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STD Program Management

STD Clinical and Laboratory Services Prerecorded Module



National
Network of
**STD
HIV**
Prevention
Training Centers



CDC
CENTERS FOR DISEASE
CONTROL AND PREVENTION

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Participant Objectives

- ❑ Describe the role of medical and laboratory services in a comprehensive STD program
- ❑ Describe core components of STD clinical and laboratory services
- ❑ List 5 methods to improve access to STD clinical services
- ❑ Discuss 3 strategies to leverage partnerships for delivery of STD clinical and laboratory services
- ❑ List 4 ways to conduct clinical and laboratory provider education

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STD Clinical & Laboratory Management Issues and Activities

- ❑ Accessibility
 - Categorical clinics
 - Public health laboratory
 - Public-Private partnerships
- ❑ Quality Assurance
 - Clinical
 - Laboratory
- ❑ Clinical and laboratory provider education
 - Promotion of STD guidelines, policies, compliance
 - Consultation and technical assistance
 - Advocacy and Policy
- ❑ Resources, Policy and Priority Setting

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Public Health Department Core Components

- Monitor health status to identify health problems
- Diagnose and investigate health problems and hazards
- **Inform, educate** and empower people about health issues
- **Mobilize partnerships** to identify and solve health problems
- Develop policies and plans that support individual and statewide health efforts
- Enforce laws and regulations that protect health and ensure safety
- **Link people** to needed personal health services and assure the provision of health care otherwise unavailable
- **Assure competent** public and personal care workforce
- **Evaluate effectiveness** and accessibility and quality of personal and population based health services
- **Research new insights** and innovative solutions to health problems

National Coalition of STD Directors, 2009
www.ncsddc.org/upload/vyslvwyg/documents/2009_Core_Components.pdf

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Clinical and Laboratory Strategies for STD Prevention

- ❑ Education and counseling (individual-level)
- ❑ Screening (Identification of asymptomatic infection)
- ❑ Clinical diagnosis and treatment
- ❑ Case and partner management
- ❑ Pre-exposure vaccination

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Categorical STD Clinics

- ❑ High volume clinics with drop-in services assure access-to-care, disease intervention, and "safety net" health services
- ❑ Specialized clinical and disease management services
 - Experienced STD clinical specialists
 - Specialized laboratory diagnostic testing
 - Expert consultation
- ❑ Specialty referral center
- ❑ Site for disease surveillance activities, public health intervention, program development
- ❑ Serve as training site




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Typical Clinical Services Found at Categorical STD Clinics

- STD screening, testing, evaluation & treatment
- STD/HIV prevention counseling
- STD/HIV laboratory services
- Partner Management, Disease Intervention and Referral Services
- Cervical cancer screening & family planning
- Hepatitis vaccinations
- Condoms

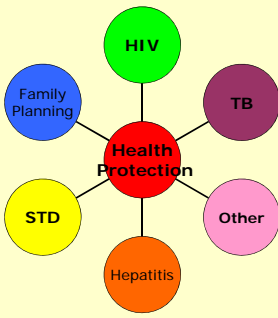



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Integrated Services & Activities

- STD Clinics ideal site for Program Collaboration and Service Integration (PCSI)
- Integrated, Holistic, Connected, Client-focused, Leveraged Services





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STD Clinic Laboratory*

- Laboratory within or adjacent to STD Clinic staffed by trained laboratorians (a.k.a. "STAT Lab")
- Point-of-care tests include:
 - Provider-performed microscopy
 - Dark-field Microscopy*
 - Gram stain*
 - Urinalysis
 - Pregnancy testing
 - HIV rapid test
 - RPR*

*NOT available in many settings

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Public Health STD Laboratory

- Part of Public Health infrastructure
- Performs high-volume STD screening and confirmatory testing
- Often serves as reference laboratory
- Serves role in public health and laboratory disease surveillance
 - E.g. Gonococcal Isolate Surveillance Project
 - E.g. Acute HIV pooled-RNA testing
- Offers specialized tests not available elsewhere

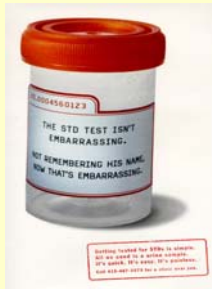


Innovations in STD Laboratory Services

- Laboratory science constantly evolves
- Major trends in STD laboratory diagnostics
 - More sensitive tests (e.g. NAATs, molecular diagnostics)
 - Point-of-care tests (e.g. HIV rapid tests)
 - Easier collection methods (e.g. urine test, self-collected vaginal swab)
- Advances must be incorporated into public health practice



New STD Diagnostic Technology: Urine-Based Tests



- Nucleic Acid Amplification Tests (NAATs) for gonorrhea and Chlamydia
- Highly accurate
- Non-invasive collection
 - High patient acceptability
 - Appropriate for screening asymptomatic persons
- Allows screening in non-traditional settings
 - Community settings
 - Correctional settings
 - Schools

STD Clinic Staff

- STD Clinicians
 - Doctors, Nurse Practitioners, Nurses, Physician Assistants
- Clinical Support Staff
 - Clerks, Medical Assistants, Health Educator, Counselors, Interpreters
- Laboratory Staff
 - Laboratory Technicians, Laboratory Director
- Disease Intervention Specialists
- Supervisors, Clinic Manager
- Information Technology Staff



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Physician's Standing Orders

- Standing orders can authorize non-physician providers (nurses, medical assistants, disease intervention specialists) to administer tests and/or medications according to an institution- or physician-approved protocol without a physician's exam.
 - May be useful for asymptomatic low-risk clients presenting for STD screening
 - May be used to treat patients with treatment lapses
 - Governed by state and local laws or regulations



STD Clinic Operations

- Patient Flow Management
 - Numbers/Letters, Walk-in vs. Scheduled appointment
 - Patient triage, Fast-Track Services
- Medical Records Documentation
 - Paper Charts vs. Electronic Medical Record
 - Surveillance Data access
- Materials Management
 - Clinic and laboratory supplies
 - Medication distribution
- Facilities Management



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STD Clinic Management Issues

- Clinical Quality Assurance Monitoring
 - Chart reviews to measure compliance with STD treatment guidelines
 - Patient satisfaction surveys
- Data and Performance Management
 - Patient care delivered
 - Clinic Productivity
 - Monitoring disease trends
- Funding for STD Clinics
 - Supported by state and local governments
 - Fees and Billing (e.g. Medicaid, Medicare)



Disease Intervention Opportunities in STD Clinics

- Symptomatic and asymptomatic higher-risk patients present for care in STD Clinics
 - Referred by external providers
 - Self-referred
 - Partners of known cases of disease
- Embedded Disease Intervention Specialists can:
 - Interview patients
 - Elicit and treat sexual partners
 - Follow-up on treatment lapses
 - Counsel high-risk patients



Surveillance Role of STD Clinics

- Sentinel clinic for detection of STDs
 - E.g. LGV first identified by astute clinicians in STD clinics in U.S. (2004)
- STD prevalence monitoring site
 - Genital Wart surveillance to assess impact of HPV vaccine
- Monitoring of behavioral trends
 - E.g. MSM Prevalence Monitoring Project
- Special public health investigations

But what do we do if we do NOT have an STD clinic?

...then develop partnerships and leverage your resources.

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Establishing Partnerships to Assure Access to STD Services

- Developing partnerships can meet the shared goals STD programs and community agencies
- Programs can leverage available resources to assure access to clinical services
 - Medications, Lab Tests, and Staff
 - Technical Assistance and Program Guidance
 - Funding Support
 - Contractual Agreements



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Examples of partnerships to assure access to clinical services

- STD screening & treatment in...
 - School-based health centers
 - Correctional settings
 - Drug treatment centers
 - Family Planning settings





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Examples of partnerships to assure access to clinical services

- STD screening & treatment in other settings that serve clients at high-risk
 - Sex worker clinic
e.g. St. James Infirmary, San Francisco
 - LGBT Health Centers
e.g. Howard Brown Health Center, Chicago; Fenway Health Center, Boston
 - Adolescent and Teen Clinics







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Additional Quality Improvement and Quality Assurance Activities


- Can be provided to county health departments or other partner agencies in form of
 - Technical assistance
 - Program Evaluation and Guidance
 - Summaries of Deficiencies and Recommendations
 - Trainings
- Conduct annual surveys of clinical & laboratory services

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Federal, State, and Local Laws Relevant to STD Clinical Programs

- Health Insurance Portability & Accountability Act (HIPAA) of 1996
- Communicable Diseases, HIV/AIDS & Sexually Transmitted Diseases Control Acts
- HIV confidentiality and testing regulations
- Child abuse & sexual abuse reporting laws
- Adolescent & reproductive health access laws
- School-based health centers (SBHC) & Federally-qualified health centers (FQHC) laws
- Clinical Laboratory Improvement Act (CLIA) of 1998
- Expedited Partner Therapy (EPT) laws or regulations




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Clinical and Laboratory Provider Education

- Individual provider-level training
 - Presentations, lectures
 - Grand Rounds conference
 - STD Conferences
- Consultation
 - Patient referral
 - Contact with providers
 - Public health case management
- Clinical training for students, residents, fellows, and physicians




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Clinical and Laboratory Provider Education



- Community-level provider education
 - Provider letters
 - Health alerts
 - Dissemination of materials (e.g. STD treatment guidelines)
- Capacity building to support STD services
 - E.g. Urine-based testing and specimen collection
 - E.g. Phlebotomy training



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Distribution of STD Treatment Guidelines

- CDC STD Treatment Guidelines
 - Summarizes evidence-based review of literature
 - Provides guidelines for STD treatment in the United States
 - Updated every four years www.cdc.gov/STD/program/default.htm
- Guidelines disseminated through CDC, state, and local health departments

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Case Study #1: Scenario (1)

- You are the STD Program Manager in the Quaker State Department of Public Health (QSDPH). You are responsible for STD (gonorrhea, syphilis, Chlamydia, chancroid, and herpes), HIV, Hepatitis, Leishmania, and TB Prevention and Control.
- Quaker is a small rural state with a total population of under 900,000 people, does not have any categorical STD clinics, and has a low-moderate morbidity of reported STDs. You are one of three QSDPH staff responsible for STD disease control programs and activities.

Case Study #1: Scenario (2)

- The QSDPH Health Commissioner informs you that end-of-the-year one-time resources are being directed to your program that include:
 - \$20,000 in one-time funds
 - 30,000 doses of antibiotics to treat STDs
 - 5,000 doses of hepatitis A and B vaccines

Case Study #1: Questions (1)

- What is your strategy to use these resources effectively?
- How will you allocate the \$20,000 in one-time funds?
 - Will you allocate money for research, training, screening, testing, contracts, travel, marketing programs, or other program?
 - What are these decisions based?
 - Provide justification for your allocation.
- What will you do with the 30,000 doses of antibiotics and the 5,000 doses of hepatitis vaccines?
 - To whom would you distribute? Why?
 - How would you determine who receives support?
 - Describe the agencies that will receive this support?

Case Study #2: Scenario (1)

You are the STD Program Manager in the Future State Health Department (FSHD) responsible for STD/HIV Prevention Services.

You manage one (1) categorical FSHD STD clinic and one (1) FSHD HIV Clinic.

The FSHD operates three (3) Family Planning clinics strategically located throughout the state in the state's three largest cities, and partners with one community-based organization.

Case Study #2: Scenario (2)

Future is a mid-sized state with a total population of over 8 million residents. The largest city, Disney (population 1.2 million residents), is a diverse and sprawling city with large multicultural and gay communities.

Disney residents are very vocal and outspoken about many issues, except residents are very reluctant to discuss any issue pertaining to human sexuality, STDs, and HIV.

Disney is a High Morbidity Area for STDs and HIV. There are three (3) school-based health centers in the area high schools, a community college, a large university, and there is a large county jail in the city. There are many active senior and faith-based organizations in Disney.

Case Study #2: Scenario (3)

- Unfortunately, budget shortfalls this year have resulted in substantial service cuts. The Governor has decided to close the FSHD Disney STD clinic, the only STD clinic in the state; however the STD program still retains federal grant funding for STD control efforts of over \$500,000 per year.

Case Study #2: Questions (1)

- ❑ How will you assure access to STD clinical services for the residents in the state of Future and in Disney?
- ❑ What resources are available to you?
- ❑ How will you allocate the federal grant funds for STD control?

Case Study #2: Questions (2)

- ❑ What partnerships are available to you?
- ❑ Who are your allies in STD/HIV prevention?
- ❑ What are ways for you to build STD service capacity in the community? And in the State?
- ❑ What is your strategy to engage the Governor?

References

- ❑ CDC STD Treatment Guidelines (www.cdc.gov/std/treatment)
- ❑ National Coalition of STD Directors (www.ncsddc.org)
- ❑ American Social Health Association (www.asha.org)
- ❑ CDC Program Operations Guidelines (www.cdc.gov/STD/program/default.htm)
- ❑ National Network of Prevention Training Centers (www.nnptc.org)

STD Clinical and Laboratory Services

Case Study Work Sheet

Case Study # 1 – Quaker State

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Quaker State, a small rural state with a total population of under 900,000 people, does not have any categorical STD clinics, and has a low-moderate morbidity of reported STDs. You are one of three QSDPH staff responsible for STD disease control programs and activities.

The QSDPH Health Commissioner informs you that the following end-of-the-year one-time resources are being directed to your program:

- o \$20,000 in one-time funds
- o 30,000 doses of antibiotics to treat STDs
- o 5,000 doses of hepatitis A and B vaccines

Questions:

- 1) What is your strategy to use these resources effectively?

- 2) How will you allocate the \$20,000 in one-time funds?
 - a. Will you allocate money for research, training, screening, testing, contracts, travel, marketing programs, or other programs?

 - b. On what did you base your decisions?

 - c. Provide justification for your allocation.

- 3) What will you do with the 30,000 doses of antibiotics and the 5,000 doses of Hepatitis vaccine?
 - a. To whom would you distribute? Why?

 - b. How would you determine who receives support?

 - c. Identify which agencies (name and/or type) will receive this support.

STD Clinical and Laboratory Services

Case Study # 2 – Future State, City of Disney

You are the STD Program Manager in the Future State Health Department (FSHD) responsible for STD/HIV Prevention Services – which are limited to one (1) categorical FSHD STD clinic and one (1) FSHD HIV Clinic.

The FSHD operates three (3) Family Planning clinics strategically located throughout the state in the state's three largest cities, and partners with one community-based organization.

Future is a mid-sized state with a total population of over 8 million residents. The largest city, Disney (population 1.2 million residents), is a diverse and sprawling city with large multicultural and gay communities.

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Unfortunately, budget shortfalls this year have resulted in substantial service cuts. The Governor has decided to close the FSHD Disney STD clinic, the only STD clinic in the state; however the STD program still retains federal grant funding for STD control efforts of over \$500,000 per year.

Questions:

- 1) How will you assure access to STD clinical services for the residents in the state of Future – and in the city of Disney?
- 2) What resources are available to you?
- 3) How will you allocate the federal grant funds for STD Control?"
- 4) What partnerships are available to you?
- 5) Who are your allies in STD/HIV prevention?
- 6) What are the ways for you to build STD service capacity in the community?
- 7) And in the state?
- 8) What is your strategy to engage the Governor?

Suggested Pre-Course Reading

Pre-Course Handouts



- Handout 1: Definitions to Build a Framework for Cultural Competence
- Handout 2: Disparity Analysis: Health Care Barriers for African Immigrants with HIV/AIDS (example of reaching a culturally unique, high priority, small size community)
- Handout 5: Patient Centered Care and Culturally Competent Care

STD Program Management

Cultural Competence in STD Programs Prerecorded Module



Objectives

- Define culture
- Describe the concepts of cultural competence
- Discuss the impact of cultural competence in STD programs
- Identify essential skills necessary for the delivery of culturally competent services
- Describe strategies to improve the cultural competence of STD staff and programs
- Develop specific action steps for building cultural competence of STD program staff

What Is Culture?

- ▣ Culture is comprised of interrelated systems
- ▣ Characteristics of Culture
- ▣ Subgroups and Subcultures



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Examples of cultural groups

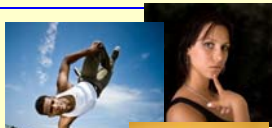


- ▣ "Mainstream" U.S. culture
- ▣ Ethnic groups
- ▣ Racial identity groups
- ▣ Regional groups within a country
- ▣ Occupational/professional groups
- ▣ Experiential subcultures
- ▣ **Intersections of the above—people belong to many cultural groups**

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Minorities within minorities

- ▣ Racial identity
- ▣ Gender
- ▣ Sexual Behavior
- ▣ Age
- ▣ Religion
- ▣ Ethnicity

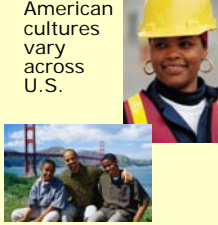


Race categories and culture

U.S. government & health care collect information about race. What is the relationship of race to culture?

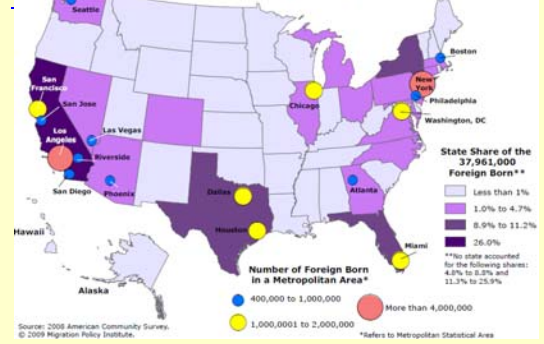
Ethnic Diversity of African Diaspora in the U.S.

- African American cultures vary across U.S.
- African refugee groups have settled in MN, D.C., San Diego, GA



State Proportion of the Foreign-Born Population in the United States

And Metropolitan Areas with 400,000 Foreign Born or More



Context is (almost) everything



Reuters / All Jarecki

Mapping influences of culture in ourselves, our clients and our staff

Complete exercises in *Packet 3-Staff-Prg-CultComp-Exercises-Binder-2.8.11pdf*.

- Exercise 1 – Layers of Culture and Cultural Identification
- Exercise 2 – Mapping the Cultural Contexts Of STD & HIV/AIDS Clients and Health Care Workers
- Exercise 4 – Organizational Self-assessment—Staff Demographics and Positions (*If possible*)

Ethnomedicine and the Cultural Context of Illness



- Etiquette that generates trust
- Different ethnomedical systems, U.S. & int'l:
 - Types of healers
 - Roles of healer/patient
 - Illness beliefs, explanatory models
 - Treatment practices

Health Beliefs are not mutually exclusive



A Paul Farmer example...

Source: Tracy Kidder. *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, a Man Who Would Cure the World*. Random House, 2003, pp. 33-35.

Cultural Competence



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Cultural Competence Is:

- ❑ Understanding cultural influences
- ❑ Showing sensitivity and respect
- ❑ Anticipating, recognizing, and addressing misunderstandings
- ❑ Promoting health equity



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Everyone needs Cultural Competence

- ❑ To work in one's home culture, or across familiar cultures
- ❑ To learn about, relate to, and communicate with people who are different from themselves
- ❑ To build trust and rapport with their patients and partners
- ❑ To work effectively with their patients' partners

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Influences of Culture

- Culture shapes the U.S. economic, political, and social systems
- Culture shapes attitudes and beliefs about specific groups
- Culture shapes patients' health beliefs and practices



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Cultural Competence is necessary because...

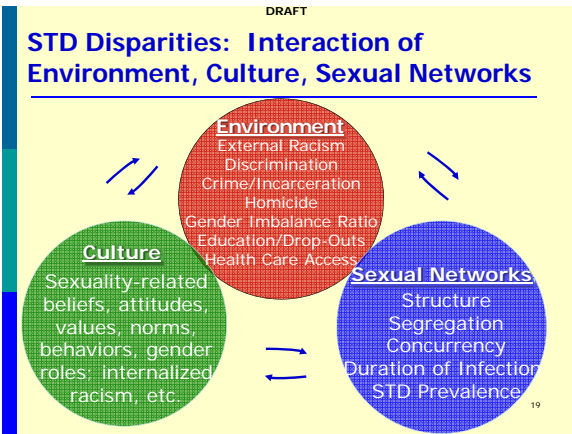
- Clients come from every cultural group or subculture
- Health care staff don't share the cultural backgrounds of many clients
- Clients and staff don't experience all of the same social structural influences in their lives
- Stigma of STDs and HIV/AIDS in all groups

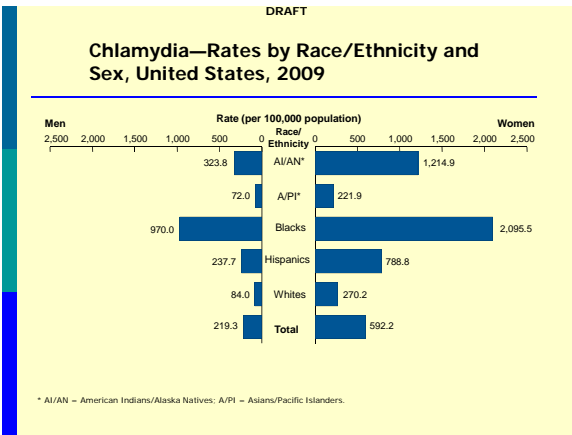
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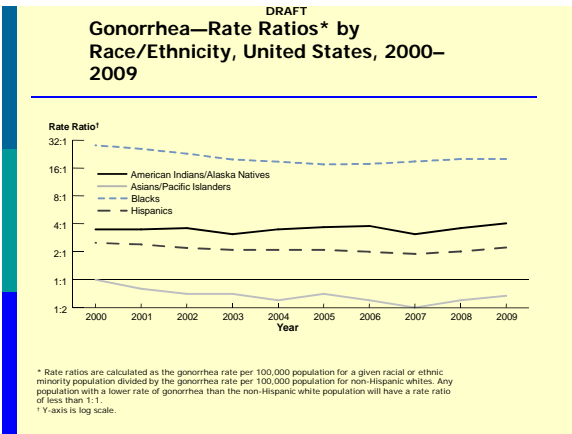
Specific Cultural Aspects of HIV/AIDS—and STDs

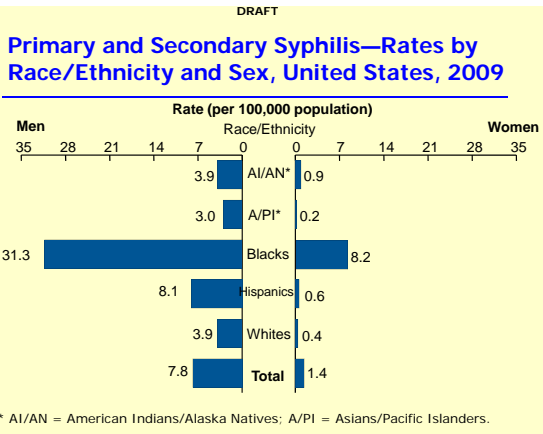
- **Or, no wonder it's so complicated!**
- Cultural aspects of HIV/AIDS are especially loaded in every culture. They are:
 - highly significant
 - surrounded with symbolism
 - include explicit and implicit meanings
 - involve social expectations, requirements, prohibitions, and moral implications

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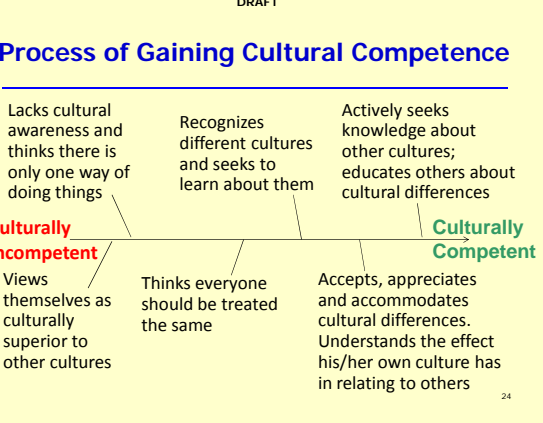


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Benefits of cross-cultural health care and cultural competence

- Cultural competence can lead to:
 - reduced disparities
 - reduced incidence overall
 - improved patient outcomes
 - improved patient satisfaction
 - more effective program collaboration & service integration



Developing Culturally Competent Staff and Programs

Cultural Competence Skills



Institute Strategies to Build Programmatic Cultural Competence

- Develop Organizational Commitment
- Develop Policies that Support Cultural Competence
- Institute Action Steps
 - Reduce Language Access Barriers
 - Build Support for Cultural Practices
 - Identify Resources for Cultural Knowledge
 - Build Community Partnerships

Establish Goals for Achieving a Culturally Competent Program

"Our organization will..."

- Value diversity in all forms
- Engage in cultural self-assessment
- Manage dynamics of cultural difference among staff and with clients
- Acquire and institutionalize cultural knowledge, resources
- Adapt to diversity and cultural contexts of communities served

Develop a Plan for Instituting Programmatic Cultural Competence

- Establish a broad conceptual framework
- Identify primary cultural groups with highest incidence of STDs
- Begin skill building
- Build in Continuity and Self/Peer Review
- Plan a professionally facilitated retreat or workshop
- Recognize cultural competence training as a continuous process
- Build in an evaluation process

Institute Action Steps for Establishing Cultural Competence

- Staff training for cultural competence
- Language access services
- Developing community partnerships
- Incorporating cultural competence into standard operating procedures



Staff Training: Building cultural competence in your staff (1)

Requisite Attitudes of Staff:

- ❑ **Non-judgmental approach** to another's culture
- ❑ **Cultural humility** about one's own beliefs
- ❑ **Awareness** of one's own biases and assumptions
 - ❑ **Willing and able to explain and describe** one's perspectives to others
- ❑ **Desire** to understand others' perspectives
- ❑ **Flexibility** to negotiate toward desired outcomes

Staff Training: Building cultural competence in your staff (2)

- ❑ **Cultural self-awareness**, including socioeconomic status and biomedical culture
 - Worldview
 - Knowledge
 - Behavior
 - Communication styles
- ❑ **Cross-cultural communication skills**
 - To elicit patients' ethnomedicine
 - To understand clients' layers of culture
 - To negotiate treatment and partner identification.



Staff Training: Building cultural competence in your staff (3)

- ❑ Awareness of how culture shapes own behavior
- ❑ Awareness of polite behavior in various cultures
- ❑ Ability to gather information about the patient, partners, and community
- ❑ Awareness of own attitudes about subcultures and cultural groups
- ❑ Ability to assess need, offer, and arrange for interpretation
- ❑ Sense of empathy and hospitality

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Staff Training:

Building cultural competence in your staff (4)

Rely on others:

- STD program staff can learn from other programs, services, and organizations that are also working with specific populations



- We're not doing it alone—learn from clients, youth, interpreters, cultural mediators, community leaders

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Assessing Cultural Issues in Healthcare Encounters - Examples of Questions to Ask

- What does the medical diagnosis/treatment/prevention recommendation mean to you (cognitively, emotionally, socially, economically)?
- Who should be in charge of decisions and actions that affect you?
- What sources of authority do you recognize and respond to?
- Where do health professionals fit in your authority hierarchy?

Source: O'Connor, Promoting Cultural Competence in HIV/AIDS Care

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Programmatic Steps to Build Cultural Competence

Language Access

- What are the most common languages in your jurisdiction?
 - Identify interpretation resources and funding
 - Train staff
 - Develop effective ways to let patients know that interpretation is available at no cost
 - Implement interpreter training standards



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Programmatic Strategies to Build Cultural Competence (2)

Support for Cultural Practices

- Acknowledge and respect ethnomedical explanations and treatments
- Support family decision making
- Identify cultural healers
- Adapt effective outreach or treatment practices from your patients' community or home country

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Programmatic strategies to build cultural competence (3)

Resources for Cultural Knowledge

- Non-medical specialists
- Social scientists
- Patients themselves
- Patients' families
- Community members
- "Traditional" or "Alternative" healers
- Members of cultural heritage or identity groups



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Community Partnerships



Martin Mejia / AP

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Programmatic strategies to build cultural competence (4)

Community Partnerships

- ❑ Which local ethnic, cultural or advocacy groups have community organizations?
- ❑ Can you partner with them for outreach or to help plan accessible services?
- ❑ Do any of these organizations have opinion leaders, cultural brokers, trained interpreters?
- ❑ Do these organizations know anything about STDs, HIV/AIDS?
- ❑ Do these organizations have formal or informal support services for patients, partners, families?

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Challenges of cross-cultural health care in STD control

- ❑ Little time in clinical encounters for many STDs
- ❑ A lot at stake: diagnosis, treatment, partner notification
- ❑ Vast diversity of patients
- ❑ No one can be fully culturally competent
- ❑ Limited time for cultural competence training and learning
- ❑ Programs have their own cultures, which influences collaboration and service integration

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Communication is possible



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Programmatic Strategies to build Cultural Competence (5)

- CC does not move in one direction, and everyone doesn't move at the same pace
- Everyone will have new cultures where they will be less familiar and less competent
- Colleagues require support to:
 - Identify their issues,
 - Change attitudes and procedures,
 - Share patient care when someone has more competence, and
 - Continue to review individual and program progress or resistance

Complementary Strategies to build and document cultural competence

- Individual staff strategies
 - Understand and explain own culture
 - Actively acquire cultural knowledge and skills, including subcultures
 - Cross-cultural communication, negotiation skills
- Programmatic strategies
 - Bridging structural factors of health disparities
 - Language access & support for cultural practices
 - Organizational partnerships / integration

Skills for Cultural Competence— Document for performance reviews

- **Questioning** skills
- **Observational** skills
- **Communication** skills



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Cultural Competence Training Principles

- Cultural issues (personal and professional)
- Take cultural issues into account when:
 - Training staff, and
 - Designing and delivering services for:
 - specific individual patients
 - patient populations



O'Connor

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Cultural Competence Training Process

- Educate staff about culture
- Continuity and self-peer review
- Include patient/community member(s)



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Summary Points

- Culture is a conceptual framework that can be used to understand:

- Diversity
- Values/behavior
- Ethnic backgrounds
- Health Care Interactions
- Factors that affect disparities



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Resources

- **Pre-Course Handouts**
 - Handout 1: Definitions to Build a Framework for Cultural Competence
 - Handout 2: Disparity Analysis: Health Care Barriers for African Immigrants with HIV/AIDS (example of reaching a culturally unique, high priority, small size community)
 - Handout 5: Patient Centered Care and Culturally Competent Care
- **Post-Course Handouts**
 - Handout 3: Ethnomedicine and the Cultural Context of Illness
 - Handout 4: Assessing Cultural Issues in Healthcare Encounters for additional questions
 - Handout 6: Legal Mandates – Federal Limited English Proficient (LEP)

Resources

- **Web-Based**
 - http://www1.georgetown.edu/research/gucchd/nccc/documents/SIDS_washington.pdf
 - **National Tuberculosis Toolkit:**
<http://www.cdc.gov/tb/publications/quidestoolkits/forge/ToolkitWord.htm>
 - **HRSA Toolbox:** <http://www.hrsa.gov/culturalcompetence/roleofcces.pdf>
 - **Social Determinants of Health (CDC)**
<http://www.cdc.gov/socialdeterminants/>
Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. 2010, CDC
- **PowerPoint Presentation**
 - [http://www.cahealthadvocates.org/_docs/cmc/2008/Importance-Language-Services-2008.ppt#385,8,Cultural Competence](http://www.cahealthadvocates.org/_docs/cmc/2008/Importance-Language-Services-2008.ppt#385,8,Cultural%20Competence)
- **Articles** (see Resource list)
 - Bonnie O'Connor article, *Promoting CC in HIV/AIDS care*
 - Betancourt: *Role of CC in reducing disparities*
 - Carillo: *Cross-Cultural Primary Care, Patient-based*

Post-Course Activity 1: "Layers" of Culture and Cultural Identification

Post-Course Activity 2: Programmatic Cultural Self-Assessment Checklist

Post-Course Activity 3: Planning for Cultural Competence in STD Programs

Additional Resource:
Send Cultural Competence
Questions to
Stephanie Spencer
Stephanie.spencer@cdph.ca.gov

DRAFT

**Post-Course Activity 3:
Planning for Cultural
Competence in STD
Programs**

CULTURAL COMPETENCE IN STD PROGRAMS
HANDOUT 3: ETHNOMEDICINE AND THE CULTURAL CONTEXT OF ILLNESS

Etiquette: Introductions and rapport

- Biomedical doctors & patients discuss symptoms;
- Shamans may consult family members for details of patients' lives;
- Herbalists may know patient, focus on symptoms

Etiquette: How an interview begins is important, so learning and following some basic etiquette helps to establish trust. What name one uses to talk to patients is very important—find out whether to use first or last name, or not to address the person by name. Find out what is respectful. Find out what kinds of questions are expected when people meet—in Indonesia, “Are you married?” “How many children do you have?”. In some cultures, you may need to talk about something besides personal questions, or illness for a while until people are comfortable, and then start the “actual interview.” Most of us do these things, but biomedical culture in the U.S. is very direct and frank, so we may need to spend more time on preliminaries than we are used to. Not seeming rushed can be very important.

Roles and relationships of healers and patients

- Doctors impart bio-medical knowledge
- Shamans perform ceremonies at patients' homes
- Herbalists prepare plant recipes
- Massage therapists make home visits.
- Patients could be active, assertive and advocate for themselves
- Patients could rely on family members to understand information about illness and make decisions,
- Patients could rely on shamans to find out things from spirits
- Patients could rely on herbalists for medicine and/or making treatments oneself

Roles: Medical sociologists and anthropologists also describe the behavior expected of patients, family members, and healers as their roles. Understanding something about what motivates patients' and their families' behavior, and what they expect from a healer helps to tailor our behavior so that it makes sense to the patient, or to realize what the patient may not understand about our behavior.

Beliefs about the cause of illness/disease vary across cultures and subcultures

- illness caused by germs
- supernatural (ancestors)
- witchcraft (evil eye)
- environment (wind)
- patient's emotions (shock, fright)

CULTURAL COMPETENCE IN STD PROGRAMS
HANDOUT 3: ETHNOMEDICINE AND THE CULTURAL CONTEXT OF ILLNESS

Illness also could be a punishment from God. Or people may have a sense that illness is caused by eating bad food, or the wrong food—sometimes there is an understanding of illness as an imbalance of eating the too much of a “hot” or “cold” food.

Many times not one-to-one word or concept corresponds to disease terms. Because language describes how we understand the world, our word for Syphilis, which is a specific set of symptoms over a particular period of time, may not match how a patient understands what is wrong with him or her. In an interview, it can be helpful to explain germ theory, and why certain tests are done, but also to acknowledge that the patient has other explanations. Patients don't have to accept the biomedical explanation, or to accept it exclusively, in order to agree to take medication.

Treatment practices across cultures

- Exam/diagnosis by bacterial culture
- Shamanic ceremony
- Figuring out who has a grudge
- Treatment by medication
- Prayer or sacrifice
- Making amends to someone

Biomedicine looks for the bacteria or viruses. Shamanic ceremonies contact spirits and ask them what or who is causing the illness, and what should be done to treat it. Someone who understands witchcraft may be able to figure out who has caused someone to become sick, and why. Treatment follows from the cause of illness in each of these cases. For example:

- Medication to kill bacteria.
- Offerings to spirits to tying a string to the body to keep the soul
- Making amends to someone who is jealous, or casting a spell back on them

CULTURAL COMPETENCE IN STD PROGRAMS
HANDOUT 4: ASSESSING CULTURAL ISSUES IN HEALTHCARE ENCOUNTERS

Questions to ask patients

These questions can help gather information to understand the patient's perspective, to figure out how to best share information, and demonstrate that you want the best outcome for the patient and you are willing to work with them to achieve that.

- What do you feel is the most pressing problem?
- What does the medical diagnosis/treatment/ prevention recommendation mean to you (cognitively, emotionally, socially, economically)?
- What special requirements and limitations do you anticipate?
- What are your goals for treatment/prevention? What do you want to gain? to avoid?
- What range of healing/health maintenance resources are you familiar with, and which do you feel are applicable to this situation?
- What level of priority do you assign to the medically indicated course of action when weighed against other personally important life goals and constraints?
- What is important to your sense of self or identity?
- What are your expectations of sick people and their caregivers?
- Who do you feel should be in charge of decisions and actions that affect the patient?
- Who is considered family and how is kinship defined?
- What do you feel is the proper (or essential) role of family members and significant others? Of health professionals?
- What do you define as an appropriate decision making process? Who needs to be involved?
- What sources of authority do you recognize and respond to? Where do health professionals fit in your authority hierarchy?

Source: O'Connor, Promoting Cultural Competence in HIV/AIDS Care

CULTURAL COMPETENCE IN STD PROGRAMS
HANDOUT 6: LEGAL MANDATES—FEDERAL LIMITED ENGLISH PROFICIENT (LEP)

Providing interpreters for limited English proficient clients whenever needed and at the client's request, free of charge, not only improves clinical outcomes and patient satisfaction, it is the law.¹

Who Must Comply and Who Can be Found in Violation?

All programs and operations of entities that receive assistance from the federal government, including:

- State agencies
- Local agencies
- Private and nonprofit entities *Subrecipients* (entities that receive federal funding from one of the recipients listed above) also must comply.

Title VI of the 1964 Civil Rights Act

"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."
42 U.S.C. § 2000d.

The United States Supreme Court in *Lau v. Nichols* (1974) stated that one type of national origin discrimination is discrimination based on a person's inability to speak, read, write, or understand English.

Federal Legal Mandates—The Americans With Disabilities Act of 1990 (ADA)

- Improves on Rehabilitation Act of 1973
- Requires ALL public & private buildings, programs, services & employment, be equally accessible.

Federal Standards for Culturally and Linguistically Appropriate Services (CLAS)

<http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>

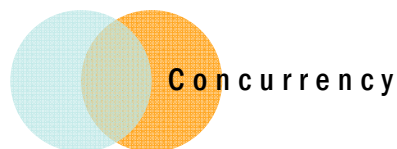
- 14 standards are organized by themes
 - Culturally Competent Care (Standards 1-3)
 - Language Access Services (Standards 4-7)
 - Organizational Supports for Cultural Competence (Standards 8-14).
- Within this framework, there are three types of standards of varying stringency
 - mandates
 - guidelines
 - recommendations

¹Jane Perkins and Mara Youdelman. Summary of State Law Requirements Addressing Language Needs in Health Care. 2008 National Health Law Program.

Presenting on Sexually Transmitted Disease (STD) Racial Health Disparities: A Resource Guide for Facilitators



Socio-economic status



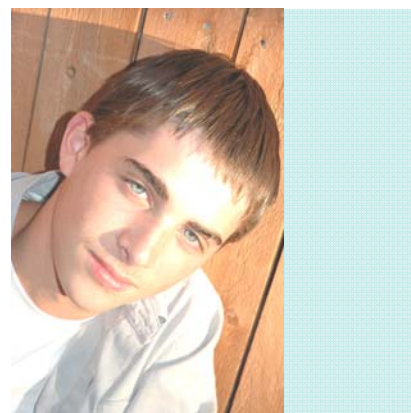
Sexual Behavior



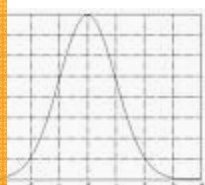
Racism & Health



Access to Testing



Prevalence



**Presenting on Sexually Transmitted Disease (STD)
Racial Health Disparities:**

A Resource Guide for Facilitators

**California Department of Public Health,
Center for Infectious Diseases
Division of Communicable Disease Control
Sexually Transmitted Disease Control Branch,
and California STD/HIV Prevention Training Center**

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I. Purpose of this Document

This document is a frequently asked questions (FAQs) resource guide for facilitators that was developed in response to the complex questions and issues raised when data on racial and ethnic health disparities are presented. The purpose of this document is to serve as a resource for public health professionals and their community partners in starting discussions and/or answering questions related to the multiple individual and societal factors that influence sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) rates among different racial/ethnic groups.

This guide is designed as a tool for experienced facilitators with established skills in conducting professional trainings and facilitating group process. It may also be used by experienced public health workers (e.g. epidemiologists, disease intervention specialists, health educators, nurses) and community agency staff who regularly conduct presentations on STD/HIV data and related factors for colleagues and community partners. For additional information on skill-based courses in group facilitation visit the CA STD/HIV Prevention Training Center (www.stdhivtraining.org) or for diversity and conflict management courses visit Quality Media Resources (www.qmr.com).

The California Department of Public Health (CDPH), Division of Communicable Disease Control (DCDC), STD Control Branch has also developed a set of data slides with presenter notes that gives information on the gender, age, race/ethnicity, and geographical break-down of STD morbidity in California. Please refer to the data slide set document for further epidemiological information at www.cdph.ca.gov/data/statistics/Pages/STDData.aspx or contact the STD Control Branch at 510-620-3400.

The main emphasis of this resource guide is to highlight the larger societal factors (e.g., poverty, racism) that influence STD/HIV rates and to encourage their inclusion in the training discussions and program planning that may traditionally focus on individual-level behavior change interventions. This document is a work in progress to which we encourage its users to add additional concepts and related research.

In the process of using this document, we encourage all facilitators to examine their own internal biases and comfort levels and to continually work on our societal development around issues of oppression and injustice. For further information on personal development related to these issues, please see the following resources: The People's Institute (www.pisab.org); Community Change, Inc. (www.communitychangeinc.org), Teaching Tolerance (www.tolerance.org) and your regional office of the National Conference for Community and Justice (NCCJ).

II. Overview of STD Epidemiological Measures and Data

A. Interpreting data measures

Epidemiological data can be shown in many different ways, depending on which aspects of the data the presenter wishes to emphasize. When presenting data on racial/ethnic disparities, it is crucial that the facilitator explain the differences in presenting STDs by number of cases, percents, and rates, and what the data mean in terms of the magnitude of infection versus level of disparities among different populations.

Number of cases is the count of the actual number of reported STD cases in a group. Percent demonstrates the proportion of cases that are represented by a particular group among all the cases. Rates are used to compare the magnitude of the problem among groups adjusting for the size of the population in each group. Rates are constructed by dividing the number of cases in each group (the numerator) by the population size of that group (the denominator), and multiplying by a constant (e.g., 100,000 population).

The examples below for reported cases of chlamydia (CT) from two counties in California demonstrate the importance of comparing the differences between number of cases, percents and rates.

Los Angeles County 2007 reported chlamydia (CT) cases among females [1]

	African American	Latina	Asian/PI	White	Total
Number	7,179	13,023	1,115	2,520	30,479
Percent *	30%	55%	5%	11%	100%
Rate †	1,502.4	544.1	154.7	167.9	586.3

* Percent calculation excludes cases of unknown race/ethnicity

† Rates are per 100,000 population.

PI: Pacific Islander

Fresno County 2007 reported CT cases among females [1]

	African American	Latina	Asian/PI	White	Total
Number	484	2,078	189	366	4,096
Percent *	15%	66%	6%	12%	100%
Rate †	2,183.1	960.0	438.1	216.4	888.3

* Percent calculation excludes cases of unknown race/ethnicity

† Rates are per 100,000 population.

PI: Pacific Islander

Tables prepared by the California Department of Public Health, Center for Infectious Diseases, Division of Communicable Disease Control, STD Control Branch.

In the tables above, Latinas account for 55 percent of the 30,479 CT cases among females in Los Angeles County, and the rate among this group is 544.1 per 100,000, in part due to the group's large population size. In comparison, African Americans account for only 30 percent of female CT cases in Los Angeles, but their rate is the highest, at 1,502.4 per 100,000 (almost three times the rate among Latinas).

In Fresno County, there was a similar number of CT cases among female non-Latina whites (366) and African Americans (484). However, the rate per 100,000 population among whites was only 216.4, compared to a rate of 2,183.1 among African Americans (more than ten times the rate among whites), again due to the smaller African Americans population size. Further, while the rate among Latina women (960.0 per 100,000) was less than half the rate among African Americans, the number (and percent) of Latina cases was much higher than any other group (2,078 cases, 66 percent of all cases), due to the large size of the Latina population in Fresno County.

When determining and examining racial/ethnic disparities, it is important to consider both the absolute amount of infection by examining the case numbers and percents, as well as the relative amount of infection by examining the rates. No one data measure alone tells the whole story or allows for the appropriate allocation of resources to control STDs.

B. Key epidemiologic characteristics

Each STD has a different magnitude of impact on different population groups, based on age, race/ethnicity, gender, sexual orientation, and other factors. For example, while only about 1 of 17 Californians is African American, well over 1 of 2 reported gonorrhea (GC) cases, and over 1 of 4 reported CT cases, were African American in 2007. Similarly, while about 1 of 3 Californians are Latino, 1 in 2 CT cases were Latino in 2007 [2].

Nationwide, in 2005, men who have sex with men (MSM) made up more than two-thirds (68 percent) of all men living with HIV [3]. Remarkable racial/ethnic disparities are also seen among heterosexuals and MSM with HIV and AIDS in California. For example, among persons living with AIDS as of May, 2008 about 1 of 5 are African American (far higher than the 1 of 17 African Americans in the California population noted above) [4]. And, this difference is even more striking among some subgroups. For example, while the rate of living AIDS cases among African American males (872.8 per 100,000 population) is 2.5 times the rate among non-Hispanic white males (347.7 per 100,000), the rate of AIDS among African American females (219.3) is almost 8.7 times the rate among non-Hispanic white females (25.2) [5]. And, there are related differences by race/ethnicity in the "exposure category" or "risk group" of AIDS cases, with about 1 of 8 MSM cases being African American compared to about 1 of 3 heterosexual contact cases [4].

A wide range of data also emphasizes these racial/ethnic disparities among HIV/AIDS cases nationally. For example, a recent report on estimates of new HIV infections in the United States indicated an incidence rate of 83.7 per 100,000 population among African Americans in 2006, almost three times higher than the next closest group (Hispanics) and more than seven times higher than the largest population group (Whites) [6]. Another recent report on HIV/AIDS diagnoses in the United States, described very striking racial/ethnic disparities among MSM cases, particularly young (13 to 24 years of age) MSM cases, with far more cases reported (7,658 cases between 2001 and 2006) among African Americans in this age category than among any other race/ethnic group [7]. Additionally, there was a higher rate of increase in this group over this time period (averaging 14.9 percent each year) than any other group.

Prevalence data from the National Health and Nutrition Examination Survey (NHANES IV), conducted 1999 through 2004, demonstrate similar racial/ethnic disparities in herpes simplex virus type 2 (HSV-2) in the United States. Seroprevalence results show that an average of 55 percent of African Americans aged 30 to 49 years have HSV-2, compared to 20 percent of whites in the same age group [8].

Among all racial/ethnic groups, CT and GC rates are highest among young women 15 to 24 years old. The rates for African American female GC cases were higher in all age groups than rates for Latina or non-Latina whites. In 2007 in California, in the female 15- to 19-year-old age group, the GC rate was over 20 times higher for African Americans (1,797) than for non-Latina whites (88); among males in this age group, the African American rate (857) was 29 times higher than among non-Latino whites (30) [9].

There are unique and important epidemiologic characteristics of STD cases among all racial and ethnic groups in California. For example, while the rate of STDs is often relatively low among the non-Hispanic white population, the absolute size of the white population results in there being a large number of cases in that group. For primary and secondary syphilis (the infectious stage of syphilis), there were more white cases than any other group and 75 percent of reported primary and secondary syphilis cases in 2007 were among MSM [10].

On the other side of the population-size spectrum, there are few Native American STD cases in California, reflecting their small population size (about 0.6 percent). However, in some instances their rates of infection are quite high, particularly in some counties with larger concentrations of Native Americans (e.g., although the numbers are small, in Humboldt County in 2007 among females, Native Americans had the highest rate of gonorrhea). The size of the Asian population in California is large relative to many states (about 12 percent of the population), but the rates of STDs are generally low, and often the lowest among both males and females, compared to other racial/ethnic groups. Hispanics, the second largest population group in California (about 36 percent of the population) have intermediate rates of

STDs, and generally high rates of chlamydia—because of the size of the Hispanic population and high rates of chlamydia, the absolute number of chlamydia cases tends to be higher among Hispanics than for any other racial/ethnic group.

African Americans are the second smallest main racial/ethnic group in California (about 6 percent of the population) but tend to have high to very high relative rates of STDs. In 2007 and in many prior years, the rates of chlamydia, gonorrhea, syphilis and HIV/AIDS are all higher among African Americans than any other racial/ethnic group. The differential in rates are so extreme for gonorrhea, that even with the small population size, the absolute number of gonorrhea cases is higher among African Americans than any other racial/ethnic group. And furthermore, as noted above, this disparity is even greater in some regions and/or groups; specifically among young persons aged 15 to 19 years.

Therefore, while it is important to describe the disparities in STDs among all racial and ethnic groups, it is particularly important to describe them in California (and much of the United States) among African Americans since their rates are overwhelming higher in many instances; the absolute numbers are higher in some instances; and, in general, the disparities are increasing.

III. Background on STD Transmission

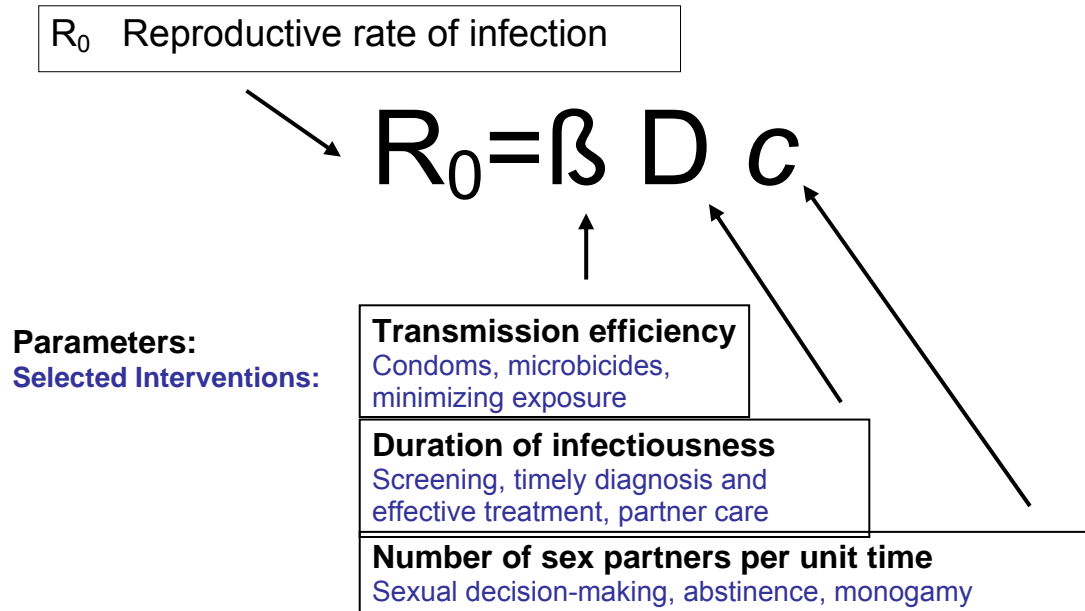
The relationship between race/ethnicity and STDs, including HIV, is multi-factorial and complex. Most of the research and program efforts in STD/HIV prevention focus on individual behavior change (e.g., condom use, number of partners, getting tested) and biomedical interventions (e.g., screening programs, treatments, and vaccines). All of these efforts attempt to prevent or slow the spread and complications of STDs. The equation below explains in more detail the main dynamics involved in population-level STD transmission.

The factors that determine the rate of population-level spread of disease (or R_0 = Reproductive Rate) are: (1) STD transmission efficiency (β) – or how easy it is for people to pass and acquire the STD organism; (2) the duration of infectiousness (D) – or how long people have the infection and can therefore infect others; and (3) the average number of sex partners (c). When any of these three factors is zero, STD transmission is stopped and there is no further spread of the infection in the population. If the reproductive rate is one ($R_0 = 1$), transmission rates are steady. If R_0 is less than one, there is a declining incidence, and if R_0 is more than one, the population incidence increases [11].

In each of the boxes below, labeling the respective three factors, there are lists of interventions that can help decrease or stop the effect of that particular factor on STD transmission.

STD Transmission Dynamics

(transmission by infected case)



Graphic prepared by the California Department of Public Health, Center for Infectious Disease, Division of Communicable Disease Control, STD Control Branch. Adapted from the Robert May and Roy M. Anderson equation in *Infectious Diseases of Humans: Dynamics and Control* (1992)

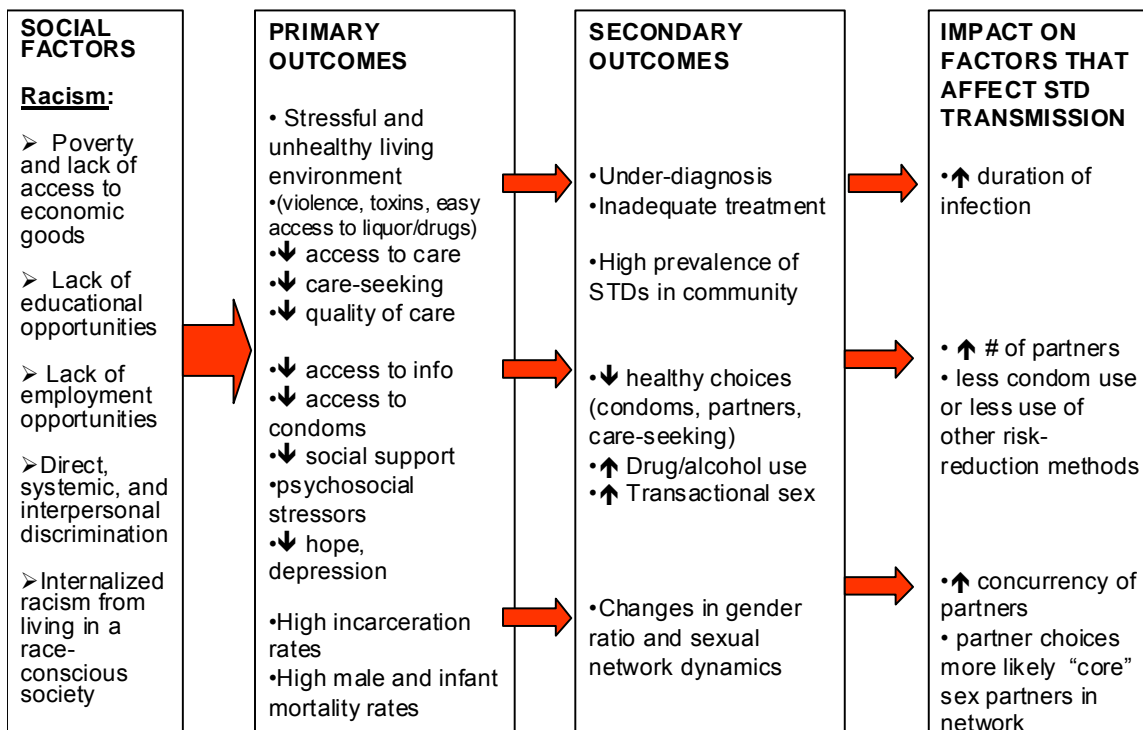
One critically important factor not represented in the above equation is STD prevalence, or the proportion of people infected in a given population. When prevalence is high, there is more likelihood that any given sex partner is infected. Therefore, the impact of factor c (or the number of sex partners) on STD transmission can be larger in a sexual network with a high prevalence.

In addition to differentials in prevalence, individual risk behaviors, and biomedical interventions, there are multiple societal factors that contribute to racial/ethnic health disparities in STDs [12]. Although this document will focus mainly on social factors that are closely associated with race/ethnicity, there are many overlapping oppressive factors including but not limited to homophobia, transphobia, xenophobia, immigration discrimination, acculturation and sexism that additionally contribute to the impact of STDs on certain groups. Some of the societal factors closely associated with race/ethnicity are racism, socioeconomic status (including educational level and income), unequal access to and quality of care, sexual network structure, and cultural differences that affect partner dynamics and individual behaviors. No single factor completely explains the racial differential in STD rates, and some of the factors are difficult to isolate in studies. More research is needed within a social justice framework

to better understand the relative weight and interplay of these factors. Undoubtedly, a multifaceted societal commitment to taking action to reduce disparities which incorporates community mobilization, interagency collaboration, and leadership is needed [13].

The model below is an attempt to demonstrate how a larger societal factor such as racism can influence STD rates through primary and secondary outcomes or indicators. For example, although it may not seem directly related, by providing more general educational opportunities to youth we are decreasing their risk of contracting an STD. Getting a good education can increase youth’s job opportunities and their hope for the future, which may then affect how they protect themselves from STDs or pregnancy. In addition, after-school and extracurricular programs that focus on youth development, athletics, arts, or community service help youth nurture their full potential and become actively engaged in productive activities that may take the place of higher-risk behaviors.

RACISM AND STD RISK: POTENTIAL THEORETICAL MODEL



Adapted from model created by Heidi Bauer, California Department of Public Health, Center for Infectious Disease, Division of Communicable Disease Control, STD Control Branch, 2007.

Below is another way of presenting how larger societal factors link to STDs:

Factors linked to racial disparities in STD rates

- Root causes
 - Racism
 - Poverty, education
 - Policies and laws
- Contributing factors
 - Lack of or reduced healthcare access
 - Differences in quality of health care received
 - Cultural competency of providers
 - Disproportionately high rates of incarceration
 - Gender ratio imbalances
 - Language/structural barriers
 - Unstable housing situations
 - Distrust of the (public) health system
- Transmission-related factors
 - Higher-risk social/sexual network structure
 - Higher STD prevalence in communities
 - Longer duration of infectiousness
 - Individual sexual behavior (e.g., number of partners, condom use)

IV. Frequently Asked Questions from Participants

Q1: How does racism affect health and STD infection?

Summary trainer note:

Racism can affect health status on a variety of levels. Institutionalized racism can be experienced as a lack of economic opportunity due to denial of jobs and/or bank loans, which can lead to the person living in an area with high levels of environmental pollutants, violence, and lack of job opportunities.

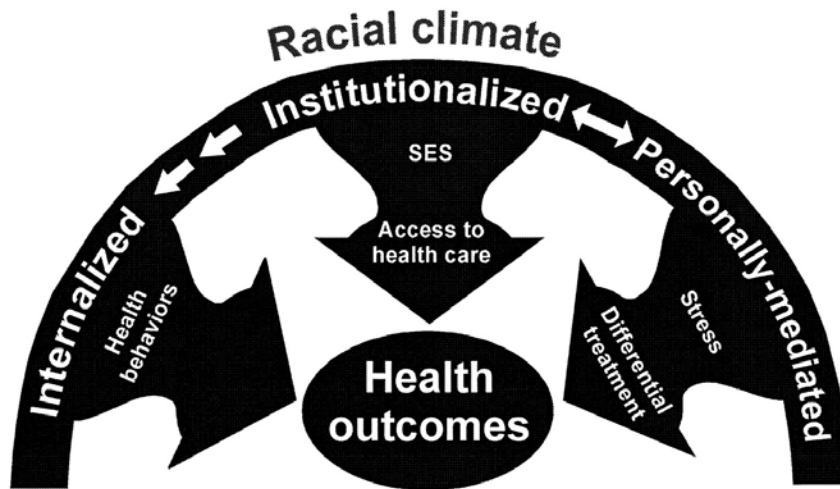
Personally-mediated racism, sustained by receiving unequal treatment from others, can affect STD outcomes, specifically through the delivery of less adequate or different care from health professionals.

Internalized racism may affect a person's sense of self-worth and his/her mental health, causing an increase in risk behaviors or a lack of healthcare-seeking behaviors [14]. In addition, racism on all levels can lead to acute and chronic stress; this stress may affect immune function and may therefore increase an individual's susceptibility to STD infection [15].

Further explanation and supporting data:

The following diagram shows the impacts of racism on health, illustrating the relationships among institutionalized racism, personally-mediated racism, and internalized racism, and various factors that contribute to race-associated differences in health outcomes [14].

The Impacts of Racism on Health



Jones CP. Am J Epidemiol 2001; 154:299-304

Most of the research in this area has been done on the effects of racism and classism on racial health disparities in chronic illnesses. It is logical to apply the same analysis to STD outcomes. For example, institutionalized racism in society and the criminal justice system (e.g., police racial profiling, unequal representation in court, a negative focus on people of color in the news media) contribute to the extremely high rates of incarceration among African Americans and other marginalized racial/ethnic groups. In 2006, African American males outnumbered imprisoned white males by six times per 100,000 population and Latinos outnumbered whites by three times per 100,000 population [16].

Incarceration and the resultant “male shortage” can affect rates of STDs by causing a gender imbalance, decreasing marriage rates, altering sexual networks, and increasing concurrency or overlapping of sex partners for both men and women [17]. In addition, approximately 25 percent of the HIV-positive population of the United States pass through correctional facilities each year [18], and the HIV prevalence in prisons is approximately five times higher than in the general population in some states [19]. Exposures within prison may include consensual and non-consensual sex, as well as needle-sharing through drugs or tattoos.

American Indians and Alaskan Natives (AI/ANs) have been shown to have far worse health outcomes than any other ethnic group in the US. In addition to the impact of

low socioeconomic status on health, the role of historical trauma and continued oppression have led to high rates of substance abuse within the AI/AN population which are linked to poor mental health outcomes and risky sexual behaviors [20].

Institutionalized racism may also lead to differential access to economic goods and opportunities, which can result in differences in underlying health status. In particular, there are significant differences across racial and ethnic groups in the amount, quality, and timing of healthcare services received [21].

Personally-mediated racism from a clinical provider can affect quality of care and future health-seeking behaviors, which may lead to increased duration of STDs or worse disease outcomes. Additionally, patient perception of clinician bias can lead to incomplete disclosure of sexual behavior risk factors and subsequent inadequate care. Research shows that clinician bias toward minorities may result in greater clinical uncertainty and clinical decisions may be made hastily based on clinician assumptions about health behaviors of the minority patients [22].

Internalized racism, or an individual's acceptance of the oppressive views of his or her race/ethnicity, can manifest in a low sense of self-worth or low self-efficacy to affect change, which may lead to higher risk behaviors (including drug use, unsafe sex, and violence) [14]. In addition, internalized racism can lead to devaluation of sex partners and community members, leading to increased abuse, lack of protection of partners, and lack of respect of other people's worth and health [12].

Racism may impact rates of STDs through the effects of stress on immune function, which is associated with susceptibility to and transmission of HIV and other STDs. Research into the relationship between social rank and health has found that, while our body's responses to stress are adaptive for acute physical stressors, those same responses are pathological for prolonged psychosocial stress (such as the long-term impact of racism in society) [15]. One study showed that, after controlling for poverty level, differences in biological indicators of repeated exposure to stressors were found between African Americans and whites [23].

Research also suggests that the way African Americans individually respond to and cope with racism and other stressors can affect health outcomes. In a study examining the use of coping strategies and breast cancer survival, significant associations among race, specific coping mechanisms, and poorer survival were found [24].

Thus, racism, on all three levels, contributes to higher STD incidence through increased risk behaviors, unequal health care, high prevalence in sexual networks, and poorer overall health.

Q2: Are there biological differences among different race/ethnic groups that explain disparities in STD rates?

Summary trainer note:

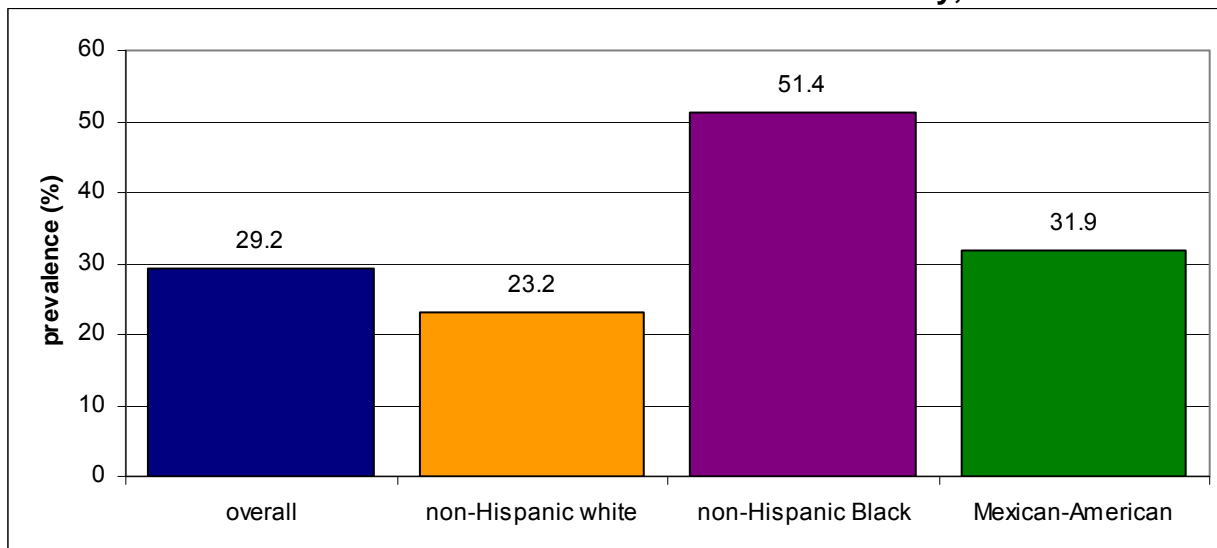
Race as a factor is less biological and more of a socially-determined classification based on phenotype that governs how someone experiences life in a race-conscious society [12]. Little research that supports explanation of racial disparities in STD rates through biology or genetics has been done. The research that has been done shows some potential biological factors relating to differences in bacterial vaginosis (BV) and vaginal pH levels.

Further explanation and supporting data:

The findings from several studies provide tentative evidence of the existence of biological differences among racial/ethnic groups that could affect acquisition of STDs [25, 26]. One study found a modest but significant racial difference in vaginal pH, while another study found an association between higher vaginal pH and GC and CT infection. Although, in the first study, the association between pH and race/ethnicity disappeared after controlling for vaginal flora, the differences in flora and their impact on vaginal pH may affect rates of STD acquisition. An imbalance in vaginal pH can lead to other conditions, such as BV and yeast infections.

The results of several large prospective studies have shown that, even when other known risk factors are controlled for, racial differences persist for rates of BV [27]. The graph below demonstrates that in the 2001 to 2004 NHANES, more than half (51.4 percent) of African American female participants had BV, compared to 23.2 percent among white females [28].

Prevalence of Bacterial Vaginosis in Women 14-49 years, by Race; National Health and Nutrition Examination Survey, 2001 - 2004



Koumans, E.H., et al. *The Prevalence of Bacterial Vaginosis in the United States, 2001-2004; Associations With Symptoms, Sexual Behaviors, and Reproductive Health*. Sex Transm Dis, 2007.

There may also be racial/ethnic-associated correlates of behaviors that lead to biological differences. For example, cultural differences exist in the frequency of male circumcision practiced by certain racial/ethnic groups. Male circumcision is strongly associated with lower rates of transmission of and susceptibility to HIV/STDs [29].

Analysis of human genes suggests that “racial” divisions, by skin tone and features, do not accurately reflect human genetic evolution and it may be more useful to think of “race” as a social construct not a biological one. The genetic diversity found on continents around the world is a subset of the genetic diversity found in Africa. Therefore, two black Africans (of the same “race”) could potentially be more different from each other genetically than a black African person and a white European person [30].

In addition to the theories above, for many American Indian and Alaskan Native communities, oral traditions contend that native peoples have always been present in North America and did not originate in Africa and then cross the Bering Strait. For trainers and educators, it is important to be aware of these various theories and what people hold true, both to not offend participants and to recognize how these traditional beliefs can give strength to individuals, which positively affects their behaviors and communities as a whole.

Q3: Does socioeconomic status (SES) and/or poverty account for the differences in racial/ethnic health disparities?

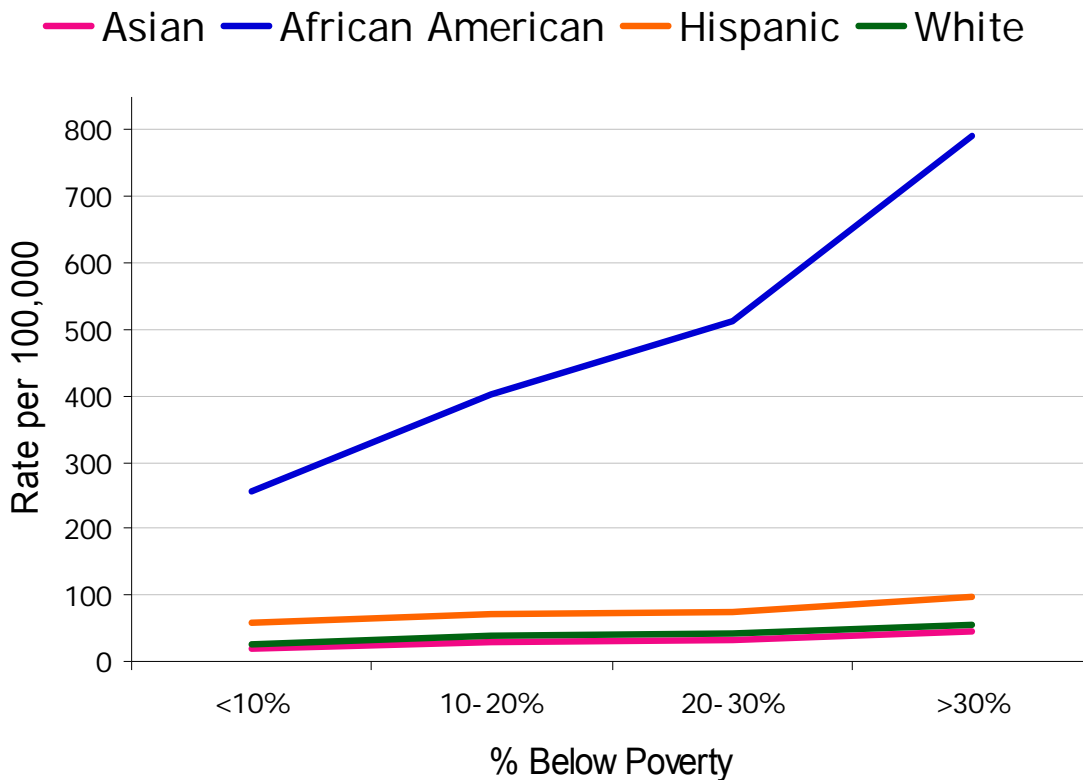
Summary trainer note:

Low SES and poverty are strongly associated with higher STD rates. Also, certain racial/ethnic groups are disproportionately affected by higher rates of poverty. However, studies have shown that even when SES is controlled for, race/ethnicity is still associated with higher rates of STD infection.

Further explanation and supporting data:

In one large national survey, after controlling for associated risk markers, including education, income, and place of residence, African Americans were still 4.7 times more likely than whites to test positive for syphilis [31]. This provides evidence that racial differences in sexual behavior and health-care behavior, combined with markers for risk (e.g., SES), do not wholly explain the racial disparity in the prevalence of some STDs.

The graph below demonstrates that in California, for all racial/ethnic groups, the rate of GC increases along with the amount of poverty. However, it also shows that, even in the higher-income areas (where zero to 9.9 percent of households are living in poverty), there is a high rate of GC among African Americans, and this rate in African Americans is substantially higher than the rate observed for other racial/ethnic groups. Therefore, the racial disparity in GC still exists regardless of poverty level [32].



Graphic prepared by the California Department of Public Health, Center for Infectious Disease, Division of Communicable Disease Control, STD Control Branch.

Q4: Are there differences in sexual behaviors among racial/ethnic groups that explain the disparity in STD rates?

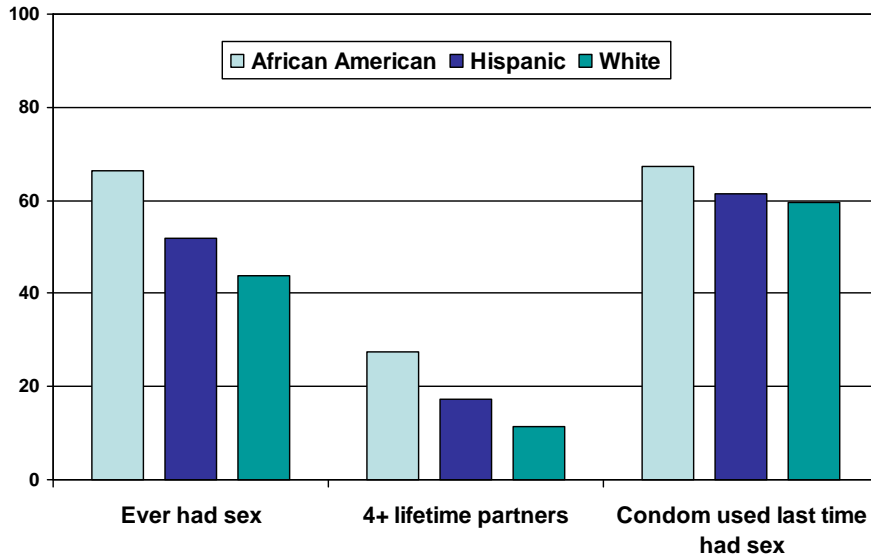
Summary trainer note:

Differences in individual sexual behaviors (e.g., average number of partners, average level of condom use) among racial/ethnic groups in both adults and adolescents have been documented. However, when these behaviors are analyzed controlling for SES, the racial/ethnic differences in individual sexual behavior do not fully account for the observed disparities in STD rates.

Further explanation and supporting data:

Several studies have found higher proportions of high-risk sexual behaviors (e.g., more partners, earlier first intercourse) reported among African Americans, compared to whites, as well as higher proportions of protective behaviors (e.g., more condom use) among African Americans and Hispanics, compared to whites, as shown in the graph below [33, 34].

STD-Related Risk Behaviors among High School Students –
United States, 2007; Youth Risk Behavior Surveillance System



Graph produced by the California Department of Public Health, Center for Infectious Disease, Division of Communicable Disease Control, STD Control Branch, with data from Centers for Disease Control and Prevention. [33]

Studies of Mexican migrant workers in California have found low levels of STDs and HIV, but relatively high levels of related risk behaviors. These behaviors would rapidly propagate STD and HIV transmission if the prevalence of STDs and/or HIV were to increase in these populations. In one recent report among Hispanic agricultural workers in rural California, 29.3 percent of males reported 2 or more sex partners in the past 5 years, and 42 percent ever had sex with a commercial sex worker [35]. In another recent report among Mexican migrant workers in San Diego and Fresno counties, males also reported high levels of past year sex with commercial sex workers and past year methamphetamine/cocaine use [36]. Moreover, Latino immigrants also have increased susceptibility to STDs depending on their level of acculturation and their subsequent sexual behaviors. Acculturation levels can be classified differently, but generally look at time of exposure to U.S. culture, English language competency, culture and residence [37].

Studies of young adult foreign-born Mexican immigrants show a protective effect of STD/HIV acquisition because they are less likely to initiate sex than US-born Mexican and non-Mexican immigrants. However, other studies indicate a continuum of risks—new immigrants may not initiate sex, however, when they do, it is more likely to be unprotected than their US-born counterparts who are more comfortable with sexual negotiation and condom-use. Additionally, greater acculturation in women has shown increased injection drug use [38]. One study of predominantly

Mexican-origin, bilingual (English/Spanish), acculturated gay, bisexual and transgender (GBT) males in San Francisco and Chicago showed that, of this already high-risk population of men, 37 percent were classified as heavy drinkers. Risky sexual behavior (i.e. unprotected anal intercourse) increases with substance use, and studies suggest that heavy drinking bordering on alcoholism is widespread in the Latino GBT community [39]. However, it is important to remember that the high-risk individuals within these communities do not account entirely for the magnitude of the disparity—even those within the community at low risk have higher rates of HIV/STDs.

The health care and other social issues related to acculturation and immigration are important things to consider for all immigrant populations, regardless of race/ethnicity, especially when this also includes language barriers and differing medical and health practices.

Society's marginalization of these populations along with complex immigration issues, low access to culturally appropriate education and services and other stressors contribute to the disparate STD rates. Although we tend to look at individual behavioral factors, they alone do not fully explain the racial disparities in STD rates. A nationally representative study found that, while white young adults are at increased risk for STDs when they engage in high-risk sexual behaviors, African American young adults are at an elevated risk even when they practice the same levels of more common, low-risk behaviors (such as few partners and low alcohol and drug use) as do low-risk whites [40]. In addition, a study on HIV infection risks among MSM showed that African American MSM reported less overall substance use and fewer sex partners, but had higher rates of STDs and HIV [41].

Factors such as access to education, migration, acculturation and alcohol/drug use, appear to account for racial disparities in STD rates, indicating the need for both population-level and structural interventions that might reduce transmission without relying solely on behavioral interventions.

Q5: How do sexual networks affect racial disparities?

Summary trainer note:

High STD prevalence within racial/ethnic groups, neighborhoods, or other dating pools, as well as the way partnerships are spaced in time, can contribute to higher rates of STD infection. Access to a pool of high-prevalence partners can mean that individuals with apparently low-risk behaviors (e.g., one partner) can actually be at relatively high risk of STD infection. There are also racial/ethnic differences in sexual network structures such as serial monogamy versus concurrent partnerships, in part due to gender imbalances in certain populations. Concurrency alone can fuel an epidemic in the network even if the average number of sex partners is relatively low, because one infected person can quickly spread disease to many people.

Further explanation and supporting data:

Three patterns of network structure in particular have been found to affect the transmission of STDs within a population: assortative mixing, in which low-risk and high-risk individuals partner sexually; concurrency, defined as sexual relationships that overlap in time; and segregation, through which individuals who reside in racially segregated neighborhoods choose partners based on geography, resulting in a concentration of infections within their community [12].

Partnerships discordant in terms of race/ethnicity, age, education, or number of partners (i.e., assortative mixing) have been shown to be associated with significant risk for GC and CT infection [42]. Several studies have found racial/ethnic differences in partner selection and STD history. One study found that the proportion of African Americans reporting an age difference of only two years or less (i.e., age concordant) with their most recent heterosexual partner decreased dramatically from 64.3 percent in 1995 to 25.9 percent in 2004 [43]. In contrast, this proportion increased somewhat in the general population during the same period.

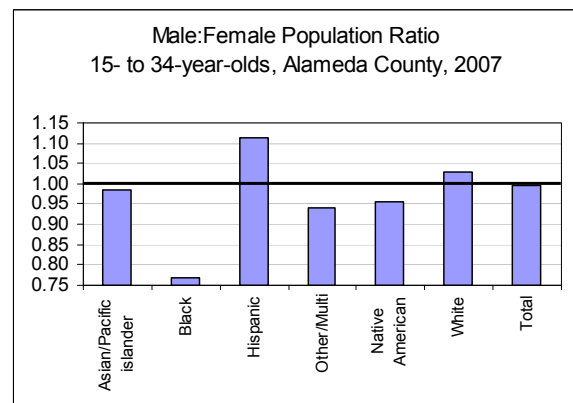
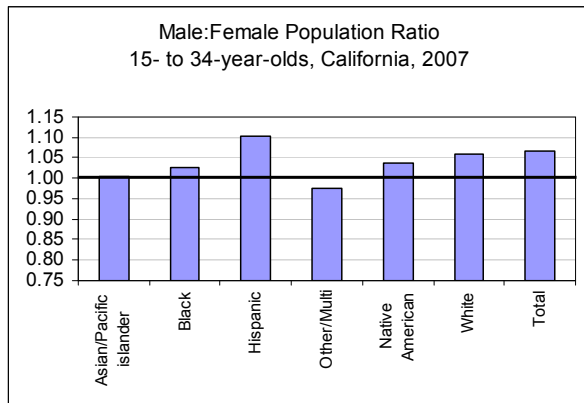
In another study, African American MSM in San Francisco had higher rates of same-race/ethnicity sexual partnerships, as well as higher rates of partners ten or more years older in age, compared to these rates in other MSM racial/ethnic groups. These differences in sexual networks among African American MSM may explain the higher HIV prevalence in this group, compared to other MSM, despite lower levels of risk behavior [43, 44].

There is a significant gender ratio imbalance of fewer men to women among African Americans in some communities in the United States, which can result in men engaging in concurrent, ongoing partnerships with multiple women. In addition, this gender imbalance influences both the practicality of and social norms regarding marriage, resulting in lower marriage rates among African Americans – and marriage has been shown in studies to be a protective factor in STD infection. Rates of partner concurrency are higher among African Americans than among other populations. Concurrency is more efficient than serial monogamy in transmitting STDs [11, 17].

The gender ratio imbalance among African Americans is partially caused by higher mortality rates in males from homicide, infant mortality, and earlier onset of chronic illness. This ratio is further impacted by disproportionately high rates of incarceration. Although African Americans account for 12 percent of the United States population, roughly 40 percent of inmates are African American, and 12 percent of African American men aged 18 to 29 were incarcerated in 2005 [45].

The bar graphs below represent the 2007 population by race/ethnicity among 15- to 34-year-olds in California overall, as well as in Alameda County, California. There is a significant gender ratio imbalance among Latinos in California (about 110 men for every 100 women) and in Alameda County (about 112 men for every 100 women). Some of this imbalance of more men among Latinos may be due to worker

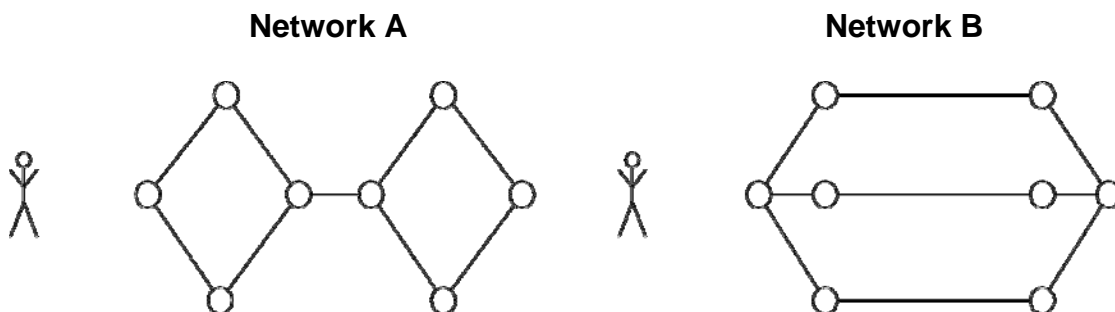
immigration patterns. There is also a significant gender ratio imbalance among African Americans in Alameda County, probably due to higher death rates, with only 77 men for every 100 women. Furthermore, because of the high numbers of African American men incarcerated in Alameda County, the ratio of African American men out of jail or prison and present in the community is actually fewer than 77 for every 100 women, which greatly affects sexual networks and STD transmission, as mentioned above.



Data Source: California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050, Sacramento, California, July 2007.

STD transmission rates remain high in African American populations because the prevalence is already high, and their partners are more likely to be other African Americans, due to individual choice and geographic segregation. Because of these factors, African Americans with lower-risk behavior and only a few partners are more likely than are lower-risk whites with few partners to encounter “core” or high-risk sex partners [46].

Network “architecture” dramatically alters risk, even though individual risk level may look the same. For outreach to succeed in reducing transmission, interventions should try to reach the most important people and cut the most important links or bridges.



In the diagram above, the two networks show that what matters is not simply risk behavior, but risk configuration. Each network has eight persons (circles) connected to nine relationships. Two persons each have three partners and the other six each have two partners, yet transmission will be less efficient in network A, and prevention will be more difficult in network B. In A, in just two steps from the index person, half the network can be infected and half spared; in B, two steps can result in everyone being infected except for the person on the extreme right. In A, sparing half the population from exposure requires intervening to prevent STD transmission at one network link or bridge, while in B, intervening at or “cutting” three bridges is required [47].

Q6: Among California reported cases, with all the missing race data, how do we know there are true disparities in STDs?

Summary trainer note:

Case-based surveillance data are often used to show racial/ethnic disparities in STD rates, but many case reports (up to 60 percent in some counties in California) are missing race/ethnic data because the provider or laboratory does not include that data with the report. However, even with the very extreme assumption that all cases with missing data were white, the African American-to-white racial differential in STD rates still remains strong. In addition, prevalence monitoring data that do not rely on reported data in California and nationwide show similar racial disparities in STD rates.

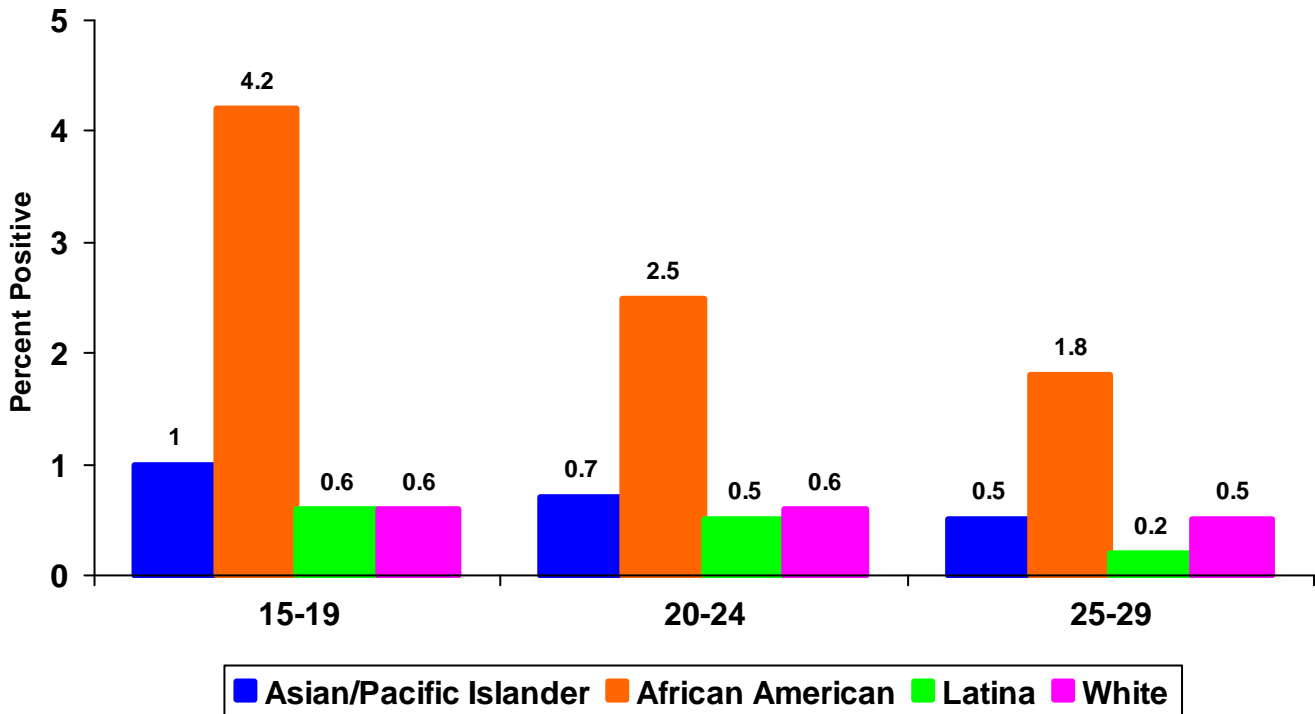
Further explanation and supporting data:

In a special California project, GC cases were interviewed and asked about their race/ethnicity after the initial case report (in which race/ethnicity is often missing) had been received. In the data from these special interviews, the pattern of race/ethnicity was essentially identical for cases for which race/ethnicity data initially had been missing compared to the cases for which the race/ethnicity data was initially complete. Based on this finding, as well as other research, we are confident that, in general, looking at the racial/ethnic differentials in case-based data gives a reasonably accurate picture of the true racial differentials, even when substantial race/ethnicity data are missing [32, 48, 49].

Prevalence monitoring projects in California that capture everyone tested at a given site and do not rely on reporting show racial disparities in STD rates similar to those found in state surveillance data. The graph below shows the percent of female clients at family planning clinics (which are generally attended by a broader range of racial/ethnic populations than are STD clinics) who tested positive for GC. For all age groups, African Americans have significantly higher proportions of positive tests than do all other racial/ethnic groups, suggesting the need for increased screening and treatment among this population.

Because this graph represents GC prevalence among women attending one type of clinic, it is a more accurate representation of actual prevalence of GC within the racial/ethnic groups that attend this clinic, compared to reported surveillance data which may be affected by different reporting rates from various sites.

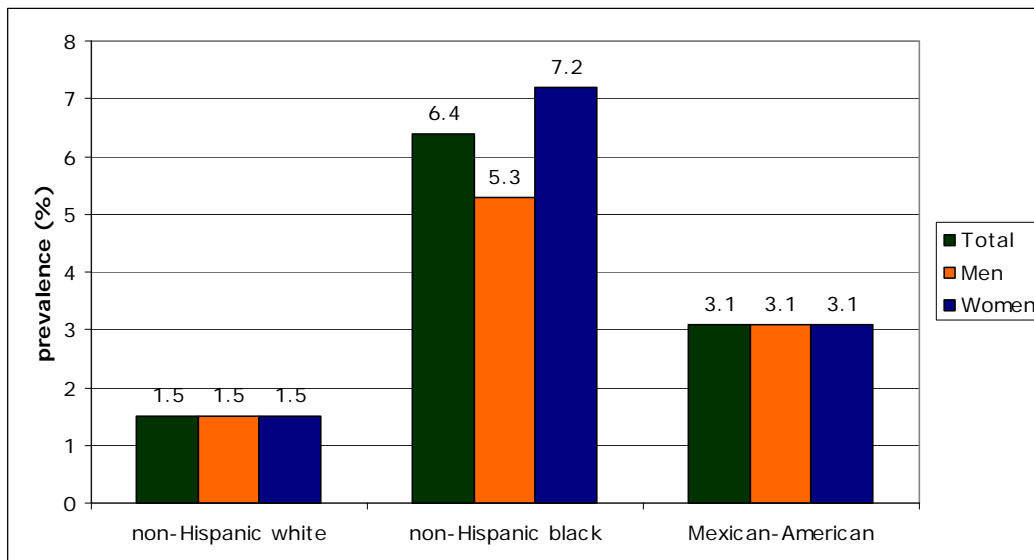
GC Prevalence Monitoring, Percent Positive for Female Family Planning Quest Clients, by Age Group and Race/Ethnicity, California, 2006



Graphic prepared by the California Department of Public Health, Center for Infectious Disease, Division of Communicable Disease Control, STD Control Branch.

In addition, national surveys that show prevalence, such as Add Health (which explores the causes of health-related behaviors of adolescents and their outcomes in young adulthood) and NHANES have found similar disparities in U.S. non-surveillance-based data, thereby supporting the accuracy of the case-based data despite missing race information [50]. The NHANES data below show the high prevalence of CT among African Americans in the United States [51].

**Chlamydia Prevalence by Race in Men and Women 14-39 years;
National Health and Nutrition Examination Survey, 1999 - 2002**



Graph adapted from: Datta, S.D., et al. *Gonorrhea and chlamydia in the United States among persons 14 to 39 years of age, 1999 to 2002*. *Ann Intern Med*, 2007. 147(2): pp. 89-96.

Q7: Is there a difference by race/ethnicity in who attends public health clinics?

Summary trainer note:

Yes, in the National Health and Social Life Survey, respondents who were young, African American, or had low SES were more likely to use a family planning clinic or emergency rooms for STD treatment than were older, wealthier, or white respondents [52]. No California-specific data is available on this topic.

Q8: Does the difference in who attends public health clinics affect STD rates by race/ethnicity in the reported cases?

Summary trainer note:

In 2006, an estimated 73 percent of STD cases were reported from sources other than public clinics in California [53]. National data suggest that non-public clinics are less compliant in reporting cases [54]. As a result, the disparity in STD rates in case-based reported data may be inflated for groups who are more likely to attend public clinics (see Q7), compared to patients who attend private clinics.

However, preliminary analysis of California surveillance data does not show a higher proportion of African American cases among those cases reported from public facilities, compared to those reported from private facilities [32], and, since African

Americans are in general less likely to seek care from any source, there could be an underestimate of their reported rate of STDs and an artificial deflation in the observed racial disparity. Randomized, population-based surveys, such as NHANES and Add Health, are a good resource for racial health disparities data because they are not affected by these same limitations in case-based reported data. As described above, the disparities seen in the California data are also found in these studies.

Q9: Are there differences in STD testing rates among races that may affect STD rates by race/ethnicity?

Summary trainer note:

It is difficult to determine rates of STD testing; however, we know from current guidelines that certain groups are the focus of targeted screening, which would increase the number of cases detected and therefore may inflate their rates. However, screening guidelines are prompted by the detection of greater morbidity among certain groups; therefore, the increased number of cases captured through screening may in fact be representative of truly higher rates.

Q10: What are some suggestions for program changes, interventions and other resources to address racial/ethnic health disparities?

Below are some general suggestions and areas of focus for action steps and programs from various resources (A through E) that may impact racial health disparities in STDs:

A. Possible strategies for decreasing racial disparities in STD rates, from CDPH CID DCDC STD Control Branch

Individual level Interventions:

- Implement culturally appropriate and effective patient counseling, health education and other behavioral interventions that aim to reduce stigma and decrease internalized oppression.

Organizational level:

- Monitor and analyze local STD/HIV data by race/ethnicity to prioritize provider technical assistance, training, screening interventions, behavioral interventions, social marketing campaigns, and other services, by high-morbidity areas and priority populations.
- Expand healthcare access programs (e.g., Family Planning, Access, Care, and Treatment (PACT)).
- Educate providers on disparities and cultural competency to improve health care service quality and usage.
- Recruit and hire professionals who are culturally competent.

- Establish, expand, and improve collaborations between public health systems and impacted communities.
- Increase implementation of culturally-appropriate programs and interventions.
 - Work with culturally-appropriate venues where people meet partners (e.g., African American MSM bars, internet sites).
 - Create, evaluate and/or implement culturally-specific and effective behavioral interventions
- Improve and increase targeted testing and treatment opportunities based on racial and geographic STD data.
 - Intervene with herpes suppression therapy when appropriate, due to the high prevalence of herpes among African Americans and the link to increased risk of HIV transmission when herpes is present.
 - Reduce high prevalence among certain racial/ethnic groups through targeted screening and earlier treatment of bacterial STDs.
 - Follow Gonorrhea screening guidelines for older African American women
 - Increase HIV testing among African American and Latina women through service integration with family planning and prenatal care
- Institute grassroots organizing, work to empower communities and local advocacy for more culturally appropriate programs and positive structural change, emphasizing assets and strengths and providing support where there are gaps.

Policy level:

- Social/political/economic change(s)
- Implement policies in correctional facilities to increase STD screening, treatment, education, and condom use during incarceration and after release.
- Implement policies in education settings to increase access to STD screening, treatment, education, and condoms for youth and young adults.
- Work to monitor the effect of and improve pre- and post-release programs and sentencing laws for the incarcerated population.
- Fund additional research on racial disparities in STDs and effective prevention strategies that affect larger social factors.

B. “Our Tasks”, outlined by Camara Phyllis Jones, M.D., M.P.H., Ph.D.

- Put racism on the agenda:
 - Name racism as a force determining the distribution of other social determinants of health.
 - Routinely monitor for differential exposures, opportunities, and outcomes by “race”.
- Ask, “How is racism operating here?”
 - Identify mechanisms in structures, policies, practices, and norms.
 - Attend to both what exists and what is lacking.

- Organize and strategize to act:
 - Join in grassroots organizing around the conditions of people’s lives.
 - Identify the structural factors creating and perpetuating those conditions.
 - Link with similar efforts across the country and around the world.

C. Results of “Health For All: California’s Strategic Approach to Eliminating Racial and Ethnic Health Disparities”, by The California Campaign to Eliminate Racial and Ethnic Disparities in Health. Adapted from the report generated by The Prevention Institute [55]:

Goal 1: Prevent the development of illness and injury by fostering healthy behaviors, healthy community environments, and institutional support of good health outcomes (not focusing only on individual health behaviors).

Twenty key factors clustered into four key areas of focus for interventions to address this goal:

Built environment:

1. Activity-promoting environment
2. Nutrition-promoting environment
3. Housing
4. Transportation
5. Environmental quality
6. Product availability
7. Aesthetic/ambiance

Social capital

8. Social cohesion and trust
9. Collective efficacy
10. Civic participation and engagement
11. Social and behavior norms
12. Gender Norms

Services and institutions

13. Public health, health, and human services
14. Public safety
15. Education and literacy
16. Community-based organizations
17. Cultural and artistic opportunities

Structural factors

18. Economic capital
19. Media and marketing
20. Ethnic, racial and inter-group relations

Goal 2: Reduce the severity of illness and injury by providing high-quality medical care to all.

1. Improve access to care.
2. Improve quality of care.
3. Provide culturally and linguistically appropriate services (including a diverse workforce).

D. Excerpts from part of the Centers for Disease Control and Prevention's (CDC) *Consultation to Address STD Disparities in African American Communities Meeting Report* (Atlanta, Georgia, June 5-6, 2007) [12]

Reducing Health Disparities: Influences and Opportunities in HealthCare Financing and Delivery (speaker Yasmin Tyler-Hill, M.D.)

- Economic, social, and physical factors converge to cause health disparities in African-American communities.
 - Geographic location of clinics: not near African-American communities
 - Insurance status and type: African-Americans are under-insured.
 - Provider payment rates: difficult to meet co-payments.
 - Linguistic and cultural competence: provider discomfort and lack of skills
 - Representation of racial/ethnic groups among health professionals
 - Implicit and explicit bias: provider value judgments and stereotypes
 - Adherence to known care standards: African-American patients may be distrustful of treatment protocols.
 - Healthcare technology: places that serve African-Americans may not have latest technology.

CDC's Heightened Response to the Ongoing Crisis of HIV/AIDS among African Americans (speaker Madeline Y. Sutton, M.D., M.P.H.)

- "Best Practices" from CDC's HIV/AIDS initiative: community mobilization, clear screening recommendations, and researchers to whom targets relate
 - Mobilizing community leaders is critical for awareness, communication and testing
 - Articulate, clear screening recommendations
 - Researchers who are culturally and demographically similar to target populations get better results.

Strategies for Prevention of Gonorrhea and Chlamydia: Achieving Common Understanding (speaker Stuart M. Berman, M.D., Sc.M.)

- Mobilize – encourage activists to develop a "passion" or cause for eliminating STDs in their communities.
- Engage – share information with communities regarding STD prevalence, and explain how these data are tracked.
- Collaborate – develop strategies for intersecting social justice causes with STD prevention at the community level.

Hearing from Us: Voices of Community Youth about STDs and Sexual Health
(moderator Dázon Dixon-Diallo, M.P.H.)

- Peer-led outreach and treatment programs are well received by young adult target audiences.
- The healthcare delivery system works best when the patient has a strong, open relationship with her/his provider.
- Treatment must be holistic and address mind, body, and spirit.

Please see the full CDC Meeting Report for more detailed summaries of speaker presentations and workshops, including topics such as social determinants of STDs, measuring health disparities, and perceptions of sexuality, faith, and STDs in African American communities.

E. Adapted from the Action Agenda from the Black AIDS Institute report titled “Left Behind: Black America: A neglected priority in the global AIDS epidemic” (August 2008):

1. Create a new sense of urgency so no one accepts that HIV/AIDS is inevitable
2. Leadership – Black ministers, civil rights leaders, and celebrities must join a national call to action and commitment to end the AIDS epidemic in America.
3. Knowledge in Black America should be increased around HIV/AIDS facts.
4. Testing should be increased – half of HIV positive Black people in the U.S. do not know their status, and therefore, do not know they can pass it on.
5. Change policy like lifting the federal ban on needle exchange programs and increasing culturally appropriate HIV/AIDS prevention efforts that include abstinence, delayed sexual activity, sexual responsibility and condom use.
6. Reduce stigma and increase support for effected groups like Black youth, women, injecting drug users and men who have sex with men.
7. Mobilization of communities to treat HIV/AIDS as a human rights issue related to economics, incarceration, homophobia, violence, and other social factors.
8. Increase Funds and Research
 - Black organizations and community leaders need more support and funds from the U.S. government in their efforts to prioritize the fight against AIDS.
 - There should be an increase in the funds allocated to HIV prevention, as well as HIV/AIDS care.
 - Public funds and private foundation funds from the U.S. that support the global AIDS epidemic should also be allocated to efforts to fight the Black American epidemic at home.
 - Research should be prioritized on HIV-related issues that Black America shares in common with other countries. And, mechanisms for a timely sharing of information gained should be established.

Q11: What are some current public health programs addressing the issue of racial/ethnic health disparities in STDs?

- I. Department of Health and Human Services Offices (www.hhs.gov):
 - A. Agency for Healthcare Research and Quality (www.ahrq.gov)
 - B. Centers for Disease Control and Prevention (www.cdc.gov)
 - 1. Syphilis Elimination Program (www.cdc.gov/stopsyphilis/plan.htm)
 - 2. HIV Testing Recommendations (www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm)
 - 3. Racial and Ethnic Approaches to Community Health – REACH (www.cdc.gov/reach2010)
 - 4. Minority AIDS Initiative (www.cdc.gov/omh/Populations/HL/HHP/MAI.htm)
 - 5. Diffusion of Effective Behavioral Interventions – DEBIs (www.effectiveinterventions.org)
 - C. Health Resources and Services Administration (www.hrsa.gov)
 - D. Indian Health Services (www.ihs.gov)
 - E. National Institutes of Health (www.nih.gov)
 - 1. The National Center on Minority Health and Health Disparities (www.ncmhd.nih.gov)
 - F. Office of Civil Rights (www.hhs.gov/ocr/)
 - G. Office of Minority Health (www.omhrc.gov) – with Minority AIDS Initiative
- II. Institute of Medicine (www.iom.edu)

III. California Department of Public Health (www.cdph.ca.gov):

A. Office of Multicultural Health

(www.cdph.ca.gov/programs/OMH/Pages/default.aspx)

B. Office of Binational Border Health

(www.cdph.ca.gov/programs/cobbh/Pages/default.aspx)

C. Center for Infectious Disease

(www.cdph.ca.gov/programs/cid/Pages/default.aspx)

1. Office of AIDS (www.cdph.ca.gov/programs/AIDS/Pages/Default.aspx)

2. Division of Communicable Disease Control

(www.cdph.ca.gov/programs/dcdc/Pages/default.aspx)

a) Tuberculosis Control Branch

(www.cdph.ca.gov/programs/tb/Pages/default.aspx)

b) STD Control Branch (www.std.ca.gov)

(1) California STD/HIV Prevention Training Center

(www.stdhivtraining.org)

IV. County of San Diego Health and Human Services Cure + Program with HIV/AIDS/TB Referrals Between the United States and Mexico

(http://www.sdcounty.ca.gov/hhsa/programs/phs/cure_tb/programa_binacional_referencia_de_tb.html)

Q12: What are some additional organizations and other resources for more information on racial/ethnic health disparities and related programs?

1. Asian and Pacific Islander American Health Forum (www.apiahf.org)

2. Black AIDS Institute (www.blackaids.org)

3. Cross Cultural Health Care Program (www.xculture.org)

4. Diversity Rx (www.diversityrx.org)

5. Kaiser Family Foundation (www.kff.org and www.kaiseredu.org)

6. National Alliance for Hispanic Health (www.hispanichealth.org)

7. National Association for the Advancement of Colored People
(www.naacp.org)

8. National Council of La Raza (www.nclr.org)

9. National Council of Urban Indian Health (www.ncuih.org)

10. National Minority AIDS Council (www.nmac.org)
11. National Native American AIDS Prevention Center (www.nnaapc.org)
12. Policy Link (www.policylink.org)
13. Project Concern International (www.projectconcern.org)
14. Tavis Smiley's Covenant with Black America (www.covenantwithblackamerica.com)
15. The California Endowment (www.calendow.org)
16. Unnatural Causes (www.unnaturalcauses.org)
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Summary

Aside from behavioral risks, multiple societal factors contribute to racial/ethnic health disparities in STD/HIV infections, including poverty, access to care, racism, and sexual networks. Addressing these health disparities is complex and requires a multidisciplinary commitment to eliminate them. The purpose of this document is to assist health departments and community agencies to build their own staff comfort levels and capacity to appropriately address health disparities, as well as to work with impacted communities to increase awareness and develop practical solutions. Accurate data, a culturally competent public health workforce, and community action are all necessary steps to develop much-needed, creative, multifaceted approaches to address and eliminate racial/ethnic health inequities.

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ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN THE PREVENTION AND CONTROL OF HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

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This special issue of *Public Health Reports (PHR)* focuses on innovations and advances in incorporating a social-determinants-of-health (SDH) framework for addressing the interrelated epidemics of human immunodeficiency virus (HIV), viral hepatitis, sexually transmitted infections (STIs), and tuberculosis (TB) in the United States and globally. This focus is particularly timely given the evidence of increasing burden and worsening health disparities for these conditions, the evolution in our understanding of the social and structural influences on disease epidemiology, and the far-reaching implications of the global economic downturn.

The global trends and adverse health impact of HIV, viral hepatitis, STIs, and TB remain among the major and urgent public health challenges of our time.¹ These conditions account for substantial morbidity and mortality, with devastating fiscal and emotional costs to individuals, families, and societies. Despite decades of investment and support, the U.S. still experiences a disproportionate burden of these conditions compared with other Western industrialized nations, with substantial health disparities being observed across population subgroups and geographic regions.² The reasons for these inequities are multifaceted and complex. It is true that individual-level determinants, including high-risk behaviors such as unsafe sexual and drug-injecting practices, are major drivers of disease transmission and acquisition risk. However, it is also clear that the patterns and distribution of these infectious diseases in the population are further influenced by a dynamic interplay among the prevalence of the infectious agent, the effectiveness of preventive and control interventions, and a range of social and structural environmental factors.^{3,4} Many of these conditions arise because of the circumstances in which people grow, live, work, socialize, and form relationships, and because of the systems put in place to deal with illness, all of which are, in turn, shaped by political, social, and economic forces.

Understanding the multilevel and overlapping nature of these epidemics, and their social and structural determinants, is key to designing and implementing more effective prevention programs.⁵ Individual risk behaviors influence the probability of contact with other infected or infectious individuals. However, these behaviors do not occur in a vacuum. With respect to STIs, an individual's sexual risk behavior occurs within the context of a sexual partnership or partnerships, which are, in turn, located within a wider sexual network. For other infectious diseases, including TB, the built or physical environment can influence patterns and opportunities for interpersonal contact, social mixing, and probability of onward transmission of the infectious agent.⁶ These more proximal determinants of transmission risk also occur within the context of wider social and structural determinants.^{7,8} Structural factors include those physical, social, cultural, organizational, community, economic, legal, or policy aspects of the environment that impede or facilitate efforts to avoid disease transmission. Social factors include the economic and social conditions that influence the health of people and communities as a whole, and include conditions for early childhood development, education, employment, income and job security, food security, health services, and access to services, housing, social exclusion, and stigma.

Our understanding of the connections between these determinants, and their relative importance to each other, has evolved over time. Earlier models for infectious disease transmission highlighted the primacy of the interactions among the individual, the infectious agent, and the environment, with infectious disease prevention and control programs being focused predominantly on targeting interventions toward the individual—e.g., individual-level counseling, testing, screening, and treatment interventions. Thus, HIV prevention has been dominated by individual-level behavioral interventions that seek to influence knowledge, attitudes, and behaviors, such as promotion of condom use, education about sexual health, and education of injecting drug users about the dangers of sharing equipment.⁴ While there has been some success with this approach, public health programs have failed to achieve sustained reductions in incidence or achieve elimination of these conditions and their associated inequities. There is also a growing appreciation that although some individually oriented interventions have shown results in reducing risk behavior, their success is

substantially improved when HIV prevention addresses the broader structural factors that shape or constrain individual behavior, such as poverty and wealth, gender, age, policy, and power.⁹

The growing recognition of the social and structural barriers to prevention and control efforts for HIV, viral hepatitis, STIs, and TB have allowed prevention experts to employ more comprehensive approaches to their interventions. Such structural approaches include actions implemented as single policies or programs that aim to change the conditions in which people live, multiple structural actions of this type implemented simultaneously, or community processes that catalyze social and political change (e.g., social mobilization to oppose a harmful traditional practice). They also include policy or legal interventions (e.g., legal actions to combat or reform a discriminatory practice), interventions to influence the way services are delivered through promoting collaboration and integration,¹⁰ contingent funding, and economic and educational interventions.¹¹ These approaches can be applied in combination with behavioral or medical interventions targeted at individuals, and aim to address factors affecting individual behavior, rather than targeting the behavior itself.

It is within this context that this special issue of *PHR* has been brought together to reflect upon the influences, opportunities, and impact of SDH on the transmission of HIV, viral hepatitis, STIs, and TB. Major strategic priorities for the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) at the Centers for Disease Control and Prevention (CDC)¹² are promoting health equity and reducing health disparities through adopting a social-determinants approach to our prevention activities. NCHHSTP also intends to place more emphasis on structural and contextual determinants of health, particularly health policy and legislation, economic and social interventions, and cross-sectoral collaboration.

COMMUNITY AND SOCIETAL CHARACTERISTICS

Five articles discuss the intersection of community and societal characteristics as a social determinant of health. Awofeso¹³ discusses the effects of prisons as social institutions that contribute to the health status and health outcomes of the incarcerated population. The article highlights the effects of prisons in mediating the risk of hepatitis C and TB transmission, and interventions and policy approaches for limiting the harmful effects of incarceration on the transmission and clinical course of these diseases.

Iralu and colleagues¹⁴ assessed the impact of socio-

economic factors and the use of traditional healing on HIV disease progression in a rural American Indian community. The study identified recent alcohol abuse, incarceration, and use of traditional medicine as important social factors affecting HIV disease management among American Indians. Winscott and colleagues¹⁵ analyzed rates, geographic distribution, and time to treatment of chlamydia, gonorrhea, and early syphilis among American Indians residing in Arizona compared with those of non-Hispanic white people. The results of this study have implications for the design of STI prevention and education programs to promote expeditious screening, diagnosis, and treatment in the American Indian population. Both articles help to address the paucity of published studies that focus on health and SDH among Native Americans.

Satcher Johnson et al.¹⁶ examine the extent to which foreign-born people contribute to the current HIV epidemic among non-Hispanic black people in the U.S. The authors found three important differences in the epidemiology of HIV among foreign- and native-born black people. First, the predominant mode of HIV transmission among foreign-born black people is heterosexual contact vs. male-to-male sexual contact for native-born black people. Second, the HIV epidemic heavily affects foreign-born black women, whose rate of HIV diagnosis in 2007 was nearly equal to that of foreign-born black men and considerably higher than native-born black women. Finally, foreign-born black people were more likely than native-born black people to be diagnosed with acquired immunodeficiency syndrome (AIDS) within one year of their HIV diagnoses. These findings have implications for the design and conduct of HIV intervention, care, and treatment programs for black people in the U.S.

Finally, Pouget and colleagues¹⁷ report on the associations of having multiple opposite-sex partners with male-female sex ratios and male incarceration rates. The authors found that sex ratios and male incarceration rates are associated with the number of opposite-sex partners in some groups. This study is important because it highlights the influence of gender imbalance on HIV and STI rates in a community.

INCOME AND SOCIAL STATUS

Four studies in the supplement focus on income or social status as a social determinant of health or examine a policy intervention. Fox¹⁸ investigates the social determinants of HIV serostatus in sub-Saharan Africa, and describes an inverse relationship between poverty and acquisition of HIV. The author reviews the literature on the positive-wealth gradient in HIV infection

in sub-Saharan Africa and discusses the implications of this finding for policy and future research around the social determinants of HIV infection in developing countries. Further, the article discusses the implications of the positive-wealth gradient for traditional HIV behavioral interventions, and suggests that economic and social policies can be leveraged as structural interventions to prevent HIV in sub-Saharan Africa.

Reed and colleagues¹⁹ examine the context of economic insecurity and debt among female sex workers (FSWs) in India, how this varies among FSWs, and its association with experiences of violence and sexual risk factors for HIV. FSWs who reported debt were more likely to report recent physical violence and risky sexual practices, including sex with occasional clients in the past week and at least one STI symptom in the past six months. This study contributes to the literature by characterizing the nature and scope of economic insecurity and HIV risk.

Dunkle et al.²⁰ explore links among economically motivated relationships, transactional sex, and HIV and STI risk among unmarried African American and white women. Study results indicate that, regardless of race, a large number of women reported staying in a relationship longer than they wanted to for economic reasons. In addition, notable percentages of black and white women reported starting a relationship in response to economic concerns. The results of this study point to the need to address economic empowerment of women in HIV/STI risk-reduction policies and programs in the U.S.

Sirotin and colleagues²¹ compare demographic and socioeconomic factors, working conditions, HIV-related risk behaviors, and prevalence of HIV and STIs among registered and unregistered FSWs. Results from their study indicate that compared with unregistered FSWs, registered FSWs lived and worked in the same location, earned more money per transaction, were more likely to have had an HIV test, and were less likely to test positive for HIV and other selected STIs. This study adds to the literature on the influence of structural determinants such as policy interventions (e.g., sex worker registration) on disease prevalence and risky sexual behavioral practices.

STIGMA

Stigma is an important social determinant and has direct relevance to health-seeking behaviors and the control and management of diseases of interest in this special issue. Courtwright and Turner²² performed a systematic review of the literature on TB stigma to identify the causes of TB stigma, and to evaluate the impact

of stigma on TB diagnosis and treatment. The review emerged with several themes: “fear of TB infection is the most common cause of TB stigma; TB stigma has serious socioeconomic consequences, particularly for women; qualitative approaches to measuring TB stigma are more commonly utilized than quantitative surveys; TB stigma is perceived to increase TB diagnostic delay and treatment noncompliance; and interventions exist that may reduce TB stigma.” The authors suggest methods to characterize TB stigma; instruments to measure TB stigma and study the effects of TB stigma on diagnosis and treatment; and interventions to reduce TB stigma.

EDUCATION

One study assesses the contribution of education to reducing STI disparities. Annang et al.²³ describe the association between education and STI diagnosis among young black and white women, and examine racial differences in this association. The authors found an inverse associated relationship between education and STI diagnosis, with the association moderated by racial group. The authors suggest that other factors besides education play an integral role in determining STI risk for young black women.

ACTIONS TO ADDRESS SOCIAL DETERMINANTS

Three articles in the supplement focus on proposed actions for addressing SDH. Satcher²⁴ issues a call to elevate the profile of SDH in public health. He expounds on four areas to ensure success: (1) “health in all policies,” as nearly all social determinants are outside the direct control of the health sector; (2) public health building stronger partnerships with non-traditional partners in the private sector, industry, and other government entities such as the transportation, education, and justice sectors; (3) including equity effectiveness analyses along with cost-effectiveness analysis in all public health work; and (4) expanding resources to address social determinants. He suggests a proactive, collaborative, inclusive, and deliberate process to advance the use of a social-determinants approach to reducing health inequities among and between populations.

Foegen²⁵ introduces the concept of “the last mile”—identifying the specific outcome to be achieved by addressing SDH. He proposes to develop a metric for health and to incorporate prevention as part of medical practice, allowing practitioners to be reimbursed for preventive medicine. Adverse social determinants could be added to the metric, and health-care reimbursement

would be linked to the impact of the determinants. He suggests that CDC develop health outcome criteria and devise a surveillance system to monitor and reward programs successfully using prevention to improve outcomes. With these expanded responsibilities, public health would serve an important role in coordinating public health and health-care delivery systems for the improvement of individual and community health.

Finally, Sharpe et al.²⁶ present a summary of a CDC consultative meeting of national public health partners to identify priorities for addressing social determinants of HIV/AIDS, viral hepatitis, STIs, and TB. The meeting resulted in a list of suggested priorities for public health policy, improving data collection methods, enhancing existing and expanding future partnerships, and improving selection criteria and evaluation of evidence-based interventions.

MOVING FORWARD: INTEGRATING SDH INTO PUBLIC HEALTH PRACTICE

Responding to increasing concern about persisting and widening health inequities, the final report of the World Health Organization's 2008 Commission on Social Determinants of Health²⁷ contained several overarching recommendations for addressing the social and structural barriers to health: improve daily living conditions; tackle the inequitable distribution of power, money, and resources; measure and understand the problem; and assess the impact of action. All of these strategies are applicable and appropriate for enhancing HIV, viral hepatitis, STI, and TB prevention programs in the U.S. and abroad. What is now needed is a paradigm shift in the willingness of prevention partners at national, state, and local levels to adopt this more inclusive approach. It is increasingly unacceptable for those planning and delivering prevention services to claim that addressing SDH is outside their jurisdiction, thereby absolving themselves of further action. In contrast, prevention specialists must begin the process of determining what collaborations, partnerships, research, and policy interventions may facilitate innovative and impactful action to address these social and structural determinants over time.²⁸

Many jurisdictions are already implementing approaches such as improving program collaboration and service integration; investing in economic interventions (e.g., micro-finance); examining opportunities for more aggressive policy and legislative approaches that change the context for prevention; shifting prevention programming to encompass a more diverse portfolio of prevention approaches that includes individual-, network-, and community-level interventions; and

investing in research to understand and address the social and structural barriers to disease prevention and control.

We hope that the information presented in this special issue will increase the dialogue about the role and impact of SDH on the epidemiology, prevention, and control of these important infectious diseases, and promote a new, re-energized, and honest dialogue that can advance and accelerate our elimination goals.

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The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of CDC.

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how do sexual networks affect HIV/STD prevention?

what are sexual networks?

Focusing on risk behavior alone does not explain why some persons and communities continue to be infected with HIV and other sexually transmitted diseases (STDs) more than others. Networks help explain why persons can have the same risk behavior and yet one may have a much greater risk of contracting or transmitting HIV.

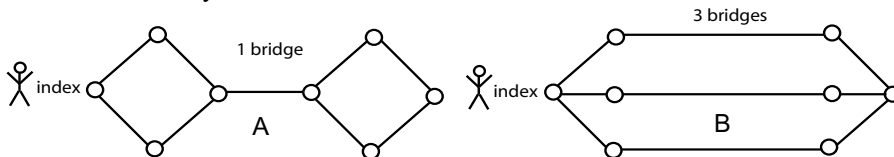
Sexual networks are groups of persons who are connected to one another sexually. The number of persons in a network, how central high-risk persons are within it, the percentage in monogamous relationships and the number of "links" each has to others all determine how quickly HIV/STDs can spread through a network.¹ Sexual networks are distinct from, but often overlap with social networks.

how do networks affect transmission?

The different ways persons select partners affect how quickly HIV/STDs can spread. **Exclusively monogamous** persons are, by definition, not part of a sexual network. If both are HIV-negative they remain so.

***Serial monogamists** are persons who go from relationship to relationship one at a time. If they have unprotected sex, they have a higher risk of HIV/STDs than exclusively monogamous persons. Earlier partners' risk may affect later partners.*

Concurrent relationships involve having more than one sexual partner in a given period and going back and forth between them. This increases the probability for transmission, because earlier partners can be infected by later partners. Further, they can serve as "nodes", connecting all persons in a dense cluster, creating highly connected networks that facilitate transmission. Concurrent partners can connect each of their respective clusters and networks as well. Concurrency alone can fuel an epidemic even if the average number of partners is relatively low.²



The two networks above show that what matters is not simply risk behavior, but risk configuration. Each has 8 persons (circles) connected into 9 relationships. Two persons each have 3 partners, and the other six each have 2 partners. Yet transmission will be less efficient in network A, and prevention will be more difficult in network B. In A, in just two steps from the index person, half the network can be infected and half spared; in B, two steps can result in everyone being infected except for the person on the extreme right. In A, sparing half the population from exposure requires cutting one bridge, while in B, it requires cutting three bridges. In a word, for epidemics, network structure is destiny.³

Says who?

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what are key concepts of networks?

Number of partners. Programs can focus on persons with the largest number of ties to others in a network. With HIV/STDs, this suggests that in addition to promoting condom usage, programs seek to identify those with a high number of unprotected partners.

Random spread broadens transmission. An infection spreads quickest when partnering is random.⁴ When partners select one another within groups such as age, ethnicity, class, religion or other characteristics, diseases may not spread to all subgroups. When partnering is anonymous or random, a disease can spread more quickly through all groups.

Core groups. Core group members have high levels of risky behaviors. They contribute a disproportionate share of HIV/STDs, and can fuel sustained transmission.

Centrality. How central an HIV+ person is to a network deeply influences transmission rates in a community. In Colorado Springs, CO, network analysts found that HIV+ persons had high levels of risk behavior but were located in peripheral areas of risk networks.⁵ This network configuration may have explained the relatively low HIV transmission levels. In contrast, HIV+ persons in New York City, NY occupied central positions within their needle-sharing and sexual risk networks, which helped explain the high observed levels of infection.⁶

can sexual networks help explain racial differences in HIV/STD rates?

Yes. Sexual networks and partner selection help explain racial differences in HIV/STD infection rates. For example, African American gay and bisexual men may take no more risk than white men, but appear to get infected much faster.⁷ In the same way, Asian American gay and bisexual men report similar risk levels but get infected at lower rates.⁸

In one national study, it was shown that heterosexual African-Americans were getting infected with bacterial STDs at rates almost five times faster than whites after controlling for individual level risk factors. Sexually transmitted infections remain in African American populations because their partner choices are more segregated than other groups. In addition, non-core African-Americans (with few partners) are more likely to choose "core" sexual partners. Non-core whites tend to choose non-core partners.⁹

what interventions influence networks?

Partner notification. Many public health departments have developed highly confidential and sound techniques of partner notification and, through network analysis, have learned to trace "up" the chain of transmission to the transmitter rather than "down" the chain to those infected.¹⁰ This allows transmitters to be identified for treatment and HIV/STD prevention counseling.

Message development. *In addition to promoting condom use and counseling, media messages can be tailored to encourage network fragmentation by encouraging serial monogamy ("one partner at a time") rather than overlapping partners.*

Community dialogue. Community-based organizations (CBOs) can play a key role in facilitating community dialogue about difficult questions about networks: How should communities balance sexual freedoms of all—including those at highest risk—with the health and future of their entire community? What community and cultural norms contribute to risky sexual networking? Additionally, CBOs should distinguish between traditionally-defined "risk groups" and those individuals with the very highest levels of risk to focus resources on them.

Addressing venues which facilitate partner mixing. *In many settings, identification of partners may be impossible. However, by focusing on venues which facilitate sexual mixing between members of both high- and low-risk networks, HIV/STD prevention workers may be able to reduce transmission. For example, many men with syphilis report meeting partners over the internet and in commercial sex venues.^{11, 12} Working with bathhouse and sex club managers and internet service providers to negotiate respective roles in promoting safer behaviors should be a priority for HIV/STD intervention workers.*

In San Francisco, CA, AIDS educators and sex club owners developed a shared set of guidelines to reduce risky behavior in the clubs.¹³ In the Netherlands, the gay dating internet site www.dateguide.nl provides interactive safer sex education for every man as he logs on.¹⁴

what still needs to be done?

At the beginning of the epidemic, network analysis helped explain some of the most important features of AIDS and helped explain its causes.¹⁵ It can still be useful now for agencies, communities, and researchers to work together to encourage sexual networks that discourage HIV/STD transmission. It has long been known and understood that some individuals contribute much more to the spread of HIV/STDs than others. Ignoring that fact, and ignoring the role of sexual networks in fueling the epidemic, hampers our ability to slow HIV/STD transmission.

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Centers for Disease Control & Prevention

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STD/STI Framing Conversation Report

March 2010

Consultation Report

Framing Conversation on Sexually Transmitted Diseases Disparities: What’s wrong? Why does it matter? And, What should be done about it?¹

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Disclaimer

The opinions reflected in this report are those of the participants of the “STD/STI Framing session and the authors.

¹ Framing Public Health Messages: <http://www.bmsg.org/documents/6HEB-Dorfman.pdf>.

Executive Summary

The Sexually Transmitted Diseases (STDs) Disparities Stakeholders Group, convened by the CDC and composed of representatives of governmental agencies, non-governmental organizations and non-traditional partners, met in conjunction with the 2010 National STD Prevention Conference to conduct a “values strategy” (framing) conversation on the issue of the disproportionate burden of Sexually Transmitted Diseases (STDs) within the African American community². Participants worked in small, facilitated groups to discuss the situation and provide CDC with suggestions and actionable items for consideration.

The framing conversation produced three major themes:

- **CDC’s internal communications and external relationships:** STDs should be addressed in concert with HIV/AIDS in the context of health in general. CDC should increase support for initiatives addressing STDs, improve coordination among divisions with overlapping activities, and, partner with external agencies and organizations that address health disparities.
- **The role of community and others in preventing and treating STDs³:** CDC should engage with the community to reach at-risk populations through culturally appropriate media, respected institutions and leaders, and health care providers. Messages need to discourage risky behaviors while avoiding stigmatization and increasing community buy-in and treatment seeking.⁴
- **Needed research and tools development:** A national plan to address STD disparities needs to clarify the goals, strategies, and measures of success based on the best practices and lessons learned by other initiatives. In framing such a national plan, CDC should draw upon the National AIDS Action Plan and relevant clinical and preventive guidelines. Additional research should be conducted and new guidelines and toolkits developed as needed to fill the gaps.

The small group discussions were organized around a series of questions regarding CDC’s recommended role in the response to the disproportionate STD burden. The questions and key findings are included below.

1. Given that African Americans are overrepresented in STD morbidity data, how should CDC be addressing this disproportionate burden?

- Federal policy and structure: STDs need to be incorporated into an all-systems approach in order to address the range of determinants of risk, including social and economic factors

2 Dorfman, L, Wallack, L, Woodruff, K. More Than A Message: Framing Public Health Advocacy to Change Corporate Practices. *Health Education & Behavior*, Vol. 32(3): 320-336 (June 2005).

3 Community: a body of persons or nations having a common history or common social, economic, and political interests (Merriam Webster Online Dictionary).

4 Community buy-in: before a nonprofit or organization can be effective the community has to get connected and desire the change. <http://www.helium.com/knowledge/123478-how-do-nonprofits-gain-community-buy-in;>
[http://www.smartec.org/smartec/dynamic/resource/sn-community.xml.pdf.](http://www.smartec.org/smartec/dynamic/resource/sn-community.xml.pdf)

such as poverty, education, and access to health care. Federal agencies should work together to develop consistent messages and guidelines.

- Research: Population data need to reflect the diversity within the African American community. A deeper and more nuanced understanding of the physiological and social determinants of increased risk to some populations is needed to better tailor interventions.
- Focus and construction of prevention and treatment programs: In order to effectively engage with the community to address the problem, collaboration among stakeholders and gatekeepers needs to be encouraged.

2. How could CDC better engage with communities, community and academic leadership, health leadership, and governmental agencies?

- Communities: Outreach to the community should include working with both health and non-health related organizations in order to reach members of the at-risk groups who might otherwise be missed.
- Community and academic leadership: CDC should engage with Black churches and Historically Black Colleges and Universities (HBCUs) while remaining cognizant that the religious underpinnings of these organizations might limit their contribution to discussions of sex, sexuality, and related issues.
- Health leadership: Outreach to health care providers could be conducted via professional organizations and through organizations with active affiliations such as Health Resources and Services Administration's (HRSA) federally funded community health centers.
- Government leadership: CDC should work with and draw on the expertise of other agencies within the Department of Health and Human Services, such as the National Institutes of Health and the Health Resources and Services Administration. It should also make the effort to move information and resources from the national level to the state and local levels.
- Thoughts on messaging: CDC should consider innovative media and methods for reaching the at-risk communities, including social networking (e.g., Facebook), the entertainment industry, and face-to-face meetings (e.g., town halls).

3. Who else needs to be engaged and how?

- CDC should engage with a variety of stakeholders in the effort to reduce the disproportionate burden, including national organizations, federal agencies, and local governments. Entities that offer health care such as colleges and universities and correctional facilities should be encouraged to standardize STD testing on an opt-out basis.

4. What are the priority steps that CDC should take?

- Actions steps that CDC should consider a priority include normalizing and integrating sexual health into its overall health agenda and integrating HIV with STD/STI issues; collaborating with other agencies to expand epidemiologic and biologic research; actively engaging diverse organizations throughout the community; developing the health care system's capacity by establishing a standard of care and other guidelines; and addressing the issue of stigma through education and messaging.

5. What will be the challenges and opportunities, and how can CDC prepare for them?

- Challenges faced by CDC include addressing the stigma attached to the issue of STDs, ensuring that messages are relevant to diverse communities within the African American population, and, ensuring that testing and treatment are covered by insurance.
- Opportunities include drawing on the community for assistance with developing relevant messages, partnering with nationally-known organizations (e.g., NAACP), and, working with groups that target youth to spread the message.

Conclusions

The participants were clear that CDC needs to play a central role in an expanded, integrated effort to address the disproportionate burden of STDs among African Americans. In addition to partnering with national, state, and local organizations, both health- and non-health related, CDC needs to work on its own internal communications and collaborative efforts. A national STD/STI agenda addressing prevention, diagnosis, treatment, and research should include the development of clinical guidelines and an outreach campaign. Above all, any effort must directly address stigmatization, have community buy-in, engage relevant stakeholders, and meet the specific needs of a diverse African American population.

Consultation Report

Framing Conversation on Sexually Transmitted Diseases Disparities: What's wrong? Why does it matter? And, What should be done about it?⁵

Introduction

In 2007, CDC established an STD Disparities Workgroup charged with initiating and expanding communication and collaboration with other governmental agencies, and with non-governmental organizations, and non-traditional partners to reduce STD disparities among African Americans. As part of the work of this group, a conversation intended to frame moving forward in addressing the disproportionate burden of STDs in African American communities was proposed. This framing conversation was intended to be a step toward engaging thought leaders to discuss the overwhelming evidence of the prevalence of STDs and HIV in the African American community and enhanced ways for CDC to address the problem. The framing conversation was held in conjunction with the 2010 National STD Prevention Conference held in Atlanta, Georgia. In this report, the process and outcomes of the framing conversation are summarized.

The Process

The framing conversation was held prior to the official opening of the Conference, following a meeting of the Sexually Transmitted Infections Curriculum: Education & Research (STICER) Coalition meeting. In addition to the STICER Coalition members, CDC staff and other experts were invited to attend the conversation. The list of participants is provided as **Attachment 1**.

The participants were welcomed by CDC staff and the purpose of the meeting was outlined. All participants then introduced themselves. It was noted that a number of the CDC staff in attendance would participate in the group discussions. It was stated that the desired outcome of the session would be to develop creative ideas and actionable items to address STD disparities. Participants were told that smaller group discussions would form the majority of the time in order to maximize the input of each of the professionals in attendance and the smaller work groups would come together to share results. It was acknowledged that the questions could easily take a day or more to discuss in-depth.

Participants were divided into four groups and charged with discussing five questions. These questions were the result of many conversations, consultations, and meetings. The anticipation was that the results of the discussion would provide CDC with suggestions and actionable ideas for consideration. The questions that were discussed were:

1. **Given that African Americans are overrepresented in STD morbidity data, how should CDC be addressing this disproportionate burden?**
2. **How could CDC better engage with:**
 - a. **Communities?**
 - b. **Community and academic leadership?**
 - c. **Health leadership?**
 - d. **Governmental agencies?**

⁵ Op.cit. page 1

3. **Who else needs to be engaged and how?**
4. **What are the priority steps that CDC should take?**
5. **What will be the challenges and opportunities and how should CDC prepare for them?**

Each group was facilitated by a member of the facilitation staff whose purpose was to guide the discussion in order to move through the questions and ensure that all had an opportunity to participate fully. At the end of the small group sessions, each group reported their major ideas and issues to the full group.

Overview of the Results

As noted, five questions were addressed in the framing conversation. In this section, an overview of the results of the framing session is provided. In the next section, a detailed review of the results of discussions of each of the questions will be presented, and, in the final section of the report, a summary and conclusions of the discussions will be presented. Several themes were pervasive in the discussions: CDC's internal communications and external relationships; the role of community and others in preventing and treating STDs; and, needed research and tools development. The issues below are organized by those themes. In this report, the findings are derived directly from the discussions and an effort has been made to maintain the voice of the participants in presenting the work and outcomes of the conversation. Therefore, some points may appear in abbreviated form or in informal language; these were derived directly from participants' responses.

CDC's Internal Communications and External Relationships

- STDs are not given the same emphasis as HIV/AIDS, and the fiscal response has been poor. STDs should at minimum be addressed in concert with HIV/AIDS, and, more appropriately, within the general context of health.
- CDC is encouraged to hold better discussions within the DSTDP and between divisions that have over-lapping initiatives. For example, STD/STI testing could be included within the HIV testing grants.
- Many governmental agencies address disparities. STD/STI should be included in all health messages, particularly those addressing health disparities.
- CDC should reach out to organizations that serve populations at risk for STDs. CDC could collaborate with many of these organizations to integrate a strong public health message on STI/STD prevention. Such agencies include those listed below.
 - Federal agencies: Departments of Housing and Urban Development, Education, and Justice; HRSA's Federally Qualified Health Centers; and, the Centers for Medicare and Medicaid Services
 - State and local health agencies
 - Correctional facilities
 - Head Start, Planned Parenthood, wellness centers
 - American Social Health Association, National Action Network
 - Colleges and universities

The Role of Community and Others in Preventing and Treating STDs/STIs

- CDC must engage with the community in delivering the message to at-risk populations.

- Population outreach efforts must work through culturally appropriate and respected leaders and institutions.
- CDC should tap into community groups with a “family-centered” approach to sexual health, sex, sexuality, and relationships.⁶ It was deemed important to engage the community on several levels; having community “buy-in” leads to inroads with other community resources and networks. The media, entertainment industry (MTV, BET), and social networks such as Facebook and YouTube would be avenues for getting the message out to diverse populations. There was concern noted that a few of the social networks depict risky behaviors and this needs to be actively addressed.
- National spokespersons representative of the populations at risk can bring awareness to the morbidity data, however, the message would need to be culturally relevant and avoid stigmatization.
- Clinicians must be reached and educated in order to advance prevention, treatment, and reporting.
- The stigma associated with STDs/STIs must be sensitively and systematically addressed.

Needed Research and Tools Development

- CDC should review the National AIDS Action Plan to identify lessons learned, best practices and goals as they continue to frame the issues as a part of a national plan to address STD disparities.
- CDC should review the HIV/AIDS plan and consider having “3 pillars” for achieving STD reduction.⁷ Currently there is not a straightforward and simple understanding about what is trying to be accomplished. Identify:
 - Targets – what are they?
 - Success – what is achievable? What are the goals?
 - Understanding – what is it that CDC wants the general public to know about STDs?
 - National Plan – work to develop a national plan to address STD disparities.
- Understanding and accounting for the diversity of populations within African American communities are essential for success in engaging with these groups and for the prevention and treatment of STDs.
- Additional in-depth needs assessments would assist CDC in determining what would work in African American communities and address the needs of these communities.
- CDC should develop tools such as guidelines. The US Preventive Services Task Force has issued a protocol for STI screening since CDC has no specific screening guidelines.^{8 9 10 11}

6 Family-centered: refers to an approach to child welfare social work in which the family is seen as the primary unit of attention. Respecting, strengthening, and supporting the family—while guaranteeing child safety—are the hallmarks of this method. National Child Welfare Resource Center for Family-Centered Practice. (2002). Program improvement plans: An agenda for change. Best Practice/Next Practice (Summer 2002), 1–6. Online.

7 National HIV/AIDS Strategy Three Pillars (Goals): Reducing HIV incidence, Increasing access to care and optimizing health outcomes, Reducing HIV-related health disparities. <http://www.whitehouse.gov/administration/eop/onap/nhas>.

8 U.S. Preventive Services Task Force has screening guidelines for STIs - <http://www.ahrq.gov/clinic/uspstf/uspsttopics.htm>.

9 CDC has STD guidelines and recommendations that include but are not limited to hepatitis B vaccination recommendations, and expedited partner therapy (EPT). <http://www.cdcnpi.org/scripts/std/cdc.asp>.

10 National Guidelines for Internet Partner Services: <http://www.ncsddc.org/upload/wysiwyg/documents/IGE.pdf>.

11 On the CDC Division of STD Prevention website (<http://www.cdc.gov/std/>), there are guidelines for many STDs. However, there is a paucity of guidelines related to community engagement and behavioral interventions specific to preventing STDs.

- CDC should develop a clear message for treatment and the standard of care for STDs/STIs by issuing guidelines with an accompanying toolkit.
- Communications should build on the latest technology as well as on low technological means.

In this section, the outcomes of the small group discussions are presented in greater detail; full data from the groups may be found in **Attachment 2**.

Question 1: Given that African Americans are overrepresented in STD morbidity data, how should CDC be addressing this disproportionate burden?

The groups provided a wide variety of ideas for addressing the disproportionate burden of STDs/STIs in African American communities. Three core areas were identified that must be addressed: 1) federal policy and structure; 2) the focus and functions of research; and, 3) the focus and construction of prevention and treatment programs. Key ideas are provided below.

Federal Policy and Structure

- Work across federal agencies and across all levels to address social determinants that potentiate increased risk and those that are protective. These must include:
 - Poverty;
 - Employment;
 - Incarceration;
 - Education; and,
 - Access to appropriate and acceptable care.
- Give STDs/STIs the same level of focus as HIV. Such focus should include increased funding for STD/STI prevention, screening, and treatment and increased levels of activity.
- Address stigma as a core issue that must be considered in order for prevention efforts to be most effective.
- Move from a public health approach to an all systems approach; broadening agenda beyond health.
- Work with other federal agencies to fund regular screening for STDs.
- Develop templates and guidelines for prevention programs to reach out to African American communities.
- Ensure that messages are accurate while being sensitive to culture; the balance is critical for credibility and fairness.
- Normalize communications around STDs/STIs across all stakeholders.

Research

- Refine the ways in which data are collected on populations to reflect the complexity of “African American” communities; this should include being able to depict the variety of people and their differing cultures.
- Develop a better understanding of the biologic/genomic factors that affect risk and protection.
- Develop clearer and better segmented understanding of the social determinants that affect risk and protection.

- Develop better understanding of why STDs affect some populations more than they affect others.
- Conduct more in-depth needs assessments in order to understand what will work; needs to take a tailored approach to learn how to deal with communities.

Focus and Construction of Prevention and Treatment Programs

- Engage with communities actively, including gatekeepers, to determine what will work best.
- Encourage collaboration of all stakeholders.

Question 2: How should CDC better engage with: Communities? Community and academic leadership? Health leadership? Governmental agencies?

Participants addressed each constituency and provided both ideas on how to engage as well as issues that may facilitate or impede engagement. Key ideas are presented by constituency below, followed by thoughts about communication. The concern about siloed funding, programs, and policies was highlighted and discussed.

Communities

- Increase efforts to engage with affected communities about STD disparities and prevention efforts.
- Work with community health centers and other neighborhood clinics to provide STD services.
- “Tap” into community groups by having a “family-centered” approach to sex, sexuality, and relationships. Also, allow community members to define the “family structure”. In some communities, the family structure may not be defined biologically.
- Establish clearer lines of communication needed between communities and CDC. Each needs to be more willing in engaging with the other.
- Build capacity among community based organizations (CBOs) already funded for other purposes.
- Consider partnering with non-traditional CBOs, i.e., athletic leagues, Boys and Girls Clubs, etc.
- Determine how to access single parent households and young parents for prevention messages.
- Determine where to find and how to reach young people who are about to reach sexual maturity.

Community and Academic Leadership

- While it is important to engage with churches, it cannot be assumed that all Black churches are progressive. It was noted that there is an ongoing struggle with issues of sex and sexuality, and homophobia persists.
- Progressive churches and ministers who are supportive and sensitive to the needs of disparate groups (e.g. gay and lesbian) should be identified.
- Many of the HBCUs were founded by religious groups; it is unrealistic to expect that all will be progressive around issues of sex and sexuality.
- Determine how HBCUs can be more progressive in their approach to HIV/STD prevention (e.g. condom promotion).
- CDC may need to reach out to a variety of institutions of higher education to reach and influence students.

Health Leadership

- Physicians should be engaged with and educated on reporting and treatment of STDs through professional organizations such as the American Medical Association, the National Medical Association, and the American Congress of Obstetricians and Gynecologists.
- The private sector could be engaged by working with insurers, community health centers, and Federally Qualified Health Centers.
- If testing is combined with outreach, the cost for expanded testing must be considered.

Government Leadership

- CDC could engage with other agencies within the Department of Health and Human Services (DHHS), including the Office of Minority Health (OMH), Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH).
- NIH should be responsible for research on genomic/biologic influences on disparities.
- CDC needs to collaborate actively within the Division of Sexually Transmitted Disease and Prevention (DSTDP) and among divisions.
- Because of the stigma associated with being a patient at the health department, local health departments may not be the most appropriate advocates for reaching into and engaging communities of color.
- CDC, working on national level shares information with states. States should utilize that information to work with local level resources, and in turn, local information should be reported to CDC. Local providers should also share information with communities. Standards for such information sharing need to be developed.

In addition to the ideas above, the groups shared thoughts about methods for reaching out and promoting prevention messages.

- When using media, the message must be rotated.
- New sources of media, Facebook, MTV, BET, should be included.
- The entertainment industry could also be engaged.
- National campaigns help at the state and local levels because states do not have the capacity to develop.
- CDC consultation meetings help; small meetings are best.
- Town hall meetings may bring community together.

It was noted that silo funding and poor data are barriers to effective STD prevention, testing, and treatment. Data is an area in which communities of color may believe that they are not well represented. It is especially important that the data effectively represent the complexity of people who are generally captured under “African American”. Accounting for the differences and similarities among segments of the population is essential to developing and implementing effective policies and programs. Such segmentation will also allow CDC and its partners to determine the best ways to deliver effective messages. The identification of spokespersons who have sufficient visibility and influence with the populations was seen as an important issue. It was also noted that better prevalence data be collected and that geocoding be done to identify high burden areas without racial coding.

Question 3: Who else needs to be engaged and how?

Discussion groups identified the following lists/organizations/facilities/groups to be engaged by CDC in preventing and treating STDs/STIs; some overlap with groups identified in Question two. Addressing stigma and overcoming silos to work across health issues was again highlighted.

- National Organizations:
 - American Social Health Association;
 - HRSA's Federally Qualified Health Centers;
 - Head Start; and,
 - Planned Parenthood.
- Federal Agencies:
 - Department of Education;
 - Department of Justice; and,
 - Department of Housing and Urban Development.
- Local Governments:
 - Municipalities; and,
 - Include cities in the Urban Health Initiative.
- Colleges and universities:
 - Wellness centers on campuses; and,
 - Social organizations on campuses that can promote prevention and intervention strategies.
- Private Sector:
 - Internet service providers, particularly those that implicitly or explicitly condone high-risk sexual behaviors.

Several additional ideas were proposed by the group discussion. First, correctional facilities at all levels should be encouraged and supported to screen both men and women for STDs. However, they will need dedicated resources in order to support screening. It was suggested that CDC make this a standard of care for jails and prisons, which will then provide leverage for incorporating screening into jail and prison health protocols.

Stigma was again noted as a persistent barrier to testing. It was suggested that if STD/STI testing became part of a standard package of testing for those under the age of 30 and paid for routinely by insurers, testing would be less likely to be stigmatized. This suggestion is in line with the current movement to offer HIV testing as a regular part of health care on an opt-out basis. It was again noted that HIV and STDs/STIs are clearly related and yet addressed separately; HIV should be integrated into all STD work and STDs/STIs into all HIV work.

Question 4: What are the priority steps that CDC should take?

While there are many action steps included in the earlier questions, participants provided a number of suggestions for immediate steps that the CDC should undertake.

- Make sure that HIV is integrated with STD issues.
- Work with CMS to increase screening age to 30.
- Focus on better internal collaboration and increased collaboration with other agencies.

- Engage with future health leadership through the Student National Medical Association and HBCUs.
- Engage with and promote the communication of STD/STI issues with the Surgeon General.
- Seek to normalize sexual health as part of CDC's priorities.
- Develop a standard of care for STDs for correctional facilities to put them in a better position for obtaining resources.
- Actively engage with religious communities.
- Improve surveillance/data.
- Urge NIH to do biologic/genomic research.
- Actively engage with community; structure activities to allow for continuous and ongoing engagement.
- Engage with diverse organizations and address stigma through education.

It was suggested that CDC undertake the following in support of moving forward with an enhanced prevention and treatment agenda:

- Review the National AIDS Action Plan to see how that plan is framing issues.
- Review the HIV/AIDS plan and consider having “3 pillars” for STD achievement – currently in STD, there is not a straightforward and simple understanding about what is trying to be accomplished. Identify:
 - Targets – what are they?
 - Success – what is achievable? What are the goals?
 - Understanding – what is it that CDC wants the general public to know about STDs
 - National Plan – work to develop a national plan to address STD disparities.

Question 5: What will be the challenges and opportunities and how do we prepare for them?

The groups identified a few additional challenges and opportunities.

- Consider how to address STDs and race without stigma. The whole sexual health conversation needs to be normalized.
- Make sure tests are covered by insurance.
- Reach out to groups that work with other groups of youth (i.e., sexual abuse groups).
- Let the community craft the message so it is relevant to them.
- Partner with nationally recognized organizations such as National Association for the Advancement of Colored People (NAACP), and fraternities and sororities.
- Message must be relevant to African Americans (African American women that have same risk level of other women, but have increased incidence of disease).

Conclusions

The framing conversation generated rich information that CDC may use to strengthen and expand its prevention, diagnostic, and treatment efforts. Several themes were prominent in the discussions and are highlighted here.

Participants were clear that CDC is the key to the prevention, diagnosing, and treating of STDs/STIs. They were equally clear that CDC, and in particular, the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), must be in an open partnership with others and that the divisions within CDC and with other organizations are impeding successful prevention and treatment. It is through such partnerships that STDs/STIs will lose their stigma and become a routine part of wellness.

In reaching out to communities, participants were focused on the appropriateness of the understanding of the populations that comprise “African American” communities and the need to better focus prevention and treatment efforts. Engaging communities must be a process in which the gatekeepers and opinion makers in these communities are actively involved in opening doors, creating and supporting messages, and changing the culture(s) that impede prevention. A national STD agenda could include developing other guidelines for behavioral intervention, community engagement, and an outreach campaign to broaden message delivery. The communities would become collaborators. The communities must have buy-in and be willing to engage with CDC in the message delivery. The communities have many components: local grass roots and community-based organizations, government agencies, academia, churches, and professional organizations. All can play a role in the development and dissemination of information, and in opening lines of communication on the topics of STD/STI prevention, overall sexual health, sex, and sexuality.

The need for ongoing research, cultural, contextual, behavioral, and biological, to best understand the etiology and means of affecting the prevention and treatment of STDs must be pursued. This research must be rooted in a clear understanding of the communities within the population and needs to be translated into information resources and guidelines that can be rapidly and widely disseminated.

Participants were pleased with the opportunity to engage with CDC and others in this conversation. It was noted in participant evaluations that the conversation was brief and that continuing such conversations could help to inform ongoing efforts. The results of participant evaluations are provided as **Attachment 3**.

Attachment 1

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	LTG Team			

Attachment 2

Full Group Data

Question 1 – All Answers by Group

Given that African Americans are overrepresented in STD morbidity data, how should CDC be addressing this disproportionate burden?

	Discussion	Follow-Up Steps
Group 1	<p>Has to 1st address the why before it can be addressed. There are some things we do know – it’s not just due to behavior. There is a greater burden of infection in African American populations; issues of access to health care; social determinants contribute to the why (poverty, incarceration, joblessness); another why is AA seeking services and overrepresented; distrust of health care system and the govt; prevention agenda and increase the capacity and look to places that are not getting this message out; broaden approach beyond health-to other services; self esteem; more out of public health approach into an all systems approach; broaden prevention agenda beyond health; biologic/genomic factor in disparities</p>	
Group 2	<p>From the data presented by T. Gift, it would have been beneficial to see corresponding data on males</p> <p>Male Screening:</p> <ul style="list-style-type: none"> • African American (AA) males have high levels of sexual activity; should there be more of a focus on men? • How can the cost of screening men be covered? <p>Larger structural issues:</p> <ul style="list-style-type: none"> • Need to address incarceration rates of black males, along with unemployment and education. 	<p>Provide data on male screening, where are men being screened, who is screened, and what is the outcome</p> <p>Develop plans and strategies to start “tackling” the structural issues</p>
Group 3	<ul style="list-style-type: none"> • Support media campaigns that are community based (CDC) • Not just AA; HIV over represented in Florida • Addressing stigmas around STD/HIV • Want to avoid things like what happened to Haitians (Haitian as risk factor) • Must be careful to not promote stigmatizing information (STIGMA) • PA around Gonorrhea/Chlamydia data, took census data to community meeting, approaching geographically can assist. • More in-depth needs assessments to determine what will work; tailored approach to learn how to deal w/ community • Once you define the area, determine gate keepers to community to find out what will work • Look @ subgroups of AA (Caribbean, African) • CDDC would help come up w/ templates • Access to services, # of factors impact • # of social determinants to access to care • How do we know what impacts this? • Why is this an issue in one population than another? (CDC) • Try to find a common denominator that is not stigmatizing (CDC) • Normalizing communications 	

Question 1 – All Answers by Group

Given that African Americans are overrepresented in STD morbidity data, how should CDC be addressing this disproportionate burden?

	Discussion	Follow-Up Steps
Group 4 Guidelines, policy, vocabulary in the msg.	<ul style="list-style-type: none"> • Launch serious effort like HIV. • STD's have not given the same respect. • Fiscal response to STD has been dismal • Stigma what is it... • Blacks are not getting fair/equitable treatment based on being PC • Credibility could be an issue if the msg is PC or correct...balance • Stake holder should/could take more effort. May not be possible b/c of affluent blacks don't want that word out (precursors to AA HIV) • US preventative task force issue protocol for STD b/c CDC has no specific guidelines. 	CDC clean up your backyard

Group 4 Notes: Fund prevention programs – providing direct services – collaborate w/ other entities to public/private surveillance, issue guidelines (STD, program) i.e., high risk is explored, training providers, public education, raise awareness, STD no recognition for STD.

Question 2 – All Answers by Group

How do we better engage with: Communities? Community & Academic leadership? Health leadership? Governmental agencies?

Group	Discussion	Follow-Up Steps
Group 1	<ul style="list-style-type: none"> • How to better engage in other gov't agencies? • CDC could better engage w/ other agencies in HHS, OMS, HRSA, NIH • Health in all policies approach • CDC division does not engage with a group that provides services for low income groups • Need to engage NIH in terms research to determine genomic/biologic influence on disparities • Need to pull details from the data as AA is a heterogeneous group – you have blacks and recent immigrants but you never see that in the data; mixed race sometimes put into the “don’t know” group; need to understand also how immigrant groups integrate into these networks • Better discussions within the DSTDP and between divisions • Integration is good but there are funding issues (disparities w/ other diseases) – siloed funding is a barrier • Include urban & suburban areas 	<ul style="list-style-type: none"> • Health leadership – engaging doctors (AMA) (NMA) to educate about the disease – morbidity moving out of clinics and into private practices – need educated about reporting and treatment of STDs – (ACOG) • Need better prevalence data • Geo-coding to show what areas have high burden and target by area and not by race – even though the area is one race • Need culturally relevant messages to address various groups with “black” population • Who delivers the message is important.
Group 2	<p>Perception:</p> <ul style="list-style-type: none"> • Communities of color distrust data, often feel that data is incorrect <p>Churches:</p> <ul style="list-style-type: none"> • Are they progressive, cannot assume that all black churches are progressive. • Struggle with the issue of sex/sexuality. Pervasive homophobia within Black churches <p>Community & Academic Leadership:</p> <p>Where are social networks for single parent households and where would you access that population? Where do you find young parents? How do you reach children that about to reach sexual maturity?</p> <p>Most of the HBCUs founded by religious institutions – hard to expect that these same institutions would be progressive related to sex</p> <p>Other universities are more progressive in their efforts to sustain health prevention (e.g. University of Miami)</p> <p>Governmental Agencies:</p> <p>Stigma associated with being at the health department – health departments may not be the best advocate for communities of color</p>	<p>Double efforts to engage affected communities about STD disparities and prevention efforts.</p> <p>Identify progressive churches and ministers who are supportive and sensitive to the needs of disparate groups (e.g. gay and lesbian).</p> <p>“Tap” into community groups by having a “family-centered” approach to sex, sexuality, and relationships. Also allow community members to define the “family structure”. In some communities, the family structure may not be defined biologically.</p> <p>Determine how HBCUs can be more progressive in their approach to HIV/STD prevention (e.g. condom promotion).</p> <p>Work with community health centers and other neighborhood clinics to provide STD services.</p>

Question 2 – All Answers by Group

How do we better engage with: Communities? Community & Academic leadership? Health leadership? Governmental agencies?

Group	Discussion	Follow-Up Steps
Group 3	<ul style="list-style-type: none"> • Faith based community ??? action → Nashville • Promoting Pastors to develop health initiatives to promote sexual health; lasted about 14 months → ??? comfort level of pastors talking about sex, MSM issues from the pulpit. • Build capacity up among CBOs already funded for other purposes (CDC) • Look to partner w/ non-traditional CBOs → Athletic leagues, youth → (CDC + State Level) • Combine testing w/ outreach must consider cost factor for expanded testing • If using media, must rotate message; (CDC) • Must include new sources of media, Facebook, MTV, BET • Get a spokesperson: Bill Cosby, Think about cancer promotion (Tony Dungy) → (CDC) • Discuss with Dr. Satcher – Focus on the Family. Gay & Lesbian (how he brought these groups together) • Must have spokespersons that are also a part of the target audience. • Need more clear lines of communication, less bureaucratic red tape between community and CDC • The community must engage w/ CDC and be receptive to engagement • Engage entertainment industry • The community should attempt to engage CDC also • CDC works on the national level “Community”, States would work w/ local level; local level → Community • Pastors for prevention in Nashville → when mayor was involved, Pastors engaged more • Information should be shared from CDC to States, to local community • National campaigns help states & local levels because states don’t have the capacity to develop • CDC consultation meetings help; small meetings • Townhall meetings may bring community together for Information sharing, ideas around certain topics • Private sector engagement; HEDIS, work w/ insurers, CHCs (community health centers), federally qualified health centers • Develop standards to pass on to the above groups • Clear line of communication from CDC to community (not necessary to be present throughout engagement) 	

Question 2 – All Answers by Group

How do we better engage with: Communities? Community & Academic leadership? Health leadership? Governmental agencies?

Group	Discussion	Follow-Up Steps
Group 4	<p>External</p> <ul style="list-style-type: none"> • Prevention • Screening <p>Stake holders</p> <p>National Action Network that could</p> <ul style="list-style-type: none"> • Get Maxine (CA) help • Preacher • Socially conscious <p>Issue:</p> <ul style="list-style-type: none"> • Community are already doing some of on the ground. They are already doing CDC could help. • CDC is not really looking at the community.. • CDC playing supportive role not the lead. • Believes that CDC (academics) don't want (to support) them. 	<ul style="list-style-type: none"> • Engage major stakeholder in the community. • Combine HIV/STD. • CDC can collaborate more effectively & look like a partner. • Go directly to the consumer w/ msg <p>The MSG</p> <ul style="list-style-type: none"> • Raise awareness & use a grassroots impact empower individuals which would generate leadership buy in • academics

Question 3 – All Answers by Group Who else needs to be engaged and how?

	Discussion	Follow-Up Steps
Group 1 Access to care issue	<ul style="list-style-type: none"> • CDC collaborate w/ other organizations like HUD to address health disparities. • Health leadership • Corrections – screen men & women • Bathhouse, internet service providers – engage those that allow for high risk sex – dist. Condoms; chat lines • Engage religious community – to overcome the stigma • Internet – Adam for Adam - primarily for AA but we can't engage them (like manhunt) b/c we don't know who owns Adam 4 Adam • Need to overcome the perception of personal responsibility • If insurers paid for standard pkg of testing – to get more people screened while not increasing the stigma – cover up to 30yrs old (CMS) • Make sure HIV integrate all of STD issues 	<ul style="list-style-type: none"> • Corrections needs resources to make the screening occur – to reallocate or raise funds • CDC could make this standard of care – screening in jails (not prison)
Group 2	<p>National Organizations: American Social Health Association (ASHA), Federally Qualified Health Centers (FQHCs), Head Start, Planned Parenthood</p> <p>Federal Agencies: Departments of Education, Justice, and Housing and Urban Development</p> <p>Local Governments: Engage municipalities, bring cities into Urban Health Initiative</p> <p>Colleges & Universities: Engage Wellness Centers on these campuses, engage social organizations on these campuses to help promote prevention & intervention strategies (example given was activities conducted on Univ. of Miami Campus)</p>	<p>Work with federal agencies to present at STD conferences that outlines how these agencies can collaborate and integrate with public health</p>
Group 3	<p>Private sector engagement</p>	
Group 4		

Question 4 – All Answers by Group
What are the priority steps that CDC should take?

Group	Discussion	Follow-Up Steps
Group 1	<ul style="list-style-type: none"> • Make sure HIV integrates STD issues – HIV embrace STDs • CDC work w/ CMS to increase screening to up to age 30 • Better collaborate w/ more agencies and within the CDC • Engage w/ future health leadership SNMA, HBCUs • Communicate issues to the Surgeon General • Normalizing sexual health as part of CDCs priorities (re: Dr Satcher) • Get standard of care for STDs – get a standard for Corrections – to put them in a better position of getting more resources • Engage religious community • Improve surveillance/data • Urge NIH to do research 	
Group 2	<p>Community: Structure format to allow for continuous and ongoing engagement with “friendly” faith leadership, HBCUs, and other “key” community groups Engage disparate organizations, address stigma through education</p>	<p>Priorities: Review the National AIDS Action Plan to see how that plan is framing issues Review the HIV/AIDS plan and consider having “3 pillars” for STI achievement – currently in STI, there is not a straightforward and simple understanding about what is trying to be accomplished. Identify:</p> <ul style="list-style-type: none"> • Targets – what are they? • Success – what is achievable? What are the goals? • Understanding – what is it that CDC wants the general public to know about STIs? • National Plan – work to develop a national plan to address STI disparities

Question 4 – All Answers by Group
What are the priority steps that CDC should take?

Group	Discussion	Follow-Up Steps
Group 3	<ul style="list-style-type: none"> • Spearhead leadership in community w/ each other (key leaders) • Establish ties w/ leadership, work w/ leaders to determine the social determinants that are leading to ↑ rates (needs assessments would help w/ determining social determinants) • Message must be provocative to be seen on You Tube (CDC normally can't produce these types of videos) • Media messages can be spread using little money • Keep in mind the goal → what are we trying to change? Behaviors, attitudes • Peer to Peer discussions • Add STD testing to HIV testing grants (prisons, jails, CBO grants) • A kit on how to work w/ local Health Departments on how to engage (school boards), how to run that type of meeting to promote discussion, discussion guides, key messages to include • Peer groups discussions should include difference types of students, need student that may be marginalized. • Include/clear up misconceptions around STDs • It's real • Promote other testing → online testing • CDC working w/ AA Radio 	
Group 4		

Question 5 – All Answers by Group

What will be the challenges and opportunities and how do we prepare for them?

	Discussion	Follow-Up Steps
Group 1	<ul style="list-style-type: none"> • How to address STDs and race w/o stigma? – need to normalize the whole sexual health conversation. • You need political spin-make sure tests are covered by insurance. 	
Group 2		
Group 3	<ul style="list-style-type: none"> • Go to groups that work w/ other groups of youth (sexual abuse groups) • Let community craft the message so it is relevant • Partner w/ nationally recognized organizations (also consider private) • Need clarity to data presented • NAACP, Urban League, fraternities & sororities are nationally recognized organization that CDC can engage • Message must be relevant to AA (AA women that have same risk level of other women, have ↑ incidence of disease) 	
Group 4		

Attachment 3

Participant Meeting Evaluation Data

STD/STI Framing Conversation Evaluation Results

ID #	GROUP	The objectives of the meeting were clear	The meeting was managed effectively.	The physical arrangements were adequate	The format of the meeting was appropriate and allowed enough time for work groups to be productive	The facilitators were prepared.	The facilitators effectively moved the group through the work session	I was satisfied with the meeting summary and wrap-up
1-1	1	4	4	4	2	4	4	3
1-2	1	4	4	4	4	5	5	5
1-3	1	4	3	2	3	5	4	3
1-4	1	5	4	4	4	5	5	5
2-5	2	5	4	4	4	5	5	5
2-6	2	4	3	4	5	5	4	4
2-7	2	5	4	5	5	5	4	5
2-8	2	4	4	4	4	4	4	4
2-9	2	4	5	3	3	4	4	5
2-10	2	4	4	4	4	4	4	4
2-11	2	4	4	4	5	5	4	4
3-12	3	5	5	5	5	5	5	5
3-13	3	4	5	3	5	5	4	5
3-14	3	3	4	4	3	5	4	4
3-15	3	5	5	5	5	5	5	5
4-16	4	4	4	4	4	5	5	4
4-17	4	5	5	4	5	5	5	5
4-18	4	5	5	5	5	4	4	3
4-19	4	5	4	5	2	4	4	4
4-20	4	5	5	5	4	5	5	5
4-21	4	4	4	3	4	4	3	4
0-22	UNK	4	5	4	4	5	4	4
0-23	UNK	5	4	5	5	5	5	5
0-24	UNK	5	4	4	4	4	4	4
AVERAGE		4.42	4.25	4.08	4.08	4.67	4.33	4.33
AVERAGE BY GROUP								
1		4.25	3.75	3.50	3.25	4.75	4.50	4.00
2		4.29	4.00	4.00	4.29	4.57	4.14	4.43
3		4.25	4.75	4.25	4.50	5.00	4.50	4.75
4		4.67	4.50	4.33	4.00	4.50	4.33	4.17

Scoring Key: 1= Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree, 5= Strongly Agree