

Note: PDFs are available upon request from Dan, email: dan@jba-cht.com

STDs

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October 28, 2008

Dear Colleague:

The November 7, 2008, edition of the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report* (MMWR) will include the *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection* (*Recommendations*). The *Recommendations* will be available electronically on October 30, 2008. The purpose of this letter is to highlight key points contained in these new recommendations.

Primarily directed to health department managers responsible for overseeing state and local HIV, STD, or integrated HIV/STD programs, the *Recommendations* will guide the delivery of partner services to individuals newly diagnosed with early syphilis, HIV/AIDS, chlamydia or gonorrhea. The new recommendations are the product of a collaborative process that involved federal, state and local agencies; national and local organizations; state STD and HIV prevention program and surveillance staff; and subject matter experts in relevant areas such as law and ethics.

The new *Recommendations* replace two separate CDC documents that until now have guided the provision of partner services for HIV and for other STDs: the 1998 *HIV Partner Counseling and Referral Services Guidance* and the Partner Services module of the 2001 *Program Operations Guidelines for STD Prevention*. By revising and integrating these guidelines, the *Recommendations* will make delivery of partner services more efficient and more efficacious, thus allowing programs to better realize the full prevention benefits of this public health strategy. At the same time, they implicitly recognize and respect the value of local innovation and the variety of contexts within which our partners operate. While the *Recommendations* indicate what an effective partner services program should include and why, they do not specifically instruct how partner services programs should operate or implement recommended practices.

The following are key points made in the *Recommendations* and exemplify the balance struck between uniform, directive guidance and respect for operational flexibility and program innovation:

- All persons with newly diagnosed or reported early syphilis or HIV/AIDS infection should be offered partner services, typically at, or as soon as possible after, diagnosis.
- Programs should use surveillance and disease reporting systems to assist with identifying persons with newly diagnosed or reported STDs, including HIV, who are potential candidates for partner services.
- At a minimum, health departments should use provider- and aggregate-level data from their surveillance systems to help guide partner services. If appropriate security and confidentiality procedures are in place, health departments should strongly consider using individual-level data to maximize the number of persons offered partner services.
- Regardless of the particular approach used to notify partners of their exposure, the health department should be directly involved.

- Programs should create strong referral linkages with care and prevention services providers to ensure that the needs of patients and their partners are addressed. Moreover, in the case of HIV-infected individuals, follow-up should be conducted to verify that they have accessed medical care or HIV case management at least once.
- Program managers should assess and eliminate barriers to programmatic collaboration and service integration within their jurisdictions, with the goal that, at a minimum, services are well integrated at the client (service delivery) level.
- Programs should have systems in place to monitor and evaluate program performance and identify areas that need improvement.

CDC is developing products and services to support implementation of the new *Recommendations*, including an Operational Guide and monitoring tools; a new, modular training curriculum; a formal system for requesting and receiving technical assistance; and a supplemental interview form to assist in gathering HIV Partner Services data not included on the current STD Interview Record form. CDC will introduce these products in early 2009. In the interim, CDC strongly encourages health departments to begin implementing recommendations that are appropriate to their operations, and begin assessing the policy and programmatic changes that will be needed to implement the remaining recommendations.

The new *Recommendations* and related information will be available as of October 30, 2008, at <http://www.cdc.gov/nchhstp/partners/>

You can order a hard copy of the *Recommendations* through the CDC National Prevention Information Network at 800-458-5231 (Monday to Friday, 9 am-6 pm ET) or contact info@cdcnpin.org.

We sincerely appreciate our collaboration with many of you during the development of these *Recommendations*, and we look forward to working with you in the coming months as you begin implementing them in your jurisdiction.

Sincerely,

/John M. Douglas, Jr./

/Richard J. Wolitski/

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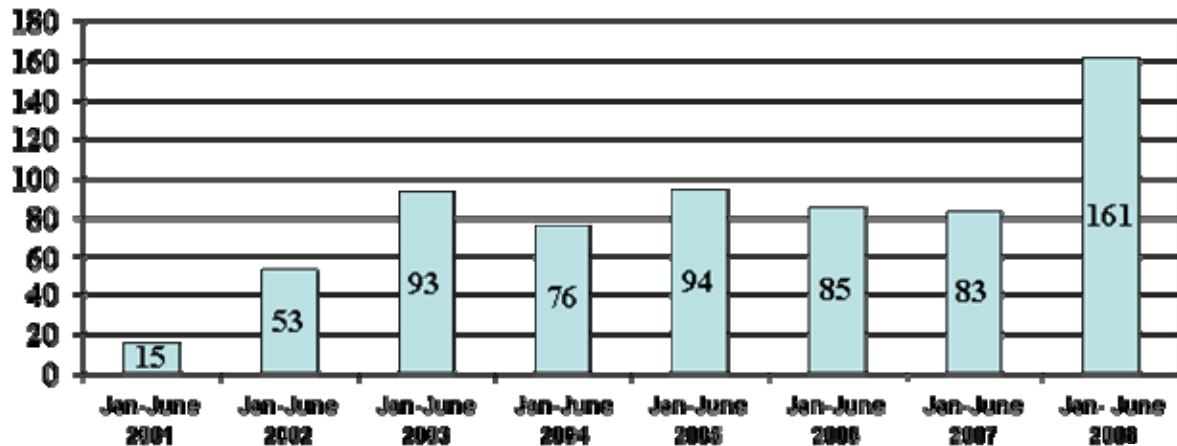
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**Program and Training Branch (PTB) Thursday Report
Monthly Highlights from the STD Programs
August/September 2008**

MASSACHUSETTS

1. After a leveling off from 2003 through 2007, Massachusetts has experienced an unprecedented rise in infectious syphilis rates in Men Who Have Sex With Men (MSM) during the first six months of 2008. According to surveillance data, 161 cases of infectious syphilis in MSM were reported from January through June 2008, for a 94% increase over the same period in 2007.

**Infectious Syphilis Cases in MSM
Massachusetts, January through June 2001-2008**



Addressing the rise in infectious syphilis includes the engagement of the MSM community- a population that has been inundated with social marketing and safer sex messages for more than twenty-five years. The rise in infectious syphilis rates has prompted the Division of STD Prevention to develop new materials with a different approach to STD prevention, as well as to bolster existing initiatives.

2. “STD Prevention for You and Your Partner” is a new brochure being developed for people in whom infectious syphilis has been recently diagnosed. The brochure emphasizes that Massachusetts Department of Public Health (MDPH) partner services are private and confidential: all partners are contacted without using the index patient’s name or any identifying information. The brochure also describes how named partners are encouraged to seek medical care and to be promptly screened and, if necessary, treated for syphilis. The brochure will be available at all state-funded STD clinics and private provider offices.

3. The Website www.gettestedboston.org has been in existence for five years. The target audience of the Website is MSM. The goal of “Get Tested Boston and Beyond” is to increase the number of MSM getting screened for STDs. People visiting the site can find a testing location by reading a user-friendly map. Recently several new testing sites have been added to the map. A new feature, “The Top Questions,” has been added to the home page. These questions were culled from STD clinics, based on commonly asked questions from MSM patients. In collaboration with Fenway Community Health, a promotional campaign for “Get Tested Boston and Beyond” will be launched in September 2008.

Please contact David Goudreau, MDPH’s Syphilis Elimination Coordinator, at david.goudreau@state.ma.us or by phone at 617-983-6835 with any questions, or if you would like to share ideas on prevention initiatives.

Contact: David Sullivan, DBS1@cdc.gov

MICHIGAN

Starting in March 2008, the Michigan Department of Community Health (MDCH) STD Program initiated an outbreak response plan to a drastic rise in syphilis in Genesee County. In 2007, Genesee County had 15 early cases, of which 13 were diagnosed as primary or secondary (P&S) syphilis. Through February of 2008, 18 early cases had already been reported, of which 13 were primary or secondary, equaling the entire P&S total for 2007. Most cases have been found in the city of Flint, the largest city in the county.

MDCH staff members met with Genesee County Health Department (GCHD) personnel, specifically the County Health Officer, the Medical Director, the Epidemiologist, and with STD Program staff members to develop a plan on how best to intervene and how best to target resources. It was determined that the GCHD would initiate their emergency response committee, the Communicable Disease Investigation Response Team (C-DIRT). This group is chaired by GCHD’s epidemiologist and is comprised of managers from various public health programs to share knowledge, skills, and resources as outbreak investigations and activities are coordinated. C-DIRT members were mobilized within 48 hours. MDCH staff was asked to participate during this outbreak.

A multifaceted plan was created which included physician notification to members of the Genesee County Medical Society; alerts to surrounding county health officers; press releases; additional personnel support; outreach activities; and targeted screenings based on analysis of behavioral and demographic information gained during syphilis interviews. A surveillance issue, delinquent reporting, was immediately identified with the largest hospital in Flint. The medical director, the state surveillance manager, and local DIS worked with lab and hospital officials to improve the timeliness of reporting. As many cases had been reported out of hospital emergency departments, those cases were specifically targeted for intervention. Placards displaying pictures of the most common infectious symptoms and the contact information for Genesee County staff

members were posted to increase the awareness of medical staffers and to ensure appropriate testing and treatment. MDCH assigned DIS from other areas of the state on a daily basis to support local DIS interviewing and investigative efforts. Screenings were performed initially at dance clubs where dancers had been identified as sex partners of infected cases. Additionally, commercial sex workers, housing projects, and MSM clubs were targeted.

As of September 12, 2008, Genesee County has recorded 85 early cases of syphilis with 52 of them being diagnosed as primary or secondary. Forty-five (52.9%) of the cases have been linked together. Additionally, six cases have been linked to more than one case. This is primarily a heterosexual outbreak, as only eight have MSM involvement. Four cases are co-infected with HIV, and three of those are MSM. Twenty-five clients have admitted to drug use, with 21 of them naming marijuana as the only drug they use. Nine clients claimed use of cocaine or crack and only one client cited the use of ecstasy. Six clients admitted to multiple drug use. Anonymous partners remain a significant thrust of the outbreak, as 22 cases indicated anonymous sex. The average age of clients is 34.4 (35.4 – Heterosexual, 25.5 – MSM.) Seventy-five clients are black and 10 are white. Forty-five are male and 40 female.

The prevention of congenital syphilis remains a priority. Outreach has been conducted to all area hospitals regarding the increase in congenital cases. The CDC recommends testing pregnant women during the third trimester and at delivery. Genesee County is experiencing such a high increase in early syphilis morbidity that a follow-up letter reemphasizing this recommendation has been distributed to the County Health Care Providers, who see pregnant women in their practices

C-DIRT meetings were held weekly during the first three months of the outbreak, and they continue on a biweekly basis. MDCH staff members remain active participants.

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SAN FRANCISCO

1. Rates of early syphilis are continuing to increase. For the month of July 2008, a total of 53 early syphilis cases were reported. This was the highest number of cases reported in any single month since the beginning of the year. As of the end of July 2008, 331 cases of early syphilis had been reported, compared with 281 for the same period last year, an increase of 18%. Additionally, a total of 163 cases of P&S syphilis had been reported, compared with 116 for the same period last year, an increase of 41%.

(Correction: As of the end of June 2008, a total of 278 early syphilis cases had been reported, compared to 240 cases for the same period last year, an increase of 16%. Additionally, a total of 138 cases of P&S syphilis had been reported, compared to 104 for the same period last year, an increase of 33%)

2. Effective July 16, 2008, individuals can be directly referred to www.askdrk.org for common questions and answers (Q&A) on sexual health.

3. In response to increases in the patient census at the STD Clinic combined with budget cuts and staffing shortages, effective July 2, 2008, the STD Program instituted a volume cap for walk-in clinic patients on Mondays, Wednesdays, and Fridays. On these days, the clinic opens as usual, but closes once the number of patients reaches 100. Patients who are referred by providers and those who require treatment for a diagnosed STD, or who have a partner with an STD, or who require evaluation for HIV Post-Exposure Prophylaxis (PEP) will continue to be seen.

4. Dr. Jeff Klausner, the STD Section Director, in collaboration with CSI Medical Education, is conducting a series of Web conferences focusing on syphilis prevention and management. These conferences began in September 2008. They are two-day Web conferences--one hour each day--and are appropriate for both clinicians and non-clinicians.

5. In response to an increase in the number of HIV-negative patients with new rectal infections, the STD Section convened several focus groups to help us create effective interventions. Here are some of the findings from the Groups.

a. The men were concerned about a biomedical intervention because they felt that taking a drug might encourage them to take more risks. They were also concerned about the long-term effects of taking an antibiotic or creating more drug resistance.

b. The men were more concerned about becoming infected with HIV rather than a bacterial infection and didn't understand the connection between HIV and other STDs.

c. The men reported that they wanted to be safe, but that it was a struggle for the following reasons:

1. Drug use
2. Steady partners who "bring home" infections
3. Not knowing as much about non-steady partners with whom they have sex
4. Condom breakage or improper condom use
5. Difficulty maintaining an erection when using a condom
6. Lack of awareness of the prevalence of infections and ways to prevent them

d. The men reported being interested in talking about their risk-taking issues and concerns in a caring, gay-sex-positive setting and said they would participate in a group or consider one-on-one counseling to discuss issues around being safe and staying HIV-negative.

6. Trichomoniasis, caused by the protozoan *Trichomonas vaginalis* (TV), is the most common curable sexually transmitted infection in the United States and worldwide and has been associated with PID, preterm delivery, and increased risk of HIV acquisition. To understand the burden of TV in San Francisco residents, the STD Section tested 1,105 leftover and de-identified urine specimens collected for chlamydia (CT) and gonorrhea

(GC) screening at the San Francisco County Jail. TV prevalence was 31.6% in specimens from females, 2.1% from males, and 0% from transgenders. In specimens from women 25 years or less, TV was present in 25% of specimens; TV was present in 38% of specimens from women over 25. At the time of testing, CT and GC prevalence in women was 3.4% and 1.7% respectively. The CT and GC prevalence in males was 4.4% and 1.1% respectively. These data indicate that TV infection may be common in women incarcerated at the San Francisco County Jail, particularly women over 25 years, and that additional resources to screen and treat women for TV infection may be warranted.

7. In August 2008, 56 cases of early syphilis were reported, the highest number of cases reported in a single month since April 2003. To date, early syphilis in San Francisco has increased over 35% compared to the same time period in 2007. The demographic characteristics of syphilis cases in 2008 are largely the same as those in 2006 and 2007. Most cases are in white, gay men between the ages of 35-45. Nearly 2/3 of early syphilis cases occurred in HIV+ individuals. Thirty-one percent of early syphilis cases reported meeting partners on the Internet and 11% in bathhouses and sex clubs. Nearly 30% of early syphilis cases reported six or more male sex partners during their critical period.

8. In August 2008, 61 cases of rectal chlamydia were reported, the highest number of cases reported in a single month since August 2006. To date, rectal chlamydia in San Francisco has increased over 18% compared to the same time period in 2007. The demographic characteristics of rectal chlamydia cases are the same as those for the early syphilis cases.

9. On September 6, 2008, the STD Section's Adolescent STD Team collaborated with Southeast Health Center, the district health center in the neighborhood with the highest STD rates in San Francisco youth, to conduct free school/sports physicals along with STD screening for young men and women ages 14-22 years of age. The decision was made to go into the community and offer more than just STD screenings, since many youth are delayed in starting school or participating on teams because they cannot afford one or parents have procrastinated. Three clinicians donated their time from 11:00 a.m. to 3:00 p.m. to conduct the physicals. Donations have been received from L'Oreal (hair products for young women of color); Old Navy (boxers, t-shirts, soap, and four backpacks filled with school supplies); the Produce Market (cases of fresh produce); and Rainbow Grocery Store (for \$100 worth of items from their store).

10. Five hundred twenty-eight STD Clinic patients were surveyed to assess childhood exposures to violence, abuse, and other adverse events to determine whether there was a relationship between these experiences and getting an STD. It was found that persons who had adverse childhood experiences were more likely to report them when the surveys were anonymous. Also, it was found that these individuals were more likely to have an STD. These findings suggest that child abuse may often be underreported, that childhood stress may have a long-term effect on adult sexual health and that more comprehensive assessment and care, including access to mental health services may be needed at STD Clinics.

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INFERTILITY PREVENTION PROJECT

The Infertility Prevention Project awarded one-time only funds in 2007 to support special projects in each of the 10 IPP regions. The following are brief descriptions of each of the 10 special projects:

Region I John Snow Inc (JSI) IPP Data Analysis Capacity Building

The Region I IPP Infrastructure increased the capacity of the Region I grantees to better use and interpret the data from the Region I Prevalence Monitoring Access Database on a regional, state, and clinic-specific level. The Region I Infrastructure first assessed baseline knowledge and identified gaps in ability to analyze and utilize the data. Training sessions were conducted in the fall of 2007 to increase regional capacity using the database for efficient and substantive reporting. Topics covered included database management, basic query writing, and reports development. The existing IPP database was used to demonstrate data cleaning as well as more advanced query and reports development on a state and facility level.

In order to maintain the skills learned from the trainings, practice exercises were developed and distributed. Using the IPP database, the exercises were designed to give data managers an opportunity to practice advanced query development and report design. Post training evaluation responses found the trainings have improved the data manager's ability to work with the data and their confidence in working with Access. Through the trainings and telephone support the data manager's have developed the ability to create and run queries and reports meeting local needs independent of JSI. As a result of these trainings, all of the data managers have a better understanding of the Access database structure, and are now able to build their own customized queries and data reports.

Region II Cicatelli Associates Adolescent Health Care Confidentiality

In September 2006, the Region II Infertility Prevention Project established a public private partnership with the Foundation for Healthy Living, the Blue Cross Blue Shield (BCBS) of Western New York (WNY) benevolent foundation. The project aims to address the conflict in Federal laws, and in New York State (NYS) Insurance Law (Section 3234) which require an Explanation of Benefits (EOB) be sent home to the primary insurance subscriber (usually a parent/caregiver) with the New York State Minors Reproductive Rights Laws that guarantee the provision of confidential reproductive health care for all adolescents. A NYS Stakeholders group comprised of approximately 30 members from diverse professional backgrounds, representing commercial insurance, professional medical associations and advocacy groups, state and city public health departments, and legal experts, have served to guide and inform all project activities through two formal face-to-face meetings and conference calls over the last two years.

Activities to date have revealed significant challenges related to the interplay of relevant federal and specific state regulation/law, health plan billing systems, and significant gaps

in health care providers' knowledge of these laws and systems. To address legal/regulatory challenges, the project has established a collaborative working relationship with The Center for Adolescent Health and the Law, the New York Civil Liberties Union and the American Academy of Pediatrics New York State District's Policy and Advocacy Arm to engage in ongoing dialogue and research to identify similar challenges and responses across the nation. The project supported the development and delivery of a Symposium at the 2008 National STD Prevention Conference in Chicago and is planning another Symposium at the Society for Adolescent Medicine Meeting in Los Angeles in March of 2009. In addition, the NYS Stakeholder group Co-Chair, Dr. Gale Burstein, has applied for funding to conduct focus groups to determine local primary care physicians' perceived systems barriers to providing confidential adolescent care and will use this information to partner directly with BCBS of WNY to establish a pilot system to enhance the confidentiality of commercially insured adolescents seeking reproductive health related services. Other partners include NYS medical professional associations and New York State and City Health Departments.

Region III Family Planning Council Chlamydial Predictive Factors in Women > 25 years

Region III is currently evaluating predictive factors that would ultimately allow clinicians to reduce overscreening for chlamydia in low-risk asymptomatic populations while providing targeted testing to clients based on predictive behavioral risk factors and recent disease history.

Consistent with CDC recommendations, females age 25 and under are typically screened regularly for chlamydia, while females over age 25 are diagnostically tested when medically indicated, or based on history and risk factors. The predictive factors for chlamydial infections in females over age 25 however, are not well understood.

The evaluation is a review of 500 charts of female clients at four Planned Parenthood locations in Philadelphia. A similar study in Region IX (Developing CT Screening Guidelines for Women over 25; Howard, et.al.) found that multiple partners and a recent bacterial vaginosis diagnosis to be key determinants to chlamydia infection. A sampling process has been developed and a case-control analysis will be performed to identify any salient factors predictive of chlamydial infections among females in this age group.

Region IV Emory University NAAT Verification for non-genital specimens among MSM

The Florida Public Health Laboratory in Jacksonville performed a verification study to show that the Gen-Probe APTIMA Combo 2 assay would detect the presence of *Chlamydia trachomatis* in rectal swabs on males having sex with males (MSM). A sample panel of specimens with known results was provided by the Molecular Section at the San Francisco Public Health Department. The specimens were received and tested using the Aptima Combo 2 Assay for *Chlamydia trachomatis* and/or *Neisseria gonorrhoeae* procedure (3) on the Tigris instrument. All *Chlamydia* and gonorrhea results were confirmed and samples forwarded to the Centers for Disease Control and

Prevention for additional LGV serogroup typing. CDC has confirmed all as positive for Chlamydia; none have been LGV.

Region V Health Care Education and Training Race and Ethnicity Data Quality

Despite a significant decrease in the overall rate of missing key data elements in the Region V Infertility Prevention Project (RVIPP) data set between 2002 and 2006, the collection of race and ethnicity data from key states remained less than optimal. HCET, partnering with the Michigan Infertility Prevention Project, developed and implemented an intervention to significantly reduce missing race and ethnicity data elements.

A review of the Michigan data discovered there were specific patterns in labs and sites having high amounts of missing data. In addition, there was misinformation regarding the importance of accurately completing the race and ethnicity fields on test requisitions. Forms are often submitted with either a race or an ethnicity response but not both. Some submitters were reticent to provide this information, voicing concerns data usage, what it may say about infection rates, especially in communities of color.

The “Why We Ask” campaign has been launched and is in the pilot phase. Information provided to clients includes an explanation of why both race and ethnicity fields must be completed, a brief message about how the data would be used and its importance, and a thank you for completing all forms as thoroughly as possible. Data collection continues and results should be available soon.

Region VI CHT Austin Race, Ethnicity, SES, and Zip Codes

CHT Austin began a data analysis project to assess chlamydia and gonorrhea positivity among women aged 15-24 years seen in Region VI FP clinics, exploring CT/GC positivity and its relationship to race/ethnicity after adjusting for client age, provider type, and test type, as well as accounting for racial/ethnic differences in positivity based on socioeconomic status (SES). It is well-known race, ethnicity and SES are inter-related and each is associated in complex ways with individuals’ health status.

Measuring SES is an evolving process, particularly when ascribing class status to adolescents or young adults who have not yet transitioned fully to adult roles. SES indicators in this situation have included household income, parents’ job classification, parental educational attainment, and youth educational aspirations. However, collecting SES indicators on clients during routine clinic services is challenging and, probably, unrealistic. Alternative strategies for measuring individuals’ SES have been described.

One general approach relies on aggregate descriptive information concerning the area within which clients reside. Areal units may include U.S. Census tracts or blocks, as well as ZIP code tabulation areas (ZCTA), a relatively new areal estimate generated by the U.S. Census Bureau.

We assessed racial/ethnic differences in CT/GC positivity among women and men seen at FP and STD clinics in Region VI states using individual-level IPP variables and area-based socioeconomic measures (ABSM). Analyses are continuing, but general findings

involving women seen at FP clinics include: 1) CT/GC positivity often varies across levels of ABSM/aggregate measures (e.g., percent racial minority); 2) CT/GC was not simply linearly associated with areal household income levels; 3) clients in rural areas had lower STI infection levels; and 4) racial/ethnic disparities in CT/GC remained after adjusting for individual and aggregate factors such as racial makeup and SES indicators of the 'neighborhood' (ZIP code area where clients lived).

ABSM appear to be useful for general analyses of CT/GC positivity and is associated with socioeconomic status measured at the ZCTA level for clients. Racial/ethnic differences in CT/GC remained even after controlling for other individual-level IPP variables (e.g. age) along with areal socioeconomic measures.

Limitations exist and will be further characterized at a later date. We plan similar analyses for women and men seen at STD clinics in Region VI. For additional information contact David Fine at dfine@jba-cht.com.

Region VII Development Systems Inc Repeat Negatives.

Ongoing review of project area-level data revealed several individuals were repeatedly negative for Chlamydia after multiple annual screenings. Region VII clients and sites having the highest frequency of multiple Chlamydia negative tests were identified. For Multiple tests were defined as two or more tests with negative results in a twelve month period of time. Chart audits were conducted in order to determine the initial and subsequent charted reasons for the repeat tests. One thousand seven hundred eighty-eight charts, representing 3901 tests, were reviewed.

Numerous explanations multiple testing were noted including recurring or unresolved clinical signs, screening within criteria (new partner, many partners), and screening as part of prenatal clinic visits. Additional regional discussions and analyses are planned.

Region VIII JSI Chlamydial RNA Persistence

JSI Research & Training Institute-Denver and Wyoming Public Health Laboratory proposed a study to determine how long residual chlamydial RNA is detected, after antibiotic treatment, when using the APTIMA Combo 2 assay. Current CDC Guidelines (U.S. Centers for Disease Control & Prevention) suggest an interval of at least 3 weeks before follow-up testing after a positive Chlamydia trachomatis infection has been treated. Previous studies to monitor persistence of chlamydial RNA/DNA after therapy were done with earlier amplification assays. With newer amplified technology, minute amounts of nonviable organisms may be detected beyond 3 weeks post treatment, and in some instances may be mistaken as treatment failure.

The study obtained IRB approval through the WDH Institutional Review Board, but has encountered two major obstacles: 1) there has been a limited number of sites that have signed on to participate, and 2) some states (i.e., Montana and South Dakota) do not have their own IRB; JSI will research whether a blanket IRB approval could be granted through JSI.

The project will enroll at least 75 women between now and December 31, 2008, hoping at least 70% will complete the 6 week program (weekly testing and completion of a sexual activity diary). Data analysis will follow.

Region IX CHT Oakland Racial Disparities

Recent focus of racial and ethnic disparity analyses and STD/HIV interventions has been on social networks and concurrent partners. To identify and mitigate these disparities, the Region IX IPP Infrastructure is analyzing Arizona and Nevada data at family planning clinic sites to identify geographic locations where racial disparities are most evident. A combination of Family Planning Annual Report data and data from the Regional prevalence monitoring system are being used. Final products will be graphs, tables and/or slide sets for use by Nevada and Arizona Project Areas in discussions on racial/ethnic disparities in specific communities within their Project Area.

Region X CHT Seattle Chlamydia among Asian and Hawaiian/Pacific Islanders

The Region X Infertility Prevention Project analyzed chlamydia (CT) positivity among Asian and Native Hawaiian/Other Pacific Islander women age 15-24 screened in Region X FP clinics from 2000-2006. Trends were compared between non-Hispanic White, Asian, and Native Hawaiian/Other Pacific Islander women. Multivariate logistic regression was used to identify demographic, sexual risk behaviors and clinical findings associated with CT.

Of 428,562 tests, 94.4% were non-Hispanic White, 4.5% Asian and 1.1% Native Hawaiian/Other Pacific Islander. CT positivity ranged from 5.0% for non-Hispanic White women to 6.7% for Asian women to 9.9% for Native Hawaiian/Other Pacific Islander women. Unadjusted CT positivity by race varied significantly over time from 4.4-5.2% for non-Hispanic Whites to 7.5-6.1% for Asians to 9.4-11.2% for Native Hawaiians/Other Pacific Islanders.

After adjusting for age, test type, sexual risk behaviors and clinical findings, Asian (OR=1.23) and Native Hawaiian/Other Pacific Islander women (OR=1.80) were at increased risk of CT compared to non-Hispanic White women. Asians and Native Hawaiians/Other Pacific Islanders had consistently higher levels of CT than non-Hispanic Whites, even after adjusting for other factors. Significant differences were also found between Asian and Native Hawaiian/Other Pacific Islander women. Findings confirm the importance of exploring racial/ethnic disparities in CT positivity, and analyzing data separately for Asians and Native Hawaiians/Other Pacific Islanders. They also support the need for better assessment of individual and community-level factors among Asian and Native Hawaiian/Other Pacific Islander women, e.g. sex partner characteristics, sexual networks, cultural identity or acculturation, and socioeconomic status.

Contact: Steve Shapiro, SJS4@cdc.gov

The “Training Highlights” section provides information on upcoming STD training activities of the National Network of STD/HIV PTCs (NNPTC) and the Health Professional Training and Education Unit in the DSTDP. For complete descriptions of classes and self-study educational resources, please visit the NNPTC website www.stdhivpreventiontraining.org, and the CDC STD training website <http://www.cdc.gov/std/training/>

Partner Services and Program Support Training

Introduction to STD Intervention (ISTDI) courses

December 2-12, 2008, Placerville, CA

Sponsor: California PTC, <http://www.stdhivtraining.org/>

Contact: Veronica Espinoza, VEspinoz@dhs.ca.gov, or 562-570-4085

February 3-13, 2009, Carson City, NV

Sponsor: California PTC, <http://www.stdhivtraining.org/>

Contact: Veronica Espinoza, VEspinoz@dhs.ca.gov, or 562-570-4085

Advanced STD Intervention (ASTDI) and Supervisory Courses

Please check the DSTDP Training Webpage <http://www.cdc.gov/std/training/courses.htm> for the 2008 and 2009 Training schedule for the Advanced STD Intervention (ASTDI) course, the STD Intervention for Supervisors (STDIS) course, and the Principles of Supervision course.

Clinical and Laboratory Training

STD Intensive Clinical Courses

STD Intensive

January 12-16, 2009, Cincinnati, OH

Sponsor: Cincinnati PTC, www.stdptc.uc.edu, and the Cincinnati Health Department

Contact: Barbara Forney, forneyba@usmail.uc.edu or 513-558-3197

Fundamentals of STDs in Clinical Practice

January 26-28, 2009, Oakland, CA

Sponsor: California STD/HIV Prevention Training Center

Contact information: www.stdhivtraining.org, or (510) 625-6043

Three day STD Clinical Intensive Flex course

January 27, 2009, Boston, MA

Sponsor: Sylvie Ratelle STD/HIV Prevention Training Center of New England,

<http://www.state.ma.us/dph/cdc/stdtcmmai/stdtcmmai.htm>

Contact: Janine Dyer, Janine.Dyer@state.ma.us, or 617-983-6964

STD Adolescent Intensive Course

January 27-28 2009, New York, NY

Sponsor: Region II PTC, www.nyc.gov/health/std, and the NYC Department of Health and Mental Hygiene

Contact: Region II PTC, nycptc@health.nyc.gov, or 212-788-7466

Three Day STD Clinical Intensive course

February 23-25, 2009, Boston, MA

Sponsor: Sylvie Ratelle STD/HIV Prevention Training Center of New England, <http://www.state.ma.us/dph/cdc/stdtcmai/stdtcmai.htm>

Contact: Janine Dyer, Janine.Dyer@state.ma.us, or 617-983-6964

STD Advanced

February 23-27, 2009, Cincinnati, OH

Sponsor: Cincinnati PTC, www.stdptc.uc.edu, and the Cincinnati Health Department

Contact: Barbara Forney, forneyba@usmail.uc.edu or 513-558-3197

STD/HIV Clinical Update Courses

Clinician Update

December 9-10, 2008, Cincinnati, OH

Sponsor: Cincinnati PTC, www.stdptc.uc.edu, and the Cincinnati Health Department

Contact: Barbara Forney, forneyba@usmail.us.edu or 513-558-3197

Update on the Management of STDs, 2009

February 12-13, 2009, Seattle, WA

Sponsor: Seattle STD/HIV Prevention Training Center, www.SeattleSTDHIVPTC.org

Contact: Ronnie Staats, rstaats@u.washington.edu, or 206-685-9848

Clinical Exam Skills and Laboratory Skills Courses

Microscopic Examination of Vaginal Fluid

January 6, 2009, Seattle, WA

Sponsor: Seattle STD/HIV Prevention Training Center, www.SeattleSTDHIVPTC.org

Contact: Ronnie Staats, rstaats@u.washington.edu, or 206-685-9848

Male and Female Genital Exam Skills Practicum

January 29, 2009, San Francisco, CA

Sponsor: California STD/HIV Prevention Training Center

Contact information: www.stdhivtraining.org, or (510) 625-6043

Wet Mounts for the Practicing Clinician

January 29, 2009, San Francisco, CA

Sponsor: California STD/HIV Prevention Training Center

Contact information: www.stdhivtraining.org, or (510) 625-6043

Wet Mount Laboratory Course

February 25, 2009, Boston, MA

Sponsor: Sylvie Ratelle STD/HIV Prevention Training Center of New England,

<http://www.state.ma.us/dph/cdc/stdtcmai/stdtcmai.htm>

Contact: Janine Dyer, Janine.Dyer@state.ma.us, or 617-983-6964

Self-Study Clinical Continuing Education Offerings (free CE credit available)

Online Chlamydia Course

Sponsor: California STD/HIV Prevention Training Center

Contact information: www.stdhivtraining.org, or (510) 625-6043

Web Based STD Update with FREE CME (1 hour, category 1, CME)

Available at <http://www.cecentral.com/STDupdate>

STD Clinical Intensive Continuing Education Module

This offering features clinical illustrations and video segments on topics such as syphilis, gonorrhea, viral hepatitis, syndromic approach to STDs, and more.

Available at <http://www.bu.edu/cme/std/>

Chlamydia Case-Based Training

This course provides screening, diagnosis, and treatment information for chlamydial infections in women in case-based, interactive format.

Available at http://www.stdhivtraining.net/educ/training_module/index.html

NNPTC STD Case Series

This web-based case series is designed for practicing clinicians who diagnose, treat and manage patients with, or at risk for, STDs. The series includes case presentations of common STD-related syndromes with a guided, interactive process to evaluate each case, arrive at a diagnosis and provide recommended treatment.

Available at <http://www.stdhivtraining.net/nnptc/start.cfm>

CDC Self-Study STD Modules for Clinicians

This site offers seven web-based educational modules, each based on a specific STD topic. Each module is considered to be an individual course. The target audience is clinicians in primary care settings who desire a basic introduction to STD diagnosis and management.

Available at <http://www2a.cdc.gov/stdtraining/self-study/default.asp>

Other Clinical Resources

Clinical Preceptorship in an STD Clinic

Dates made by arrangement, San Francisco, CA

Sponsor: California STD/HIV Prevention Training Center

Contact information: www.stdhivtraining.org, or (510) 625-6043

Illuminate Live!

Free Monthly Webinar Sessions

Join us for online distant learning trainings. Sit at your desk and participate in lectures and discussions on all the hottest STD topics.

CME's are available.

All eLearning seminars are 12:30 – 2:00 PM Eastern Time

To learn more about eLearning Seminars contact Barbara Forney at forneyba@usmail.us.edu or 513-558-3197.

STI Provider Toolkits now available.

The toolkit includes information on screening, syphilis diagnosis and management, reporting information and a summary laminated STD treatment guidelines card.

Contact: Region II PTC, nycptc@health.nyc.gov, or 212 788 7466

*New offering this quarter.