

REPORT OF THE  
**SYPHILIS ELIMINATION EFFORT CONSULTATION**

**AUGUST 1-2, 2005**

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ATLANTA, GEORGIA

TOGETHER  
WE CAN

**SEE**

**SYPHILIS**  
ELIMINATION EFFORT

Report prepared by the Division of STD Prevention  
National Centers for HIV, STD and TB Prevention  
Coordinating Center for Infectious Diseases



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
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“The reward of a thing well done is to have done it.” EMERSON (1844)

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# 1. Introduction

In 1999, the Centers for Disease Control launched the National Campaign to Eliminate Syphilis from the United States. The National Plan, developed in consultation and collaboration with local and state health departments, other federal agencies, private interests, and the communities most affected by syphilis, had as its chief goal the reduction of infectious syphilis to 1,000 or fewer cases in the U.S. by 2005. The 1999 national plan was organized around 5 strategies: 1) Enhanced Surveillance, 2) Strengthened Community Involvement and Organizational Partnerships, 3) Rapid Outbreak Response, 4) Expanded Clinical and Laboratory Services, and 5) Enhanced Health Promotion. At the national level syphilis elimination was defined as the absence of sustained transmission in the U.S. At the local level it was defined as the absence of transmission of new cases within a jurisdiction beyond 90 days of report of an imported index case.

In the six years since the launch of the 1999 plan, the changing disease epidemiology and consequent shift in prevention priorities have driven the need to reframe the future direction of the Syphilis Elimination Effort (SEE). To achieve this, a comprehensive review of the progress made is required, alongside early and meaningful consultation with external stakeholders.

## 2. Aims and Objectives

The overall purpose of the August 2005 SEE Consultation Meeting was therefore to provide key partners with a SEE progress update, including achievements and challenges, and to solicit partner input for adapting implementation strategies. Specific objectives were:

- 1) To provide stakeholders with an update on the current status of the SEE and achievements to date;
- 2) To explore the nature of elimination as it applies to syphilis, including new challenges facing the SEE in the 21st Century;
- 3) To identify best, promising and innovative practices which might be relevant to future SEE; and
- 4) To identify new ways of framing the SEE, based on a new understanding of disease epidemiology.

## 3. Organization of the Meeting

### *Participants*

Expert consultants from both the Centers for Disease Control and Prevention (CDC) and external partners and stakeholders were invited to participate in the meeting. The participants included a wide range of individuals from a variety of disciplines and professions (see Appendix C). Additionally, participants were ethnically and geographically diverse, and represented both the public and private sector. CDC partners included colleagues external to the Division of STD Prevention.

## ***Meeting Structure***

The meeting was organized into 4 sessions (see Appendix A). An introductory session (Celebrating the Syphilis Elimination Successes and Acknowledging the Challenges) was followed by three sessions which focused on specific aspects of SEE review and implementation: Session 2 - Improving the Health Services Response for Syphilis Elimination; Session 3 - Creating Effective Partnerships for Syphilis Elimination; and Session 4 - Enhancing Implementation of the Syphilis Elimination Effort. Sessions 2, 3, and 4 also included individual breakout workgroup discussions. The breakout workgroup topics were as follows:

**Table 1 Breakout Session Topics**

<b>SESSION 1 Improving the Health Services Response for Syphilis Elimination</b>	<b>SESSION 2 Creating Effective Partnerships for Syphilis Elimination</b>	<b>SESSION 3 Enhancing Implementation of the Syphilis Elimination Effort</b>
<ul style="list-style-type: none"> <li>• SEE and Surveillance</li> <li>• Enhancing Outbreak and Incident Response</li> <li>• Enhancing Clinical and Laboratory Services</li> <li>• Enhancing Partner Services</li> </ul>	<ul style="list-style-type: none"> <li>• Tailored Interventions: Jail Screening</li> <li>• SEE Interventions and Ethnic Minorities</li> <li>• SEE Interventions and MSM</li> <li>• SEE and Community Involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Training, Staff Development and SEE</li> <li>• Monitoring and Evaluation</li> <li>• Health Care Provider Mobilization</li> <li>• Effective Local Implementation of SEE</li> </ul>

## ***Key Questions for the Meeting***

In preparation for the meeting DSTDP staff prepared a series of background position papers based on each of the topics listed in Table 1. Included in each of the papers was a set of key questions that emerged as a result of findings from the position papers. These central questions formed the focus of the discussions conducted during the breakout sessions. A complete list of the key questions by topic area is included in Appendix B of this report.

## ***Summary of Breakout Session Discussions***

As previously noted, key questions from each of the topic areas (enhancing the health services response for syphilis elimination, creating effective partnerships for syphilis elimination, and enhancing the implementation of the syphilis elimination effort) formed the basis of the discussions in each of the breakout sessions.

This report summarizes the presentations and discussions held during the consultation meeting. What follows is a summary of each the respective discussions under each of the topic areas.

## 4. Syphilis Elimination: Celebrating the Successes and Acknowledging the Challenges

### *Recent Trends in the Epidemiology of Syphilis in United States*

By Dr Tom Peterman

During the 1990's the primary and secondary (P&S) rate of syphilis decreased by approximately 90%, and by the year 2000, the rate had reached it lowest point since reporting began in 1941. Reported early latent syphilis cases have also continued to decline from a high of 55,397 cases in 1990 to 8,361 cases in 2003. However, there are recognized challenges associated with correctly classifying early latent cases; many of which may actually be incorrectly staged P&S cases.

In 2003, approximately 80% of U.S. counties reported no cases of P&S syphilis, and fully half of the total numbers of P&S cases in the U.S. were reported from only 18 counties and 1 city. Despite increases in P&S syphilis among men, between 1991 and 2003, the average yearly percentage *decrease* in P&S syphilis rate in women was 21.4%, and the average yearly percentage *decrease* in the congenital syphilis rate was 17.2%. The U.S. syphilis epidemic, although a long-standing health disparity for African Americans, by 2003 was down from 44:1 to only 5.2 times greater than the rate among whites. In 2003 only among African Americans was there a decline in P&S rates (17.9%). Table 2 illustrates the percent changes in P&S rates across U.S. racial/ethnic groups during 2002-2003.

**Table 2. Percentage change in P&S Rates 2002-2003**

Racial/Ethnic Group	% Change in P&S Rates 2002-2003
African Americans	17.9% decline
Asian/Pacific Islanders	25% increase
Hispanics	20% increase
American Indians/Alaska Native	38.1% increase
Whites	25% increase

Unfortunately a significant factor in the reduction of the syphilis health disparity between African Americans and whites is attributable to the increasing rate of P&S syphilis in white men who report having sex with men (MSM). Based on provisional data from 2003-2004, it is estimated that more than 60% of infectious syphilis cases are in men-who-have-sex-with-men. Since the late 1990's almost simultaneously there have been increases in syphilis cases among MSM in large cities across the U.S. A large proportion of these persons, whose median age is in the mid-30s, are also infected with HIV.

\* Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2003. Atlanta, GA: US Department of Health and Humans Services, September 2004.

Associated with the recent syphilis outbreaks in MSM is the growing epidemic of crystal-methamphetamine abuse. As an example, during the consultation meeting it was noted that in the last month, 30-40% of infectious syphilis in San Francisco involved crystal-methamphetamine use. Other participants also expressed concern that they may be seeing an emerging problem with syphilis infections and crystal-methamphetamine abuse in heterosexuals.

## ***Overview of the U.S. Syphilis Elimination Effort***

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**By Dr Kevin Fenton**

Syphilis remains easily preventable and readily curable. Infectious syphilis rates remain very low and relatively geographically concentrated. Eliminating infectious syphilis would: 1) improve infant health, 2) reduce HIV transmission, 3) reduce health care costs, 4) eliminate a long-standing health disparity in the U.S., and 5) strengthen U.S. public health capacity. Building on the lessons learned from past syphilis prevention and control efforts, the 1999 National Plan to Eliminate Syphilis from the U.S. had as its primary goal the reduction of P&S syphilis cases to 1,000 or fewer and to increase the number of syphilis-free counties to 90% by 2005.<sup>†</sup> The 1999 plan, developed in collaboration with state and local partners, was organized around 5 key strategies: 1) enhanced surveillance, 2) strengthened community involvement and organizational partnerships, 3) rapid outbreak response, 4) expanded clinical and laboratory services, and 5) enhanced health promotion. The 1999 plan called for new STD prevention and control measures, such as more active participation of affected communities in intervention efforts, combined with intensified more traditional approaches, such as partner notification and rapid outbreak deployments enhance local outbreak response.

Since the launch of the 1999 campaign, there have been important gains made in the prevention and control of infectious syphilis. The numbers of cases in women and in African Americans have continued to decrease every year, and congenital syphilis, which peaked in 1991, has declined by more than 90% in 2003. In general, Syphilis Elimination has meant additional fiscal and staff resources, increasing access to quality STD screening, treatment, and health education services. Since 1999, CDC has invested more than 107 million dollars in the Syphilis Elimination Effort (SEE). SEE funding is approximately at \$18 million for 2005. Between 2000 and 2003, 36 comprehensive *Syphilis Elimination Program Assessments*<sup>‡</sup> of health department syphilis elimination activities were conducted and there have been 11 *Rapid Response Team*<sup>§</sup> deployments to local communities.

Despite the significant gains made towards eliminating syphilis in the U.S. since 1999, there are important challenges to achieving elimination. The overall number of cases of P&S syphilis did increase between 2000-2003, due mainly to increases in men, associated with the syphilis outbreaks in MSM in large urban areas across the U.S. Maintaining syphilis elimination

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<sup>†</sup> Centers for Disease Control and Prevention. The National Plan to Eliminate Syphilis from the United States. Atlanta, GA: US Department of Health and Human Services, October 1999.

<sup>‡</sup> Centers for Disease Control. The syphilis elimination program assessment and findings monograph: "Lessons Learned". Atlanta, Ga: U.S. Department of Health and Human Services, 2005.

<sup>§</sup> Centers for Disease Control and Prevention. Rapid Response Team Procedures. Atlanta, GA: US Department of Health and Human Services, November 2003.

momentum in the initially targeted populations of heterosexual minorities while expanding efforts to respond to newly affected groups, such as MSM, is likely to be a challenge in a time of limited resources. Additionally interventions which have been relatively successful in heterosexual minority communities may not translate effectively to MSM groups. As an example, the term *elimination* may need to be changed to *eradication* to more effectively mobilize recently affected gay communities. Specifically tailored interventions may require further tailoring for ethnic and cultural differences in gay-identified MSM and non-gay-identified MSM. And given the current co-infection rate of HIV and syphilis in MSM groups in particular, it is likely that there will be interactions between HIV and syphilis that result in the altered natural history of syphilis and reduced effectiveness of syphilis treatments, in addition to the enhanced transmission of HIV. New community partners may require a more holistic approach to health if they are to fully engage in the elimination effort. It will be important to review and potentially reframe the Syphilis Elimination Effort (e.g., health disparity affect vs. HIV viral load affect).

Additionally, with the ever increasing use of rapid tests for HIV infection, there is a pressing need to develop and use effective rapid tests for syphilis, since such tests as OraQuick can act as a barrier to syphilis testing which requires a blood sample. A rapid test could enable more syphilis screening in a variety of traditional and non-traditional settings, although it is imperative to regularly evaluate the effectiveness of these screenings activities.

Eliminating syphilis requires ongoing commitment and resource investment. Early budget estimates for a national syphilis elimination effort were set at upwards of \$80 million annually and the federal portion of this budget was estimated to be at approximately \$37-39 million annually. Despite increases in the federal resources the estimated annual budgets were not achieved, and currently increases in federal funding is still more limited. In general the CDC operating budget has decreased, and state and local budgets have decreased as well.

The Syphilis Elimination Effort exists within a context of competing public health priorities, and greater community level advocacy will be needed to garner resources to continue to support syphilis elimination activities adequately. Further, to be effective an elimination initiative will involve meaningful collaboration among key stakeholders, such as community opinion leaders, STD program managers, and affected community members. Perhaps too there is a need promote further integration of STD and HIV prevention and control efforts in general. Cross-training for health department and community-based organization staff could result in improved health promotion broadly. Indeed the restructuring currently underway at CDC may actually advance this level of program integration.

## ***A Syphilis Elimination Progress Report from Four Perspectives: An Invited Panel Discussion***

The meeting also featured a moderated panel discussion, comprised of 4 panelists drawn from the Division of STD, state and local health departments, and an academic institution. The discussion was organized around 4 central questions (one per panelist). Table 3 lists the questions and the respective panelist assigned.

**Table 3 Panel Discussion Questions**

<b>Question</b>	<b>Panelist</b>
1. Given competing issues and priorities, why should syphilis elimination remain a top priority for CDC?	Susan DeLisle, Division of STD Prevention
2. Given recent increases in STDs among men who have sex with men (MSM), is eliminating syphilis among MSM a valid goal? What should we do to achieve syphilis elimination in MSM?	Dave Novak, Massachusetts Department of Health
3. What impact would rapid (point-of-care) tests make on syphilis elimination activities? How can we expedite their implementation in the U.S. setting?	Sheila Lukehart, University of Washington
4. What is the role of affected community participation in syphilis elimination? Should 30% of available funds still be earmarked for community organizations?	Stephanie Bailey, Metro Public Health Department of Nashville/Davidson County

As part of the panel discussion audience participation was encouraged. What follows is a summary of the discussions around each of the questions.

### **1. Given competing issues and priorities, why should syphilis elimination remain in a top priority for CDC?**

Syphilis elimination should remain a CDC priority. Much has been invested in the effort thus far, and without these efforts it is likely that the U.S. syphilis epidemic would have worsened. It is important to note that U.S. STD programs have never had the luxury of looking at one disease. Competing priorities are to be expected. Efforts should be expanded to address the emerging disease among men-who-have-sex-with-men. Programs will need to examine what works and what does not. Interventions used in the past may not be appropriate now. There will be increased costs, yes, but disease elimination is a costly undertaking. It is important to be efficient and effective in resource allocation, but it is also important to measure the intangible benefits that may not be counted in cost-effectiveness formulas. And it would not be appropriate to risk “pitting” affected communities and groups against each other for limited resources.

CDC should leverage CDC’s “clout” and perhaps provide incentives to private companies for support, particularly as it relates to the development of a rapid syphilis test. In general,

public health practitioners at all levels should be thinking of more effective ways to use the limited funds available. As another example, CDC could lead the way in providing incentives to Disease Intervention Specialists (DIS) such as improved training that leads to professional certification, similar to what is currently done for those in the medical profession. The certification core competencies could include provider visitation, and lab visitation, etc.

In the Syphilis Elimination Effort there should not be a clash between history and the present. There are valuable lessons to be learned from the past and important innovations emerging now. Syphilis elimination can inform other STD program prevention efforts, including those aimed at preventing HIV. There should be careful consideration of the heterogeneity across the groups of persons who are at increased risk for syphilis. There should be no marginalization of one group over another, and again no encouraged competition for the public health response. "When the syphilis elimination effort is successful, this will be the most cost effective disease elimination in history."

**2. Given recent increases in STDs among men who have sex with men (MSM), is eliminating syphilis among MSM a valid goal? What should we be doing to achieve syphilis elimination in MSM?**

Eliminating syphilis in MSM is a valid goal. However it cannot be "business as usual." To effectively control and prevent syphilis in MSM, STD programs will need to move forward, finding more positive ways to intervene. For example, although the current ISTD intervention model is effective with many MSM, for some others the model could be perceived as manipulative and victimizing. MSM, after all, are not a monolithic group. Prevention materials that assume uniformity are likely to be less effective. This heterogeneity in MSM could also be important for the quality of syphilis surveillance. For example, perhaps surveillance systems should also be able to capture transgender status, in addition ethnic identities such as Afro-Caribbean. In general disease intervention specialists need training to improve cultural competency for interactions with MSM. They need specialized tools to work in different intervention venues. It could prove very valuable to observe the DIS staff who are more effective in their partner interview encounters with MSM to ascertain what makes these interactions more effective. How does the more effective DIS staff person gain the confidence of MSM clients such that they are able to learn the names of sexual partners who may be at risk for syphilis?

It is important to identify MSM gathering places as well as identify where MSM seek testing services. MSM are being tested at private providers in private practice. STD programs will need to better identify the key private doctors and work more effectively with them around such issues as sexual risk assessments and sexual risk reduction counseling. Achieving syphilis elimination in MSM groups is also likely to mean addressing social prejudice and discrimination directed towards MSM, in much the same way achieving syphilis elimination in African Americans had to address racial prejudice, discrimination, and ongoing health disparities. Involving relevant MSM-serving community-based organizations in the effort is one means of building trust with MSM populations.

It is also critical to more fully understand the role of the Internet in sustaining the U.S. syphilis epidemic. A number of health departments are making use of the Internet as a means to raise awareness of syphilis, promote testing, and facilitate partner notification, however many use weak wording such as *you may have been exposed to a STD* for partner notification purposes; or use a false profile to provide health education information.

It may be better to be honest and use the health department's true profile. Increased use of the Internet is likely to mean more collaborative partnerships with the private sector, such as with Manhunt.com. The Massachusetts State Health Department STD program has developed a toolkit for mobilizing providers serving MSM, as well as a guide for working with Internet Service Providers such as Manhunt.com.

**3. What impact would rapid (point-of-care) tests make on syphilis elimination activities? How can we expedite their implementation in the U.S. setting?**

A test for distinguishing treated vs. untreated syphilis would be great. Robert George, a microbiologist at the CDC is currently working to identify antigens that can be used for such a test. The point-of-care tests may have a place in very low resource areas but interpretation (of these tests) is going to be a very big issue. These tests will stay reactive even in people who have been adequately treated which may lead to unnecessary treatment. A rapid VDRL-based test would be better than the existing treponemal tests because of this issue. However, in the antenatal clinic setting in developing countries, there are social implications of telling a woman that she has syphilis if, in fact, she does not have active disease. Her husband may accuse her of having sex with others; he may kick her out of the house, he may kick her. This is an issue that public health practitioners and program planners, in the U.S., may not fully appreciate.

**4. What is the role of affected community participation in syphilis elimination? Should 30% of available funds still be earmarked for community organizations?**

Based on the Nashville/Davidson County experience, community partnership and mobilization is an essential component. Communities need to select local leadership to support and sustain efforts regardless of funding increases and decreases. The mayor of Nashville has publicly supported the syphilis effort and there has been an integration of syphilis into other programs to "make the money stretch." Nashville/Davidson's County local public health infrastructure is stronger because of the SEE collaborations. Integration has been essential in improving the quality of syphilis elimination services.

Syphilis rates have declined in Nashville/Davidson County. The successes in syphilis prevention and control are attributed to the health department's proactive approach to partnerships with affected communities. In the past that has primarily meant partnerships with African American heterosexual groups, however recently the partnerships have been expanded to include MSM, to better understand MSM populations and their risks for syphilis, and HIV, as well as other STDs.

The one critical lesson the local program quickly learned is the important role of the private healthcare sector for preventing and controlling syphilis in MSM. As an example, approximately 349 cases have recently been reported from the private sector, and because many of these cases had not been entered into their system initially, some have gone without standard partner notification follow-up. Health departments are encouraged to enter into MOA's with community agencies, hospitals and clinics and with one another to create a local standard of care. Such an approach could ensure the appropriate prioritization of needs and community mobilization activities around specific issues as they happen. This kind of partnering should include diversified funding streams versus single-source resources and promote suitable levels of funding flexibility to enhance more effective program planning and implementation.

## 5. Enhancing the Health Services Response for Syphilis Elimination

### Quick Summary

#### Box 1. Suggestions for Enhancing the Health Services Response for Syphilis Elimination

Strategy:	Suggestions for enhancement
<b>Surveillance:</b>	<ul style="list-style-type: none"> <li>• Ensure evaluation and epidemiological skills at the local level</li> <li>• Ensure adequate local training available for NEDS</li> <li>• Examine surveillance indicators at local level</li> <li>• CDC to mentor and support local epidemiologists, provide guidance and TA</li> <li>• Develop ready-reckoner to easily assess functioning of local surveillance systems</li> <li>• CDC to work with CSTE to support local areas and provide TA and build capacity</li> <li>• Make gender of sex partner reporting a performance measure.</li> </ul>
<b>Outbreak and incident response</b>	<ul style="list-style-type: none"> <li>• Project areas and CDC must be clear about what constitutes an outbreak.</li> <li>• CDC should create an outbreak response plan template</li> <li>• Good disease and behavioral surveillance are key to inform the outbreak plan</li> <li>• Guidance is needed to assist project areas to determine outbreak thresholds</li> <li>• A "best practice" model is required to help program areas develop outbreak plans</li> <li>• Outbreak plans should identify resources for surge capacity</li> <li>• Project areas should be encouraged to collaborate regionally</li> <li>• CDC should provide guidance for local STD programs on testing outbreak plans</li> </ul>
<b>Clinical and laboratory Services</b>	<ul style="list-style-type: none"> <li>• Recognize that an increasing proportion of cases are being diagnosed in the private sector – especially MSM.</li> <li>• Do not lose sight of the heterosexual epidemics and the need to provide culturally sensitive services to pregnant women and in venues where cases are found</li> <li>• Encourage medical schools to include STD in their curricula</li> <li>• STD programs should work with community partners to advocate for their services</li> <li>• Health departments should aim for maximum efficiency of their services e.g. by improving utilization of resources or patient flow.</li> <li>• Health departments should create robust and innovate partnerships with private practitioners e.g. STD training, regular liaison, grand rounds, online courses</li> </ul>
<b>Partner Services</b>	<ul style="list-style-type: none"> <li>• CDC should educate health department partners about HIPPA guidelines as they apply to partner services</li> <li>• Clustering is a good tool for long-term use by more experienced DIS, however standardized training is required</li> <li>• CDC should take the lead in improving DIS training including competency based straining and professional certification.</li> <li>• Although PN in non-health department settings is important, it may be cost-effective to assign HD employees to non-traditional sites</li> </ul>

## ***Syphilis Elimination and Surveillance***

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### **Question 1: What steps can be taken to improve surveillance and epidemiologic capacity locally in the short- and long-term?**

It is critical to ensure the efficacy of evaluative and epidemiological skills at the local level in order to support any national surveillance system. "Any national system is only as good as the local system that feeds it." To collect appropriate surveillance information and to correctly analyze, interpret, and disseminate it, project areas must have appropriate epidemiologic expertise on staff and opportunities for epidemiologic training so that such expertise may be enhanced over time. Innovative approaches for training and career development of STD surveillance personnel should be developed and supported at the national level and local levels. Some approaches may include these: providing training for health department personnel in a variety of program areas (e.g., STD, HIV, or communicable diseases) and public health disciplines (e.g., epidemiology, biostatistics, and program management), to improve the capacity of existing personnel to conduct effective surveillance; using a variety of training approaches (e.g., rotation of staff through "model programs," distance learning, train-the-trainer programs, teleconferencing, data analysis workshops); and encouraging NCSD and CSTE to work with CDC to help provide technical assistance to STD prevention programs that have a limited capacity to conduct syphilis surveillance.

The implementation of the National Electronic Disease Surveillance System (NEDSS) and specifically the sexually transmitted disease program area module (STD PAM) will require that State and Local control programs have staff that is adequately trained in information technology system and surveillance policies and principles. Epidemiologic expertise is necessary to help ensure that syphilis surveillance data are collected systematically, data are analyzed and interpreted appropriately, and that surveillance findings are disseminated effectively to promote the elimination of syphilis transmission.

Important to all of this is sufficient funding for surveillance that will also support solid surveillance infrastructure. Additionally consistent use of case definitions would greatly improve surveillance, both domestically and internationally. In some locations there seems to be a disconnect between case reporting and case definitions. One example of this is the reporting of cases (a completeness issue) versus reporting the treatment or non-treatment of cases.

### **Question 2: What measures should be taken to monitor adequacy of surveillance activities?**

Currently CDC has minimal capacity to routinely and systematically assess the quality and usefulness of local surveillance data, nor does CDC request that such assessments be conducted locally. However, the quality of national surveillance data and its consequent usefulness is only as good as the quality of the data collected locally.

Examining surveillance indicators at the local level would inform the national and local stakeholders. CDC needs a means of assisting local programs to provide incentives for

improved provider reporting. Local programs and CDC should work together to ensure that data is reported and analyzed in a timely manner to make it more useful for local efforts. Perhaps providing specialty certifications associated with quality case reporting and surveillance would encourage better case surveillance from private providers. There may be value in making syphilis a Health Plan Employer Data and Information Set (HEDIS) measure to promote better private provider reporting. CDC may want to explore medical coding standards for syphilis and ensure that private providers are educated about the legal parameters for reporting. CDC could possibly mentor and support local epidemiologists to build capacity.

A simple ready-reckoner is needed that can identify if the surveillance system of a jurisdiction is working effectively. This could be in the form of a check-list to assist in ascertaining what a surveillance system needs to do and how well it is capturing necessary data. This could possibly be done annually. Such a check-list could be used as an audit tool. Audit results could be linked to funding awards.

However, it was also recommended that CDC *guide* versus *direct* programs in the field related to surveillance. Perhaps identifying a CDC epidemiological person to provide technical assistance and support for surveillance activities in the field would be very useful. In general raising the level of importance of local surveillance in the CSPA announcement and encouraging DSTDP leadership/managers to support local surveillance advancement is important. However, it was also recommended that CDC *guide* versus *direct* programs in the field related to surveillance. Identifying CDC personnel with surveillance and epidemiological expertise to provide technical assistance and support for local surveillance activities in the field would be very useful as better surveillance guidance is needed. DSTDP program consultants and epidemiologists could conduct joint site visits to support local program surveillance efforts. In addition, the Council of State and Territorial Epidemiologists (CSTE) may be useful in supporting, providing technical assistance, and building capacity for local STD surveillance programs.

**Question 3: What steps can be taken to improve the collection of gender of sex partner information for all (>90%) early syphilis cases?**

Reporting the gender of the sex partners is mandated for syphilis, but it is not being consistently collected. The chief recommendation is to make this a surveillance performance measure. Soon CDC will require reporting the "sex of the sex partner" which could then include the option of *transgender*. It is unclear if it would also include a specification of either male-to-female or female-to-male.

## ***Enhancing Outbreak and Incident Response***

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**Question 1: Are there elements of outbreak response or development and implementation of an outbreak response plan that are not being currently addressed?**

Defining an Outbreak. Project areas and CDC need to be clear about what constitutes an *outbreak*. How should project managers decide if they are experiencing an outbreak in their jurisdiction? Nationally there is limited consensus about when to apply the term

“outbreak” for syphilis. When a definition is established then a program is ready to develop an outbreak response plan or plans as warranted. Participants urged CDC to create an outbreak response plan template.

**Quantitative and Qualitative Surveillance.** Project areas must have good disease and behavioral surveillance in order to inform the outbreak response plan. The disease surveillance data must be analyzed periodically (e.g. monthly or quarterly) to determine if there are significant changes in morbidity. In addition to disease surveillance, project areas are strongly encouraged to include qualitative surveillance from observations conducted in community based settings with gatekeepers or opinion leaders who could have more intimate knowledge of populations who are at risk.

**Setting the Threshold.** Although thresholds must be determined locally and are likely to vary from one locale to the next, guidance is needed to assist project areas to determine their outbreak thresholds.

**An Integrated Approach to Trend Analysis.** Outbreak response plans need to include an integrated approach to conducting trend analyses to determine or evaluate syphilis morbidity trends. This could be achieved by integrating other socioeconomic indicators (e.g. substance use, teen pregnancy, and unemployment) in a comparative analysis with increase (or decreases) in syphilis morbidity.

**The Need for a Best Practices Model.** A “best practice” model could provide project areas with much needed structure for developing outbreak response plans. The CDC needs to review the outbreak response plans and work with project areas to identify those plans that are best in addressing the specific standards.

**Surge Capacity.** Outbreak response plans should include information or elements that describe surge capacity for addressing an outbreak.

**Enhanced Program Activity.** Project areas are encouraged to have cross-district collaboration by sharing information between neighboring states. The information might include such things as: increases in syphilis morbidity; peer-to-peer technical assistance in disease investigation, and surveillance.

**Identifying Protective Factors.** Project areas need to determine those “protective factors” (i.e. biological, psycho-social, environmental, and social-cultural risk factors) that minimize or reduce the risk of certain populations for infectious diseases.

**Question 3: How can project areas periodically “test” and evaluate the outbreak response plan?**

It is important to note that there may be significant differences between testing the plan for operation and evaluating the plan for effectiveness. That noted, many project areas do not currently have the sophistication to test the outbreak response plan. Some project areas are using the outbreak response plan as a working document and have not tested the plan. In general, guidance is needed from CDC on how best to test an outbreak response plan. As part of this guidance, CDC should create a template for evaluating the outbreak response plan. Some participants wondered about the value of testing a project area’s surge capacity.

Project areas should assess the capacity of an outbreak response plan to allow flexibility for local adaptation. It would be helpful if there was a list of national standards that all project areas could use. It was also suggested that project areas test their plans using a public health prevention model, which includes: 1) defining the problem, 2) identifying causes (i.e. risk and protective factors), 3) developing and testing interventions, 4) implementing interventions, and 5) evaluating interventions.

**Question 4: What criteria should be used to determine when an outbreak has ended?**

The CDC should provide guidance for defining the end of a syphilis outbreak. There was consensus among the participants that rather than establishing an endpoint it may be more useful to determine when an outbreak has become endemic. As an example, one location has been in an outbreak mode for five years. The outbreak has become “business as usual.” Could this then be considered endemic? It was also suggested that a program should compare deterministic cases versus probable cases and include variances of all factors associated as part of the criteria. DSTDP might want to contact TB and HIV to learn how they define the end of an outbreak and assess the applicability to syphilis.

## ***Enhancing Clinical and Laboratory Services***

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**Question 1: How has the need for clinical services changed with the shift in the syphilis epidemiology and how can we efficiently respond to these needs?**

Traditionally, STD diagnosis and treatment has occurred in publicly-funded STD clinics, however increasingly this is changing to include more involvement of private providers, particularly as it relates to MSM groups. As an example in Chicago, 75% of syphilis cases are reported by private providers. While it is important to note the growing role of private providers, it is critical to note too that in a number of these practices there are no stat labs, no darkfields, and sometimes even treatment is inadequate. Private sector providers may even need training to become more comfortable with asking their patients sexual behavior assessment questions. Encouraging medical schools to include STDs in their curricula could improve the quality of STD care broadly.

Changes in the populations affected by syphilis require adaptations in the way STD services are delivered. In addition to appreciating the growing role of private providers, there may also be a growing need to provide STD outreach services that involve non-traditional settings (e.g., mobile vans, bars/clubs or correctional settings) and during non-traditional hours (e.g., evenings or weekends). Effective clinical interventions will require cultural sensitivity to and competence with different populations (e.g., MSM, ethnic minorities). In one example a participant described an outreach intervention to young MSM (18-25) in club setting, which requires an ongoing collaboration with a private business partner. The intervention utilizes a mobile van where clients can obtain tests for syphilis, gonorrhea, Chlamydia, and HIV. As an incentive, persons who test for syphilis get a reduced entry pass to club. The hours of operation require dedicated staff willing to work as late as 3 a.m. on Saturdays. Outreach screening is popular approach to expanding clinical services to reach those at highest risk, however it is critical to monitor yield from such activities. For

example, it was reported that in the “8 Cities Project” 14,000 syphilis tests were conducted and less than 1% were reactive (23 cases).

And although there is a growing syphilis epidemic in MSM, the fact remains that there is still syphilis in women, and there are still congenital syphilis cases, and there are important demographics shifts in these populations as well. Many at-risk women may be delivering their babies in suburban hospitals and practitioners in these settings may be in need of STD clinical training particularly as it relates to syphilis prevention and control. Additionally there are significant border issues to consider, especially in the Southwest and western United States. Some Mexican mothers actually cross the boarder to deliver, but do not remain in the hospital long enough to get syphilis test results. They return to Mexico and the mother and baby go untreated.

## **Question 2: How do we ensure sustained clinical services for underserved populations?**

Although there was general consensus regarding the crucial role of outreach for syphilis elimination, it was also noted that while an individuals may take a test on a mobile van, that same person may not come back for the results. In these situations, in particular, the DIS is critical to locating the person and providing treatment. The goal should be ensuring the continuity and quality of care. STD is primary care, as one participant stressed, and so it is essential to expand the health care network by recruiting primary care providers to the effort. In some instances free health care may be available to persons who are at risk for syphilis, and in other instances it may be necessary for the local public health department to pay for testing and treatment supplies to better ensure the provision of quality of STD services. In addition to primary care providers, STD services should be available in HIV care settings and in substance abuse treatment centers. The continuity of care should be ensured.

Ensuring the continuity of care is likely to involve a variety of partners and advocates, going beyond just healthcare providers. CDC does not directly fund clinical services, and a number of states are experiencing large budget deficits which results in competition for limited resources. Partners could advocate at the local and state levels for resources needed to sustain care. Otherwise there may be a real risk of decreasing access to STD care. Already in some larger cities there is only one STD clinic. In addition to the limited resource issues are macro level policy issues that can also affect the accessibility of services. For example, in some locations immigration laws prevent persons from accessing STD care. Ensuring the provision of services to underserved persons will likely mean educating policy makers and other government officials about these important needs. In another example, a participant described how it was a city alderman who got involved in an STD clinic closing. This alderman was able to get the clinic reopened.

Finally, it is critical for health departments to maximize the efficiency of clinic operations. This is likely to mean developing innovative ways to improve patient flow. As an example, in one location where they were experiencing significant staffing shortages the clinic managers established a procedure of conducting risk assessments of patients to determine who would receive a full examination or shortened one. This improved clinic capacity to serve more persons. The risk assessment process has now been expanded to 10 centers in the area. In another example, in another city, the STD clinic patients are registered initially and given a later time slot to come back for their physical exam. This decreased waiting room time and clinic congestion.

**Question 3: How can we improve testing, diagnosis, and reporting by private providers?  
How do we better target guidance to the appropriate provider populations?**

Although some providers are aware that they can call their respective local health departments for assistance, further improvements in the quality of STD care by private providers may need to begin with consultations with these providers. Health departments may also want to develop liaisons private providers and laboratories to promote syphilis screening and reporting. As several participants noted, it is critical to offer STD training to private providers. One health department described a poster-based training for local physicians to use in their examination rooms. Conducting regular grand rounds around STD in general and syphilis in particular is an essential means of providing training to private providers. To further encourage private providers to participate in the elimination effort CMEs and CMUs could be offered for syphilis and STD courses taken online. Physicians often go online to look up information. Also syphilis lab testing could be expedited through the use of electronic reporting of results. However, although electronic lab reporting could make it is easier to get reports, private providers will still need to be contacted to get more information regarding the patients.

In addition public health departments may also need to pay for syphilis testing and treatments to encourage private providers to test for syphilis. In one example a local health department offers to provide laboratory services at cost to providers and as a result private providers conduct more syphilis testing. In another example, state health department reportedly works with pharmaceutical company representatives to help reinforce STD reporting rules. CLIA waivers for private clinics could also facilitate more frequent use of syphilis RPRs and Darkfields. And private providers could also benefit from raised awareness about substance abuse and mental health challenges in their patients. It would be helpful to at-risk persons to provide related referrals for these problems, or at least have information available in private medical settings.

**Question 4: Is the quality of lab testing for syphilis in the United States adequate to support the objectives of the SEE strategy?**

There are significant challenges for syphilis elimination that are associated with the quality of laboratory testing for syphilis. Principally there is a great need for a test that can tell if the positive result is indicative of a new infection or previously treated one. Another cited challenge is the confusion that results from using a treponemal test used as as a screening test. In particular, the IgG is of special concern for mothers. Even when physicians order an RPR, there is still the question of what to do. Many pediatricians, for example, do not know how respond to these tests (i.e., should they treat the infant or not), since the mother could have been treated for syphilis many years ago. There is a need for treatment guidelines to address this problem, as it has become a major issue in some areas.

## ***Enhancing Partner Services***

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**Question 1: What level of collaboration can be expected among jurisdictions conducting partner notification? What will CDC contribute? This applies to sharing strategies, and to sharing data and resources for evaluation.**

There was consensus that collaboration is very much needed across the board. STD directors should be working with chronic disease directors, and other state health affiliate groups for example. In general out-of-state investigations often do not produce good returns, with respect to the proper disposition of syphilis cases. There was a general consensus that HIPAA could be a barrier to collaborative provision of partner services across jurisdictions. It was recommended that CDC take the lead in educating health department partners about HIPAA guidelines as they apply to Partner Services. It was also recommended that every state have a mobile staff that is ready to not only provide increased support to their own district in a syphilis outbreak situation but also for neighboring jurisdictions. In some instances, it was observed, DIS might close syphilis cases without sufficient follow-up because the clients are mobile and do not reside in a specific jurisdiction. It was also noted that there may be many missed opportunities for collaboration across jurisdictions as it relates to mobile clients who make use of the Internet to meet partners.

The new SEE needs a major paradigm shift with consideration of the following issues: 1) integration of private providers; 2) addressing substance abuse, HIV services, and family planning; 3) developing intervention efforts that are more venue-based to promote screening and testing, and less partner-information based; and 4) sharing best practices and program successes. SEE needs more holistic approaches towards Partner Services, such as clustering, Internet and venue-based as opposed to name-based. Partner Notification policies and procedures should vary based on online partner notification versus field partner notification. Internet contact tracing should be added to community-based organization training. Clustering is a good tool for long-term use but the start-up costs can be a barrier. Clustering is perhaps best used by more experienced DIS, and standardized training in the method may be required for the process to be more effective. Challenges to the quality of Partner Services include: 1) low and inconsistent salaries; 2) the high turnover rate in DIS staff around the country; 3) the current DIS employee performance measures which contribute to lowered staff morale; 4) current perceptions that training is an added responsibility, duty, a task that is often burdensome; and 5) the need for increased DIS cultural competence and sensitivity to the changing affected populations.

CDC should take the lead in promoting the professional status of DIS by improving DIS training. Much of the DIS training has remained essentially the same for the past 15 years. As an example, the 1992 PCRS manual appears outdated. It may be time to assess the skills of DIS, leading to the development of competency measures that could include such things as cultural sensitivity training. Improved training could ultimately lead to a professional certification model, such as the ones for health educators or social workers.

**Question 2: How willing are those conducting partner notification to permit partner elicitation and notification in non-health department settings? How willing are they to train and allow non-health department personnel to conduct any part of the partner notification process?**

It could perhaps be helpful to permit partner elicitation and notification in non-health department settings; however, there could be significant challenges to this method. It may be more productive to assign health department employees to non-health department settings in order to facilitate partner notification. In another example, one state STD program contracts with community health centers to do partner elicitation and notification in non-health department settings, and the relationship has worked so well that they now have plans to integrate the process in methadone treatment sites.

In still another example of expanding partner services to non-traditional settings, it was suggested that health departments provide incentives to private providers for providing partner elicitation and notification services. However, a number of participants expressed reservations about this method. Their list of concerns about this idea included:

- legal and liability issues (only DIS can do door-to-door outreach);
- ensuring confidentiality;
- the training for DIS is 6-9 nine months, and community-based organizations may not have the infrastructure for staff to complete such intensive training; moreover improved DIS training should take priority over CBO staff training; and
- health department employees often do not have access to sexually explicit websites.

**Question 3: What are the minimum data required to evaluate strategies? How much of this prospective data collection falls outside the parameters of standard collection? What would be the remedy?**

The group agreed the following indicators should be collected:

- traditional demographic information;
- location of high-risk venues; behavioral identification, instead of group identification to reduce stigmatization;
- history of other STDs and treatments;
- gender of partners; and
- routes of transmission.

While it was recognized that collecting group identification may be stigmatizing, most participants described it as necessary for conducting meaningful evaluations of interventions. There was also concern that the current STD\*MIS data management system is not adequate for tracking Internet partner notification. As an example, DIS staff persons are not evaluated favorably if there is a “no contact elicited” noted. It may also be more useful to track self-referrals; when a client says they will contact their partner directly.

## 6. Creating Effective Partnerships for Syphilis Elimination

### Quick Summary

#### Box 2. Creating Effective Partnerships for Syphilis Elimination

Strategy:	Suggestions for Enhancement
<b>Jail screening</b>	<ul style="list-style-type: none"> <li>• Evidence suggest that jail based screening is important for finding cases in high risk women, but less so for finding high risk men.</li> <li>• Evaluative studies of jail screening programs are needed</li> <li>• CDC should lead the development of national standards for jail-based screening</li> <li>• STD programs should regularly monitor jail-based morbidity</li> <li>• STD programs may consider screening for more than one STDs to raise cost-effectiveness</li> <li>• Jails should have outbreak response plans</li> </ul>
<b>Ethnic minorities</b>	<ul style="list-style-type: none"> <li>• Although focus currently on African American and MSM populations, Hispanic communities also an emerging population</li> <li>• Multi-sectoral collaborative approaches may facilitate more efficient use of resources</li> <li>• Avoid stereotyping and consequent normalizing of risk behaviors within communities.</li> <li>• Adopt an integrated approach to preventing syphilis among ethnic groups by taking other, more pressing priorities to be addressed.</li> <li>• Health alliances and partnerships can help to expand and improve the quality of STD services</li> </ul>
<b>Men who have sex with men</b>	<ul style="list-style-type: none"> <li>• CBOs play a vitally important role in the MSM response to syphilis epidemics</li> <li>• Collaborations with HIV programs, private providers also essential</li> <li>• Internet based interventions and community level outreach activities are recommended</li> <li>• Formative research and needs assessments are required to design more effective prevention activities.</li> <li>• Encourage private doctors to take sexual histories for their patients</li> </ul>
<b>Community involvement</b>	<ul style="list-style-type: none"> <li>• There need s to be a commitment to disseminate best practices and lessons learned</li> <li>• Ensure flexibility to use the 30% of funds to support CBO activities, especially when there is no local capacity.</li> <li>• STD programs should promote syphilis screening alongside HIV screening</li> <li>• Holistic messages are needed</li> <li>• The following should be considered in promoting community participation: 1) flexibility, 2) integration of efforts, 3) evaluation, and 4) mobilizing and forming defined partnerships.</li> </ul>

## ***Tailored Interventions: Jail Screening***

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### **Question 1: How well has model jail based syphilis intervention programs performed when compared to other SE interventions and activities (i.e., syphilis case management activities, community outreach syphilis testing, enhanced syphilis testing and/or treatment hospital ERs, etc.)?**

The performance of jail-based programs, in terms of case detection, has varied considerably depending largely on the epidemiology of syphilis in the community. An analysis of all early syphilis reported to CDC from 1999 -2002 found that 7,725 (12.5%) noted corrections facilities as the site that first identified the case. Among men, 4,747 (13.0%) cases were from corrections and in women 2,974 (11.8%) of cases were. Counties with a higher proportion of cases from corrections facilities were likely to have lower male-to-female rate ratios suggesting that areas with primarily heterosexually transmitted syphilis were likely to find significant numbers of cases in jails.

An analysis case detection in two syphilis elimination demonstration sites found that private physicians identified the largest number of female cases. However, jail screening was the most productive case detection strategy for identifying high-risk females. The jail identified the largest number of male cases and the STD clinic (self-referred) identified the most high-risk males. Partner notification identified relatively few high-risk cases.

The privatization of prisons increasingly impacts the availability jail-based screening. Additionally wardens and local police chiefs may also have competing priorities that rank above implementing jail screening. Nonetheless good epidemiology analysis is essential to assessing where to find syphilis cases, and epidemiology is likely to vary from city to city. Given this, jail-based screening is important for finding cases in high risk women because incarcerated women are often involved high risk sexual or drug using activities for which they are arrested. Identifying high risk men in jail settings seems to be more difficult. Evaluative studies of jail screening programs are very much needed.

Several participants strongly supported the idea of establishing national standards for jail-based screening. Perhaps these standards should be developed by CDC. Using existing data, CDC should disseminate “best practices” for jail screening. This may be best accomplished through site visits to individual project areas to engage local health officers and corrections officials and elevate importance of the activity. Such guidance should provide specific directions for organizing STD healthcare such as screening in correctional settings. The guidance could ensure standardized jail screening language, which would be especially helpful for those programs that contract out for jail screening services. The guidance should also highlight important partners such as the:

- National Commission on Correctional Health Care;
- American Correctional Association;
- National Association of Sheriff’s Departments;
- National Association of Police Chiefs; and
- Federal Bureau of Prisons.

And the guidance should also include methods for conducting PCRS with incoming prisoners, who may already know what infections they have. However, it remains important to note that among discussion group participants there was not agreement that there should be universal screening in jails.

**Question 2: At what point should an HMA initiate jail screening vs. sentinel surveillance?**

It was recommended that there should be routine screening in jail settings. Risk behaviors of incarcerated persons can be a meaningful measure to assess possible syphilis disease trends and anticipate potential local outbreaks. Regularly monitoring jail-based morbidity rates is one way STD programs could establish sentinel surveillance. In some project areas STD Programs are screening not only for syphilis, but others STDs as well. Screening for multiple infections as opposed to just one (i.e., syphilis) may increase the likelihood of jails instituting screening programs. It was agreed that incarceration facilities should have outbreak response plans in addition to a standardized inmate health program that supports screening for syphilis. Resources for jail-based screening will need to be addressed up front, and this may mean concerted efforts to prioritize activities (e.g., screening for other STDs). In general, building epidemiological capacity in local health departments, including in partnership with correctional facilities is an important activity for syphilis elimination.

**Question 3: In those project areas where virtually no jail testing services occur, what are the specific issues and what types of technical assistance is needed to ensure jail-based syphilis testing in those project areas?**

Primarily the issue may have to do with epidemiological capacity in an individual project area. An independent assessment may be needed to determine the level of disease in a community. CDC may need to be prepared to support this kind of activity in order to develop an epi-profile which could then be used to encourage establishing a syphilis jail-based screening program. However, it was generally agreed that the local area with low or no disease will probably not invest resources in jail-based screening.

## ***The Syphilis Elimination Effort and Ethnic Minorities***

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**Question 1: What ethnic minority populations are currently the foci of syphilis prevention efforts?**

The current foci of efforts are mainly on African Americans and men who have sex with men (MSM). There may be some “bridging” of MSM at risk populations to heterosexual at-risk populations. Latino communities may also be emerging as at-risk populations in a number of project areas. It is important that individual project areas focus on the target populations and groups that are most relevant based on their epidemiological data. However, is it more appropriate to define target populations based on race/ethnicity or is it more appropriate to define target groups based on risk behaviors?

**Question 2: What contributes to continued morbidity and what strategies can be implemented to enhance current SE efforts?**

A primary contributor to the continued morbidity is what is often referred to as a “silo mentality” as it relates to STD programs syphilis prevention and control efforts. This

perspective may cause STD programs to disregard other useful resources, both inside and outside the health department. As state and local health departments contend with the declining availability of funds, these missed opportunities to share resources or generate a more synergistic approach to the health status of persons at risk for multiple problems should be addressed. Increased collaboration between agencies could more effectively use limited resources.

Another noted contributing factor is the tendency to “normalize” highly risky behaviors. As an example, participants noted that there is a pervasive perception that all men who engage in sex with other men also engage in very risky behaviors such as “bare-backing”, crystal-methamphetamine abuse, and numerous multiple sex partners. Once these perceptions become normalized then they can become what are often referred to as a “self-fulfilling prophecies”, which can lead to still more risk-taking behaviors. A strategy to counteract these perceptions is to also identify and utilize the protective factors in populations that can work to reduce risk taking. STD programs need to better understand the cultures that may affect disease risk, and then tailor their intervention efforts.

Again, an integrative approach to intervening to prevent and control syphilis was recommended as vital strategy to enhance syphilis elimination efforts. An integrative approach could better allow for multiple points of entry into communities. Participants urged partnering with other health department resources (e.g., maternal and child health) and non-health department resources (e.g., drug treatment programs) to expand and improve the quality of STD services. STD programs could work with the agencies to raise awareness about increases in syphilis morbidity and the importance for testing. A more integrative strategy will mean more collaboration between STD programs and relevant partners. The resulting collaboration means greater sharing of information (e.g., surveillance data) and other resources. Collaborative agreements will need to be specific in the descriptions of collaborative efforts (e.g., capacity building, or mutual referral arrangement). Essential to assessing the effectiveness of these collaborations is cost evaluations that measure the resulting interventions to ensure that limited funds are prudently used in support of worthwhile activities.

**Question 3: What first steps can be taken to prevent syphilis emergence in populations who are at-risk for syphilis emergence?**

See the answers to Question 2.

**Question 4: Are there standards for monitoring emerging diseases?**

There was consensus among the participants that STD programs regularly (e.g., quarterly) review disease data, and that there needs to be CDC guidance to assist programs to better accomplish this task. There were a number of suggestions regarding what data that should be (socioeconomic data, illegal drug use, and other economic indicators). The information gleaned from monitoring of sexually transmitted diseases (e.g., syphilis) could be further enhanced by mapping these diseases in conjunction with other communicable diseases (e.g., TB), or substance use patterns. Combining these data could provide STD programs with better knowledge about the susceptibility of populations in their communities.

## ***The Syphilis Elimination Effort and Men who have sex with Men***

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### **Question 1: What interventions should be recommended for preventing syphilis in MSM?**

Several intervention strategies were discussed during the session. The role of community-based partnering organizations was especially emphasized. The value of the Division of HIV/AIDS Prevention's Diffusion of Effective Behavioral Interventions (DEBI) standards was also significantly noted. Modifying effective HIV interventions, including testing programs, syphilis interventions may resonate very effectively with MSM. Collaborations with HIV programs are essential and intervention will need to be flexible. Collaborations with private providers who serve MSM to expand the availability of quality STD health care are also critical. In one location, the STD program is piloting a project whereby the STD program pays for the patient's visit to the private provider when a syphilis test is done.

Several participants recommended Internet-based interventions as well as community level outreach activities. In particular there may be a growing role for Internet-based or web-based partner services activities in addition to the provision of health education. Outreach settings should include a variety of venues ranging from such places as churches to bars and clubs. Educational mentoring programs aimed at young adults for instance may be an important means reaching young men. In several locations STD programs are using community-based teams to conduct street testing for syphilis. In another example, the STD program supports an information hotline aimed at reaching young MSM. Hotline operators can make referrals for syphilis testing.

There is an important role for formative research and needs assessment to design more effective syphilis prevention and control activities. For example, it was noted that some gay men in San Francisco will not go to a program referred to as an MSM program. Formative research and needs assessments would inform health communications for MSM by assisting with framing the syphilis elimination messages (e.g., linking syphilis infections with viral load status). Given the extent of HIV prevention information it is possible that many MSM are in sexual health information "overload," and syphilis simply may not be important enough. It may be more effective to frame syphilis elimination as a men's health matter, as opposed to STD prevention. Again, community partners can be very valuable in developing and disseminating media messages and materials.

### **Question 2: What data are required to enhance our interventions with MSM?**

There were a number of important recommendations regarding ways to enhance data collection in support of interventions for MSM. In general there was a call for improved technologies to manage data (e.g., computer software, and electronic records capacity.) In addition to traditional demographic data variables, such as race/ethnicity and age, participants recommended that STD programs collect:

- socio-economic data;
- the patient and patient partner's travel history;
- the patient's country of origin
- sexual identity and sexual behavioral data (including transgender identity);
- preferred source of health information; and
- preferred source of health care.

Participants also recommended that STD programs develop methods for collecting important service delivery data such as accessibility of health care in communities and evaluation data regarding the implementation of programs. Some participants also urged that STD programs, as part of their evaluation activities, collect cultural sensitivity/competence of their disease intervention staff to ensure a quality of care to MSM. Finally, it was suggested that STD programs may want to gather behavioral data from affected community members who have not been infected with an STD to perhaps better understand important protective factors, although there was a caution that STD programs be judicious in what information they attempt to collect and analyze.

**Question 3: Are there methods to monitor syphilis transmission in MSM and women who may be bridging populations for spread between MSM and heterosexual communities?**

While more syphilis screening is recommended for MSM, it is also critical that women be informed about this potential risk. Women, and men, need to become comfortable conversing about their sexual health, associated with this is a need for persons to be able to honestly discuss their sexual preferences and practices as well (e.g., bisexual behaviors, or sexual fidelity). One way to facilitate this is to encourage private providers to take sexual histories for their patients, for both men and women. Providers also need to become more adept at sexual risk reduction counseling and partner management. Some providers are reportedly unaware of the need to report or provide more information to the local health department. Many of them may believe that laboratories are solely responsible for reporting cases. Moreover some private providers may actually be working against health department surveillance and disease intervention efforts. Some of these challenges to monitoring are likely linked to MSM distrust of government entities.

## ***The Syphilis Elimination Effort and Community Involvement***

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**Question 1: How do we maintain syphilis elimination community participation in originally targeted populations while initiating new efforts in communities recently impacted by syphilis?**

It is crucial that syphilis elimination efforts in originally targeted populations be maintained as new efforts are implemented in newly affected groups. To best accomplish this there needs to be a commitment to the dissemination of best practices and lessons learned for interventions efforts (e.g., media campaigns).

It may also be important to ensure flexibility in the use of the “30% funds”, particularly in situations where community-based organization infrastructure may not be adequate to meet syphilis prevention and control intervention needs. When forging community partnerships and mobilizing community participation it is critical that partners have the credibility, skill and expertise to accomplish proposed prevention and control tasks. Target populations are likely to continue to evolve over time (e.g., MSM, more affluent heterosexual persons). As an example, 30-39 year-old MSM came of age in a time of STDs *and then* HIV, but younger MSM are not likely to have a similar cultural experience. Community organizations and their

methods and messages that have been relatively successful with 30-39 year old MSM, simply may not resonate with a younger target audience.

Health departments may need to develop more active partnerships with such agencies as: family planning agencies, HIV/AIDS organizations, and drug treatment agencies. It may also be more appropriate to target intervention activities to venues as opposed to individuals. In general STD programs will need to work to ensure the quality of collaborative partnerships that are sensitive to organizational challenges common to non-profit agencies, particularly as it relates to contractual arrangements and delayed payments.

**Question 2: How do we assist state and local programs to ensure flexibility in resource allocation to serve populations in the context of changing epidemics?**

It was agreed that human sexuality is changing due to changing social norms as well as the impact of the HIV epidemic. There is a growing intersection between the HIV and STD epidemics, and in this context, particularly for MSM syphilis and gonorrhea prevention messages are often lost, due to an attitude that seems to suggest that if one already has an HIV infection there is less cause to practice safer sex. Common STDs are usually considered curable while HIV infection is not.

STD programs should promote syphilis screening along with HIV screening. Risk reduction counseling should be encouraged for bacterial STDs whenever HIV is being addressed. Holistic messages are needed. Although there are important historical reasons for creating a separate division for HIV/AIDS prevention it may be time now for reintegration of the HIV and STD programs. However, there could be a disincentive for HIV programs to reintegrate with STD programs. Resources are increasingly limited in many locations. Programs will need to identify and demonstrate the positive effects of a more synergistic approach to promoting sexual health.

**Question 3: What are the best means of promoting meaningful and practical levels of community participation in the development, delivery, and evaluation of syphilis elimination interventions?**

The following should be considered in promoting community participation: 1) flexibility, 2) integration of efforts, 3) evaluation, and 4) mobilizing and forming defined partnerships.

## 7. Enhancing the Implementation of the Syphilis Elimination Effort

### Quick Summary

#### Box 3. Enhancing the Implementation of the Syphilis Elimination Effort

Strategy:	Suggestions for enhancement
<b>Training and staff development</b>	<ul style="list-style-type: none"> <li>• CDC and partners should take a strategic look at frontline DIS and their roles in the public health system</li> <li>• Guidance needs to be specifically developed for SEE coordinators</li> <li>• CDC should take advantage of distance learning technologies such as web-casting</li> <li>• Can bio-terrorism funds be made available for satellite or distance learning</li> <li>• The barriers to training within STD programs are many</li> <li>• DIS recruitment and training should involve professional certification</li> <li>• CDC should lead the effort to set national standards for DIS staff positions</li> </ul>
<b>Monitoring and evaluation for the SEE</b>	<ul style="list-style-type: none"> <li>• There should be written policies and standards to enhance interventions aimed at reducing syphilis</li> <li>• Local programs should be able to tailor their local priorities and standards</li> <li>• Local programs should aim to develop measurable process and outcome measures</li> <li>• STD programs should consider databases for evaluation activities</li> <li>• Monitoring should be required of local SEE activities</li> <li>• Priorities need to be identified and evaluation plans developed that reflect local priorities</li> <li>• Approximately 20% of allocated resources should be used to for M&amp;E activities</li> <li>• Evaluations should demonstrate the worthiness of intervention efforts</li> </ul>
<b>Health care mobilization</b>	<ul style="list-style-type: none"> <li>• STD programs must engage with private sector providers and collaborate to develop strategies for effective mobilization</li> <li>• Involve pharmaceutical reps in carrying the messages about STD prevention and control to private docs</li> <li>• Prevention Training Centers should be used in disseminating information about effective strategies</li> <li>• CDC's "Prevention for (HIV) Positives campaign is one example of an effective mobilizing intervention – what can we learn from this?"</li> <li>• Health departments need funding for a specific staff person to visit private providers and organize provider seminars.</li> <li>• With adequate resources, health departments could develop newsletters</li> </ul>
<b>Effective local implementation</b>	<ul style="list-style-type: none"> <li>• Accountability for implementation of syphilis elimination activities can be increased by utilizing best practices; through advocacy, education and increased syphilis awareness; By instituting performance measures at the state and at the local levels; Through increased organizational development; Ensuring outbreak readiness; Conducting evaluation; and Celebrating SEE successes throughout the year.</li> <li>• Local programs should consider monitoring syphilis rates; partner service indices; timeliness of outbreak response times; provision of services outside of STD clinics; types and quality of partnerships.</li> <li>• Increase the efficiency of local program implementation by establishing priorities; developing templates to facilitate routine activities; implementing lab reporting.</li> </ul>

## ***Training and Staff Development and the Syphilis Elimination Effort***

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### **Question 1: What are the current SEE training needs?**

There is a need to take a strategic look at the frontline disease intervention specialists (DIS) and their roles in the public health system across the U.S. Participants agreed that nationally “the DIS pool is relatively dry” and some considered the situation a public health crisis. It was noted that CDC once recruited DIS similarly to the way the Peace Corps recruits, however this process has indeed changed. Currently the emphasis seems to be on CDC recruitment for the Public Health Prevention Specialist Programs. These specialists are not exclusively reserved for STD disease intervention specialist roles.

Participants identified the enhancement of training for Disease Intervention Specialists, in particular, as well as other STD program staff as being critical to achieving syphilis elimination. Undoubtedly training needs will be different for newly hired versus current DIS staff, but training components should be developed for a variety of duties and levels of responsibilities, which are ultimately aimed at improving STD program operations from surveillance and data management to basic partner notification services. Participants also discussed the need to develop guidance specifically for the roles and responsibilities of syphilis elimination coordinators. A job description template for local coordinators was suggested.

Training content should incorporate relevant and recent research as well as emerging best practices or lessons learned from the field. And as one means of making the training more available, CDC and local and state STD programs should make use of distance learning technologies, such as web-casting for example. It was suggested that bio-terrorism funds might be available to facilitate satellite or distance training.

### **Question 2: What are the barriers to training and how can programs overcome barriers such as travel restrictions and limit resources?**

Some participants discussed the loss of more traditional training methods that have supported DIS staff in the past, such as chalk-talks, in-service training, and supervisor mentoring. In addition, a number of barriers were also noted, one being the timely evaluation of training materials to assess the effectiveness and impact of their methods and content, and the updating of training materials as warranted. Local travel policies that may restrict or even prohibit staff travel for training opportunities is a challenging barrier to providing training for STD program staff. Reportedly because some managers do not consider DIS positions as professional level positions (with commensurate credentials), they are less inclined to support or approve ongoing training, particularly when travel is required. Therefore, credentialing DIS positions could lead to more supportive policies regarding training. It was also noted that there are also important implications of moving federal field staff from state to state since this sometimes means that well-trained staff persons are transferred away from programs in need of their skills.

### **Question 3: How can we raise the priority of training in the program agenda?**

DIS recruitment and their training should involve professional certification. It was suggested that CDC lead the effort to set national standards for DIS staff positions. There should be more effort to market and advertise training. More proactive approaches to assist local programs to overcome barriers such as travel restrictions and costs will need to be applied. The participants offered a set of action steps to raise the priority of training in the program agenda. The list of recommendations is as follows:

- evaluate current training materials (making use of the CDC evaluation framework tools);
- update/revise training materials for syphilis elimination (including the Employment Development Guide and STDI training modules);
- assess retention issues associated with maintaining quality DIS staff;
- develop DIS core competencies for professional certification;
- use IPP regional meeting model for STD training; and
- organize regular SEE coordinators conference calls, website updates, and a newsletter to enhance communication and best practice-sharing.

## ***Monitoring and Evaluation for the Syphilis Elimination Effort***

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### **Question 1: Should SEE require written priorities and standards to be developed at the local, project area and federal levels? If so, how could SEE ensure the adoption and routine evaluation of these priorities?**

There should be written priorities and standards to enhance interventions aimed at reducing syphilis. However, there should also be flexibility in these priorities and standards, and local programs should be able to tailor their local priorities and standards. Program standards will need to allow for priority shifts based regular and thorough reviews of epidemiological data. STD programs are encouraged to collaborate with relevant community groups as well as with CDC to collect and analyze data. Programs may also want to review findings from the recent 8 Cities Project. Also CDC is already in a position to guide local programs by adhering to the basic standards through the performance measures, in addition to grants language, program announcements, and program operations guidelines. Local programs should also aim to develop measurable process and outcome measures. To improve evaluation efforts, it is useful for STD programs to construct databases for evaluation activities. Although arguably resource intensive, such databases should account for both qualitative and quantitative collection and analyses.

### **Question 2: Should SEE require and support monitoring at the local, project area, and federal levels?**

Monitoring should be required and priorities set by internal and external consensus. Priorities need to be identified and evaluation plans developed that reflect the identified priorities.

**Question 3: How much time and money should be committed to these activities?**

There was some consensus that a 20% allocation of resources to support monitoring at local, project areas, and federal levels seems reasonable, particularly in light of international programs (e.g., WHO) allocations of 5% to 15% of budget dollars for evaluation. STD programs are encouraged to partner with academic institutions that have the expertise to assist evaluation including determining the time and money needed to support such activities. Monitoring goals should be tailored to local STD program capacity. Evaluation should aim to clearly demonstrate the fundamental worthiness of intervention efforts; and as programs improve and syphilis morbidity declines, the evaluation analyses may reveal that the cost-per-case or case- averted may in fact get higher.

***Health Care Provider Mobilization for the Syphilis Elimination Effort***

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**Question 1: What were the successful strategies, challenges, and relevant barriers to mobilizing health care professionals between 1999 and 2005? How can these inform future efforts?**

It is crucial that STD programs engage with private sector medical providers and collaborate to develop common strategies for effective mobilization. External organizations, such as medical associations and civic organizations can be important facilitators for developing relationships with private providers. One suggestion was made to involve pharmaceutical sales representatives in carrying the messages about STD prevention and control to private doctors. Prevention Training Centers will be helpful in disseminating information about effective strategies. As part of that information private doctors need to better understand the public health importance of reporting syphilis cases and doing partner management.

CDC's "Prevention for (HIV) Positives" campaign was cited as a successful strategy for mobilizing healthcare providers. The lessons learned from this effort could inform syphilis elimination activities, although STD programs will need to be careful to tailor components of the campaign more specifically to their target populations (e.g., heterosexual African Americans, white gay men).

**Question 2: What are the local issues around mobilizing HCPs? Which ones are generalizable issues that transcend local issues? What are possible strategies that would help tackle these issues?**

One problem is that in many areas there is a shortage of local healthcare providers who have the expertise to treat STDs. Smaller communities experienced a drain of their primary care providers, because they have gone to larger metropolitan areas. Additionally many physician training programs do not specifically address STDs or human sexuality.

Still another problem is the fact that some insurance companies will not reimburse for frequent STD repeat testing (e.g., quarterly). It could be important to syphilis elimination to get syphilis testing adopted as a HEDIS measure. Perhaps CDC could work with the American Medical Association and state AMA chapters to reduce the effects of capitation. Still another challenge to address is the need for substance abuse treatment services.

Often times medical providers have no drug treatment referral resources for their patients. Private providers should be encouraged to seek more information about substance abuse and perhaps develop partnerships with local drug treatment agencies.

**Question 3: What kinds of support do health departments need to mobilize HCPs?**

Health departments need funding for a specific staff person whose primary job is to visit private providers and private laboratories. Such a provider liaison could work with clinical medical directors and organize provider seminars. With adequate resources health departments could perhaps produce newsletters about STDs in general and syphilis in particular for provider audiences. CDC could be instrumental too in getting state laboratories to report cases in a more timely manner. Finally it was recommended again that health departments pay for syphilis tests and treatment. Health departments would need additional resources to be able to accomplish this.

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***Effective Local Implementation of the Syphilis Elimination Effort***

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**Question 1: How can we increase accountability for SEE related activities in the field?**

Accountability for implementation of syphilis elimination activities can be increased in the following ways:

- by utilizing best practices
- through advocacy, education and increased syphilis awareness
- by instituting performance measures at the state and at the local levels
- through increased organizational development
- ensuring outbreak readiness
- conducting evaluation; and
- celebrating SEE successes throughout the year.

**Question 2: Apart from action planning, are there other ways of improving monitoring and implementation of SEE related activities in the field?**

The group agreed on several core components for monitoring the implementation of SEE activities. These components obviously would include monitoring syphilis rates. Participants also suggested careful and regular reviews of partner service indices, as well as the timeliness of outbreak response time, and the expansion of syphilis elimination services in new venues based on the identification of new at-risk populations. And the types and quality of partnerships is another recommended indicator.

**Question 3: How much time and money should be committed to these activities?**

Specific amounts of time or money were not set in the context of the discussion. However what was recommended is that there should be careful prioritization of activities, and that there be enthusiastic support for more efficient ways of using resources for the syphilis elimination effort. Increased efficiency could be achieved not only by establishing priorities, but also by using such things as electronic lab reporting and the development of templates to assist individual local programs to work more competently.

## 8. Summary of the Meeting and Next Steps

There have been major accomplishments in eliminating syphilis in the U.S. Significant among these successes is the reduction in the black:white health disparity for infectious syphilis, and more importantly is the substantial reduction in the incidence of congenital syphilis.

However there are emerging threats to these successes. The declines in P&S syphilis in African American women may be ending, and infectious syphilis in men is increasing. The epidemic seems to be growing fastest in western and northeastern parts of the U.S. Syphilis Elimination 2005-2010 will have to be achieved in a challenging social context that includes rising poverty and unemployment rates. As was true in 1999, there are persistent problems with social inequality and discrimination, as well as ongoing illicit substance abuse and increasing social polarization. Public health resources at the federal level are limited, while state and local programs are contending with budget cuts that profoundly impact their capacity to provide STD prevention and control services.

During the meeting a list of general next steps in the Syphilis Elimination Effort began to emerge. Participants recommended:

- a reformulation of the current Disease Intervention model to improve the effectiveness of partner services;
- an examination of the cost of syphilis case found versus the cost of a syphilis case averted;
- development of better tools for diagnosing incident infection, which could improve both clinical and surveillance efforts; and
- organization of a national syphilis elimination coordinators forum to discuss current activities, provide supports, and facilitate relevant training.

In addition to the general steps discussed above, there were specific next steps related to the consultation meeting itself. The first step is the publishing of the consultation meeting report. Work on the 2005-2010 plan should also commence. A first draft of the new plan is anticipated by the end September 2005. Following this there will be an extensive period of internal and consultation.

Other consultation activities addressing Syphilis Elimination were also suggested. Participants also recommended that CDC and its partners consider hosting some sort of event to recognize the successes achieved through the syphilis elimination effort to date.

# **APPENDICES**



## Appendix A

<b>Day 2: August 2, 2005</b>			
<b>8:30 a.m. – 5:30 p.m.</b>			
<b>Time</b>	<b>Item</b>	<b>Speaker</b>	
8:30	Welcome	<b>Chair: Gail Bolan</b>	
8:30 - 8:45 <i>Plenary</i>	Introduction: <i>Objective of Day: Review of Key Points from Yesterday</i>	Sevgi Aral	
<b>Session 3: Creating Effective Partnerships for the SEE</b>		<b>Chair: Gail Bolan</b>	
8:45 - 9:15 <i>Plenary</i>	<b>Mini-Presentations</b>		
	SEE Interventions and Ethnic Minorities	Samantha Williams	
	SEE Interventions and MSM	Kevin Fenton	
	Tailored Interventions: Jail Screening	Norm Fikes	
9:15 - 9:30	Break		
9:30 - 11:00 <i>Group discussions</i>	<b>Break-Out Session 3:</b> <i>Enhancing Partnerships and Tailoring SEE Interventions</i>		
	LENOX Tailored Interventions: Jail Screening	Norm Fikes	
	CASCADE SEE Interventions and Ethnic Minorities	Samantha Williams	
	NEW YORK SEE Interventions and MSM	Fred Bloom	
	SAN FRAN SEE and Community Involvement	Jo Valentine	
11:05 - 12:30 <i>Plenary</i>	<b>Feedback Plenary from Break-Out Session 3:</b> <i>Effective Partnerships for the SEE</i>	<b>Chair: Tom Bertrand</b>	
12:30 - 1:45	Lunch		
<b>Session 4: Enhancing implementation of the SEE</b>		<b>Chair: Jim Lee</b>	
1:45 - 2:15 <i>Plenary</i>	<b>Mini-Presentations</b>		
	Healthcare Provider Mobilization	Sureyya Hornston	
	Training and Staff Development	Hilda Shepeard	
	Monitoring and Evaluation	Cathleen Walsh	
2:30 - 3:30 <i>Group discussions</i>	<b>Break-Out Session 4:</b> <i>Effective Implementation of the SEE</i>		
	LENOX Training, Staff Development and SEE	Darien Ogburn	
	CASCADE Monitoring and Evaluation	Cathleen Walsh	
	NEW YORK Health Care Provider Mobilization	Sureyya Hornston	
	SAN FRAN Effective Local Implementation of SEE	Jo Valentine	
3:30 - 3:45	Break		
3:45 - 5:00 <i>Plenary</i>	<b>Feedback Plenary from Break-Out Session 4:</b> <i>Effective Implementation of the SEE</i>	<b>Chair: Kevin Fenton</b> <i>Rapporteurs</i>	
5:00 - 5:30	Summary - Next Steps	Kevin Fenton	
5:30	Adjourned		

## Appendix B

### Work-group questions for the SEE Consultation Meeting: August 1-2, 2005

Topic Area	Questions
<b>SEE &amp; Surveillance</b>	<ul style="list-style-type: none"> <li>• What steps can be taken to improve surveillance and epidemiologic capacity locally? In the short and long terms?</li> <li>• What measures should be taken to monitor adequacy of surveillance activities?</li> <li>• What steps can be taken to improve the collection of gender of sex partner information for all (&gt;90%) early syphilis cases?</li> </ul>
<b>Enhancing Clinical &amp; Lab Services</b>	<ul style="list-style-type: none"> <li>• How has the need for clinical services changed with the shift in the syphilis epidemiology and how can we efficiently respond to these needs?</li> <li>• How do we ensure sustained STD clinical services for underserved populations</li> <li>• How can we improve testing, diagnosis, and reporting by private providers? How do we better target guidance to the appropriate provider populations?</li> <li>• Is the quality of laboratory testing for syphilis in the United States adequate to support the objectives of the SEE strategy?</li> </ul>
<b>Enhancing Partner Services</b>	<ul style="list-style-type: none"> <li>• What level of collaboration can be expected among jurisdictions conducting partner notification? What will CDC contribute? This applies to sharing strategies, and to sharing data and resources for evaluation.</li> <li>• How willing are those conducting partner notification to permit partner elicitation and notification in non-health department settings? How willing are they to train and allow non-health department personnel to conduct any part of the partner notification process?</li> <li>• What are the minimum data required to evaluate strategies? How much of this prospective data collection falls outside the parameters of standard collection? What would be the remedy?</li> </ul>
<b>Enhancing Outbreak &amp; Incident Response</b>	<ul style="list-style-type: none"> <li>• Are there elements of outbreak response or development and implementation of an outbreak response plan that are not being currently addressed?</li> <li>• How can project areas periodically “test” and evaluate the outbreak response plan?</li> <li>• What criteria should be used to determine when an outbreak has ended?</li> </ul>
<b>SEE and Community Involvement</b>	<ul style="list-style-type: none"> <li>• How do we maintain syphilis elimination community participation in originally targeted populations while initiating new efforts in communities recently impacted by syphilis?</li> <li>• How do we assist state and local programs to ensure flexibility in resource allocation to serve populations in the context of changing epidemics?</li> <li>• What are the best means of promoting meaningful and practical levels of community participation in the development, delivery, and evaluation of syphilis elimination interventions?</li> </ul>

**Appendix B**

<b>Topic Area</b>	<b>Questions</b>
<b>SEE Interventions for Ethnic Minorities</b>	<ul style="list-style-type: none"> <li>• What ethnic minority populations are currently the focuses of syphilis prevention efforts?</li> <li>• What contributes to continued morbidity and what strategies can be implemented to enhance current SE efforts?</li> <li>• What first steps can be taken to prevent syphilis emergence in populations who are at-risk for syphilis emergence?</li> <li>• Are there uniform standards for monitoring emerging diseases?</li> </ul>
<b>SEE Interventions for Men who have sex with Men</b>	<ul style="list-style-type: none"> <li>• What interventions should be recommended for preventing syphilis in MSM?</li> <li>• What data are required to enhance our interventions with MSM?</li> <li>• Are there methods to monitor syphilis transmission in MSM and women who may be bridging populations for spread between MSM and heterosexual communities?</li> </ul>
<b>Tailored Interventions: Jail screening</b>	<ul style="list-style-type: none"> <li>• How well has model jail based syphilis intervention programs performed when compared to other SE interventions and activities (i.e., syphilis case management activities, community outreach syphilis testing, enhanced syphilis testing and/or treatment hospital ERs, etc.)?</li> <li>• At what point should an HMA initiate jail screening vs. sentinel surveillance?</li> <li>• In those project areas where virtually no jail testing services occur, what are the specific issues and what types of technical assistance is needed to ensure jail-based syphilis testing in those project areas?</li> </ul>
<b>Training and Staff Development</b>	<ul style="list-style-type: none"> <li>• What are the current SEE training needs?</li> <li>• What are the barriers to training and how can programs overcome barriers such as travel restrictions and limit resources?</li> <li>• How can we raise the priority of training in program agenda?</li> </ul>
<b>Effective Local Implementation of SEE</b>	<ul style="list-style-type: none"> <li>• How can we increase accountability for SEE related activities in the field?</li> <li>• Apart from action planning, are there other ways of improving monitoring and implementation of SEE related activities in the field? What are they? How can they be implemented?</li> <li>• How do we increase the efficiency of our monitoring activities in the field?</li> </ul>
<b>Monitoring and Evaluation</b>	<ul style="list-style-type: none"> <li>• Should SEE require written priorities and standards to be developed at the local, project area and federal levels?</li> <li>• If so, how could SEE ensure the adoption and routine evaluation of these priorities?</li> <li>• Should SEE require and support monitoring at the local, project area, and federal levels?</li> <li>• How much time and money should be committed to these activities?</li> </ul>

## Appendix B

Topic Area	Questions
<b>Healthcare Provider Mobilization</b>	<ul style="list-style-type: none"><li>• What were the successful strategies, challenges and relevant barriers to mobilizing health care professionals (HCPs) between 1999 and 2005? How can these inform future efforts?</li><li>• What are the local issues around mobilizing HCPs? Which ones are generalizable issues that transcend local issues? What are possible strategies that would help tackle these issues?</li><li>• What kind of support do health departments need to mobilize HCPs?</li><li>• Which organizations can help? How?</li></ul>

## Appendix C

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## Appendix C

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