NASTAD HIV Prevention Community Planning Bulletin

February 1999

related to HCV. They were likely influenced by the sheer numbers of folks they were seeing who were infected with HCV.

Geoff said that the next steps for Maine's Hepatitis C Work Group are to:

- Consider models of care with the HMO Council Meeting this month;
- Educate primary care providers about the CDC guidelines;
- Involve HCV-positive individuals in the Work Group;
- Deal with testing and counseling; Maine has been waiting to see what will be happening nationally on this front.

NASTAD interviewed Geoff Beckett for this story and thanks him for his assistance.

My First Month in "STD-Land": Lessons From a Different Front

By Dan Wohlfeiler, MJ, MPH

I've made the leap from HIV to STD's, and from the community to government. After eight years as education director at STOP AIDS Project, a community-based organization in San Francisco, I have spent my first month with a title so long I have to resort to a cheat-sheet to remember it: "Acting Chief, Program Policy and Development Section, STD Control Branch, California Department of Health Services." It's been, to say the least, a heck of an eye-opener.

These words aren't just for those of you who may be also considering a similar transition. Maybe you're the kind of armchair tourist who appreciates reading about life in some exotic land, but is happier staying home. Or maybe you're the kind of citizen who loves reading about how tourists perceive your town. So if you're working in HIV prevention and wondering what the STD world is like - or working in STDs and wondering how the other side sees you, this is for you.

A big disclaimer here: these are my own observations, and I'm making them after barely a month's transition. So take these as first impressions. But as any of you know who have ever built a coalition, hired or fired someone, or even dated, first impressions count for a lot.

Differences

At my first STD Conference ("The First Annual North American Sexual Health Management Symposium" in Dallas, last December), differences between HIV-land and STD-land soon became obvious. We started promptly at 9:00 am and by 9:17, after a few housekeeping details, we were down to serious clinical business. No rallying-the-troops songs or cheery videotapes, no speeches, and certainly no multicultural anything. The "cultures" being talked about at this session were those being used for detecting gonorrhea and chlamydia. Even these seem to be falling out of favor as more sophisticated and less invasive screening methods become available. We soon were listening to discussions (with high-tech overheads) not of one disease, but of ten, with names that have undoubtedly slipped beneath the radar screen of any web-smut detector (and prove a challenge to any spell-check program). Trichomoniasis. Chlamydia.

A word about chlamydia. When my new boss, Dr. Gail Bolan, asked if I was going to be able to get excited about chlamydia, I had to pause a minute and say I thought that I would. But in the back of my mind, I had to ask myself, "who else cares?"

Most of us who cut our public health teeth in HIV barely know what chlamydia is, and are too caught up in the life and death struggle to be able to focus on different, less dramatic, diseases. In case any of you are worried about asking a question you're afraid might sound dumb,

chlamydia is a bacterial disease that infects at least four million men and women each year. Between five and 10 percent of all teenage girls are infected. It is often asymptomatic and goes undetected, but its presence can be identified by a simple-to-administer urine test. It's easily treated with a single dose of one drug or seven days of another. Like gonorrhea, chlamydia can cause pelvic inflammatory disease (PID) - and is a leading cause of preventable infertility and ectopic pregnancies. (These are pregnancies during which a fertilized egg stays in the ovaries or fallopian tubes and never makes it to the uterus. This can cause major health complications - and even death - for the mother.) On top of that, there's a clear link to HIV: if you're infected with chlamydia, it makes you three to five times more likely to get infected with HIV if exposed.

Is Anyone There?

The answer to the question "who cares" gets at one of the fundamental differences between HIV-land and STD-land.

First, from the perspective of someone who's worked in HIV, there's comparatively little community advocacy around STD prevention. Dr. Judy Wasserheit, Director of the CDC's Division of STD prevention, gave a very frank report card at December's National STD Conference. STD folks do pretty damned well at epidemiology and clinical services but HIV folks are way ahead at getting the community involved, and building partnerships with media and local constituencies. A panel presentation, led by Harlan Rotblatt, Director of the Adolescent STD/HIV Services Project in Los Angeles, during that same conference, featured heavy hitters discussing how to get condoms on television. The panel – which included the Kaiser Family Foundation, the head of broadcast standards from Fox Television, and the marketing representative for Ansell condoms – only attracted some fifty individuals, most of whom appeared to be line staff. It's clear to me that if real progress is going to be made in building relationships with the media, sessions like these will need to be given higher, even plenary status.

Mike Shriver, former Director of Policy of the National Association of People with AIDS, was in his usual glory at the National STD Conference podium. But there's a striking absence of PWSTD's in STD prevention. No people with chlamydia, herpes, trichomoniasis or even crabs demanding better treatment or prevention. At a recent roundtable sponsored by the coalition set up expressly to mobilize community support for STD prevention, the STD Prevention Partnership, there was one lone PWH (Person With Herpes). As a single volunteer willing to go public with herpes, he seems to have the corner on the volunteer effort, and has been invited to conferences around the world.

STDs and Managed Care

And there are important questions which are beginning to be debated in managed care and STD prevention that HIV prevention, both at the government and community level, has pretty much ignored: who should pay for treatment of partners who aren't covered by the same plan? Should managed care organizations be expected to cover the costs of screening and treatment when an enrollee goes to an STD clinic, either because it's more confidential, or there's no wait for an appointment? Who should assure quality, the managed care organizations themselves or public health? And should they be expected to support community-based organizations - whether HIV or STD-specific - who are reducing the risk of their enrollees? And what about managed care's doctors? What are they able to do to help their patients reduce their risk?

STOP AIDS provided an interesting reference point to this last question. We trained hundreds of volunteers in two- and four-hour workshops how to carry out brief behavioral risk assessments, and they're able to interview some 8000 different people each year during outreach. These risk assessments serve to start conversations. They also provide a valuable data set. It turns out, however, that doctors may receive only two to ten hours training in medical school on the entire subject of sexually transmitted diseases, and few are skilled - even today - in how to carry out sexual histories. In an era when doctor appointments which last more than fifteen minutes are meeting the same fate as housecalls, this means bad news

for the diagnosis and treatment of STD's.

The Big Picture: What's Success? And What's The Right Mix?

Both HIV and STD prevention share a remarkable reluctance to define success. Although certainly nowhere close to the "failure" in HIV/STD prevention that many nay-sayers proclaimed some years back, it's not clear what a reasonable goal is. Should we accept 1% infection rates? Will we ever reach zero?

STD folks, meantime, are talking about syphilis elimination, meaning that there would be no more domestic transmission. And while there is some deserved self-congratulating going on, most of the discussion centers on where prevention efforts are failing. There is an understandable reluctance to proclaim success too loudly, lest funders remove all funding and use it somewhere else. But can efforts, particularly team and community-wide efforts, succeed when there is no clear consensus - nor even honest, open debate - about what success is? Is our goal to reduce the number of new infections in every disease, or wipe them out altogether?

STDs' challenges in building community support should also serve as a wake up call for HIV prevention efforts. With so many possibilities for treatment in HIV, and success in reducing new infections, HIV prevention advocates are focusing less attention on behavioral interventions, and even less on community interventions. It will be hard to resist relying on post-exposure treatment. It will be harder still to reverse the trend of relying more and more on resource-intensive prevention counseling efforts, while abandoning our broad-reaching community mobilization strategies. What's the right balance?

I was astonished to realize that many of my new STD colleagues had been in their jobs for 25 or more years, before HIV even came on the scene. It's clear that we need to let go of our egos and agendas, be willing to learn from each other, and be willing to assert what we can teach as well. We also need to be more aware, on both sides of the fence, that there are obvious links between the two, both epidemiologically and behaviorally.

Before I sign off, one bit of organizing: if you are interested in exploring the potential role of managed care in HIV prevention, please contact me at <Dwohlfei@dhs.ca.gov>. Thanks.

Dan Wohlfeiler has contributed to the Bulletin in the past, profiling his perspective on HIV prevention. NASTAD thanks Dan for this thought-provoking story.

Adolescent and School-Based HIV Prevention

How and What Do Teens Think: Doin'It 98

Purpose and History

The literature clearly supports sexual health education for youth and peer education as an important mode of information dissemination. While young people have at least heard the message about HIV, their knowledge of sexually transmitted diseases lags behind. In addition, knowledge alone is not enough – motivation and intent to change behavior must be present. High rates of sexually transmitted diseases among youth indicate the general lack of behavioral change as well as the need to do more. The *Doin'It Speak Outs* in Wisconsin provide a forum to get young peoples' views on HIV/AIDS, STDs and alcohol and drug use issues.

Presented in this article are the information and insights gathered at the five regional *Doin'It Speak Outs* in Wisconsin in October 1998. *Doin'It* teen peer conferences have been held annually in Madison since 1995. First envisioned as large teaching and networking conferences for youth and their advisors, they evolved into a standard format of large plenary sessions and small instructional breakout sessions. Time was devoted to having youth share their unique educational formats though "share shops" and networking was encouraged