



## Infertility Prevention

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Long before HIV topped the charts for public awareness of sexually transmitted infections (STIs), public health departments have been laboring to fight the wide spread transmission of sexually transmitted disease (STD), which cause long term negative health outcomes. First called “venereal diseases,” STDs begin with a sexually transmitted infection, often without symptoms\*.

Syphilis and gonorrhea were the objects of early public health STD control efforts in the 1940's – 1960's, when the prevention focus was on men. During the 1970's (the dawning of the Age of Aquarius and ‘the pill’) there was increased emphasis on gonorrhea prevention and women.

Today the most common STD is chlamydia. Chlamydia wasn't really understood until the 1980's, with an increased awareness of its asymptomatic nature and its role in causing pelvic inflammatory disease (PID) and subsequent infertility if left untreated.

More than 50% of all preventable infertility is related to STDs according to the national Centers for Disease Control and Prevention (CDC). Together chlamydia and gonorrhea are major causes of reproductive health consequences especially in women.

Public health needed to become proactive with chlamydia, a sexually transmitted infection that was asymptomatic (52%) for men and even more

\*Currently the national Centers for Disease Control and Prevention (CDC) still uses the term STDs and the MDCH follows suit. Planned Parenthood, which has used STI, is reverting back to STD to be consistent with the CDC. The acronym STD will be used here.

for women (75%). Screening was needed in multiple venues to find those who would not show up at the doorstep of STD clinics complaining of symptoms.

### A NATIONAL INFERTILITY PREVENTION PROGRAM (IPP)

In the 1980's several factors led toward development of a national infertility prevention program. The first non-culture diagnostic tests were developed, making diagnosis easier. Also, the CDC began accepting chlamydia case reports. From these data the prevalence among young women could be identified.

In 1985, CDC published “*Policy Guidelines for Prevention and Control of Chlamydia trachomatis infections.*” Those guidelines highlighted the prevalence and morbidity of chlamy-

*Continued on page 12*

### Chlamydia

In Michigan, chlamydia prevalence is highest among those ages 15 – 19 and 20 - 24, with rates of 1906 and 2406, respectively, per 100,000 population in 2004. Additionally, screening conducted at adolescent venues (school-based clinics, juvenile detention facilities, and teen health centers) show high positivity, up to 24%, in females and 21% in males. Among school-based clinics studied, 49% of the students that tested positive for chlamydia accessed service for reasons other than an STD check. *From MDCH-DHWDC Newsletter Spring 2006*

*See chlamydia morbidity report on page 8*

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## DHWDC News

*MDCH Division of Health Wellness and Disease Control*

### STD Section Update

The Michigan STD Program has been selected to participate in an evaluation pilot project, sponsored by the CDC. See "New Directions" on page 3.

#### DETROIT STD SURVEILLANCE AND INTERVENTION (DSTDSI)

Dawn Jackson as acting manager for the program reported decreases in primary and secondary syphilis. 2005 was an historical year in the program success toward the elimination of syphilis in the city of Detroit. The 2005 program goal was to decrease primary and secondary syphilis in the City of Detroit by 25%, from 2004 totals. There were 57 cases of primary and secondary syphilis reported in 2005, this represents a 55% decrease from December 2004 cases (n=126).

Health Promotion and Prevention provides education and intervention strategies to reduce the risk and/or eliminate Sexually Transmitted Diseases (STDs). In order to best direct syphilis intervention efforts, the DSTDSI staff target interventions to individuals most at risk. These individuals are identified by the STD Epidemiologist from case management documents, surveillance reports, and STD Risk Factor Survey Forms. Findings from the data identify potential outbreaks and target interventions at a community level for health promotion activities. For 2005, the STD program conducted 49 targeted syphilis screenings. Three cases were identified for field investigation.

Detroit STD Surveillance Supervisor Bruce Nowak reported on some trends looking back at surveillance data for the past five years. January and October have consistently had the most syphilis lab reports. Nowak attributed this to the increased holiday and summer sexual activity resulting in infections.

#### STD OUTSTATE REPORT

In January, 2005, twenty-nine local health jurisdictions were designated as low HIV/STD morbidity areas. It was decided that MDCH would provide HIV positive test notification, Partner Counseling and Referral Services (PCRS) and Syphilis Investigation/Case Management to these areas via a new contract with Central Michigan District Health Department.

CMDHD provided three employees to receive the necessary training and certification to conduct these operations in 26 of the 29 low morbidity jurisdictions; the other three are serviced by MDCH STD-Disease Intervention Staff (DIS) Robert Cochran, assigned to Berrien and surrounding counties.

Last summer HIV training and certification was provided by HAPIS to CMDHD staff. Cochran assisted the staff in completing the pre-requisites for the two-week CDC course that focuses on STD interviewing, investigation, and case management. CMDHD syphilis reactor /case follow-up began October 1, 2005, as scheduled. Cochran continues to assist and advise CMDHD staff, as needed.

#### STD NEEDS ASSESSMENT

The HAPIS training unit staff conducted a needs assessment to determine what information on sexually transmitted infections was needed throughout public health staff and community-based organizations. The training unit and the STD section then determined STD trainings to be offered for the rest of the calendar year. (See Training Calendar page. 10) HAPIS says "Thank you" to all who participated in this survey.

*Continued on page 13*

## FOCUS ON: STD Unit Infertility Prevention Program



**Kristine Judd**

**STD Control Program Administrative Program Manager**

manages STD activity in outstate Michigan and coordinates Michigan's Infertility Prevention Project (IPP). Judd began her public health career in 1988 working in Fort Lauderdale, Florida as a public health advisor for the Centers for Disease Control and Prevention (CDC). Her assignments with CDC included Disease Intervention Specialist and Front Line Supervisor in the Fort Lauderdale STD/HIV program, as well as STD Front Line Supervisor and Assistant AIDS Coordinator for the Detroit Health Department. Since joining the Michigan Department of Community Health in 1995, she also worked in the HIV/AIDS Prevention and Intervention Section as the HIV Counseling and Testing Coordinator and as a prevention consultant. She holds a BS in Public Health, Indiana University. Contact: (313) 456-4426; (313) 456-4428 fax; e-mail: juddk@michigan.gov

**Shawn Woods**

**Disease Intervention Specialist**



performs disease investigation for Genesee County and Saginaw County, conducts workshops/classes concerning STD/HIV information to local schools and CBOs, and is involved with Michigan's Infertility Prevention Project (IPP). Woods began his public health career in 2001 as a Health Educator/DIS for the Genesee County Health Department before moving on to MDCH in 2005. His work duties for the Genesee County Health Department included; disease investigation, conducting workshops and classes, developing educational materials, HIV testing and counseling and PCRS.

## New Directions

**T**he Michigan STD Program was recently selected to participate in a program evaluation pilot project sponsored by the CDC. Michigan chose to evaluate chlamydia screening in the Emergency Department (ED) at St. John Hospital, in Detroit. "This is a great example of the Infertility Prevention Project's (IPP) partnership with the private sector," said Judd.

As part of this evaluation, St. John ED staff will offer universal chlamydia screening to females ages 15–24, for a six month period. "It was the data from the Michigan Adolescent Screening Project that compelled St. John's to participate in this screening of young women who come in for emergency care," said Judd.

Results will be analyzed to determine how many cases of chlamydia

would have gone undetected had their existing screening protocol been followed. Urine tests will be run at the Detroit Regional Laboratory. All patients testing positive will be referred for treatment by the Detroit Department of Health and Wellness Promotion, STD Program. Additionally, Detroit STD staff will assist the Emergency Department, as needed, with specimen batching and transport. MDCH anticipates this program to begin sometime in August at St. John.

The STD Unit is also "exploring the use of expedited partner therapy," said Judd. This is providing prescription medication for the treatment of one's sexual partner at the time of an STD diagnosis. It saves time and the possibility of reinfection from an asymptomatic partner who may not go in himself for screening.

However, the IPP federal funding is

specifically for chlamydia screening in women. Only 30% of the IPP funds are available for gonorrhea screening and 10% can be used to screen men. Michigan has been fortunate in receiving additional funding from the State of Michigan that allows for more screening of males, particularly adolescent males who have shown to be most at-risk.

Every year there are decisions to be made regarding a balance between available funding and targeting those sites and projects with the greatest prevalence and need for screening and testing. In the light of budget cuts, Judd said they are hoping for level funding next year.

See this issue's feature story, *Infertility Prevention* on page 1, for more on the IPP. Also, see the MDCH Morbidity report on Chlamydia on page 8.

# HIV at 25



June 5 marked twenty-five years since the first opportunistic infections in gay men were reported by the CDC in 1981. This milestone was an opportunity to note both the progress and continuing obstacles in the War on AIDS.

The pandemic has now claimed 21.8 million lives worldwide (438,795 M in the U.S.) and a reported 36.1 million persons are living with HIV/AIDS. AIDS now impacts on national security in many countries, according to two executive directors in the global fight, Global Fund's Richard Feachem and Peter Piot of UNAIDS, in a report released by *PLoS Medicine* (6/13/06).

On June 4, the CDC opened the third meeting of the HIV Prevention Leadership Summit in Dallas with its review of prevention successes and challenges. Kevin Fenton, director of the CDC National Center for HIV, STD and TB Prevention (NCHSTP) noted several prevention successes, including stabilization of new cases

despite the increasing prevalence of HIV infection, the significant reduction in mother-to-child transmission, improvements in diagnostic screening tests, which have helped knowledge of serostatus, and the decline in new infections among injection drug users (IDUs). The increasing awareness among communities of color, the advent of the diffusion of evidence-based interventions (DEBIs) and the presence of HIV programs at the state, local and community levels, as well as in drug treatment settings, were also considered prevention successes by the NCHSTP director.

Challenges that Fenton posed include: the limitations on diffusing ef-

fective behavioral interventions; men who have sex with men (MSM) remain disproportionately impacted, particularly young gay men who are least likely to know their status; and the increasingly complex public health workforce and infrastructure challenges. About 25 percent of those infected with HIV are unaware of their status. *NASTAD HIV Prevention Bulletin* (7.06)

The CDC's upcoming guidelines that propose routine HIV tests for individuals 13 to 64 years old has some advocates concerned. "CDC's recommendations make sense in a world that can provide accessible health care without stigma," said Dean of the School of Public Health at Drexel University in Philadelphia. "Regretfully we are not living in that world."

While the CDC lays out its plans, HIV testing policy was a global discussion between the World Health Organization and UNAIDS in Geneva on how to best scale up testing to increase access to prevention and care around the world. WHO's new AIDS Director Kevin de Cock said, "Testing has to become normal." *Wall Street Journal* (7.5.06)

Worldwide, the issue of providing care for those who test positive is bound by the reality of the developing world. WHO missed its 3 by 5 Initiative target of treating three million HIV-positive people in developing countries with antiretroviral drugs by the end of 2005 because of a lack of international cooperation and coordination, as well as a lack of national leadership. *Kaiser HIV/AIDS Daily HIV/AIDS Report* (6.15.06)

The WHO lost one of its dedicated leaders in May when the Director-General died suddenly. Anthony S. Fauci, M.D expressed deep sorrow on behalf of the National Institutes of Health for the loss of Dr. Lee Jong-Wook, "a valued colleague and tireless crusader for the improvement of global health." Dr. Lee dedicated his life to bettering the health and well-being of millions of people throughout the world, leading efforts to offer universal access to drugs



## Closing in on CARE

**T**he Ryan White Comprehensive AIDS Resources Emergency Act (CARE) was enacted by Congress in 1990 to address the funding needs for HIV care and support services and has since been amended twice before it technically expired in September 2005.

The Administration's Principles for Reauthorization release was last July 25. For over a year the debate and discussion has heated up over what changes are necessary for a reenactment of this legal document that defines the parameters for Congressional allocation of national funds for the (currently four) titles of the Act and even whether the titles should be redefined.

There are many contentions to the draft legislation (S 2823) proposed on May 10. Factions of special interest, along with collaborative groups, have sent a flood of response to Congress in the many weeks since its release. Key issues at stake are 1) incorporating the use of HIV statistical data into the funding formulation and how that will be done; 2) the robbing Peter to pay Paul redistribution and other issues, i.e. solving the ADAP waiting list problem; 3) changes in the formula for Title II base grants; and 4) with Katrina as an example and Avian flu on the horizon there is also the new caveat, a national emergency waiver of the CARE Act requirements.

The founder and director of MI-POZ, Michigan's advocacy group for persons living with HIV/AIDS, thinks the reauthorization discussion is coming from the wrong set of arguments. Mark Peterson said, "Instead of taking funds from one title

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# MICHIGAN: On the Cutting Edge

## News Briefs

### Breaking the Silence! in Michigan

Two conferences this spring had 'Breaking the Silence' as their theme. They were Michigan's Persons Living with HIV/AIDS Conference and a workshop to address HIV in the Arab community as part of a national Arab Health Conference.

### "Empower Women: Fight AIDS"

It was a whirlwind tour in metro Detroit for the UNAIDS representatives on the first stop of the Global Coalition of Women and AIDS U.S. Tour June 9- 10. Detroit's own daughter, Mary Fisher, founder of the Mary Fisher CARE Fund and recently appointed UNAIDS special representative, led the Tour. She was accompanied by three women representing underdeveloped countries that have been hit hard by the HIV/AIDS pandemic, India, Zambia and Honduras.

### MAF's Venture into Public Policy

The Michigan AIDS Fund, following its most recent strategic planning process to focus on advocating for constructive HIV/AIDS prevention policies, had an outside research group gather information from a broad range of stakeholders and advisors.

As a result of 19 interviews that led to the report, "Public Policy Initiatives for HIV/AIDS Prevention in Michigan," MAF will create a diversified coalition and a Public Policy Committee to address the most important public policy issues facing the nation and Michigan.

First identified was the lack of access to needle or syringe exchange. Second, but closely linked, was the need to advocate at the federal level for a change in restrictive policy for all kinds of prevention funds.

*All briefs are continued on page 16.*

## On 25th Anniversary of First HIV Case, Revised Stats Mark New Disease Trends

While the country recognized the 25th anniversary of the first cases of AIDS reported in the United States on June 5, MDCH officials released information to the press on the current state of the epidemic in Michigan. More than 5,000 Michigan residents have been diagnosed with HIV since January 1, 2000. "We cannot afford to become complacent with HIV and AIDS in Michigan," said MDCH Director Janet Olszewski. Disease trends in Michigan have changed appreciably since 2000:

- Michigan is seeing significant increases among young people aged 13 to 24, however most new diagnoses of HIV still occur among persons aged 30 to 44 years. (See graph on page 7.)
- Among these young people, prevention efforts need to be focused, relevant and accessible to African American youth in particular, since most of the increase is seen here.
- African American, white and Hispanic men who have sex with men (MSM) continue to lead the epidemic in Michigan and we have seen significant increases in HIV among these men.
- HIV trends among injecting drug users are showing promising declines.
- The proportion of African American women getting diagnosed with AIDS at the same time as testing HIV positive has declined significantly. This likely indicates that they are getting tested earlier in the course of their infection.

## Statewide Prevention Plan Unveiled

The spring meeting of Michigan's HIV/AIDS Council (MHAC) premiered the final Comprehensive Plan for Prevention representing a lot of hard work for the committee and HAPIS staff. The Needs Assessment and Comprehensive Planning process for both prevention and care in the state is MHAC's biggest responsibility. Needs Assessment is now underway for the Care plan, similar to the assessment done in 2003. A survey has been mailed to all DAP and MDA clients statewide. Also, PWA public forums were conducted around the state. This information will be combined with that gathered by the Title I forums already conducted in the Detroit EMA.

Another very active MHAC committee is the African American Workgroup. Members are planning to develop a short fact sheet about the HIV/AIDS epidemic among African Americans for elected officials in the highest HIV/AIDS prevalence areas. Following a very successful 2<sup>nd</sup> Annual Black AIDS Awareness Campaign this past March, the committee has begun organizing activities for the 3<sup>rd</sup> campaign in 2007.

MHAC member Jeanne Sullivan, who is retiring from her position as HIV coordinator for the Ingham County Health Dept., was recognized by several members for her long and dedicated service to the HIV cause and her valued assistance to colleagues over the years.

All reports, including two on survey results from at-risk populations as well as the Comprehensive Plan are available at [www.mihivnews.com/mhac.htm](http://www.mihivnews.com/mhac.htm).

**Table 1: Characteristics of Michigan Residents Living with HIV and AIDS as of April 1, 2006**

	Estimate of HIV Prevalence <sup>1</sup>	Estimated Prevalence Rate <sup>2</sup>	Reported Living with AIDS <sup>3</sup>		Reported Living with HIV not AIDS <sup>3</sup>	
			Number	Percent <sup>4</sup>	Number	Percent <sup>4</sup>
<b>MICHIGAN TOTAL</b>	<b>16,200</b>	<b>163</b>	<b>6,226</b>	<b>100%</b>	<b>5,956</b>	<b>100%</b>
<b>SEX</b>						
Male	<b>12,430</b>	255	4,922	79%	4,427	74%
Female	<b>3,770</b>	74	1,304	21%	1,529	26%
<b>BEHAVIOR</b>						
Male-Male Sex	<b>7,470</b>	N/A	3,046	49%	2,575	43%
Injecting Drug Use <sup>4</sup>	<b>2,130</b>	N/A	900	14%	704	12%
<i>IDU w/ heterosexual</i>	<i>1,000</i>	<i>N/A</i>	<i>419</i>	<i>7%</i>	<i>336</i>	<i>6%</i>
<i>IDU w/o heterosexual</i>	<i>1,130</i>	<i>N/A</i>	<i>481</i>	<i>8%</i>	<i>368</i>	<i>6%</i>
Male-Male Sex/IDU	<b>750</b>	N/A	312	5%	252	4%
Blood Products	<b>160</b>	N/A	77	1%	44	1%
Heterosexual <sup>5</sup>	<b>2,150</b>	N/A	800	13%	818	14%
<i>Partner IDU</i>	<i>650</i>	<i>N/A</i>	<i>242</i>	<i>4%</i>	<i>244</i>	<i>4%</i>
<i>Partner Bisexual</i>	<i>120</i>	<i>N/A</i>	<i>37</i>	<i>1%</i>	<i>52</i>	<i>1%</i>
<i>Partner Rec'd Bld</i>	<i>50</i>	<i>N/A</i>	<i>20</i>	<i>0%</i>	<i>20</i>	<i>0%</i>
<i>Partner HIV +</i>	<i>1,330</i>	<i>N/A</i>	<i>501</i>	<i>8%</i>	<i>502</i>	<i>8%</i>
Perinatal	<b>190</b>	N/A	39	1%	106	2%
Undetermined/Other	Not Applicable	N/A	1,052	17%	1,457	24%
<i>Presumed Hetersexual<sup>6</sup></i>	<i>Not Applicable</i>	<i>N/A</i>	<i>833</i>	<i>13%</i>	<i>1,029</i>	<i>17%</i>
<i>Other<sup>7</sup></i>	<i>Not Applicable</i>	<i>N/A</i>	<i>219</i>	<i>4%</i>	<i>428</i>	<i>7%</i>
<b>AGE AT DIAGNOSIS</b>						
0 -12 years	<b>200</b>	11	35	1%	118	2%
13 -19 years	<b>410</b>	41	66	1%	244	4%
20 -24 years	<b>1,520</b>	236	318	5%	827	14%
25 -29 years	<b>2,340</b>	357	709	11%	1,049	18%
30 -34 years	<b>3,090</b>	437	1,189	19%	1,133	19%
35 -39 years	<b>3,150</b>	400	1,349	22%	1,022	17%
40 -44 years	<b>2,440</b>	301	1,114	18%	723	12%
45 -49 years	<b>1,500</b>	204	707	11%	419	7%
50 -54 years	<b>890</b>	141	426	7%	242	4%
55 -59 years	<b>380</b>	78	177	3%	110	2%
60 -64 years	<b>170</b>	45	85	1%	43	1%
65 years and over	<b>100</b>	8	51	1%	23	0%
Unknown	Not Applicable	N/A	0	0%	3	0%
<b>RACE / ETHNICITY</b>						
White, Non-Hisp.	<b>5,790</b>	74	2,274	37%	2,079	35%
Black, Non-Hisp.	<b>9,440</b>	673	3,633	58%	3,464	58%
Hispanic	<b>590</b>	182	250	4%	195	3%
Asian	<b>70</b>	39	30	0%	26	0%
American Indian	<b>50</b>	94	12	0%	27	0%
Unspecified/Other	Not Applicable	N/A	27	0%	165	3%

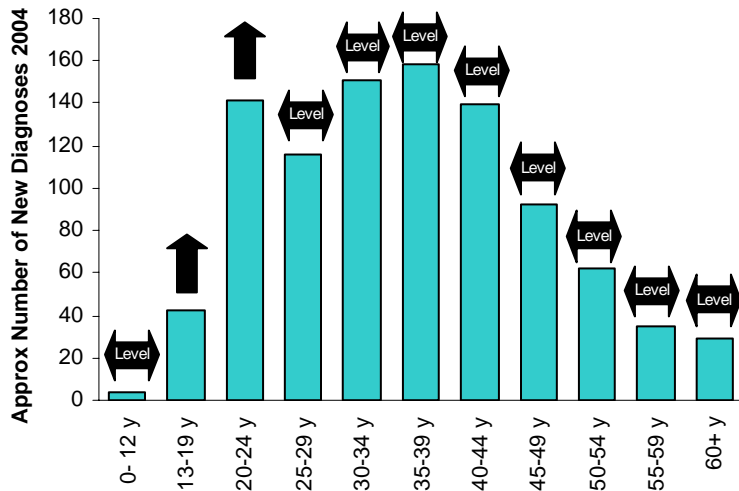
**Footnotes for Table 1**

1. This estimate includes all persons living in Michigan at diagnosis of HIV or AIDS, including those not reported or not yet diagnosed. All estimates are rounded to the nearest ten, and the minimum estimate given is 10. See below for explanation of this estimate.
2. Rates are calculated per 100,000 population in 2000.
3. Includes reports that contain patient name or are otherwise unduplicated.
4. Age, sex, race, and behavior percentages are calculated excluding missing data. The percentages of total cases missing this demographic information are given in parentheses.
5. The IDU risk category is further subdivided to indicate the number and percentage of persons who also had a sexual partner who is considered to be a "high risk" heterosexual, (i.e., partner is an IDU, a bisexual male (for females), a recipient of HIV infected blood or blood products or a person who is known to be infected with HIV).

Continued on page 8

# Status of the HIV/AIDS Epidemic in Michigan, 2005

**Number of New Diagnoses in 2004 and Trends 2000-2004 According to Age at HIV Diagnosis**



## Age at HIV Diagnosis 2000-2004

The proportion of persons diagnosed each year with HIV infection increased significantly among those diagnosed at 13-19 years from 2% to 4% (22 to 43 cases) and also increased significantly among those diagnosed at 20-24 years of age from 7% to 15% (61 to 142 cases). In all other age groups, the trends in new diagnoses are level. In 2004, there were 3 (<1%) persons diagnosed at 0-12 years of age, 43 (4%) 13-19 years, 142 (15%) 20-24 years, 116 (12%) 25-29 years, 150 (15%) 30-34 years, 159 (16%) 35-39 years, 140 (14%) 40-44 years, 92 (9%) 45-49 years, 63 (6%) 50-54 years, 35 (4%) 55-59 years, and 30 (3%) 60+ years.

See the complete report at the website: [www.mihivnews.com/surveillance\\_in\\_mi.htm](http://www.mihivnews.com/surveillance_in_mi.htm).

**Table 3: Michigan Residents Reported Living with HIV or AIDS: Sex by Race by Behavior April 1, 2006**

<b>MALES:</b>	White		Black		Hispanic		Other or Unknown		TOTAL	
Male-Male Sex	2,844	75%	2,526	50%	171	50%	80	37%	5,621	60%
Injecting Drug Use	172	5%	736	15%	47	14%	12	6%	967	10%
Male-Male Sex/IDU	221	6%	320	6%	16	5%	7	3%	564	6%
Blood Recipient	75	2%	18	0%	1	0%	4	2%	98	1%
Heterosexual	92	2%	342	7%	31	9%	8	4%	473	5%
Perinatal	14	0%	59	1%	1	0%	4	2%	78	1%
Undetermined/Other	365	10%	1,008	20%	74	22%	101	47%	1,548	17%
<i>Presumed Heterosexual</i>	234	6%	737	15%	61	18%	33	15%	1,065	11%
<i>Other</i>	131	3%	271	5%	13	4%	68	31%	483	5%
<b>MALE TOTAL</b>	<b>3,783</b>	<b>(40%)</b>	<b>5,009</b>	<b>(54%)</b>	<b>341</b>	<b>(4%)</b>	<b>216</b>	<b>(2%)</b>	<b>9,349</b>	<b>100%</b>
<b>FEMALES:</b>	White		Black		Hispanic		Other or Unknown		TOTAL	
Injecting Drug Use	108	19%	503	24%	18	17%	8	11%	637	22%
Blood Recipient	12	2%	10	0%	1	1%	0	0%	23	1%
Heterosexual	297	52%	773	37%	55	53%	20	28%	1,145	40%
Perinatal	11	2%	48	2%	6	6%	2	3%	67	2%
Undetermined/Other	142	25%	754	36%	24	23%	41	58%	961	34%
<i>Presumed Heterosexual</i>	120	21%	635	30%	21	20%	21	30%	797	28%
<i>Other</i>	22	4%	119	6%	3	3%	20	28%	164	6%
<b>FEMALE TOTAL</b>	<b>570</b>	<b>(20%)</b>	<b>2,088</b>	<b>(74%)</b>	<b>104</b>	<b>(4%)</b>	<b>71</b>	<b>(3%)</b>	<b>2,833</b>	<b>100%</b>
<b>GRAND TOTAL</b>	<b>4,353</b>	<b>36%</b>	<b>7,097</b>	<b>58%</b>	<b>445</b>	<b>4%</b>	<b>287</b>	<b>2%</b>	<b>12,182</b>	<b>100%</b>

6. The heterosexual category includes only those persons with "high risk" heterosexual partners as defined in footnote 5.  
 7. This subset of undetermined includes persons who had heterosexual sex but their partner(s) risk is unknown. This includes unconfirmed occupational exposures (1).

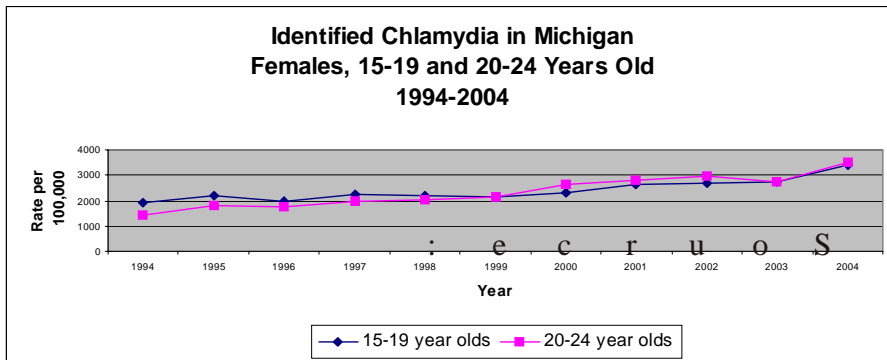
8. Includes persons with confirmed exposure in the health care setting in the U.S. (2) or other countries (1), and pediatric cases with probable sexual mode of transmission (2).  
 Statistics, provided by the MDCH HIV/AIDS Surveillance Section, are from *HIV/AIDS Quarterly Analysis*.

For complete Michigan and latest National statistics:  
[www.mihivnews.com/stats.htm](http://www.mihivnews.com/stats.htm)

## Focused Indicators

### Morbidity

### *Chlamydia*



MDCH Bureau of Epidemiology  
For additional statistics on reported sexually transmitted diseases go to: [http://www.mdch.state.mi.us/PHA/OSR/chi/std\\_h/frame.html](http://www.mdch.state.mi.us/PHA/OSR/chi/std_h/frame.html)

#### How are we doing?

Chlamydia is a bacterial infection predominately spread through sexual contact. It is one of the most common sexually transmitted diseases (STD) in the United States, responsible for an estimated one million cases each year. Chlamydia can be successfully treated with antibiotics.

In Michigan, reporting for chlamydia began in 1992. Although the rates of chlamydia have increased since then, this may be due to the results of improved reporting, increased levels of testing, particularly for women, and advances in testing technology that have identified more asymptomatic infection. However, testing in men still lags behind. In 2004, there were 41,247 cases of chlamydia, 79% of which were among women.

As 20% of untreated chlamydia is shown to result in Pelvic Inflammatory Disease (PID), it is important to examine the medical costs saved by treating chlamydia. **PID is estimated to cost between \$1300 and \$3000 in immediate medical ex-**

**penses, not accounting for lost work time or infertility costs.** Based on data from the Michigan Infertility Prevention Project (IPP), over 90% of reported chlamydia cases are treated. For all females reported, this represents savings of between \$8 and \$20 million, per year, just in avoided expenditure of public and private health care dollars to manage PID caused by chlamydia.

#### How does Michigan compare with the U.S.?

The rate of chlamydia in Michigan was 409 per 100,000 population in 2004, significantly higher than the national rate of 320. Michigan has, historically, followed national trends, with a slightly higher average rate.

Michigan's rate can be attributed to several factors. Unlike many states, Michigan dedicates STD, family planning, and adolescent health resources, above federal grant awards, to screening. This screening is highly targeted, resulting in high positivity. Michigan's IPP program is part of a region that includes Illinois, Indiana, Minnesota, Ohio, and Wisconsin. In 2004, Michigan had the second highest volume of tests, and had a higher positivity rate than the regional average.

Additionally, the increased rate in 2004

is likely due to a surveillance data system change.

#### How are different populations affected?

The highest rates of chlamydia are found among those 15-19 and 20-24 years old. These two groups combined accounted for 71% of the 2004 morbidity. The rates are highest among women in this age range, especially African-American women. **The rate among African-Americans is 14 times that of whites.** The rate among African-American women is 13 times higher than white women. There is no evidence that African-Americans are more sexually active, this rate is evidence that once a pathogen is in a community or social network, the likelihood of acquiring that infection increases significantly, also resulting in higher rates of transmission.

Chlamydia infection results in increased health care cost, especially among women. Chlamydia is the most common cause of infertility due to blocked fallopian tubes and complications of pregnancy. Perinatal chlamydial infections are a common cause of infant pneumonia and the most common cause of newborn eye infections.

The overall rate among women is 3.6 times higher than men, largely due to targeted screening towards females. Males are more often symptomatic and treated presumptively (without testing), based on symptoms. Additionally, young females are at increased risk for infection for anatomical reasons. An immature cervix has a thin layer of epithelium; this provides less protection from bacteria than a mature cervix.

The five highest rates of chlamydia, in 2004, were in the City of Detroit, Genesee County, Kalamazoo County, Ingham County, and Calhoun County.

#### What other information is important to know?

New, more sensitive testing methodology

have resulted in a higher detection rate of disease over time. Also, new screening criteria has been recommended in HMOs, hospitals, and private physicians, resulting in more testing and more case detection over time. However, testing resources are targeted, based on known risk groups, and, to geographic areas with high rates of STDs.

Individuals infected with chlamydia remain infectious until they are identified and treated. Many infections are asymptomatic, and, therefore, difficult to diagnose. Insufficient program resources make it difficult to identify, treat, and provide partner referral to the growing number of individuals infected with chlamydia.

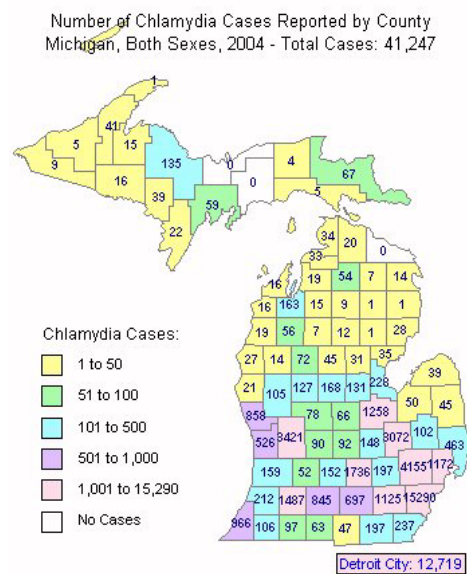
**What is the Department of Community Health doing to affect this indicator?**

Because chlamydia causes costly complications such as PID, the Department is actively working to decrease the prevalence of chlamydia and its health consequences. The Department participates in the national Infertility Prevention Project (IPP). Adolescents and young adults, age 15 – 24, are a population to which Michigan places special emphasis; IPP is the core of these efforts. Adolescents, for both psychological and physical reasons, are vulnerable to STDs, and particularly to ‘gateway’ diseases such as chlamydia. The IPP provides screening in STD and family planning clinics, as well as adolescent sites, including school-based clinics, juvenile detention, and alternative adolescent sites such as runaway shelters and alternative schools.

MDCH and local public health personnel provide follow-up and partner referral to persons testing positive for chlamydia; priority is placed on females of child bearing age. The Department is exploring innovative methods of partner management including expedited partner therapy. The Department distributes antibiotics to local health department clinics to treat chlamydia and also provides presenta-

tions on the chlamydia epidemic in Michigan that explain the consequences and related costs of untreated disease. Increased screening is advocated for in several ways. As part of accreditation, HEDIS, and IPP, screening is promoted outside of local public health.

As part of the Department’s effort to advocate for increased testing in the private medical community, the Michigan STD program is partnering with the Centers for Disease Control and Prevention (CDC) to conduct a program evaluation that will assess chlamydia screening in the emergency department (ED) of a large hospital in SE Michigan. Because data has shown that a large percentage of adolescents testing positive for chlamydia do not have symptoms, this evaluation will promote universal screening of female patients age 15-24 that present to the ED, regardless of reason for visit. Results of this evaluation will inform future collaborations and provide support for increased screening in other facilities.



*This MDCH report (above) is also available on the Michigan HIV News website. “About Chlamydia” (right) Written by Dr Angela Robinson, consultant in sexual health Netdoctor.co.uk <http://www.netdoctor.co.uk/diseases/facts/chlamydia.htm>*

## About Chlamydia

Chlamydia is the most common treatable STD. It often presents no symptoms in men or women unless it leads to complications - when treatment can sometimes be too late to stop permanent damage.

In some women, [untreated] infection can damage the Fallopian tubes, which conduct eggs from the ovaries to the womb. This can stop the tubes working properly and they can become completely blocked.

Chlamydia is the most common preventable cause of infertility in women. When the fallopian tubes are blocked, no pregnancy is possible naturally. One option is IVF (in-vitro fertilisation), but this has variable success rates.

Women with damaged tubes do occasionally [get] pregnant, but there is an increased risk of the pregnancy developing in the tubes rather than the womb. This is called an ectopic pregnancy. The tube can split apart causing serious pain and bleeding. This is an emergency, because the bleeding can be life threatening.

Infection sometimes leads to pain in the lower abdomen that is often mistaken for some other problem rather than pelvic infection.

Men can also run into trouble. Chlamydia is the most common cause of inflammation in the testicles and sperm-conducting tubes (epididymo-orchitis) in men under 35. This causes marked pain, swelling and redness in the scrotum on the affected side, or on both sides. Chlamydia infection can also trigger joint inflammation in some men.

**Statewide Training**

Schedules and/or contacts for training provided by CHAG, MAPP, the MATEC Michigan AIDS Education and Training Center and MDCH are provided on the website ([www.mihivnews.com/train.htm](http://www.mihivnews.com/train.htm)).

**MDCH Training**

You will find on the website the complete Division of Health Wellness and Disease Control training schedule for 2006. Following is a listing of those scheduled April through August. Application forms are also available to download at: [www.mihivnews.com/dhwdc\\_train.htm](http://www.mihivnews.com/dhwdc_train.htm).

**HAPIS HIV Prevention/Test Counselor Related Training**

To register for prevention/test counselor trainings, contact Training Unit Secretary Julie Babb at (517) 241-5903.

**Module 1: Basic Knowledge Training**

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
August 15-16	Detroit	July 28
September 18-19	Lansing	August 25

**Module 2: HIV Prevention Specialist Certification Training**

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
August 28-29	Detroit	August 4
September 20-21	Lansing	August 25

**Module 3: HIV Test Counselor Certification Training**

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
August 10-11	Lansing	July 21
September 7-8	Detroit	Aug. 18

**One-Day HIV Prevention Specialist/Test Counselor Update**

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
September 13	Lansing	Aug. 25

**Topic: Domestic Violence**

This update will focus on disparities in health and health care among people of color. It will review current disparities in several areas of health, including cancer, infant mortality and HIV. Additionally, it will examine factors that contribute to the growth of disparities, and fi-

nally, building a plan of action for addressing health disparities in HIV work.

**HIV/AIDS Case Management Certification Training**

For information on the Case Management Trainings, please contact Julie Babb at (517) 241-5903, or e-mail: [babbj@michigan.gov](mailto:babbj@michigan.gov).

Training is designed to certify HIV/AIDS case managers who are required to adhere to the *Principles and Standards of Service for HIV/AIDS Case Management in Michigan*. Participants must have already completed the HIV Test Counselor Certification Training.

<u>Date</u>	<u>Location</u>	<u>Reg.</u>
August 22-25	Lansing	July 28

**Partner Counseling and Referral Services Training**

For more information contact Audrea Woodruff at (313) 456-4421.

**Partner Counseling and Referral Services Supervisory Training**

Trainings are required for supervisors in LPH and CBOs. This course is designed to teach supervisors to evaluate PCRS activities of agency staff.

Day one will explore the role of PCRS supervision and elements for evaluating the quality of PCRS delivery in agency and outreach settings. Day two will focus primarily on the evaluation of field investigations, documentation and techniques for enhancing staff skills.

Registrants for this course **must** have received prior certification in PCRS, and as an HIV Test Counselor.

<u>Date</u>	<u>Location</u>	<u>Reg.</u>
August 23-24	G. Rapids	Aug. 4

**STD Training**

For more information or to register, please contact Carol French (517) 241-0868, or email: [frenchc@michigan.gov](mailto:frenchc@michigan.gov)

**STD Management**

This training will focus on management of common STDs. This training will discuss issues faced and procedures during a typical clinic visit. Objectives

include: describe effective triage techniques in identifying appropriate services needed for clients; identify sample collection for STD testing; identify current technology used for STD screening; described treatment options for STDs; and define patient and partner management (including risk reduction counseling).

<u>Date</u>	<u>Location</u>
August 16	Grand Rapids
September 21	Detroit
November 8	Lansing

**Viral STDs**

This training will focus on clinic and laboratory diagnostics. Participants will have an opportunity to build skills in working with clients who are infected with viral STDs. Objectives include: identify signs and symptoms of viral STDs; discuss basic information surrounding viral STDs; define partner and disease management; identify most recent vaccine options; and describe treatment options for viral STDs.

<u>Date</u>	<u>Location</u>
September 12	Okemos
October 30	Detroit

**Statewide Meetings**

**HIV/STD and Adolescents Networking Committee**

This statewide committee for professionals in youth serving agencies meets on October 11 in Whitmore Lake. **Contact:** Ardith Alderdyce, [aaardith@sbcglobal.net](mailto:aaardith@sbcglobal.net).

**MHAC**

The Michigan HIV/AIDS Council is the statewide planning group for prevention and care. The next meeting will be held in Eaton Rapids on September 13. **Contact:** Belinda Chandler, (517) 241-5926.

**Program Review Panel (PRP)**

*New Members Welcomed* - the PRP always seeks new members to ensure that there is representation from a wide variety of people within the community. **Contact:** Dee Hurlbert, (517) 241-5921.

**Conferences and Events**

**Michigan Conferences and Events**

September 11-12 Grand Rapids  
*7th Annual Michigan Substance Abuse Conference*

To be held at DeVos Place, 303 Monroe Ave, NW, Grand Rapids, MI 49503. Overnight Accommodations are at the Amway Grand Plaza Hotel. You can register online at [www.macmh.org](http://www.macmh.org).

September 15 Flint  
*4th Annual National Latino Awareness Day Kick-off*

MDCH and the Latino AIDS Advisory Committee are sponsoring this event in preparation for Latino Awareness Day October 15. This meeting and luncheon will be held at U of M Flint. MDCH will provide participating organizations with condoms and brochures in Spanish and English and for designated CTR sites, OraSure and OraQuick kits. Plan of Action and Materials Request forms should be submitted by August 7. For more information, contact Robin Orsborn (517) 241-5936, or e-mail: [orsbornr@michigan.gov](mailto:orsbornr@michigan.gov).

November 2-3 Kalamazoo  
*"STDs and HIV as Health Disparities"*

The 12th Annual Michigan STD & HIV Conference will be held at the Radisson Plaza Hotel and Suites. (Call 269-343-3333 and reference the MDCH conference to receive the conference rate.) Conference brochure and registration form coming in Sept. Save the Dates >

**National Conferences and Events**

August 20 - 25 Olympia, Washington  
*Drawing Water from a Deeper Well: A National Conference for Professional Excellence in Sexuality Ed and Training*

Conference program information and registration is now available online at [www.deeperwellconference.com](http://www.deeperwellconference.com).


August 25 - 26 New Orleans, LA  
*Staying Alive 2006*  
NAPWA's 2006 Staying Alive Leadership Summit will be held in New Orleans from August 25 through August 27, 2006. For more information about Staying Alive 2006, contact Keith Folger at [kfolger@napwa.org](mailto:kfolger@napwa.org).

**International Conferences**

August 13 - 19, 2006 Toronto, Ontario  
*XVI International AIDS Conference*  
Web site: <http://www.aids2006.org>.  
[Kaisernetwork.org](http://Kaisernetwork.org) will provide compre-

hensive online coverage of the XVI International AIDS Conference taking place in Toronto, Canada in August. Coverage will include live and archived webcasts of select sessions, along with the transcripts, podcasts and slide presentations from those sessions; French- and Spanish-language audio podcasts of select sessions; daily narrated video highlights of Conference developments; interviews with news makers and journalists; and summaries of the news coverage in the Kaiser Daily HIV/AIDS Report.

Sign up to receive a free daily update E-mail during the week of the Conference at [www.mihivnews.com/world.htm](http://www.mihivnews.com/world.htm).

12th Annual  
**STD & HIV**  
CONFERENCE: 

**STDs and HIV as Health Disparities**

November 2-3, 2006  
Radisson Plaza Hotel & Suites  
Kalamazoo, MI

**SAVE THE DATES!**

Sponsored by:  
**The Michigan Department of Community Health**

**FOR MORE INFORMATION**  
Complete and return the attached form to request registration information (available in September) and sponsor and exhibitor information (now available).  
**Contact Diane Drago at:** [DMSdiane@concentric.net](mailto:DMSdiane@concentric.net) or 517-663-5147.  
**More information at:** [www.mihivnews.com/std\\_hiv\\_conference.htm](http://www.mihivnews.com/std_hiv_conference.htm)  
**RETURN TO:** 2006 STD & HIV Conference  
c/o Diversified Management Services  
620 Hall Street • Eaton Rapids, MI 48827  
FAX: 517-663-5245

Yes! I would like to receive the following information about the conference:

Mail me        COPIES of the conference registration brochure (available in September)  Information on EXHIBIT opportunities

E-MAIL me a copy of the brochure.  Information on how to help support the conference as a SPONSOR

NAME \_\_\_\_\_

ORGANIZATION \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

**Join us for the 12th statewide STD & HIV Conference!**  
The program will feature three general sessions, 30 interactive workshops, roundtable discussions, a reception and the Awards Luncheon on November 3.

**WHO SHOULD ATTEND?**  
Local public health department staff, STD program staff, HIV prevention counselors, AIDS coordinators, caregivers, health educators, health care providers, substance abuse providers, people living with HIV/AIDS, case managers, social workers and school personnel.

**LOCATION**  
The 2006 conference will be held at the Radisson Plaza Hotel & Suites in downtown Kalamazoo. A block of guest rooms, at the conference rate of \$85 plus tax, has been reserved for the nights of November 1 and 2. Call the Radisson at 269-343-3333 and reference the Michigan Department of Community Health Conference to receive the conference rate.

**FEATURING KEYNOTE SPEAKERS**  
**Jean Lee, PharmD**, St. Mary's McAuley Health Center  
**Judith DeSarno, President/CEO**, Reproductive Rights/Family Planning, National Family Planning and Reproductive Health Association  
**Kristy F. Woods, MD, MPH**, Maya Angelou Research Center on Minority Health

# Infertility Prevention

*Continued from page 1*

dial infections and stressed the need to include antibiotics effective against chlamydia when treating patients for gonococcal urethritis, mucopurulent cervicitis, and PID, all indicators of chlamydia trachomatis infection.

## THE REGIONAL IPP MODEL

By 1988 a new public health model for disease control was implemented with regional offices for the CDC and OPA (Office of Population Affairs), which runs the Office of Family Planning. At that time

state family planning, STD and lab personnel also began working together to address chlamydia.

A demonstration project was initiated the same year in the northwestern US (IPP Region X) to screen and treat women in family planning clinics. This was funded by Title X, the only Federal program devoted solely to the provision of family planning and reproductive health care (<http://opa.osophs.dhhs.gov/titlex/ofp.html>) with matching dollars from the CDC.

This regional prevention model for

chlamydia control provided joint management of the program by state Title X and STD programs through a regional committee that included public health labs. This new collaborative arrangement and the Region X demo screening project were both considered successes. Chlamydia positivity declined 51% in the first three years (1988 – 1991) of the project in Region X. Also, the centralized purchasing and administration reduced screening costs by 50% and improved the quality of services.

Packaged as 'Infertility Prevention' instead of 'STD Control,' with the success of the demo project, in 1992 Congress passed Preventive Health Amendments, PHS Act, Section 318A. This Act appropriated funds to support: 1) screening and treatment of STDs for women; 2) counseling of women on STD prevention and control; 3) follow-up services; 4) screening and treatment of partners; 5) outreach to inform women of services and information as well as education about prevention and control; and 6) training for health care providers. Unfortunately, this funding only supported expansion of the program to three additional regions, not including Region V – the Great Lakes states region, including Michigan.

The 1990's saw more progress in the move to get chlamydia under control. In 1993 the CDC published "*Recommendations for the Prevention and Management of Chlamydia trachomatis infections*," which updated the 1985 guidelines and proposed a national strategy for reducing the morbidity of chlamydial infections by detection and treatment and through the prevention of transmission to uninfected persons. In 1994 chlamydia became a nationally notifiable infectious disease;

*Continued on page 13*

## Cervical Cancer Vaccine

In June, the FDA approved the first vaccine to prevent cervical cancer. Merck & Co.'s vaccine Gardasil protects against the two HPV strains responsible for 70 percent of all cervical cancers and two strains that cause genital warts.

FDA approved the vaccine for use in females ages 9-26. Public health officials say the three-shot series should be administered at a young age. For sexually active teens and young women who may have already been exposed to HPV, it is less clear whether Gardasil will be of benefit. Also, it is not known how effective Gardasil would be for women older than 26.

Women should continue to get routine Pap smears, which look for cell changes caused by HPV that can lead to cervical cancer. Dr. Mark Wakabayashi, director of gynecologic oncology at City of Hope said, "There are still going to be one-third of the HPV strains out there that will cause cervical cancer" and are not blocked by Gardasil. *Los Angeles Times*, (06.19.06)

Following the FDA approval of Gardasil, the Advisory Commission on Immunization Practices (ACIP) voted on June 29 to recommend that the newly licensed quadrivalent HPV vaccine be given routinely to girls 11-12 years old. The ACIP recommendation allows for vaccination of girls beginning at nine (9) years of age, as well as catch-up vaccination of girls/women ages 13-26. The ACIP also voted to include the HPV vaccine in the Vaccines for Children (VFC) program.

In light of this news, the CDC has updated their HPV vaccine Q&A, available at [www.cdc.gov/std/hpv/STDFact-HPV-vaccine.htm](http://www.cdc.gov/std/hpv/STDFact-HPV-vaccine.htm). CDC has also issued a press release, which can be accessed at [www.cdc.gov/od/oc/media/pressrel/r060629.htm](http://www.cdc.gov/od/oc/media/pressrel/r060629.htm)

A new study in the *New England Journal of Medicine* reveals that consistent condom use can prevent the spread of HPV in up to 70 percent of cases, helping to dispel any myths that they are not effective. *ABC News Medical Unit* (06.21.06)

*Continued from page 12*

and in 1995 the first Chlamydia Monitoring Surveillance Report was published. By 1996 the last regions were phased into the program as more funds were made available. Also, a single dose therapy – azithromycin – likely improved adherence to treatment.

*Written with information from the PowerPoint presentation by Janine Hines, who was at the time STD Program Consultant, Division of STD Prevention, CDC (12.2.04)*

## REGION V INFERTILITY PREVENTION PROJECT

Michigan is one of the six states in Region V (Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin), which have been working together since 1994. State and local collaborations include STD clinics, Planned Parenthoods, Title X funded clinics, university health centers, community health centers, juvenile detention centers, school-based clinics, private providers, Maternal & Child health and Women's health.

Region V statistics for 2003 indicate distinctly different demographics for chlamydia than gonorrhea. While the smallest sampling of test numbers for screening provider types came from school-based clinics, this group showed the highest percentage of positive testers. For gonorrhea, STD clinics illuminated the greatest percentage of positive testers. While family planning facilities provided the greatest number of tests for both chlamydia and gonorrhea (55% and 52% respectively in 2003) among all the test venues, they did not identify most of the positive testers. MDCH-DHWDC- STD Section, STD Administrative Program Manager Kristine Judd pointed out, however, that family planning facilities are the backbone of the IPP program and that grant funds require half of IPP supported tests be done in family planning venues. *Written with information from the PowerPoint presentation by Rachel Smith, who was at the time Regional IPP*

*Coordinator (12.2.04) For more information on Region V, contact Kristine Judd.*

## YOUTH AT RISK

During the 1980's screening criteria were developed indicating that young age and female gender were the most important risk factors to determine the need to screen for chlamydia. Screening began in Michigan in 1994 with the implementation of the Infertility Prevention Project in Region V. "Our charge is to screen, identify those who are positive, treat them and refer their partners," said Judd.

This is not prevention education, but secondary prevention, preventing the long term consequences of unprotected sex. With more emphasis on abstinence-only education, and as teens continue to have unprotected sex, the need for this secondary prevention grows.

The recently released 2005 Michigan Youth Risk Behavior Survey (<http://www.emc.cmich.edu/YRBS/>) indicated that 31% of Michigan's high school students surveyed had sexual intercourse before the age of 16. Of those who had sex, 62% said they used a condom during their last sexual intercourse.

Given these statistics, it's not surprising that in 2004, 41,247 cases of chlamydia were reported in Michigan; 24,155 (59%) of these occurred in teens/adult females ages 15-24. There were also over 6,000 cases of gonorrhea reported among young women aged 15-24 in 2004.

Michigan leads Region V in providing chlamydia testing in adolescent venues, including school-based clinics, juvenile detention facilities, and teen health centers. "Michigan has been on the cutting edge with adolescent screening in

many ways; we've been highlighted nationally several times because of our adolescent program," said Judd.

## ADOLESCENT SCREENING PROJECT

The Michigan Adolescent Screening Project, begun as a pilot study in Oakland County in 2000, screens youth ages 13 to 20 in special settings. To date nearly 6,500 adolescents have been screened at juvenile detention, jail, shelter care, and two school-based clinics. Chlamydia positivity has ranged between 12-20% for females at all of the sites, according to Lynda Byer, coordinator for the Adolescent Screening Project.

Male chlamydia positivity on average has ranged from 10% - 14%, although Byer reported in May that there had been a marked in-

crease in schools the past six months, with male positivity as high as 24%. The males that have been screened are mostly asymptomatic with chlamydia (80%) and surprisingly also with gonorrhea (65%). This pilot study funded through MDCH with IPP funds found that, at the school clinics screening for chlamydia, 50% of infections discovered through universal testing would have been missed if testing had only been done for those students who came to the clinic for an STD check.

The project expanded into St. Clair County and Berrien County in 2003 with similar results of high chlamydia positivity within the school clinics. The screening project is now in nine detention/ correctional facilities and eight school-based clinics throughout the state.

## NEW TECHNOLOGY

In April 2005, new testing technology dramatically changed the way screening could be done. "What it allowed us to do was to more appropriately target our

**This pilot study funded through MDCH with IPP funds found that, at the school clinics screening for chlamydia, 50% of infections discovered through universal testing would have been missed if testing had only been done for those students who came to the clinic for an STD check.**

*Continued on page 15*

## HAPIS UPDATE

### CONTINUUM OF CARE UNIT



**Patrick Yankee** became manager for the Unit on May 15 after 16 months as acting manager. The Title IV program moved from the Core Public Health Services Unit to the COC,

since both programs share HRSA as their funding source.

The Care needs assessment kicked off in April with a survey distribution to all PWAs in late April. PWA Community Forums were scheduled to be held around the state June 19-20, with a conference call for the Upper Peninsula.

Service Provided – Unduplicated Uniform Reporting System (URS) data for all Title II – IV providers including the Drug Assistance Program (DAP) and the Michigan Dental Program (MDP) indicate there were 7,325 clients (infected and affected) served statewide during 2005.

Of the 6,875 clients who were HIV positive, 1,314 (19%) were new to the CARE Act service system, 26% were females, 55% were African American, 35% were White and 5% were Hispanic. The most frequently reported service delivered to CARE Act clients was primary medical care with 3,842 (56%) clients receiving 17,429 medical visits (an average of 4.54 per client). Client advocacy and case management services were the next most frequently reported service categories, followed by DAP, which provided needed medications to 2,155 clients in 2005.

Unduplicated URS data for all Title II, Title III and Title IV providers, including DAP and the MDP indicate that there were 7,325 clients (infected and affected) served statewide during the 2005 calendar year. Of the 6,875 clients who were HIV positive, 1,314 (19%) were new to the CARE Act service system.

Michigan's CARE Act Title II award for the grant period of April 1 '06 through March 31 '07 will total of \$15,983,050, which includes a DAP earmark of 11.9 million for HIV medications. This award represents level funding but shifts some resources from the Minority AIDS Initiative and Base awards and places those dollars into DAP, which is currently serving over 2,200 persons.

### CORE PUBLIC HEALTH SERVICES UNIT

Unit staff has been compiling an HIV Record Retention document. This will list specific client records and suggest time parameters for storing such materials.

PCRS staff continues to collaborate with the HIV/AIDS Surveillance Section to provide education on PCRS to physicians. PCRS brochures and fact sheets have been printed, and are being distributed by surveillance staff.

### COMMUNITY PARTNERSHIPS

The completed Statewide Comprehensive Plan for HIV Prevention 2006-09 is the result of close collaboration between MHAC and HAPIS. It was released prior to the Prevention RFP and presented to MHAC members at the May 17 meeting. Any questions about the plan should be directed to Leanne Savola (savolal@michigan.gov).

May was Hepatitis Awareness Month and the MDCH Hepatitis Workgroup held an educational breakfast session for legislators and policy makers in Lansing. This event focused on hepatitis C as an emerging and critical public health issue.

A new initiative has begun, designed to maximize the effectiveness of HIV Counseling, Testing and Referral (CTR). Former HAPIS Training Unit Coordinator Ellen Ives will be a HAPIS consultant

*Continued on page 15*

## Special Recognition



**Liisa M. Randall, PhD** was honored by the National Alliance of State & Territorial AIDS Directors (NASTAD) with one of its prestigious Nicholas A. Rango Leadership Award at NASTAD's 2006 Annual Meeting this spring.

The award is named in honor of a founding member of NASTAD, Dr. Nicholas A. Rango, who died of AIDS in 1993. It is given annually to NASTAD members who best exemplify Dr. Rango's qualities of superior intelligence, dedication, government activism and tenacity. Randall was presented the Rango

Award "for her unflagging attention to the quality, coherence and feasibility of proposed CDC evaluation requirements in the Program Evaluation Monitoring System (PEMS)."

One of three state health department HIV/AIDS program staff honored this year by NASTAD, Liisa Randall is currently Manager of HIV Prevention Partnerships for HAPIS. She has nearly 20 years of progressive experience in health policy and strategic planning and evaluation. Her expertise in health promotion and disease prevention, social and behavioral science and community-based health planning has helped guide HAPIS' nationally recognized prevention work here in Michigan, as well as make her a valued member of the NASTAD Prevention Advisory Committee. She has provided technical assistance to her colleagues in the U.S. and abroad through NASTAD's Domestic and Global TA Programs.

Randall holds a PhD in Medical Anthropology from Michigan State University, and has published several articles and reports on counseling and testing, program management, community planning and capacity building.

## DHWDC News

*Continued from page 14*

to develop tools and strategies to enhance the assessment and feedback process. Please contact Technical Assistance Coordinator Amy Peterson with any questions [peterstonam@michigan.gov](mailto:peterstonam@michigan.gov).

HAPIS staff has been collaborating to implement assessments of CTR and PCRS services in the 16 high prevalence local public health (LPH) agencies. Through visits to these LPH best practices for increasing targeting and yield, while maintaining high quality of services and return rates are being identified. These best practices will then be compiled into a document to be share across health departments.

### NEW STD SCREENING TECHNOLOGY

*Continued from page 13*

resources. It allowed us to do chlamydia only screening in sites where the gonorrhea prevalence was so low that the predictive value of the tests didn't indicate it," said Judd. Using the chlamydia-only test – being cheaper than the combined test – in these sites allowed for more

### "Prevention Messages and Teens: Are we on the Right Track?"

This was the topic discussed at the June meeting of the HIV/STD and Adolescents Networking Committee with a panel of nine Planned Parenthood Peer Educators who came from multi-cultural backgrounds, from schools in Fint and Ann Arbor with diversified politics around sex education and homes with varied parental attitudes towards teen sex. All of the teens said prevention messages need to be more personal, and they want sex ed to contain all of the information they need to make safe choices.

chlamydia screening.

"This was a huge thing," said Judd. "Now that we have a year's worth of data under our belts, it has proven to be a good decision." Saving the combined chlamydia/gonorrhea tests for those instances where they were clinically indicated allowed for better targeting of resources.

"This has allowed us to expand more into juvenile detention facilities and school-based clinics in high prevalence areas, aided by the networking of the adolescent coordinator."

While abstinence-only education

funding is growing, it's hard to do science-based prevention work with adolescents, so the STD program is focusing on increasing screening and educating private providers about the need for screening adolescents.

"We're advocating for increased screening – in the private sector as well. We would like to get the message out that there is a lot of

"We would like to get the message out that there is a lot of chlamydia in this population, much of it asymptomatic, and screening sexually active adolescents is a good thing to do," said Judd.

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*Kristine Judd's contact info - pg 3.*

## HIV at 25

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to treat tuberculosis and HIV/AIDS.

Drug treatment hit a milestone this summer. The Food and Drug Administration approved a new pill, called Atripla, that combines three of the most widely prescribed HIV drugs in the United States into a once-daily pill. The new pill combines Bristol-Myers Squibb's drug Sustiva (efavirenz) with Gilead Sciences' Truvada, a drug combining Viread (tenofovir) and Emtriva (emtricitabine). *Washington Post* (7.13.06).

The once-daily pill cost will be about the same as Sustiva and Truvada bought separately, or about \$1,200 a month. The FDA encouraged the drug's development to facilitate low-cost treatments for the President's Emergency Plan for AIDS Relief (PEPFAR). The companies are still negotiating cost for developing nations.

A once-daily treatment should make adherence easier, but mental health and substance use issues, rather than convenience, are the obstacles for some patients adhering to treatment, said Michael Weinstein, president of AIDS Healthcare Foundation in Los Angeles. Furthermore, a drug's strength and side effects are more important to patients than convenience, said Bob Huff, who edits a treatment newsletter for New York-based Gay Men's Health Crisis. *New York Times* (07.09.06)

### CARE

*Continued from page 4*

to pay for services in another, we should be FULLY funding the entire CARE act. Instead of restricting services categories to the lowest common denominator, maybe we should be concentrating on the increased needs that newly infected individuals bring to an already stressed system. We now have more people entering

Ryan White CARE services who have more intense levels of need. Now's not the time to restrict services; it's the time to expand them."

According to the National Association of State and Territorial Directors' (NASTAD) Reauthorization Watch (6.28.06), negotiations continue between the four principal Members of Congress (including Michigan's Rep. John Dingell) and the Administration in an effort to reach consensus and then send to the House and Senate floors for passage of this legislation as identical bills to avoid a conference committee process.

Once agreement on the remaining issues is reached, the bill is expected to move quickly. See a comparison between the currently extended law and proposals for reauthorization at <http://www.kff.org/hiv/aids/7531.cfm>.

Stay tuned to [www.mihivnews.com/in\\_the\\_news.com](http://www.mihivnews.com/in_the_news.com) for the latest updates.

## Michigan News Briefs Con't

### Breaking the Silence! in Michigan

This year, 138 PWAs gathered in Bay City for "Break the Silence, Coming Alive," the 4<sup>th</sup> HAPIS sponsored conference for this group. MHAC Co-chair Paula Sirls and MHAC member Felix Sirls were very active in the planning and as presenters. The weekend was filled with workshops on education, advocacy, community skills building, disease management, and healthy lifestyle activities.

A new workshop this year, created by the HAPIS conference coordinator Debbie Cornell and the conference committee, allowed the conference attendants to create a panel for a new conference quilt. While there was a rainbow of color, culture, life circumstance, gender and age around the room, all of the participants had at least one thing in common, living with HIV. This was truly a bonding experience. Cornell will be assembling a PWA conference quilt from these panels. Look for it at the HIV & STD Conference in Kalamazoo in November.

The Arab Health Conference HIV/AIDS workshop "Break the Silence," coordinated by the Arab Community Center for Economic and Social Services (ACCESS) Community Health and Research Center, was held at the Arab History Museum in Dearborn. An in-depth look at HIV/AIDS internationally in the Arab world was provided by guests from UNAIDS and the World Health Organization. Additionally, cultural barriers to prevention and care were identified. Included in the day long activities was an exploration of metro Detroit issues.

The May 13 workshop began a new dialogue among health professionals and community and religious leaders. It also kicked off a one-year, Internet-based national campaign promoting HIV/AIDS awareness among Arabs by ACCESS and federal health officials. "It's our job to break the silence," said Adnan Hammad, health director for ACCESS.

#### "Empower Women: Fight AIDS"

MDCH-DHWDC-HAPIS Manager Debra Szwejdja said, "I have been inspired and profoundly moved by the stories of these women, and I hope they inspire the people of Detroit and Michigan to reenergize around the issues of women with HIV infection and the very real need for additional services and additional support targeted to this population."

"They are visiting with women living with HIV but they are also making sure to talk to policy makers," said MDCH-DHWDC Director Loretta Davis-Satterla. "We talk about the community becoming complacent, but the policy makers and the decision makers are also becoming complacent, so I think this is the right time and the right place to put the emphasis on HIV again."

#### MAF's Venture into Public Policy

The report stated, "If state agencies, foundations, and community groups could use federal funds without value based restriction, it would make possible effective science-based sex education in public schools and elsewhere, awareness campaigns and research for new prevention drugs."

#### Note: Changes to the CDC HIV/AIDS Hotline

The CDC HIV/AIDS hotline (800-342-2437) is now part of CDC-INFO (800-CDC-INFO), the new one source for public health information from CDC. Calls to the CDC HIV/AIDS hotline number are automatically being forwarded to CDC-INFO. This new service provides English, Spanish, and TTY service. As of January 2007, the old number (800-342-2437) will no longer be in service.

## WHERE TO CALL

### National Prevention Information

**Network: (800) 458-5231**

Expanded resource center, contracted by CDC, includes STDs and TB.

### HOTLINES

#### CDC INFO:

**(800) CDC-INFO (800-232-4636)**

**(888) 232-6348 TTY**

Hours: 24/7

#### Michigan AIDS Hotline:

**(800) 872-AIDS (2437)**

Hours: 9 a.m. to 5 p.m. weekdays

#### Teen Hotline (Red Cross):

**(800) 440-TEEN (8336)**

Hours: 6 p.m. to midnight Fri.-Sat.

#### Hotline for Women:

**(800) 554-4876**

Hours: 2 p.m. to 9 p.m. Monday, Wednesday, Friday

#### National HIV/AIDS Treatment

##### Hotline:

**(800) 822-7422**

Hours: 9 a.m. to 5 p.m. weekdays, 1 p.m. to 7 p.m. Saturday

Confidential treatment information by phone call provided by Project Inform. Volunteer operators (most are PLWH/As) can answer questions on HIV treatments and related diseases.

## INFORMATION

#### Clinical consultation:

**(800) 933-3413**

The Health Resources and Services Administration provides consultation for health care professionals.

#### Clinical trials:

**(800) TRIALS-A (874-2572)**