

Michigan HIV & STD News



WINTER-SPRING 2007

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When is the best time to plant a tree? Twenty Years ago

by Barb Wood

Prevention resources are decreasing and the number of HIV positive persons continues to grow. Nationwide, federal resources for HIV prevention have shrunk by \$25 million in the past three years. Even while funding shrinks, the epidemic grows. The latest statistics released by MDCH indicate more persons than ever before are living with HIV in Michigan. MDCH now estimates that 17,000 Michigan residents are infected with HIV. (January 1, 2007 Quarterly HIV/AIDS Analysis, page 6).

Faced with increases in prevalence and diminishing funding, CDC, state and local health departments and the prevention service providers they support are working harder than ever to stem the tide of HIV. In an attempt to work smarter and make the best use of scarce resources, programming supported by these dollars is targeted to populations at increased behavioral risk for HIV.

CDC supports this approach, requiring its funded programs to follow epidemiologic profiles and stacking its list of supported evidence-based interventions (DEBIs) with those targeting communities of color. This clearly isn't enough. CDC recognized the need for broader impact in its "Revised Recommendations for HIV Testing for Adults, Adolescents, and Pregnant Women in Health-Care Settings." The revised recommendations, released in September 2006, advise routine HIV testing (for ages 13-64) in high prevalence health care settings. However, CDC has provided neither additional funds, nor a clear road map on how to implement these recommendations.

The question remains on how to round out

targeted interventions and reach the broader community. Twenty-two years ago, when the American Red Cross targeted gay men and Haitians in a campaign to stop those most at-risk from donating blood, a precedent was set and a perception reinforced that only certain populations were vulnerable to HIV infection. The unspoken message was that if individuals were not in the targeted population there was no need to worry. Today, as the composition of the communities hardest hit by HIV/AIDS looks dramatically different than that of twenty-two years ago, we have to wonder who will comprise the next wave of infection. Who are we missing now with prevention?

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The Shifting Landscape of Sexuality Education in 2006

NASTAD HIV Prevention Bulletin (12/1/06) *Reprinted with permission from the National Alliance of State and Territorial AIDS Directors (NASTAD)*

One of the most important landmarks in the ongoing debate about abstinence-only education occurred in November, when a report was released by the non-partisan Government Accountability Office (GAO). This report documented that the U.S. Department of Health and Human Services (HHS) has wasted millions of tax-payer dollars by delivering abstinence-only-until-marriage programs with minimal oversight and review for scientific accuracy.¹

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DHWDC News

MDCH Division of Health Wellness and Disease Control

HAPIS Report

CONTINUUM OF CARE UNIT

Drug Assistance Program (DAP)

Through the Michigan AIDS Drug Assistance Program over 2000 individuals with HIV and AIDS receive free medications and/or vaccines to help treat their disease or a co-infection each year. Clients must be re-certified/re-approved by April of each year.

The DAP continues to offer eligible clients up to five free viral load tests, five CD4/CD8 tests and two free genotype tests per calendar year through the MDCH Bureau of Laboratories. These resources are also used to help people in need pay for insurance co-pays.

Michigan's use of a pharmacy benefits manager (PBM) complements our revenue enhancement and will help contain DAP costs. Michigan's contract with RxAmerica for PBM services began in December 2005. As projected, the program experienced immediate cost savings, which was a result of an efficient, automated system, better and more efficient access to a broader pharmacy network, a greater purchasing power volume, and better pricing and dispensing fees.

Michigan Dental Program (MDP)

The MDP is currently closed, but throughout the year offered a compre-

hensive list of services to enrolled clients. Services include routine prophylaxis, x-rays, dental extractions, partial and full dentures, some crown and bridgework, and scaling and root plan-

ning. All services are required to be pre-approved, via submission of a dental care plan by the treating dentist. After care plan approval and completion, the treating dentist is reimbursed by the MDP. Over the last 12 months, the Michigan Dental Program (MDP) provided reimbursement to dentists who served more than 800 dental clients.

Dental providers that participate with the MDP come from a

wide variety of backgrounds and range from private practice dentists, Federally Qualified Health Centers (FQHC) and two dental schools.

Upcoming Conferences

MDCH has held an annual conference for Persons Living with HIV/AIDS since 1999. This year the annual conference will be held at the Thomas Edison Inn in Port Huron on April 28 and 29. The purpose of this conference is to provide the opportunity for participants to meet other people living with HIV. It also provides a great opportunity for participants to hear current information on medical

Continued on page 14



MDCH hosted an observance of World AIDS Day 2006 at the Charles H. Wright Museum of African American History in Detroit

Awards & Recognition

2006 STD & HIV Awards

Several dedicated individuals were honored in Kalamazoo at the annual STD & HIV Conference



Mary Dillinger, RN
“Compassionate Heart”
 Award presented for her work at the Thomas Judd Center in Traverse City



Lynda Byer
 first to receive the
“It takes a Village” Award
 for her work with the STD Adolescent School Project

Bernard Mallisham
 was recognized posthumously with the
“Living Memory Award” for his many years of HIV work in the Detroit EMA

Felix Sirils
“In the Trenches” Award
 for HIV/STD Prevention Test Counseling in Clinical Settings, in Detroit



In memory of Derrick Anderson



Michigan lost one of its earliest activists for black MSM in November, when Derrick Anderson passed on. His memorial service was appropriately held on World AIDS Day 2006.

Anderson was an outspoken and sometimes controversial figure during the 1990's. He stepped up as a public speaker for HIV/AIDS, when the African American community was still in denial. And he didn't shy away from his identity as an HIV-positive man who had sex with men.

Very active with the former Statewide HIV/AIDS Council (SHACC), Anderson was a past Chair of the Persons Living with HIV/AIDS Council. He was presented Michigan's 2000 HIV Lifetime Achievement Award.

On a local level he volunteered for the HIV/AIDS Resource Center (HARC). Patrick Chandler, a case manager at HARC remembers Anderson as being passionate about educating others on HIV prevention. “To me he was just a unique person in all areas: strong, compassionate, forgiving, a poet,” Chandler was quoted in *Between the Lines*.

In recent years, Anderson had removed himself from the AIDS spotlight to further his education. He received his masters degree from the U of M School of Social Work in 2003.

A year ago June, Anderson presented a paper on HIV at an Eastern Michigan conference, “The State of the African American Male in Michigan: A Courageous Conversation,” where he brought his message to a new audience.

One of the important outcomes of that EMU conference was a special edited volume, being published by the Michigan State University Press. “Derrick's chapter, “Coming Out of the HIV/AIDS Closet,” will be included in *The State of the African American Male in Michigan: A Courageous Conversation*,” said Vernon C. Polite, Dean of the College of Education at EMU.

“Derrick not only produced the commissioned paper, but also participated in the summit as the lone voice addressing HIV among African American males and its impact on the African American communities of the State.” An electronic copy of Anderson's paper is available at: <http://www.emich.edu/coe/summit/index.php>



Derrick Anderson with his 2000 HIV Lifetime Achievement Award

Finally, Ryan White HIV/AIDS Funding



Congress finally passed a three-year Ryan White HIV/AIDS Treatment Modernization Act during the final hours of the 2006 legislative session. Held up for months in a battle over how to equitably fund the nation's HIV/AIDS programs in both rural and urban areas, and approved for a shorter time than originally planned, this may actually jumpstart efforts to create something better than a reworked "Emergency" plan. First passed in 1990, the CARES Act was never intended to be a long-term solution to the epidemic.

The Institute of Medicine, in a 2004 analysis commissioned by Congress, found that the financing and delivery system for publicly financed HIV care was too complex and concluded, "The Committee's principal recommendation to address system deficiencies is the establishment of a new federal program for financing HIV care." *New York Blade Online* (12/16/06)

While the debate between the states over the Care dollars was temporarily resolved, another provision inserted into the act's budget by conservative Republican Sen. Tom Coburn (R-OK) could dramatically reduce funding for prevention programs.

Coburn's HIV Early Diagnosis Grant initiative mandates that \$30 million in CDC's HIV/AIDS prevention dollars be set aside annually to fund grants for states that meet a specific set of qualifications regarding HIV testing.

The problem, according to HIV/AIDS community advocates, is that no states cur-

rently qualify for the grant program. However, the CDC's prevention budget will still lose that \$30 million annually, whether any state qualifies and applies or not.

The HIV Early Diagnosis Grant program would make available multi-million dollar grants to states under two categories. Twenty million dollars would be available annually for states that have voluntary (opt-out) HIV testing of pregnant women and

ciated with connecting those diagnosed with HIV to care and treatment.

When the Senate approved the 2007 budget resolution, Democratic leaders included language which bars the use of CDC prevention funds for the early diagnosis program *this* year, saving a \$30 million CDC budget cut. President Bush signed the bill into law on February 15. Community HIV/AIDS Mobilization Project (CHAMP) Report (3.2.07)

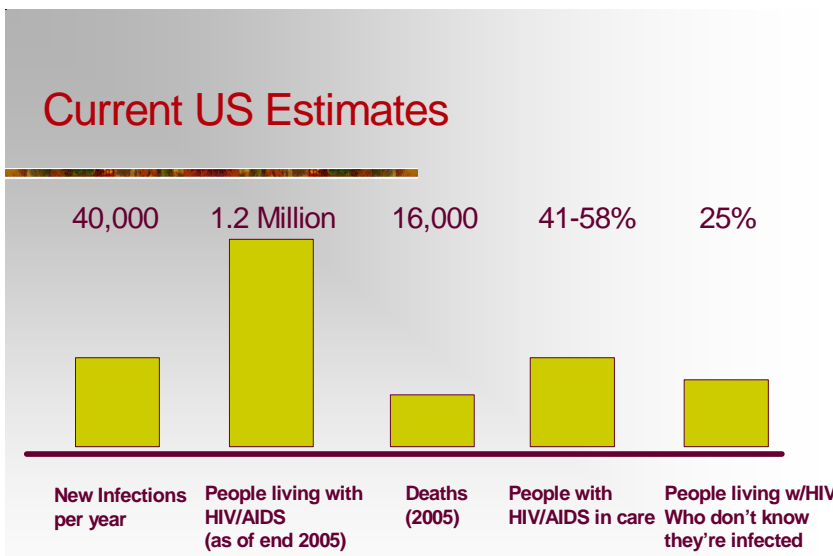
The first round of the contentious new formula allocations (the former Title I grants) under the new act were announced by HHS' Health Resources and Services Administration (HRSA) on March 3.

HRSA announced \$376 million in grants to support HIV/AIDS care and services in 51 cities and major urban areas. The awards are provided under Part A of Title XXVI of the PHS Act, previously referred to as Title I.

The new Ryan White law changes the

method of determining eligibility for Part A funds by including both Eligible Metropolitan Areas (EMAs) and newly designated Transitional Grant Areas (TGAs), which qualify with at least 1,000 but less than 1,999 cumulative AIDS cases in the last five years.

Twenty-nine of the total 34 TGA grants were announced. The change gives funding priority to urban areas with the highest number of people living with AIDS, while helping mid-size cities with emerging needs. HRSA Press Release (3.3.07)



Sources: CDC A Glance at the HIV Epidemic, 2006; CDC, Special Data Request for the /Kaiser Family Foundation, 2006; UNAIDS, 2006 Report on the Global AIDS Epidemic, May 2006; Fleming P et al., HIV Prevention in the US, 2000, 9th Conference on Retroviral and Opportunistic Infections, 2002; Glynn K, Rhodes P, Estimated HIV Prevalence in the US at the End of 2000, 2005 National HIV Prevention Conference; An Overview of HIV/AIDS in Black America, Jennifer Kates (KFF), Black AIDS Institute Special Symposium, August 2006. Slide from Dr. Kristy F. Woods STD & HIV Conference presentation

universal testing of newborns, with a yearly \$10 million grant limit per state. Another \$10 million would be available for states that perform voluntary HIV testing of clients at sexually transmitted infections clinics and at substance abuse treatment centers.

The money can be used by states to pay for HIV/AIDS testing, prevention counseling, treatment of newborns exposed to HIV/AIDS, treatment of infected mothers and newborns exposed to HIV, and costs asso-

MICHIGAN: In the News

Michigan Shines in National Competition

The Institute of HIV Prevention Leadership (IHPL) chose three Michigan scholars from a pool of approximately 300 applicants. Kaye McDuffie, Lansing Area AIDS Network; Brianne Moore, Midwest AIDS Prevention Project and Xiomara Torres, Detroit Hispanic Development Corporation were three of 50 individuals provided a 2007 IHPL scholarship.

The IHPL, sponsored by the Centers for Disease Control and Prevention (CDC) in partnership with the Association of Schools of Public Health (ASPH), provides an intensive program to build public health and management capacity for HIV prevention program managers working in community based organizations (CBOs). The IHPL is designed to help CBO staff enhance their organizational capacity to deliver HIV prevention programs grounded in public health and management principles. This nine-month program includes quarterly on-site Institute instruction and distance learning assignments. Since the origin of the Institute in 2000 only ten individuals from Michigan have been awarded this scholarship.



AIDS Walk Michigan – Detroit

At the MDCH World AIDS Day celebration held at the African American Museum, Barbara Murray, AIDS Partnership Michigan's executive director, presented the Walk awards to ten metro Detroit agencies:

Simon House - \$378

Taylor Teen Center - \$920

Detroit Community Health Connection - \$977

Sinai Grace - \$1,416

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Detroit EMA Receives Slight Ryan White Increase

Detroit, Michigan's only Eligible Metropolitan Area (EMA), received \$5,648,743 in a 2007 Part A grant from HHS' Health Resources and Services Administration (HRSA), announced March 3. This was an increase just short of \$1,200,000 from 2006 (\$4,450,466). Part A grants will go to 22 cities that qualify as EMAs under the new Ryan White Act, as well as the new TGAs (see national news story.)

To be eligible as EMAs under Part A as amended, metropolitan areas must have a cumulative total of more than 2,000 AIDS cases over the most recent five-year period and a population of 50,000 or more persons.

These grants represent the first funding phase under Part A. Metropolitan areas will also have the opportunity to compete for supplemental funding based upon need, and to apply for Minority AIDS Initiative grants, to be awarded later this year.

Title II CARE Needs Assessment Final

The Michigan HIV/AIDS Council met near Lansing for its last meeting of the 2006 on November 15. The Council voted to approve the six new members and ten new advisors selected by the membership committee, as well as the renewal of nine members/advisors. HAPIS staff commented that the entire group of 40 members for the 2007 council now has better "PIR," parity, inclusion and representation of those demographics most affected by the epidemic in Michigan.

The Council also approved the Title II Care Needs Assessment as an MHAC document. Much appreciation was expressed for all the work that the committee had put into creating this document. Mark Peterson, director, Michigan Positive Action Coalition (MI-POZ) as well as the MAPP coordinator for the Prevention with Positives program, said he was "pleased to see that prevention questions were asked," that there was more integration of prevention with care. "I think this committee has done an even better job than in 2003 - you can see the comparison," he said. "Great job and I really appreciate it." Peterson said that the efforts of those involved with the needs assessment "have helped us get a clearer picture of the needs of Michigan's PWAs," and that this information will help us in providing better services. Peterson added that he would like to see more of a collaborative effort with the Title I (Detroit EMA) needs assessment, "so that we can have this kind of data for the area most impacted."

MDCH-HAPIS Manager and MHAC Chair Debra Szwejdja expressed appreciation to the Needs Assessment committee members for all of their hard work on both this and the prevention document. (These documents can be viewed on the website: www.mihivnews.com/mhac.htm.)

Another action item was to approve the status of the African American

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Table 1: Characteristics of Michigan Residents Living with HIV and AIDS as of January 1, 2007

	Estimate of HIV Prevalence ¹	Estimated Prevalence Rate ²	Reported Living with AIDS ³		Reported Living with HIV not AIDS ³	
			Number	Percent	Number	Percent
MICHIGAN TOTAL	17,000	171.1	6,534	100%	6,069	100%
SEX						
Male	13,060	268	5,173	79%	4,512	74%
Female	3,940	78	1,361	21%	1,557	26%
BEHAVIOR						
Male-Male Sex	7,910	N/A	3,187	49%	2,676	44%
Injecting Drug Use ⁴	2,170	N/A	919	14%	689	11%
IDU w/ heterosexual	1,010	N/A	424	6%	322	5%
IDU w/o heterosexual	1,160	N/A	495	8%	367	6%
Male-Male Sex/IDU	760	N/A	315	5%	250	4%
Blood Products	200	N/A	92	1%	55	1%
Heterosexual ⁵	2,220	N/A	829	13%	820	14%
Partner IDU	660	N/A	244	4%	248	4%
Partner Bisexual	140	N/A	40	1%	62	1%
Partner Rec'd Bld	60	N/A	21	0%	20	0%
Partner HIV +	1,370	N/A	524	8%	490	8%
Perinatal	200	N/A	44	1%	103	2%
Undetermined	Not Applicable	N/A	1,148	18%	1,476	24%
Presumed Heterosexual ⁶	Not Applicable	N/A	913	14%	1,042	17%
Other ⁷	Not Applicable	N/A	235	4%	434	7%
AGE AT DIAGNOSIS						
0 -12 years	200	11	37	1%	114	2%
13 -19 years	450	44	70	1%	263	4%
20 -24 years	1,610	250	338	5%	852	14%
25 -29 years	2,460	376	755	12%	1,067	18%
30 -34 years	3,170	448	1,216	19%	1,133	19%
35 -39 years	3,320	422	1,440	22%	1,022	17%
40 -44 years	2,570	317	1,157	18%	751	12%
45 -49 years	1,580	215	743	11%	427	7%
50 -54 years	930	147	441	7%	249	4%
55 -59 years	420	86	197	3%	114	2%
60 -64 years	180	48	86	1%	49	1%
65 years and over	110	9	54	1%	25	0%
Unspecified	Not Applicable	N/A	0	(0%)	3	(0%)
RACE / ETHNICITY						
White, Non-Hisp.	6,100	78	2,380	36%	2,142	35%
Black, Non-Hisp.	9,960	710	3,804	58%	3,581	59%
Hispanic	650	201	266	4%	215	4%
Asian/Pacific Islander	80	45	33	1%	27	0%
American Indian	60	112	15	0%	28	0%
Unspecified/Multi-race	Not Applicable	N/A	36	(1%)	76	(1%)

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).

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Changes in Reporting & Collecting Data

MDCH released a revised version of the Adult HIV/AIDS Case report form on March 2. The primary reason behind this revision is to incorporate testing history questions into the case report form. This will further integrate incidence surveillance into routine case reporting and help accurately assess HIV incidence. Copies of the new report form with instructions are available at www.mihivnews.com/surveillance_in_mi.htm.

In July 2006, the HIV surveillance program upgraded its surveillance system software to a restricted-access browser-based system called eHARS (the “e” stands for Evaluation, HIV/AIDS Reporting System). This change in software necessitated changes in the way HIV and AIDS cases are counted (e.g. race is now required for all cases reported after January 1, 2002 in order for the cases to be counted). This affected the case counts included in the October 2006 statistics (available on-line). Throughout the last quarter, MDCH Surveillance resolved the discrepancies between the two software systems in order to provide statistics in January, reported here, that are more representative of the epidemic. The entire Surveillance report is available at the

website: www.mihivnews.com/stats.htm.

Also, available on-line is a PowerPoint presentation (in a PDF file) explaining the January statistics with graphs and pie charts, e.g. see graph below.

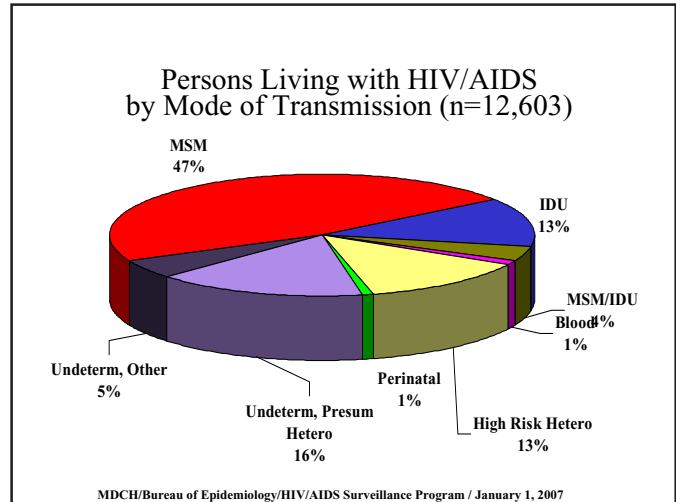


Table 3: Michigan Residents Reported Living with HIV or AIDS: Sex by Race by Behavior January 1, 2007

MALES:	White		Black		Hispanic		Other or Unknown		TOTAL	
Male-Male Sex	2,938	75%	2,663	51%	189	51%	73	46%	5,863	61%
Injecting Drug Use	173	4%	745	14%	47	13%	13	8%	978	10%
Male-Male Sex/IDU	224	6%	319	6%	14	4%	8	5%	565	6%
Blood Recipient	85	2%	32	1%	4	1%	3	2%	124	1%
Heterosexual	92	2%	341	7%	35	10%	4	3%	472	5%
Perinatal	15	0%	62	1%	2	1%	3	2%	82	1%
Undetermined	401	10%	1,069	20%	76	21%	55	35%	1,601	17%
<i>Presumed Heterosexual</i>	251	6%	771	15%	61	17%	24	15%	1,107	11%
<i>Other</i>	150	4%	298	6%	15	4%	31	19%	494	5%
Male Subtotal	3,928	(41%)	5,231	(54%)	367	(4%)	159	(2%)	9,685	100%
FEMALES:	White		Black		Hispanic		Other or Unknown		TOTAL	
Injecting Drug Use	107	18%	494	23%	20	18%	9	16%	630	22%
Blood Recipient	14	2%	6	0%	2	2%	1	2%	23	1%
Heterosexual	304	51%	795	37%	59	52%	19	34%	1,177	40%
Perinatal	13	2%	45	2%	6	5%	1	2%	65	2%
Undetermined	156	26%	814	38%	27	24%	26	46%	1,023	35%
<i>Presumed Heterosexual</i>	127	21%	678	31%	24	21%	19	34%	848	29%
<i>Other</i>	29	5%	136	6%	3	3%	7	13%	175	6%
Female Subtotal	594	(20%)	2,154	(74%)	114	(4%)	56	(2%)	2,918	100%
GRAND TOTAL	4,522	36%	7,385	59%	481	4%	215	2%	12,603	100%

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

Prevention Research Focus on Adolescents

"Factors that shape young people's sexual behavior: a systematic review"

Lancet in November (vol. 368, pp 1581-1586)

This was a review by British researchers of 268 qualitative studies conducted around the world between 1990 and 2004 that examined sexual behavior among young people (ages 10 - 25). After analyzing the data, seven key themes that determine this behavior emerged. Four of them have to do with social influence: gender stereotypes determine social expectations and behavior; social rewards and penalties influence behavior; reputations and social displays of sexual activity or inactivity are important and differ for young women and men; and social expectations hamper communication about sex. Also, sexual partners influence behavior. Only two themes were exclusive to individual decision making, young people label sexual partners as clean or unclean and condoms were associated with not trusting sexual partners.

"Sexual communication and contraceptive use in adolescent dating couples"

Journal of Adolescent Health Vol. 39; No. 6: P. 893-899, (12..2006)

This research examined data on 209 couples who had been dating for at least four weeks and who participated in the Study of Tennessee Adolescent Romantic Relationships. Included in the current analyses were 73 couples (ages 14-21) who had had sexual intercourse and who completed a sexual communication questionnaire. According to the University of Tennessee authors, this was the first known study to address sexual communication using reports from both members of established adolescent dating couples. Findings suggest that open sexual communication between intimate partners is important to sexual decision-making. Specific findings included: more open sexual communication by both partners was associated with increased contracep-

tive use; and adolescents who said they were more satisfied with their relationships reported more open sexual communication, "and adolescent females who self-silenced* reported less open communication about sex."

In mediation analyses, boys' and girls' relationship satisfaction and girls' self-silencing "indirectly predicted contraceptive use through their effects on general sexual communication."

* According to one of the authors, Laura Widman, MA, "Self-silencing is the tendency to silence one's wishes or desires in the context of a relationship, particularly when one fears that these desires will cause conflict. In our study of adolescent communication, self-silencing was measured with a 9-item scale published by Jack & Dill in 1992. Sample items on this scale include, 'I think it's better to keep my feelings to myself when they conflict with my partner's' and 'Instead of risking confrontations in an intimate relationship, I would rather not rock the boat.' In our study, we found that adolescent girls who reported more self-silencing in their relationships also reported less open sexual communication with their partners - and this association led to reduced contraceptive use."

"Having Sex and Condom Use: Potential Risks and Benefits Reported by Young, Sexually Inexperienced Adolescents"

Journal of Adolescent Health Vol. 39; No. 4: P. 588-595 (10.06)

What do young adolescents themselves identify as the potential positive and negative outcomes of having sex, using a condom or not using a condom? This study set out to answer these questions. The subjects of the study were 418 ethnically diverse ninth-graders from suburban northern California schools, 86 percent of who reported never having had sex. Written surveys were used to collect the students' responses to scenarios involving two adolescents who had sex.

The students were randomly assigned to one of two groups. One group read a scenario in which a condom was used; the other read a scenario in which no condom was used. All the students were asked to list the risks and benefits of having sex. Depending on the scenario read, participants were asked to list the risks and benefits of using or not using a condom.

The students spontaneously identified a range of health and psychological risks and benefits to having sex with or without a condom. Their answers evidenced a strong aversion to pregnancy. Commonly mentioned were the risks of HIV/STDs as well as condom malfunction. Condom use benefits cited included preventing pregnancy and STDs. The benefits listed by the students of having sex and not using condoms included improving the relationship, fun and pleasure.

The researchers concluded, "Communication with adolescents regarding safe sexual activity could benefit from widening the communication from a focus on health risks to include discussion of the psychosocial risks and benefits that adolescents themselves think about with respect to sex and condom use."

Parent Opinion of Sexuality Education in a State with Mandated Abstinence Education: Does Policy Match Parental Preference?

Journal of Adolescent Health 39 (2006) 634-64

This study conducted in North Carolina used a computer-assisted, anonymous cross-sectional telephone survey of 1306 parents of public school students in grades K-12. "Comprehensive sexuality education" was defined as education that includes a discussion of how to use and talk about contraception with partners. The results were that parents in North Carolina overwhelmingly support sexuality education in public schools (91%). Of this group, the majority (89%) support comprehensive sexuality education. Less than a quarter of parents oppose teaching any specific topics viewed as more controversial, such as discussion about sexual orientation, oral sex and anal sex.

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Public Opinion on Sex Education in US Schools

Arch Pediatr Adolesc Med. 2006;160:1151-1156

The researchers who conducted this cross-sectional survey of a randomly selected nationally representative sample of 1096 US adults aged 18 to 83 years came to this conclusion: "Our results indicate that US adults, regardless of political ideology, favor a more balanced approach to sex education compared with the abstinence-only programs funded by the federal government. In summary, abstinence-only programs, while a priority of the federal government, are supported by neither a majority of the public nor the scientific community."

Legislating Against Arousal: The Growing Divide Between Federal Policy and Teenage Sexual Behavior

Guttmacher Policy Review Summer 2006 Vol 9: No. 3

This report explored the evolving government policy and funding support for abstinence-only education since the federal government first promoted premarital abstinence in 1981 and how this is discordant with actual behavior practices among adolescents and young adults. Most notably the report explored the negative impact that the abstinence emphasis has had on adolescent relationship development and choice of other sexual expression in order to technically remain "virgins," i.e. the increase in oral sex practices among teens.

Compared with northern European countries where sex among older teenagers is generally accepted and strong cultural norms emphasize that sexual activity should occur within committed relationships, US teens are now seeking "friends with benefits," and casual "hook-ups."

The author concludes, "All of this suggests that the U.S. emphasis on stopping young people from beginning intercourse – almost at any cost – may be directly and indirectly harming American youth."

Investment Level in HIV Prevention Programs Related to HIV Incidence in the United States

American Journal of Preventive Medicine (1.30.07)

Researchers at Johns Hopkins Bloomberg School of Public Health conducted a historical analysis to examine the relationship between the Centers for Disease Control and Prevention's (CDC) HIV prevention budget and HIV incidence in the U.S. from 1978 to 2006.

The researchers found that from the beginning of the epidemic until 1985 (when new infections peaked), incidence of HIV predicted investment levels. During this period, society responded to increasing levels of infection with more investment in prevention programs. Things changed in the mid 1980s when investment levels began to predict incidence. That is, as the nation continued to increase the funding of HIV prevention programs, HIV dropped substantially from 160,000 infections per year to about 40,000 infections per year. In the early 1990s, as the level of investment (adjusted for inflation) flattened out with little annual change, so too did the number of new infections per year. This suggested to the researchers that level investment yields level incidence.

"Our analysis helps explain why the number of new HIV infections has remained at 40,000 per year for over 15 years," said David R. Holtgrave, PhD, chair of the Department of Health Behavior and Society at the Bloomberg School of Public Health and lead author of the study. "Investment levels have predicted HIV incidence since the mid-1980s. If we want to lower infections further in the U.S., these analyses suggest we should consider increasing our national investment. Yes, that may seem expensive, but HIV medical care easily tops \$20,000 per patient per year. Therefore, funding of effective, scientifically sound HIV prevention services are likely to have a very favorable return on investment in terms of both lives and dollars saved."

Experts Advise Focus on HIV Prevention

Prior to the start of the 14th Conference on Retroviruses and Opportunistic Infections community advocates for prevention research heard from experts on several medical prevention strategies. The following is edited from a report by Bob Roehr in Medscape <http://www.medscape.com/viewarticle/552840?src=mp>

Circumcision "Fantastic" for Prevention

Prevention expert Thomas J. Coates, PhD, now a professor in residence at UCLA, said circumcision is not just an issue for the developing world or for countries with high prevalence of infection. He pointed out that the rate of circumcision in the United States has declined to about 50% of all adult men, and it is low-

est among the younger age groups in which half of new infections occur.

Several states have dropped Medicaid coverage of circumcision of newborns. In addition, African Americans are less likely to be circumcised, which is likely a factor contributing to higher rates of HIV infection within that population.

Treatment of HSV-2 Coinfection

The recently published study showing that treating herpes simplex virus type 2 (HSV-2) can reduce genital shedding and disease progression for those already infected is another opportunity to revitalize prevention. It led Dr. Coates to suggest "universal access to herpes suppressing medications, which are very cheap, very effective, have an incredibly safe profile, and resistance doesn't develop."

Continued on page 16

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).

MDCH Training

You will find on the website the complete Division of Health Wellness and Disease Control training schedule for 2007. Following are trainings scheduled April - May deadlines. Application forms are also available to download at: www.mihivnews.com/dhwdc_train.htm.

HAPIS HIV Prevention/Test Counselor Related Training

For more details on these trainings please see the entire calendar on the website. 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>
April 3-4	Detroit	March 9
May 7-8	Lansing	April 13
June 6-7	Detroit	May 11

Module 2: HIV Prevention Specialist Certification Training

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
April 12-13	Detroit	March 23
May 9-10	Lansing	April 13
June 12-13	Detroit	May 18

Module 3: HIV Test Counselor and PCRS Certification Training for CBOs

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
April 18-19	Detroit	March 30
May 17-18	Lansing	April 27
June 14-15	Detroit	May 25

Module 3: HIV Test Counselor and PCRS Certification Training for LPH

<u>Date</u>	<u>Location</u>	<u>Reg.</u>
April 18-20	Detroit	April 10
June 5-7	Lansing	May 11

LPH Staff: to register for Module 3, please

use the PCRS Training Application form. Contact Tracy Peterson-Jones for more information at (313) 456-4422.

One-Day HIV Prevention Specialist/Test Counselor Update

Topic: Adolescents and Street Youth

This topic will be an overview of trends of adolescents and risk behaviors that are related to HIV. See the complete calendar for more options.

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
April 18	Detroit	March 23

Topic: Health Disparities

This will focus on disparities in health and health care among people of color; review current disparities in several areas of health, including cancer, infant mortality and HIV; examine factors that contribute to disparities; and build a plan of action for addressing health disparities in your HIV work.

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
May 23	Lansing	May 4

Topic: Domestic Violence, Sexual Assault and HIV

Domestic abuse and sexual assault mix dangerously with HIV and are much more common than most providers realize. This workshop will assist HIV providers in recognizing abuse and providing appropriate support and services when at-risk clients are identified.

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
June 20	Detroit	June 1

Please note this is a new date.

Specialized HIV Training Courses

Complete "HIV Training Application Form" and fax/mail. Approximately three weeks prior to the training, applicants will be notified by mail regarding acceptance/rejection. For more information, contact Julie Babb at (517) 241-5903 babbj@michigan.gov.

Assuring the Quality of HIV Prevention Counseling

This workshop is open **only** to supervisors of HIV prevention and test

counseling staff and is required for supervisors at DHWDC-funded sites. It is designed to help supervisors assure the quality of HIV prevention counseling. Supervisors must have attended the HIV Test Counselor Certification Training since 1994 or a supervisor's update.

<u>Dates</u>	<u>Location</u>	<u>Reg.</u>
May 30 - 31	Detroit	May 12

Please note new dates and registration.

Partner Counseling and Referral Services (PCRS)

Contact Tracy Peterson-Jones at (313) 456-4422 or PetersonT@michigan.gov. PCRS training is required for those individuals who will provide HIV test counseling, elicitation and/or field investigations, and are currently working at an LPH Dept. receiving HIV categorical funding.

Certification Update

This is a **required** course that PCRS staff must complete at least **every two years** to maintain their PCRS certification. See Summer Calendar.

PCRS Supervisory Training

Trainings are required for supervisors in LPH (both days) and CBOs (day one only). 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>
April 25-26	Detroit	March 30

Specialized PCRS Courses

Application: Please note application deadlines, complete the PCRS Training Application Form (available on our website.) Contact: Tracy Peterson-Jones at (313) 456-4422 or PetersonT@michigan.gov.

PCRS & the Internet Workshop

This workshop is a review of the PCRS Internet Protocol to assist local health department staff access the internet and provide PCRS to partners who are identified as at risk for HIV. This course is designed to provide local health department staff with hands on experience to initiate the internet as a prevention tool.

<u>Dates</u>	<u>Location</u>	<u>Reg</u>
May 23	TBA	May 14

PCRS & Women: A Dialogue for Empowerment

In collaboration with the Ryan White Title IV (Part D) program, this workshop is designed to assist local health department PCRS staff to enhance their skills in areas of working with HIV-infected women by examining concerns around disclosure, and improving their safer sex negotiation skills with their partners.

<u>Dates</u>	<u>Location</u>	<u>Reg</u>
June 19	TBA	May 30

HIV/AIDS Case Management Certification Training

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. Complete the "Case Manager Certification Application Form", obtain supervisor signature and fax/mail the application

For information on case management trainings, contact Julie Babb at (517) 241-5903, e-mail: babbj@michigan.gov or Rhonda Bantsimba at (313) 456-3322, bantsimbar@michigan.gov.

<u>Date</u>	<u>Location</u>	<u>Reg.</u>
April 24-27	Detroit	March 30
August 28-31	Lansing	August 3

All MDCH-certified HIV/AIDS case managers must be recertified every two (2) years. See the complete 2007 DHWDC training calendar on the website: www.mihivnews.com/dhwdc_train.htm.

STD Training

For more information or to register, please contact Carol French (517) 241-0868, or email: frenchc@michigan.gov Complete enclosed "STD Training Application Form" and fax/mail. This trainings includes a half-day of the following topics:

Syphilis 101: Focus on Syphilis. This portion of the training will provide an overview of symptoms, disease progression, transmission, epidemiology, testing, treatment and prevention strategies for the more common STDs. This event will provide an introduction to STDs for anyone working in sexual health and will include basic clinical information for nurses.

Advanced Interviewing for Gonorrhea and Chlamydia. This half-day workshop will include an overview of interviewing and investigation theory.

<u>Date</u>	<u>Location</u>	<u>Reg.</u>
June 12	Traverse City	May 18
June 14	Marquette	May 18

Conferences and Events

Michigan Conferences and Events

April 3 Detroit
HIV Update: Findings from the 14th CROI
Roy Gulick, MD; Lawrence Crane, MD
Harper Hospital, Morse Auditorium
1:00pm – 3:30pm This is a program of WSU's MATEC. Open to the public.

April 28-29 Port Huron
Michigan's PWA Conference 2007
This year's conference for Persons Living with HIV/AIDS scholarship application deadline is March 28. See the website: www.mihivnews.com/conferences.htm.

June 20-22 Traverse City
Michigan's Case Management Conference
Contact Belinda Chandler at (517) 241-5926 or chandlerbel@michigan.gov.

Save the Dates:
November 1-2 Ypsilanti
STD & HIV Conference
Contact: Diane Drago, e-mail: dmsdiane@dmsdiane.cnc.net.

December 4 Plymouth
2007 Hepatitis C Conference
Several tracks will be offered, geared towards physicians, nurses, local public health, CBOs and consumers. Contact Lisa TatonMurphy at (517) 241-5932 or e-mail: tatonl@michigan.gov.

National Conferences and Events

April 5 - 7 Bloomington, IN
HIV/STD Prevention in Rural Communities: Sharing Successful Strategies V
website: www.indiana.edu/~aids .

May 20-23 New Orleans, LA
HIV Prevention Leadership Summit (HPLS)
For more information, visit the conference website: http://www.nmac.org/conferences__trainings/hpls/4690.cfm

Statewide Meetings

HIV/STD and Adolescents Networking Committee

This statewide committee is for professionals in youth serving agencies - See box on page 13.

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 June 7. 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. The next meeting is April 20 in Detroit. The deadline for materials submissions is April 3. Contact: Christina Bolden, 517-241-5929, or boldenc@michigan.gov.

When is the best time...

Continued from page 1

One place to start is sound, evidence-based, culturally appropriate education for all teens.

“Abstain until marriage” – not helpful advice for the 31 percent of Michigan high school students surveyed in 2005, who already had sex before the age of 16₃, not realistic when 95% of Americans polled in 2002 reported they had premarital sex, and completely irrelevant for a 16 year-old MSM, when the news headlines tell him he can never get married to another man in Michigan.

Unarguably teens are having sex and they aren't all using protection. The evidence is in the reported sexually transmitted disease statistics. The highest rates of two of the three reported STDs in Michigan, chlamydia and gonorrhea, are among those ages 15 – 24₁. Besides the health risks that these infections themselves pose, there is also the known risk that some sexually transmitted infections increase risk of HIV₂.

How many of the estimated 17,000 Michigan residents infected with HIV (approximately 5,800 of who don't know

about their infection) would have made better choices, and would have used the tools to protect themselves if their teachers had been honest with them, respected them for who they are, and given them the tools to live safe and healthy lives?

Twenty years ago many Michigan schools had progressive, comprehensive and honest health education, when their school boards adopted The Michigan Model for Comprehensive Health (now The Michigan Model for Health®₄). This very innovative curriculum facilitated interdisciplinary learning through lessons that integrate health education into other curricula, including language arts, social studies, science, math and art. Teacher training in the implementation of the Model ensures that students and school staff get maximum benefits from this carefully structured program.

But not all school systems adopted the model. Social mores and politics got in the way. And as politics increasingly overshadowed science, Michigan legislators added a host of new requirements for sex education into the school code that

were not based on research or best practice₅. This resulted in Michigan Department of Education (MDE) having to make changes to the Michigan Model.

Under the direction of the MDE a compromise package for high schools has been developed and will be released this Spring. This new 9-12 grade HIV/STD Prevention Module of the Michigan Model for Health offers an abstinence-based program with an abstinence-only option is available.

Michigan HIV/AIDS Council (MHAC) members were provided a sneak preview at the November meeting. Several MHAC members were advisors in creating this new curriculum, which is skill-based and comprehensive. While this curriculum is not perfect, it meets the objective of many different stake holders as well as new legal requirements and objectives.

“This new curriculum provides one-stop shopping for districts wanting a research-based curriculum that complies with the new Michigan laws,” said Laurie Bechhofer, MDE HIV/STD education consultant.

It's a new year. Each of us has an opportunity to make an impact locally. If we are truly committed to STD and HIV prevention, our voices need to be heard in

Continued on page 13

References

1. Selected Sexually Transmitted Diseases, 1996-2005 Michigan Total http://www.mdch.state.mi.us/PHA/OSR/chi/std_h/frame.html

2. According to the CDC, other STDs increase both HIV infectiousness and susceptibility. For example: Syphilis, genital herpes type 2, chancroid, and other infections that cause genital or rectal ulcers may increase the risk of HIV transmission per sexual exposure 10 to 50 times for male-to-female transmission and 50 to 300 times for female-to-male exposure. Nonulcerative STDs (e.g., chlamydia and gonorrhea) have been shown to increase the risk of HIV transmission by

two-fold to five-fold. Treatment of gonorrhea in HIV-infected men reduces the prevalence of HIV shedding in urethral secretions by approximately 50%.

The Journal of Infectious Diseases March 1 issue reports that women who have the common sexually transmitted disease trichomoniasis have a significantly increased risk of HIV infection. This adds yet another unreported and sometimes asymptomatic sexually transmitted infection that can increase an individual's risk for HIV infection. See HIV/STD connection reports from CROI on the website in Research.

3. Youth Risk Behavior Survey in Michigan 2005 <http://www.michigan.gov/>

[documents/mde/_NEW_2005_YRBS_Fact_S_176035_7.pdf](http://www.michigan.gov/documents/mde/_NEW_2005_YRBS_Fact_S_176035_7.pdf)

4. Michigan Model for Health <http://www.emc.cmich.edu/mm/default.htm>

5. For more information on school legislation referred to here see: http://www.mihivnews.com/adol/mde_akk_in_k12_curriculum.pdf

6. “No Rite of Passage: Coming to Grips with Harassment and Bullying” The National School Boards Association's “Leadership Insider” newsletter, August 2006 issue compiles viewpoints and resources about how school districts can

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support of using the abstinence-based comprehensive school health curriculum in every community.

The education of children, pre-adolescents and adolescents must be conducted in a safe environment that protects each individual student's right to be who they are, as long as the rights of others are not denied. Regardless of the cultural milieu, all teens need support to make healthy decisions.

Civil rights must be upheld by school staff through anti-bullying policies. Teachers, administrators and other school staff can be trained to create safe environments in schools for sexual minority youth. We can all support the pending anti-bullying legislation (see insert.)

After-school and alternative education programs offer great opportunities to reach young people. Peer education programs allow for the provision of comprehensive education and training of teens and youth. However, funding for these programs is scarce, in contrast to abstinence-only programs. These programs receive federal funding with little to no scrutiny of their scientific accuracy, according to a Government Accountability Office report, released last year.

Here in Michigan many good out-of-

address these problems. Articles include an overview of the legal considerations, a review of court decisions relevant to cyber-bullying, a warning about pitfalls in the anti-bullying push, profiles of anti-harassment and anti-bullying efforts in several states and communities, and a success story about how one school board set up a process to resolve a controversy over whether sexual orientation should be specified as a protected category in its anti-harassment policy. <http://www.nsba.org/site/docs/39100/39055.pdf>

7. Safe Schools for Sexual Minority Youth Project
www.cj.msu.edu/~outreach/safe_schools/cd_apr2003/sex_monority.PDF

school programs that reach youth are still operating, and new programs that target those most at-risk are starting up. At the last Michigan STD, HIV and Adolescents Networking Committee, in January, members shared news of some exciting developments around the state.

Taylor Teen Health Center has added a new peer ed group in Romulus. And the teens in Taylor, who were trained by the Planned Parenthood Peer to Peer program, decided to create their own six presentation program, "Taylored" to their local needs, called IMPACT for Informing My Peers About Choices for Teens. Program coordinator Jesse Rvelle said she is a former peer educator herself, and she realizes that the teens need ownership of the program.

Horizon's Project, a Detroit Medical Center program, is planning to "spice up" their HIV 101 presentation. And big news – they just received permission from the Detroit Public Schools to do their programs in the schools. Horizon's Project works with HIV positive teens and does prevention programming.

Barb Flis, formerly with the Michigan Parent, Teacher and Student Association, has a new venture, Parent Action for Healthy Kids. She now works with par-

8. The Michigan STD, HIV and Adolescents Networking Committee is open to all adults who provide services to youth. At the quarterly meetings, agency representatives share program information and hear presentations on various adolescent/youth relevant topics.

The Committee also has a voice and representation on MHAC and the planning committee for the annual STD & HIV conference, which has a youth track. Information on The Michigan STD, HIV and Adolescents Networking Committee, including meeting dates and summaries of past meeting presentations, can be found on the Michigan HIV News website in the Youth-Teen section. www.mihivnews.com/teens.htm

ents and provides technical assistance for school districts' PA226 required Sex Advisory Committees. Recently Flis worked with the first district in Michigan to meet the new MI law requirement for at least 50% participation by parents on PA 226 committees. This district, which previously had dropped sex education, is now using the research-based Safer Choices curriculum.

This "proved the point that if you talk to (parents) and you don't hide anything, they want more," she said. A well known advocate for parent involvement, Flis was appointed to coordinate the Governor's 2005 initiative, "Talk Early, Talk Often" program for parents. The pilot was very successful and there is still funding available for communities that would like to hold this program. For more information contact Barb@parentactionforhealthykids.org.

Each of us has an opportunity within our own community to make a difference, to speak up for comprehensive science-based health education for the next generation and to respect young people in their diversity.

STD, HIV/AIDS & Adolescents Networking Committee

Wednesday, April 18, 2007
10:30 A.M. - 2:30 P.M.

Meeting Topic: New Healthy and Responsible Relationships Curriculum

Planned Parenthood Mid-MI
3100 Professional Drive
Ann Arbor, MI 48104

Please RSVP by April 13
to Ardith Alderdyce, aaardith@sbcglobal.net or (734)484-9865.

Join us and find out all about the new high school Michigan Model HIV, STI and pregnancy prevention curriculum.

HAPIS UPDATE

Continued from page 2

advances, pharmaceuticals and treatment guidelines and allows people the opportunity to discuss other continuum of care issues. There are limited number of scholarships available. For more information, contact Debbie Cornell at cornellde@michigan.gov or call her at 517-241-9406.

This year's case management conference will begin on the eve of June 20th and continue for two days (June 21-22) in Traverse City, MI. The purpose of this statewide conference is to bring case managers together to network and hear about neighboring agency's best practices. The focus will continue to remain on access to and retention in care, prevention practices for those already infected, linkages into care, adherence and drug issues. For more information about the conference, contact Belinda Chandler at 517-241-5926 or chandlerbel@michigan.gov.

CONTINUOUS QUALITY IMPROVEMENT MANAGEMENT UNIT

Michigan Local Public Health Accreditation Program

Thirteen scheduled site visits were completed in 2006. All agencies were found to be in compliance at the time of the official visits.

Quality Assurance & Technical Assistance visits

All sixteen high morbidity local health departments participated in QA TA visits during 2006. Agency best practices were noted, and are in the process of being compiled in a document to share with all local health departments.

The document, "Strategies to Improve Client Return Rates for Receiving HIV Test Results 2002," is being revised and updated to reflect changes in policies and data, and should be available for distribution in Spring 2007.

The guidelines for retaining client HIV records has been updated for 2006 and has been distributed.

The Michigan Drug Users Health Alliance will be providing trainings in upcoming conferences and workshops, with special attention to overdose prevention and development and implementation of harm reduction/syringe exchange programs.

COMMUNITY PARTNERSHIPS – PREVENTION UNIT

HIV Prevention Services Grantees Meeting

On October 16th, DHWDC convened a meeting of agencies funded for HIV prevention services for the 2007-2009 project period. At this meeting, grantees were provided with an overview of quality assurance priorities, updates to the HIV Event System (HES) and reporting requirements. Additionally two community providers spoke about best practices from the field, including a yield analysis of CTR sites, and using needs assessment findings in program planning.

The meeting finished with a presentation on technical assistance and capacity development priorities and resources for the upcoming year. Each agency received a "Prevention Toolbox" which includes helpful information about reporting, administrative requirements, sample documents and contact information.

Quality Assurance Updates

In conjunction with the start of a new project period for HIV prevention services, the Community Partnerships Unit is revising qual-

ity assurance and monitoring processes and tools for funded programs. The Unit has updated its quarterly narrative report format and initial program review protocol, implemented a quarterly events tracking tool, and developed a user guide and data management tool for HIV Event System (HES) Health Education and Risk Reduction module.

In the coming months, staff will initiate use of these tools, continue to conduct Counseling, Testing & Referral (CTR) direct observation quality assurance visits, and develop a user guide and data management tool for the HES CTR module. For more information, please contact Jane Conklin at (517) 241-5938 or conklinjane@michigan.gov.

CDC Recommendations for HIV Screening in Health Care Settings

In response to the Centers for Disease Control and Prevention (CDC) recently released *Recommendations for Routine HIV Testing in Clinical Settings*, MDCH is currently developing a position statement regarding HIV screening in clinical settings. Contact Liisa Randall at (517) 241-5924 or Jeanine Hernandez at (517) 241-5940 for additional information.

See page 16 - Health Disparities Reduction/ Minority Health Section

Rachel Mroz was welcomed to the HAPIS Training Unit in November. Mroz will be based in the Detroit Cadillac Place DHWDC office. She brings with her a wealth of knowledge and working in the the past year, worked with the for Healthy *tator for Governor Granholm's Often Work-ously, she prevention the Taylor Teen*



experience HIV field. For Mroz has Parent Action Kids as a *facilitator or Talk Early, Talk shop. Pre-viously worked as a counselor at Health Center and a Prevention Case Manager at the Teen Pregnancy Prevention Project. She has been a member of Michigan's STD, HIV and Adolescent Networking Committee.*

The Shifting Landscape of Sexuality Education in 2006

Continued from page 1

Abstinence-only education promotes abstinence as the only guaranteed method to prevent HIV, STDs, and pregnancy, and provides information about contraception and safer sex methods only in terms of failure rates.

The report was published at the request of several Members on Congress, concerned about the administration of abstinence-only-until marriage programs, which over the past decade have received more than \$1 billion in taxpayer funds. The GAO report specifically states that the Administration for Children and Families (ACF), the division of HHS that supervises two multimillion dollar abstinence-only programs, “does not review its grantees’ education materials for scientific accuracy and does not require grantees of either program to review their own materials for scientific accuracy.”² Proponents of comprehensive sexuality education hope the GAO report will result in increased oversight of these programs, including standardized and rigorous measures to determine the effectiveness of abstinence-only education.

The other pivotal document released this year came from the Society of Adolescent Medicine, which unveiled findings from an extensive review of federally-funded abstinence policies and programs. The report, *Abstinence-only Education Policies and Programs: A Position Paper of the Society for Adolescent Medicine*, stated:

“...abstinence-only education programs provide incomplete and/or misleading information about contraceptives, or none at all, and are often insensitive to sexually active teenagers,” and that “federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning

youth, as federal law limits the definition of marriage to heterosexual couples. ‘Abstinence only’ as a basis for health policy and programs should be abandoned.”³

Another major development occurred when New Jersey rejected federal funding to provide abstinence-only-until-marriage programs. In a letter from New Jersey’s Commissioners of the Department of Health and Senior Services

“...abstinence-only education programs provide incomplete and/or misleading information about contraceptives, or none at all, and are often insensitive to sexually active teenagers,” and “federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning youth, as federal law limits the definition of marriage to heterosexual couples.”

Society of Adolescent Medicine

and the Department of Education to HHS Secretary Michael Leavitt, the state informed the federal government of its decision, explaining that the abstinence-only-until-marriage guidelines contradict the core curriculum content standard in comprehensive sex education that New Jersey has had in place for more than 25 years.⁴

Moreover, the governor’s office cautioned that accepting federal abstinence-only funds may, in fact, cost the state

money because students may require additional sex education to clarify the partial and misinformation taught in abstinence-only-until-marriage programs.⁵ New Jersey joined other states including Maine, Pennsylvania, and California, which have also rejected Title V federal funding.

In FY2006, Community Based Abstinence Education grants were flat funded at \$113 million in both the House and Senate Appropriations Committee bills. State Abstinence Grants, authorized under the Temporary Assistance for Needy Families (TANF) program, remained flat funded at \$50 million, and the Adolescent Family Life Abstinence earmark was flat funded at \$13 million

in both bills.

In 2006, the flat funding of federal funds for abstinence-only-until-marriage programs, the continued push for the accuracy and evaluation of abstinence-only-until-marriage programs by the public health and medical communities, and the bold statement made by New Jersey’s leadership in their decision to turn back Title V funding, demonstrated a shift towards effectiveness and medical accuracy in the landscape of sexuality education.

References:

1. Press Release. SIECUS. “A New Congress Should Enforce Accountability Over Abstinence-Only Programs. November 16, 2006.
2. Press Release. Advocates for Youth. “GAO Report Asks ‘Where’s the Oversight?’”. November 16, 2006.
3. Lyon, M, Rogers, J, Summers, D. “Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine”. *Journal of Adolescent Health* 38 pages 83–87. 2006.
4. SIECUS. “SIECUS State Profiles: A Portrait of Sexuality Education and Abstinence-Only-Until-Marriage Programs in the States”. Fiscal Year 2005 Edition.
5. *ibid.*

NASTAD is hiring an HIV Prevention Senior Program Associate. The position will assist in the development and implementation of activities for NASTAD’s technical assistance program and youth program. See the website - Career Opportunities.

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

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.

Clinical trials:

(800) TRIALS-A (874-2572)

WALKS

Continued from page 5

Michigan AIDS Fund - \$2,281

Horizon's Project - \$2,397

Project Hope - \$3,288

Visiting Nurse Association - \$3,621

Community Health Awareness Group - \$7,502

AIDS Partnership Michigan - \$9,264

Continued from page 9

Focus on Prevention Programs, PEP

University of California at San Francisco researcher Robert Grant, MD, discussed using anti-HIV drugs as pre- and postexposure prophylaxis (PrEP and PEP) as part of prevention interventions. "It could be that an effective oral prevention [pill] could serve as a daily reminder that people are at risk for HIV," which might reinforce modification of their behavior to reduce that risk.

Dr. Grant noted that risk behavior decreased among people who thought they had been exposed to HIV and participated in PEP programs in both San Francisco and Rio de Janeiro. He said, changing patterns of risky sexual behavior can be similar to stopping smoking; some people can do it without assistance the first time,

while others may try and fail a number of times before succeeding.

14th CROI: CHAMP Academy: Research Advocacy for HIV Prevention — Skills & Challenges for AIDS Activists. (2.25.07)

Continued from page 5

MHAC's A4C

Workgroup as a new standing committee, the African American AIDS Advisory Committee (A4C). The Committee has quite an agenda planned for 2007. In addition to organizing the 3rd Annual Black Awareness Campaign (held Feb. 1 - March 18), the group intends to bring more awareness to both the community and the legislature around HIV and African Americans.

Co-Chairs Amna Osman and Ricardo Bowden also intend for the committee to review current plans to ensure there are no gaps in meeting the prevention and care needs of African Americans in Michigan. A4C would like to complement the other standing committees. Szwejd commented that NASTAD has developed strategic priorities through its African American Advisory Committee, and she hopes the MHAC committee can be a "conduit" to implement some of these strategies here.

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Health Disparities Reduction/Minority Health (HDRMH) Section

Check Up! or Check Out! (CUCO)

Check Up! or Check Out! (CUCO) targets a growing epidemic nationally, and in the State of Michigan: African American males are more likely than whites to have poor health and to die prematurely. The primary objective of the CUCO program focuses on empowering African American males to be more proactive in their healthcare in an effort to improve their quality of life.

CUCO targets African American men that are residents of Detroit, between the ages of 18-64 with health insurance. CUCO seeks to accomplish three main goals among African American males:

- Increase knowledge of health risks.

- Increase knowledge of what they can do to improve their health.

- Increase their willingness to go to the doctor for health visits and screenings, even though they may feel healthy.

CUCO has partnered with Molina Healthcare to embark on a campaign that seeks to achieve the program's goals. A major focal point of this plan is establishing and maintaining a personal relationship between CUCO participants and their primary care physician, thereby allowing them to actively participate in their health care.

A physicians' educational dinner/workshop to introduce Molina's primary care physicians to CUCO was held on

January 17, 2007 at the Rattlesnake Club. Dr. Herbert Smitherman Jr. was the featured speaker. Michigan's Surgeon General, Dr. Kimberlydawn Wisdom, and MDCH Medical Director Dr. Gregg Holzman were also in attendance.

The Project Coordinators are in the process of making site visits to each health center/primary care physician to provide information on the project and answer any questions, and obtain biographies and take photographs of each provider who did not attend the introductory workshop/dinner.

For further information contact the new CUCO Coordinator, Patrick Jackson 313-456-4417 jacksonp@michigan.gov,