prevention Bulletin Sept 2001)

# National Network of STD/HIV Prevention Training Centers (PTCs)

- Integration of HIV/STD and Viral Hepatitis Prevention and Treatment Services' Needs Assessment
- Survey to develop and determine interest in, and capacity for, integrating viral hepatitis counseling and testing with existing prevention and treatment services (April 2000)

# Primary & secondary syphilis: reported rates by sex, 1981– 2001

Rate (per 100,000 population)

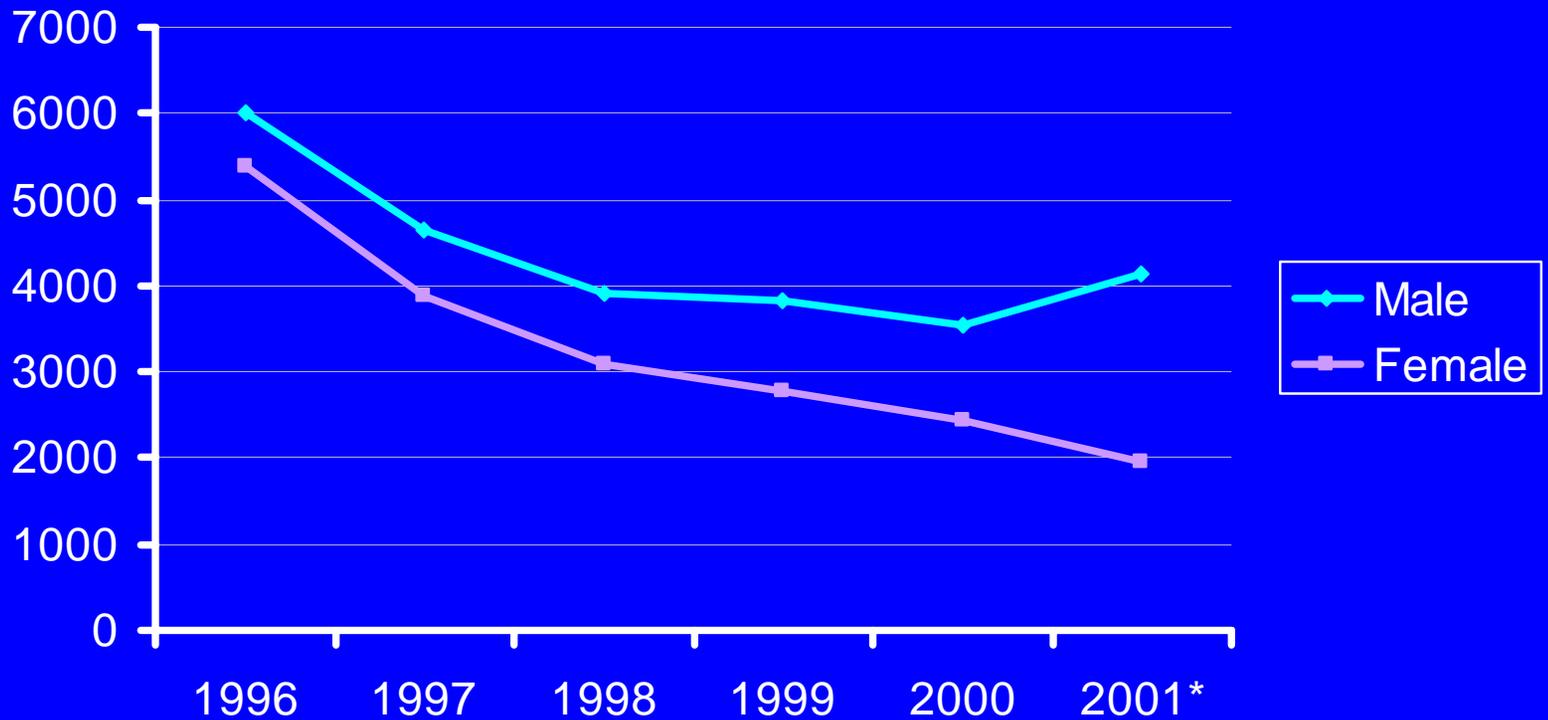


# Spring Meeting - May 12 & 13

- Composed of DHAP and DSTD project representatives, community members, and members of NCSD and NASTAD
- Overview of profiles, approaches to date, and lessons learned
- Discuss and consolidate common intervention areas
- Discuss next steps for supplemental applications

**Integration of STD and Viral  
Hepatitis Prevention  
Activities Within DSTDP**

# P&S Syphilis Cases by Gender, U.S., 1996-2001



# P&S Syphilis 2000 - 2001

Characteristic	2000		2001	
	No.	Rate	No.	Rate
<b>Sex</b>				
Male	3,532	(2.6)	4,144	(3.0)
Female	2,445	(1.7)	1,967	(1.4)
<b>Race/Ethnicity</b>				
White, non-Hispanic	1,083	( 0.5)	1,387	( 0.7)
Black, non-Hispanic	4,233	(12.2)	3,813	(11.0)
Hispanic	567	( 1.6)	754	( 2.1)
Asian/Pacific Islander	37	( 0.3)	55	( 0.5)
American Indian/Alaska	52	( 2.4)	90	( 4.2)
<b>Native Region</b>				
Northeast	371	( 0.7)	613	( 1.1)
Midwest	1,274	( 1.8)	1,191	( 1.8)
South	3,704	( 3.7)	3,429	( 3.4)
West	630	( 1.0)	870	( 1.4)
<b>Total</b>	<b>5,979</b>	<b>( 2.1)</b>	<b>6,103</b>	<b>( 2.2)</b>

# Advisory Committee on HIV & STD Prevention: Workgroup on STD/HIV Integration Meeting--10/02

- Issues raised
  - what is “integration”?---must occur at the client level
  - framing of the issue often difficult (eg.what does this mean: money, staff, messages, planning, etc??)
  - programs aware of need for integration, but limited knowledge of actions to take/degree to which CDC prioritizes integration (eg, reluctance to provide feedback to CDC--”the answers will come back to bite us...”)
  - cultural, resource, and institutional issues serve as barriers
  - integration must translate to effective service delivery & care to be relevant (eg, problem of allowing STD screening but not RX with HIV prevention funds)

# “Integration”: what does this mean?

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

(NASTAD HIV Prevention Bulletin Sept 2001)

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- **Training:** PTC curriculum modules on HIV prevention
- **Guidelines:** STD Treatment Guidelines sections on Clinical Prevention Guidelines, Special Populations (MSM), and HIV Infection

# Need for Expanded Risk Assessment and Screening Among Gay and Bisexual Men

- *The 2002 STD Treatment Guidelines* urge health care providers to assess the sexual risk for all male patients, including the gender of partners. For MSM patients who are sexually active, the guidelines recommend annual screening for STD-HIV, Chlamydia (anal, urethral), syphilis and gonorrhea (anal, pharyngeal, urethral) – and vaccination against hepatitis A and B

**Integration of STD/HIV activity  
at CDC: Response to  
Outbreaks of Syphilis in MSM**

# The Internet and STD Prevention

- Growing data of the importance of the internet as an environment contributing to STD transmission
- There are gaps in scientific data and programmatic guidance in a variety of areas:
  - Online facilitation of STD/HIV testing
  - Online pre- and post-test counseling
  - Online referrals to STD and HIV testing and treatment centers
  - Online partner notification
  - Online behavioral interventions
  - Online research efforts
  - Ethics and Privacy issues