The Syphilis Elimination Listening Tour

April - June 2005
Summary of Findings

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1 Background

During the first half of 2005, the Syphilis Elimination Effort (SEE) team from the Centers for Disease Control and Prevention (CDC) undertook a series of site visits to a number of state and local STD programs in order to observe local syphilis elimination activities. Termed the "Syphilis Elimination Listening Tour", the visits also provided an opportunity for the SEE team to obtain stakeholder feedback on the future directions of the SEE. The site visits were organized in consultation with the Program Development and Support Branch, Division of STD Prevention.

The Listening Tour visits were part of a wider strategy of external stakeholder consultation which includes: Key informant interviews with state and local STD program staff; interviews with STD program directors and local SEE coordinators; and a national consultation meeting to be hosted by the DSTDP in August 2005. This document outlines the objectives, methods and outcomes of the 2005 Syphilis Elimination Listening Tour.

1.1 Key objectives of the Syphilis Elimination Listening Tour

1. To obtain first hand experience of the social, behavioral and biomedical contexts influencing syphilis transmission in the US today

2. To initiate consultation with sites on the future directions for the SEE program

3. To initiate discussions on local issues and concerns which should be taken into consideration in the development of a new 2005-2010 SEE strategic plan

2 Methods

2.1 Criteria for selecting sites

A variety of sites were identified in order to provide both breadth and depth of experience, innovation, geographic coverage, epidemic types and prevention responses. Once selected, PDSB Program Consultants liaised with STD programs to agree and plan the logistics for the site visits. Once arranged, the SEE team then followed-up with sites to coordinate scheduling and make more detailed arrangements for the visit and discussion groups.

The original selected sites for Listening Tour included: Indianapolis; Chicago; Atlanta; Miami; Baton Rouge; North Carolina/ Robson County; Boston; New York; Seattle; Los Angeles; Maricopa Country; Navajo Nation (for a total of 12 sites). Visits were completed on half of this sites (Miami; Baton Rouge; North Carolina/ Robson County; Boston; New York; a Seattle). Others were not included in the original time frame (March – June 2005), largely due to difficulties in identifying a mutually convenient times to visit. The initial visit to Baton Rouge was used to pilot the interview process and the interview guide.

2.2 Format of interviews

At each site, between three to four, 60-minute key informant interviews were planned with local stakeholders. All interviews were chaired by Dr. Kevin Fenton, Visiting Scientist and Ms. Jo Valentine, the SEE Program Coordinator acted as the pre-designated recorder. As interviews aimed to obtain input from diverse STD program staff, the discussion groups were convened with between 7-9 individuals representing a diversity of backgrounds, for example: Disease Intervention Specialists (DIS), Front Line Supervisors (FLS), Clinic managers; Clerical and Medical staff; Community representatives. The interviews were not recorded. Instead, detailed notes were taken and subsequently written up in Word and stored in a secure, password protected database.

The detailed discussion group notes were prepared and summarized by Ms. Valentine. Key themes arising from the interviews were grouped and categorized utilizing a grounded theory approach. Where appropriate, verbatim quotes were used to illustrate important points. All interviews are confidential and this final report aggregates the feedback

from all site visits. Post-site visit, summary site visit reports were sent back to the STD program manager. These contained a broad summary of the issues discussed.

2.3 Outcomes of site visits

Sites Visited, dates (number of discussion groups)	• Robeson County, NC, April 4-5, 2005 (4) • Boston, MA, April 26-28, 2005 (4) • New York, NY, May 2-3, 2005 (3) • Miami-Dade, FL, May 17-18, 2005 (3) • Seattle, WA, June 6-7, 2005 (3)
Total number of Discussion Groups	17
Average Size of Groups	~8 persons
Participant Perspectives	• Program Management • Clinical Staff • Partner Services • Community-Based Organization Partners • External Health Care Providers
Discussion Group Domains	• Syphilis Elimination Gains, • Syphilis Elimination Lessons Learned, • Challenges and Barriers to Syphilis Elimination, • Recommendations for the new Syphilis Elimination Plan, • Core Values for the new Syphilis Elimination Plan, and • Recommendations for CDC's Role in the future Syphilis Elimination Effort

3 Site Background Information

In this section we provide some background information on the particular sites visited, based on the information obtained during the site visits. These are not meant to be comprehensive descriptions of the sites, but instead provide some insight into the important issues and contexts being faced within each location.

3.1 Robeson County, NC, April 4-5, 2005

"Syphilis used to be out of the roof in North Carolina." The high rate of infectious syphilis has largely been among African Americans and has been associated with the abuse of crack cocaine. State health department officials characterize the state of North Carolina as being more rural than urban, describing extensive geographical distances between many communities and health and social services. The challenges associated with providing STD prevention and control services are particularly significant for Robeson County, which is the largest North Carolina county in terms of physical size.

The state Syphilis Elimination project is a component of the STD-HIV Program, in the Field Development Unit, that also includes the non-traditional testing sites program, the Infertility Prevention Project, the Quality Assurance and Training & Development program, the Hepatitis C project, and the Jail Surveillance program. North Carolina STD program has a significant number of federal field staff, and has been a leading agency in the development of the model outbreak response plan template, as well as serving as the pilot site for CDC's Rapid Ethnographic

Community Assessment Process. The state STD program has also developed and now successfully conducts Rapid Intervention Outreach Team (RIOT) deployments as an integral component of syphilis prevention and control.

The RIOTs have been deployed multiple times in Robeson County in collaboration with the Robeson County Health Department. Recently Robeson County was ranked highest in infectious syphilis in the U.S. The outreach activities included syphilis and HIV testing, as well as health education and condom distribution, and are done in combination with other ongoing interventions such as jail screening and public information campaigns.

The Robeson County population of approximately 130,000 persons is a diverse population. The county is approximately one-third white, 40% Native American, and approximately 27% African American. Additionally county health officials estimate the Hispanic community in Robeson County to be as high as 10,000 persons. Many of these individuals, recruited to the area to supplement the workforce, are largely un-documented. The county is ranked among the top 5 poorest counties in North Carolina. More than 33% of county residents are on Medicaid, and it is estimated that 80% of live births are paid for by Medicaid funds. Extensive community outreach is critical for STD prevention and control and community health in general. This outreach requires an integrated approach and the local syphilis elimination taskforce has been organized to accomplish this objective. Also an essential component in their syphilis elimination effort is the participation of community- and faith-based organizations. In particular is the Healing Lodge, a faith-based ecumenical organization that provides STD outreach and houses the "My Fair Lady Project" a program aimed at recruiting, rehabilitating, and re-introducing commercial sex workers into mainstream.

3.2 Boston, MA, April 26-28, 2005

In Massachusetts the recent re-emergence of infectious syphilis has been in men who have sex with men, with the majority of cases being in white men between the ages of 25 and 39, who live in the Boston metropolitan area. The state STD program has formed a comprehensive state plan for syphilis elimination activities. The plan includes 3 principal goals: 1) to prevent syphilis through community-based education and professional skills and knowledge building; 2) to increase syphilis screening and testing through referrals and improved access to care; and 3) to reduce syphilis transmission associated with substance abuse. The plan targets efforts to: the MSM community, health care providers, CBOs and local health departments, and department of public health field staff. From 2003 to 2004, the number of infectious syphilis cases in the state declined by 20%.

3.3 New York City, NY, May 2-3, 2005

The goals of the New York City syphilis elimination project are to: 1) reduce the rate of new syphilis cases and HIV cases among men who have sex with men; 2) change the sexual risk taking behavioral norms by promoting health and wellness as a norm; and 3) address syphilis among MSM in the context of a comprehensive approach to men's health. The effort is organized around the five strategies described in the National Plan to Eliminate Syphilis from the United States. According to preliminary data for 2004, greater than 80% of early syphilis is in men, and 70% of these cases are being reported from private provider medical settings. To enhance surveillance activities the program has developed a consolidated syphilis database, incorporating: STD*MIS, an electronic medical record (EMR), and an original patient information sheet (OPIS). In addition program staff conducts research examining sexual risk taking among MSM who do not seek care for STDs to measure the incidence of new HIV infections among MSM with infectious syphilis.

In the area of community involvement and organizational partnership the program has expanded the "Healthy Men's Night Out" project city-wide, as well as maintained support for community agencies that serve populations at risk for syphilis. The program also continues to assess the delivery of syphilis prevention interventions in non-STD clinic settings e.g., drug treatment centers and jails. The Rapid Outbreak Response includes a specific response plan and a contingency plan, as well as a mobile outbreak response team. Clinical services have been expanded to commercial sex venues. Moreover the program provides syphilis screening in other non-traditional settings such as community-based organizations and social venues. The program has also undertaken an assessment of the quality of care for syphilis provided in private medical practices. Health Promotion activities for syphilis elimination include: a comprehensive health communications project, rapid field follow-up of early syphilis cases diagnosed and treated in non-traditional settings, online outreach including partner services, and commercial sex venue outreach.

3.4 Miami-Dade County, FL, May 17-18, 2005

According to current surveillance data, 8 of Florida's 67 counties account for approximately 92% of syphilis cases; and in Miami-Dade a substantial proportion (43%) of the cases are reportedly of Hispanic ethnicity, and 87% of the cases are in men. In Broward County approximately 85% of syphilis cases are found in men-who-have-sex-with-men (MSM). In both Broward and Dade there is a significant level of persons with syphilis who also have an HIV infection. It has also been noted that large number of infectious syphilis cases (50% in Dade County) are coming from the private medical providers.

3.5 Seattle, WA, June 6-7, 2005

Seattle-King County accounts for the vast majority of reported infectious syphilis cases in Washington State. Most of the cases occur among men who have sex with men (MSM). In 2004, 140 cases were diagnosed in MSM, 19 were in heterosexual men, and 8 were reported in heterosexual women. Projected data for 2005 (January through May) show a continued increase in early syphilis cases in MSM (154 cases) and a decline in heterosexuals (10 cases).

King County surveillance data suggest that most persons with syphilis are seeking care early during their infections. For MSM, 73% of cases are seen during the P&S stages, and for heterosexuals, 78% are seen during the P&S stage. Although commercial sex work is mainly associated with heterosexual risk for syphilis, substance abuse is a significant problem for both heterosexuals and MSM in King County. For MSM, it is mostly methamphetamine use and for heterosexuals it is primarily cocaine use.

Also for MSM, bathhouses and Internet sites are the places to meet sexual partners, leading to increased risk. In general the trends for sexually transmitted infections are increasing for MSM, as illustrated by cases of syphilis, gonorrhea, and Chlamydia. In addition the rate of co-infection with HIV is substantial in MSM with syphilis; however it is important to note the growing number of men who are HIV-negative who have also contracted infectious syphilis.

Public Health Seattle King County (PHSKC) has mounted a multi-component effort to eliminate syphilis. The components include: 1) providing clinical care, 2) screening in outreach settings that involves establishing new partnerships with community organizations, 3) providing partner notification, 4) providing education and raising public awareness, and 5) conducting research.

Table 1. Results of 2004 outreach testing in King County

Venue	Population	Tests	Positives
GayCity Wellness Center	MSM	395	4
Bathhouses	MSM	453	1
Madison Clinic (HIV Care Setting)	MSM HIV+ (~60% of patients screened for syphilis)	114	0
CHASE Street Outreach	Heterosexual	235	2
Jail	Heterosexual	506	4

Public education efforts are targeted to at-risk groups as well as to health care providers, such as those working in community-based organizations and community health centers, hospital emergency departments, and private practices. Research activities include a random-digit-dial study conducted with MSM examining risk behaviors and HIV status.

4 Major Gains in Syphilis Elimination

4.1 Summary of key findings

<table>
<tr><th colspan="2">Major Gains in Syphilis Elimination</th></tr>
<tr><td><u>Common Themes</u>
• Reduced cases
• Improved partnerships with communities and private providers
• Increased awareness of and knowledge about syphilis
• Expanded access to STD health care
• Improved quality of partner services</td><td><u>Robeson County, NC</u>
1. Achieved substantial reductions in P&S syphilis (79% reduction)
2. Expanded testing and treatment services
3. Instituted a jail screening program
4. Sustained involvement and mobilization of affected communities
5. Expanded public health partnerships</td></tr>
<tr><td><u>Boston, MA</u>
1. Mobilized public health partnership with Internet Service Providers (i.e. Manhunt.com)
2. Expanded testing, treatment, & community health education services with CBO partners
3. Increased communication & sharing of intervention products (templates) between state programs
4. Established a regional approach to STD control
5. Raised awareness and increased focus on syphilis as an infectious disease (e.g. hired syphilis elim coordinator)
6. Increased visibility of DIS as community resources
7. Improved training of DIS & other health department staff to intervene with affected populations (e.g., cultural competence and sensitivity)
8. Improved partnerships with CBOs
9. Promoted STD-HIV program integration</td><td><u>New York, NY</u>
1. Increased community involvement and private provider partnerships for STD prevention and control
2. Improved communication between the STD program and the HIV program
3. Reinvigorated internal and external public health partnerships
4. Improved STD program leadership in public health efforts
5. Increased cultural competence and sensitivity to GLBT communities
6. Witnessed early reductions in infectious syphilis and the elimination of congenital syphilis
7. Improved surveillance
8. Increased community awareness of and knowledge about syphilis
9. Developed a response to crystal-methamphetamine abuse</td></tr>
<tr><td><u>Miami, FL</u>
1. Increased community awareness of STDs
2. Mobilized community partners
3. Improved partnerships with providers
4. Increased resources for staff and added clinic hours
5. Increased syphilis testing
6. Enhanced surveillance
7. Reduced congenital cases
8. Improved the jail screening program
9. Introduced Internet use for STD prevention
10. Improved community perceptions of health department
11. Increased staff cultural competence</td><td><u>Seattle, WA</u>
1. Raised community and provider awareness of syphilis
2. Mobilized communities to respond to syphilis outbreak (e.g., the Community Manifesto)
3. Enhanced DIS training and improved the quality of PN services
4. Increased syphilis training for health care providers
5. Increased collaboration between STD and HIV programs
6. Improved cooperation between the STD program and private providers
7. Increased epidemiology analyses of syphilis cases and improved data systems for all STDs
8. Increased outreach to at-risk populations for syphilis</td></tr>
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4.2 Issues raised

4.2.1 Reduced Cases

Since the launch of the Syphilis Elimination Campaign in 1999, a number of project areas have seen substantial declines in infectious syphilis cases. In North Carolina for example the program staff reported that infectious syphilis cases have declined by 79%. In Robeson County, one of the sites of the listening tour, the number of cases has also declined significantly. State health department officials attribute NC's overall achievements in syphilis prevention and control to: jail screening, affected community and organizational partnerships, and the application of an integrated model of STD and HIV prevention. **"We followed the [national] plan pretty much to the letter as it was laid out nationally,"** one state official stated. However, reportedly just as critical was state and local health departments' sustained commitment and passion for syphilis elimination. And in New York City, among the syphilis elimination gains noted in the discussion groups are the reductions in infectious syphilis in women and congenital syphilis based on an improved surveillance system. **"Congenital syphilis almost disappeared completely,"** one NY DIS staff person said.

4.2.2 Public Health Partnerships with Communities, Other Relevant Agencies, and Private Providers

It was this ongoing enthusiasm for the effort in North Carolina and in other project areas that significantly contributed to the highly effective recruitment of non-traditional partners to the SEE campaign. In North Carolina, for example these important partners include: community based organizations, faith-based institutions, and corrections institutions. **"Pivotal for us was partnership with the jails,"** a NC state official said. Robeson County, NC officials also noted the value of partnerships in extending critical syphilis testing and treatment services, and one local official remarked, **"We provide staff for the most aggressive and consistent jail screening."** In addition to establishing their jail screening program, NC local officials also cited such gains as: raising awareness of syphilis among the at-risk and general populations and testing outreach in high risk venues. Robeson County officials are also enthusiastic about the extent of partnerships they have been able to foster with local community health providers and community organizations. In particular they highlighted the key role of the faith-based institution, the Healing Lodge, although it is also important to note that partnerships also include critical individual relationships with gatekeepers and opinion leaders who are themselves members of the at-risk populations.

"People in Robeson County didn't like having the #1 status. They mobilized because of the stigma," a Robeson County Health Department official said**.** Communication and collaboration were described as essential to the effective syphilis elimination response in Robeson County, as well as in North Carolina state-wide. Indeed there was a general consensus among state and local officials that syphilis inspired a committed response and sustained action throughout the communities and across multiple levels of government from disease intervention specialists to state legislators. Syphilis Elimination resources helped to improve public health infrastructure in North Carolina and in Robeson County. One community partner observed, **"The Healing Lodge grew out of the syphilis alert."**

Although the state of Massachusetts experienced an outbreak of infectious syphilis since the SEE campaign began, elimination efforts have led to vital gains in this project area as well; and according to officials at the Massachusetts State STD program one of the important gains is the increased communication and sharing of intervention products (templates) between state programs. **"The best thing that it has done is created products from other states for us to use,"** according to one MA state official. He went on to add, **"It prompted us to work regionally together**," describing support for regional cooperative agreements for STD prevention and control. There was broad consensus that the syphilis elimination effort had raised awareness and increased focus on syphilis as an infectious disease in the Boston area specifically and throughout Massachusetts. Moreover state officials noted the increased visibility of DIS as community resources, and described improved training of DIS & other health department staff to intervene more effectively with affected populations (e.g., cultural competence and sensitivity). In general, the syphilis elimination effort has improved partnerships with CBOs and promoted STD-HIV program integration.

The Massachusetts state STD program syphilis elimination funds also support a partnership with the Fenway Community Health Center, which is a long established primary health care provider and research institute with a large GLBT client population in the Boston area. The health center maintains a nationwide helpline and has an established "club-drug" initiative aimed at reducing risks often associated with STD and HIV transmission. The STD program collaborates with Fenway to provide street and community level STD health education outreach and syphilis screening in a number of non-traditional settings, as well as Internet outreach. The "Hot Male Project" is the center's Internet outreach project, and this intervention includes a significant syphilis prevention and control focus**. "If you are sexually active you should get a test for syphilis too,"** one community outreach worker said.

In New York City the increased community involvement and private provider partnerships for STD prevention and control were the most frequently cited gain as a result of syphilis elimination activities. **"CDC's requirement [to fund community-based organizations (CBOs)] has been a good thing,"** said one health department official. **"We redeveloped partnerships inside and out,"** another official added. **"Our high visibility in the community helps to demystify STDs in the community,"** said another. "**It takes personal commitment to eradicate syphilis,"** a CBO outreach worker declared during the discussion group with community-based organizations. **"All of our patients are coming in a lot more educated about STDs,"** another CBO partner reported. A variety of discussion group participants associated the increased affected community involvement in syphilis elimination with increased cultural competence and sensitivity to GLBT communities. **"We had to learn all over again how to work with MSM,"** according to one health department official. The STD program engaged in cultural sensitivity training and addressed homophobia.

In Miami-Dade increased community outreach resulted in increased community involvement in the development and delivery of prevention and control services, as one DIS staff person noted, **"Having key people at the table who are involved early in the decision-making."** According to a community-based partner, **"We have very good outcomes. Partnership with the health department has been a very good experience."** Locally strengthened community partnerships for syphilis elimination were credited with getting local politicians **"more involved and aware"** leading to **"increased advocacy for priority funds." "It [collaboration] helps ease what the health department is trying to put out there,"** another DIS concluded.

In general reinvigorated internal and external public health partnerships were seen as important gains. **"Folks are out there with other things other than STDs,"** another health department official said. According to one CBO partner the syphilis elimination effort has meant, **"A lot of opportunities to engage in dialogue about health."** One opportunity has to do with crystal-methamphetamine use in MSM. The health department has responded proactively in the context of syphilis elimination. **"The city has stepped up to the plate around the issue of crystal-meth,"** a CBO participant said.

The improved communication and collaboration between the STD and HIV programs was referenced extensively. As one health department participant put it, **"Syphilis Elimination has forced both programs to work more closely together."** During another discussion group a DIS staff person suggested, **"Piggy-back syphilis testing and HIV testing."** Improved STD Program leadership was also cited as an important gain associated with syphilis elimination throughout the city, particularly in the areas of partnerships and funding. A health department official said, **"We're more and more funders."** Another stated, **"It [Syphilis Elimination] changed our role and made us become leaders."** And still another observed, **"Syphilis Elimination is well connected to all aspects of the program."**

Finally Syphilis Elimination activities have also led to increased collaborations between the STD and HIV programs. **"Collaboration between HIV and STD is promoted,"** said one DIS. **"We wanted to marry HIV and STDs,"** a community coalition member commented. **"HIV prevention agencies are doing more STD,"** he added. More in-depth epidemiology analyses of syphilis cases and improved data systems for all STDs were also cited as again from syphilis elimination efforts.

4.2.3 Internet Interventions and Partnerships with the Private Sector

A number of discussion group participants noted that syphilis elimination activities have led to increased use of the Internet as a means of reaching at-risk persons. **"Putting the info out on the Internet has been an advantage,"** said one DIS. As part of their partnership development, the Massachusetts State STD Program is among the first public health programs to collaborate with Internet organizations serving MSM customers to provide STD education and health promotion information. A key partner in this effort is Manhunt.com. **"It's about the population and helping people,"** a Manhunt.com manager said. The Internet outreach is a critical intervention component for the program. The effectiveness of the public health partnership is enhanced by the STD program's collaborative approach and appreciation of the fact that Manhunt.com is first a business that must assure the privacy of its customers. **"You have the right to make choices,**" one Manhunt staff person said. **"Our commitment is to provide information, to make sure that information is available."**

4.2.4 Increased Awareness of and Knowledge about Syphilis

More community outreach raised community awareness about syphilis and promoted screening and treatment. **"We began to look at how we could get these persons to consent to testing,"** a community agency partner said. **"We developed an education program and helped people become more receptive to testing."** Syphilis Elimination public information campaigns have included a number of dissemination methods. **"Interventions of billboards, PSAs, palm cards, radio, TV. It's [the message] out there,"** as a health department staff person said. Another community partner, in describing the social marketing efforts for syphilis elimination said, **"When they [targeted communities] see it on TV or when they look at it as a big poster on the highway or talk to their friends, it's a great opportunity."** As an example, in Seattle-King County, the increase in community and provider awareness and the subsequent improved knowledge of syphilis, led to community mobilization for syphilis prevention and control and STD prevention and control in general. **"Media campaigns were supported by syphilis dollars,"** according to one senior health department official in Seattle. **"The Manifesto,"** another declared as a gain associated with syphilis elimination. **"At least there does appear to be priority given to syphilis more than it used to be,"** a health department clinician offered.

4.2.5 Expanded Access to STD Health Care

A primary gain frequently cited across the discussion groups was the increased local capacity to provide syphilis prevention and control services as a result of the syphilis elimination funding. **"We increased our clinic census dramatically,"** one clinician said. A health department health educator observed, **"People are seeing STD staff more than they ever have before."** A leading benefit of having more staff, according to a number of discussion group participants, is the program's increased capacity to conduct more community outreach and provider visitation. **"We're all making noise about it,"** one health department official said.

In Miami-Dade, as an example, increased outreach to partners was cited as particularly important for improving relations and partnering opportunities with health care providers serving MSM patient populations. **"We made visits out to these providers,"** a health department staff person reported. **"The approach was 'the new health department'."** A community partner, who manages an HIV early intervention care setting said, **"Our agency was awarded dollars for the MSM population."** He added that this additional funding resulted in more syphilis testing for at-risk persons. **"We were able to go to them,"** he reported. Another community partner observed, **"The owners of the businesses and bars have been open to us."**

Another participant remarked about hospital partners, **"We have a very intimate relationship with them."** These relationships were credited with enhancing surveillance activities with local hospitals. Syphilis elimination resources reportedly also meant more screening in the jails. **"We have three phlebotomists working 24 hours a day, five days a week,"** a field operations supervisor noted. **"Having DIS and screeners there, we are able to respond rapidly to any requests that we get."**

Discussion group participants credited improved organizational partnerships with key health care partners external to the health department with the substantial reductions in congenital syphilis. **"They [the DIS]**

jump on the high titers," according to one field operations supervisor. **"We did the leg work. Syphilis Elimination gives you the boost."** Other discussion group participants cited the increased the cultural competence of risk reduction methods, materials, and messages as a gain from syphilis elimination activities. **"It made the care providers sensitive to the clients we see,"** according to one community agency partner.

In general syphilis elimination has led to increased outreach to at-risk populations for syphilis and to more syphilis screening. **"There is syphilis testing at the Gay Wellness Center, an HIV testing site,"** one health department official said.

4.2.6 Improved Quality of Partner Services

There have also been syphilis elimination gains in terms of training of internal clinician and partner services staff, as well as improved training for external partners and health care providers. Many of the discussion group participants directly attributed improved partner services to the increased training supported by syphilis elimination resources. **"The numbers have risen in contacts,"** a DIS staff person reported. **"We're bringing more partners in."** And according to another DIS, **"There is heightened public awareness. At least among the MSM population and the HIV link."** Many of the discussion group participants cited the increased effort to identify key health care providers for MSM as a gain resulting from the syphilis elimination effort. **"There has been more cooperation between private docs and the health department,"** a DIS explained. Echoing this point, a senior health department management later said, **"Among MSM, provider partnerships were critical."**

5 Lessons Learned in Syphilis Elimination

5.1 Summary of key findings

<table>
<tr><th colspan="2">Lessons Learned in Syphilis Elimination</th></tr>
<tr><td><u>Common Themes</u>
• Integrate prevention programs
• Conduct epi analyses & implement data-driven programs
• Ensure substance abuse treatment
• Collaborate with communities and private health care providers
• Ensure the provision of quality STD services
• Conduct public information campaigns
• Provide training to internal staff and external partners</td><td><u>Robeson County, NC</u>
1. Successful syphilis elimination efforts require an integrative and comprehensive approach, including other STD prevention, HIV prevention and related social factors such as chronic unemployment and substance abuse.
2. Affected communities are diverse and require culturally competent and culturally sensitive interventions methods and messages.
3. Disease Intervention Specialists remain vital to the effort.
4. Partnerships with affected community organizations and health and social service providers are essential.
5. Monitoring epidemiological disease trends as well as systematic community-level observations is essential for effective program planning and management.</td></tr>
<tr><td><u>Boston, MA</u>
1. Collaboration as opposed to regulation is more successful for syphilis elimination.
2. Partnerships with affected community organizations and health and social service providers are essential.
3. It is important to integrate syphilis elimination with HIV prevention as well as other health and social services.
4. Internet-based interventions are important, and must attend to client privacy and state policies regarding access.
5. Regionally-based and organized programs facilitate STD prevention success.
6. The quality of Internet-based interventions is contingent upon skills of the outreach staff, the standardized content of approaches, and regular monitoring of activities.
7. Mobile van-based activities can increase access to syphilis testing.
8. Sharing protocols and intervention tools among state, local, and community partners is essential.
9. Behavior change strategies should also target providers.
10. Health Department STD clinics are not always the predominant source of STD care.
11. A client-centered approach may be more effective when working with emerging populations at risk for syphilis.
12. Sexuality has become a political issue and created a barrier to syphilis elimination.</td><td><u>New York, NY</u>
1. Specific requirement for CBO funding promotes partnership.
2. Syphilis Elimination facilitated increased STD program leadership.
3. High rates of syphilis raised community awareness.
4. Increased STD program visibility “demystified” STDs.
5. Political will for public health facilitates syphilis elimination efforts.
6. The syphilis elimination program assessment was a useful tool for garnering more local resources.
7. A successful STD program adapts to change and adopts new technologies.
8. The integration of STD and HIV services enhances the syphilis elimination effort.
9. It is important to ensure monitoring of epi trends in other groups, while targeting interventions to epi-defined at-risk populations.</td></tr>
<tr><td><u>Miami, FL</u>
1. Ensure program staff training and development.
2. Improve internal communications among DIS and clinical staff.
3. Pre-emptive and early interventions are critical.
4. Integrate syphilis elimination with other prevention program activities (e.g., HIV).
5. Tailor interventions to each community.
6. Develop partnerships with affected communities and key providers.
7. Provide empathetic and culturally competent primary and secondary interventions.
8. Conduct public information campaigns.
9. At-risk populations are increasingly mobile.
10. It is Important to expand clinic hours.
11. The sexual “marketplace” and sexual networks are expanding (e.g., circuit parties).
12. Increase staff accountability through performance reviews and performance plans.
13. Increase the public health accountability of private providers.
14. Use surveillance data to guide program efforts.
15. Strategic planning is valuable.</td><td><u>Seattle, WA</u>
1. Ensure private/external health care providers have adequate syphilis training and information.
2. Health care providers may not translate syphilis awareness into their medical practices with at-risk populations.
3. Health care providers need to take sexual histories on their patients.
4. Develop inter-agency referral resources for drug treatment and other mental health needs.
5. Partner identification is key.
6. Ensure DIS are able to maintain their syphilis interviewing & team-approach skills.
7. Establish participatory partnerships with affected communities and their relevant health care providers.
8. Partner with HIV Prevention and Care programs.
9. Establish a strong data management system and conduct regular local data analyses.
10. Educate clients/patients to be more adept at talking with their medical providers.
11. Establish one lab to do confirmatory syphilis testing.
12. Use a holistic approach to health to improve resonance with affected populations.</td></tr>
</table>

5.2 Issues raised

5.2.1 Program Integration

"The integration model is one key to our success in North Carolina," a state official said. The high value of an integrative and more comprehensive approach to syphilis elimination in particular and STD and HIV prevention in general was frequently described. Making the case for a more integrative approach one state official noted, **"Syphilis fueled HIV into a new population."** The consensus across the discussions groups was that North Carolina's multi-disciplinary, multi-level syphilis elimination coordination has been essential to their success thus far. This coordination is reported to include: regular reviews of the syphilis epidemiology combined with information garnered through what one official called **"human intelligence."** **"The public health system is only as good as the way you think about it,"** a state official said.

Many discussion group participants noted the need to focus more on the sexual risk behaviors and not just on the specific STD and better integrate prevention efforts. **"Explain the risks,"** one Boston area community agency staff person said, adding, **"And provide the solutions."** It is important to integrate syphilis elimination with HIV prevention as well as other health and social services. As part of a more comprehensive approach, another community participant suggested, **"Link HIV testing to syphilis testing."** A member of the MSM Sexual Taskforce said, **"Syphilis Elimination is a way to bring people in who are engaging in risk behaviors and offer them something that works."**

In Miami-Dade, participants equally emphasized the value of an integrative program, particularly as it relates to integrating syphilis elimination with HIV prevention. **"We have an integrated system in all of our clinics,"** said a local manger. **"Syphilis and HIV go hand in hand together,"** a DIS participant asserted. And according to a community participant, **"The whole syphilis elimination has to be integrated. Pregnant women have to be tested. Integrate into one program."**

And in Seattle, partnering with external as well as internal programs such as the HIV Program was also often cited as an essential lesson learned. **"Ensure that you have medical partnerships,"** a health department manager said. **"Partner with the HIV Program,"** suggested another. **"Use their community relations."** The value of establishing participatory partnerships with affected communities was frequently recognized by discussion group participants; this in addition to: establishing a strong data management system and conducting regular local data analyses and establishing one lab to do confirmatory syphilis testing.

5.2.2 Epi Analyses and Data-Drive Programs

DIS case analysis, social network analysis, and epidemiological analysis are deemed to be essential in North Carolina. **"It's critical to maintain vigilance over the cases,"** one state official said. **"You have to follow the numbers [epi data]."** The value of having good epi data and making that data available to partners was also an important lesson learned in the New York syphilis elimination effort. **"Good data gets a lot of good things,"** one health department official noted. Another official observed that the MSM outbreak had helped the program be more focused and targeted in their efforts. And according to another, **"All our outreach services are data-driven."** Several discussion group participants credited syphilis surveillance data with promoting community awareness of syphilis. **"The high rates have raised awareness,"** as one DIS staff person said. In general discussion group participants also identified the ongoing monitoring of epi trends in current targeted groups, as well as potential reemerging groups, as important. **"A large majority-60%-of syphilis cases are coming from the private sector,"** a health department official said, **"But we're maintaining our jail surveillance efforts."** And a CBO partner cautioned, **"Black women are being over-looked,"** citing the ongoing prevalence of risk for syphilis in this particular group.

Frequently described as an essential lesson learned from the syphilis elimination initiative was the need to ensure that syphilis prevention and control interventions are tailored to the targeted communities. In the words of one DIS staff person, **"Learn how to cater (e.g., clinic hours on Saturdays, language, mobility**

patterns) to the community that you are working with. Develop a relationship with the patient community." One clinician observed, **"The message has to change depending on the demographics." "Different areas need different brochures,"** said another. In general having good surveillance data available to inform strategic planning for program efforts was seen as valuable to design more effective programs. **"Know your surveillance,"** counseled one health department official.

5.2.3 Substance Abuse Treatment and other Services

The populations affected by syphilis are ethnically diverse and require different intervention approaches, including addressing other social factors such as unemployment and substance abuse prevention and treatment in addition to sexual risk reduction. "**The power of addiction is the root of our struggles,"** one participant said. A number of participants noted that drug use, primarily crack cocaine and alcohol, is worsening in Robeson County. **"It's hard to find a family that isn't affected by STDs or substance abuse,"** one participant said. **"It's really all our problem."** In areas with outbreaks of syphilis among MSM, crystal-methamphetamine use is a significant problem for syphilis elimination. **"Multiple types of people can be at risk for syphilis,"** one DIS said. **"It's an equal opportunity infection."** Clients may have a variety of other social problems including substance abuse and mental illness and family relationship problems. **"There is a need for mental health resources,"** observed a clinician. In general using a more holistic approach to health was suggested as a means of improving syphilis elimination resonance with affected populations.

5.2.4 Collaboration with Communities and Private Healthcare Providers

"You can't do it by yourself," a DIS participant declared, emphasizing an overarching theme throughout all of the site visit discussions. The role of collaborative partnership in syphilis elimination, across a variety of agencies, institutions, and communities was deemed vital. Another DIS also said, **"Partnerships are definitely the key."** Whether it was to contact named partners, provide school-based health education, or conduct outreach screening, the comment of one Robeson County Health Department official summed it up this way, **"Getting out in the community, building rapport, it's something you have to have."** The rapport building and partnership development include working with diverse groups from health care providers to religious clergy. As an example, despite a very conservative religious climate in Robeson County, one minister participating in a discussion group said, **"There's value in the church being empowered to know how to address it [syphilis, HIV, other STDs]."** He described it as not necessarily promoting condoms but promoting education instead.

In other areas too, the value of collaboration was seen as a key lesson learned. In addition to the integration of STD and HIV services that enhances syphilis elimination efforts, discussion group participants universally cited partnering with private providers and community-based organizations with established connections to groups to achieve syphilis elimination. "**Work with the community and reach out to private providers,"** one NYC health department official stressed. A community partner said, **"Our agency has been lucky enough to work with the Department of Health because of funding from DOH."** In addition to general health promotion activities and increased screening services, some discussion group participants recommended a role for private providers in providing Partner Services**. "Identify high yield providers,"** one DIS staff persons said, **"And assign a DIS to this office."** The quality of collaborative partnerships was frequently linked to the STD program's leadership. As one example, a health department official noted the organization and coordination of the New York's Syphilis Advisory Group (SAG). **"We're more of a family,"** one CBO partner said about the SAG. **"The SAG helped."** Another CBO participant also complimented the SAG, describing it as a "**regular opportunity to have all the stakeholders at the table."**

In Miami as well, participants noted the essential role of more collaborative partnerships with affected communities to enhance cultural competence in the design and delivery of syphilis services. **"Our partners are CBOs on the streets,"** one DIS staff person said. Another recommended, **"Know all your key players. Know your clientele and know their perceptions of you."** A community agency staff person cautioned, **"It is key that you be client- and culturally-centered. They're not idiots. You can't insult them. We have to open our minds, and be that open to every group. If you do that you will get a better response from the community. You have to be genuine."** These mutually collaborative partnerships were seen as especially important to address cultural differences that are related to sexual

orientation. **"We need homosexual DIS,"** one DIS staff person said. **"How comfortable can this person be to talk to me?"** she queried. **"Just like we have Haitians and Hispanics,"** she added. A number of discussion group participants raised lessons learned associated with the challenges of the **"changing sexual marketplace"** and expanding sexual networks that are accessed through the Internet or through such events as circuit parties. **"It's a new way; it's a new lifestyle that we are not fully educated on. How can we reach our clients? They have changed over the years,"** one member of the clinician discussion group remarked. Another lesson deemed valuable by the discussion group participants addressed the role of public information campaigns particularly those aimed at preventing or reducing sexual risk taking behaviors. **"Go out and educate and canvas the area before the crisis comes,"** one DIS advised.

5.2.5 Internet Interventions

A principal lesson learned from the syphilis elimination collaboration between Manhunt.com and the MA State STD program is the need to address the challenges that can emerge as a result of the competition between public health goals and corporate profitability requirements. **"Providing support to the members is our goal**," a Manhunt manager said. Assisting with outreach to MSM via Internet-based venues was described as a critical component of that business goal. **"It modernized the way we reach people,"** one DIS staff person said. However the effectiveness of the effort is likely to be highly contingent upon the interactive skills of the outreach or DIS staff, the discussion group members agreed. DIS work may have to be tempered or tailored to be effectively performed over the Internet, it was noted. Maintaining customer privacy is paramount Manhunt staff stressed during the discussion group. **"Be more proactive assuring privacy,"** one staff person said. There was also consensus during the discussion group around the need to have a standardized approach to working with Internet service providers and conducting outreach and partner services via this method. In the words of one Manhunt employee, **"The foundation is the most important part."** Another one added, **"What can we do today to be effective and having someone available to answer these questions (STD education) is important**."

5.2.6 Ensuring the Quality of STD Prevention and Control Services

Improving internal communications between and among DIS and clinical staff was identified as an important lesson learned; **"Better communication with our clinical staff and improving turn-around times,"** as one DIS staff person noted. **"Promote more internal communication within the program,"** said a clinician participant. Improving communications with external health care providers was also listed as an important lesson. **"Partnerships with these doctors [private providers] is part of your job responsibility,"** another DIS said. Another participant reiterated this point, adding a comment about reporting, **"We have to get the providers to actually do their jobs. The health department has to exert their authority [to enforce reporting laws]."**

STD program leadership in working with local government officials and policy makers was also found to be an important lesson learned. In New York, using the syphilis elimination program assessment findings, health department officials reported being able to garner more local resources, e.g., improved clinic services space. **"Do your homework with your policy makers,"** a NYC health department official said. **"And be prepared to take --- from somebody."**

In Seattle, one clinician offered as an important lesson learned, **"Train the clinicians in the private sector to look for signs and symptoms."** However another suggested, **"They should be screening whether or not there are signs and symptoms anyway. Practitioners need to push questions about sexual orientation and conduct sexual histories. Signs and symptoms are way down on the list,"** he said. **"The first on the list is taking a sexual history."** Although health care providers may not translate syphilis awareness into their medical practices with at-risk populations, a majority of discussion group participants stressed the need to ensure that private health care providers have adequate training about syphilis and taking sexual histories. One clinician suggested that patients also be educated to make them more adept in talking with their medical providers to improve the quality of STD care in general and syphilis care specifically.

Still another training lesson learned is the need to ensure that DIS are able to maintain their syphilis interviewing & team-approach skills even as the number of reported cases decreased. **"Keep syphilis skills heightened and more sharp with more training,"** a DIS staff person said. **"Conduct syphilis**

meetings," he suggested. **"Partner identification is key,"** a senior health department manager said. **"Talk to one another, use a team approach,"** recommended another DIS. **"Somebody has to go out and find these folks,"** a state health department official said in North Carolina.

In addition to the case analysis they provide, state and local officials described the role of DIS in partner services as another critical lesson learned from the efforts to eliminate syphilis. In Robeson County, the largest county geographically in North Carolina, DIS team members that do field phlebotomies for syphilis tests have been essential. Field epi treatment was also cited as helpful activity. It is vital for health department staff to be able to go **"where the cases are"**. **"You can't be afraid of the venues,"** one DIS said. **"But use common sense."** Another said, **"Find a gatekeeper in the community to get yourself credibility."** Other lessons learned associated with DIS-delivered partner services, were also cited. One DIS said, **"It [partner services] has changed. People are more reluctant to give partners."** Another added, **"You have to listen more attentively and explore any opportunity for information."** Another offered, **"Respect is the key."** And another DIS said, **"You have to humble yourself and build trust."**

In general a principle lesson learned most often cited by discussion group participants across disciplines had to with ensuring adequate STD program staff training and development; in the words of one health department official in Miami, **"Education, education, education."** In particular a number of participants stressed the importance of supporting DIS continuing education and skills development as well as DIS performance accountability. **"That's what will make the difference," a** Florida operations manager said. **"If you don't have the troops on the ground the job will not get done. Let's fund people. Let's train our people and let's pay them well."** Another local manager echoed this theme, **"The most valuable asset to our program is our staff."**

Valuing, developing, and utilizing the general knowledge and skills of the health department STD program staff was a universal theme learned from the syphilis elimination effort. **"Recognize the expertise within your organization to work with new populations,"** one health department official said. According to another health department official, the successful STD program, **"Accepts change and keeps the program moving forward."**

6 Challenges/Barriers to Syphilis Elimination

6.1 Summary of key findings

<table>
<tr><th colspan="2">Challenges/Barriers to Syphilis Elimination</th></tr>
<tr><td><u>Common Themes</u>
• Client characteristics & multiple epidemics
• Inadequate access to health care
• Inadequate DIS training and performance accountability
• Health department image and STD stigma
• Syphilis Elimination in the context of HIV/AIDS
• Funding, Contracts, and Grant Guidance</td><td><u>Robeson County, NC</u>
1. Drug addiction and alcohol abuse;
2. Transportation for clients to and from STD health care in rural communities;
3. Limited clinical physical space and available personnel;
4. Under-funded public health and social service programs;
5. Prioritizing intervention efforts in a context of multiple affected populations and needs; and
6. A socially conservative community context.</td></tr>
<tr><td><u>Boston, MA</u>
1. Internet intervention training
2. Maintaining Internet client/customer privacy
3. Inadequate DIS skill to intervene with MSM
4. “HIV-centric” risk reduction and prevention
5. “Disease fatigue”
6. populations
7. Fee for syphilis testing
8. De-funded health clinics
9. Provider behavior
10. Sexuality as a political issue and distrust of government
11. Anonymous sex partners
12. Lack of DIS-access to computers</td><td><u>New York, NY</u>
1. Lack of well-trained PN staff;
2. Increasing private sector role in diagnosing & treating syphilis;
3. HIPPA;
4. Inadequate funding for community partners;
5. Inconsistent syphilis case definitions;
6. Patient distrust of health department;
7. Unrealistic client expectations of the health department;
8. Private providers discouraging PN services through the health department;
9. Increased access to multiple partners via the Internet;
10. Increase patient knowledge about STDs;
11. Less aggressive PN approach with MSM clients;
12. Cultural competence/sensitivity;
13. Syphilis elimination in the context of HIV;
14. Local area contract rules and regulations;
15. Hardest-to-reach at-risk populations;
16. Lack of flexibility in funding guidance; and
17. Project officer bias and lack of public health training.</td></tr>
<tr><td><u>Miami, FL</u>
1. Inadequate DIS training and preparation for changing populations at risk for syphilis;
2. Retention of good DIS staff ;
3. Reduced effectiveness of partner services;
4. DIS pay disparities;
5. Accessible clinical services (e.g., hours and waiting times);
6. Lack of sensitive surveillance systems;
7. Coordination with community partners;
8. Increased risk taking in the affected groups in the absence of perceived risk for syphilis;
9. English-speaking-only staff;
10. Lack of DIS supervision;
11. Endemic “reservoirs” of infectious syphilis
12. changing demographics of MSM;
13. Providers unwilling to report syphilis cases to the health department or promote partner services;
14. Crystal-methamphetamine use;
15. Slow implementation of primary and secondary interventions;
16. Mobile at-risk populations;
17. Exclusive focus on MSM populations;
18. HIV co-infection;
19. Funding;
20. Transportation; and
21. Stigma of STDs.</td><td><u>Seattle, WA</u>
1. High risk sexual practices by persons at risk for syphilis and other STDs;
2. Substance abuse by at-risk persons (e.g., crystal meth use);
3. Mental health problems of persons at risk for syphilis;
4. Lack of drug treatment and mental health services for indigent persons;
5. Lack of supportive social networks for at-risk persons;
6. Geographic mobility of at-risk MSM populations;
7. The facilitative role of the Internet in sexual risk taking;
8. The absence of individual concern for the public’s health;
9. Lack of sexual history taking by private providers;
10. STD stigma;
11. Syphilis elimination in the larger context of HIV;
12. Communication challenges between the STD program and County jail health care;
13. Sustaining community and provider interest in syphilis elimination;
14. STD Program personnel changes; and
15. DHAP’s PEMS.</td></tr>
</table>

6.2 Issues raised

6.2.1 Client Characteristics and Multiple Epidemics

In North Carolina and in Robeson County particularly, drug addiction and alcohol abuse was frequently cited as a barrier to achieving syphilis elimination. Participants described crack cocaine use as rampant in rural areas of the state. **"Where there's addiction there's no rationality,"** a community-based organization partner said. The drug problem is exacerbated by the lack of drug treatment services particularly in rural areas where most social services are under-funded and under- staffed. **"We don't have enough workforce to deal with the magnitude,"** another discussion group participant shared.

In Boston, state officials described the changing at-risk populations for syphilis as a significant challenge to achieving syphilis elimination. It was noted that it is common for MSM to refuse to participate in Partner Services due to the prevalence of distrust of the government combined with the frequency of anonymous sex partners in this group. One DIS staff person said, **"Give people credit for the savvy they have now. The current population has changed. They're more educated."** Another state official commented, **"DIS skills can't keep up with the changes. Should we redefine a priority case based on DIS skill?"** he asked. And another DIS staff person suggested reconsidering patient geography and health care access, recognizing that traditional Partner Services may not always be applicable. **"We need to refocus what we do with DIS,"** she said.

In New York too a frequently cited challenge to syphilis elimination involves the changing nature (e.g., demographics, SES, accessible health care) of the syphilis patient. In addition to increased access to multiple sexual partners via the Internet, **"Syphilis is moving to the private sector,"** a health department official said, adding that in the private sector there are increasing implications for HIPPA regulations. **"People are changing,"** said a DIS discussion group participant. **"People are more educated about STDs."** Another clinic staff person observed, **"They don't see us as a medical provider."** A health department official explained, **"They have more health insurance. It gives people choices. The new clients and their providers have not wanted anything to do with the STD clinic."** DIS staff persons have become less aggressive at eliciting partner contacts, in response to the changing nature of the syphilis patient some discussion group participants pointed out. One DIS observed, **"Those MSM are just as educated as we are."** There was consensus across the discussion groups that there is a need to **"reinvent or redefine"** priorities for Partner Services interviewing.

Miami participants also associated challenges to achieving syphilis elimination with the changing demographics of the populations at higher risk for syphilis. As one DIS staff person observed, **"The population we deal with is changing. We need to retrain ourselves to have an impact on these persons."** Referring to the increased crystal-methamphetamine abuse, a clinical staff person noted, **"It's a new pattern of drug use."** And according to a participant from a community based agency, there are challenges to syphilis elimination associated with immigration status. **"Recent immigrants are less receptive to interventions,"** she said. Collectively these challenges also contribute to sustaining **"reservoirs of risk taking behaviors,"** one DIS staff person concluded.

Many participants saw growing MSM epidemic as particularly challenging. One important aspect of this challenge is that the syphilis prevention and control interventions aimed at MSM began later in the elimination effort. **"The prevention message was late in getting the clientele we're dealing with now,"** a health department official explained. **"It's a different mindset now. It's too politicized for us to do anything about it."** The fact that some MSM access anonymous sex partners via the Internet was described as especially challenging for partner services. **"People meet their sex partners on the Internet,"** said one DIS staff person, which results in unknown sex partners who cannot be contacted. **"How do we approach patients?"** asked another DIS regarding the Internet-using client. **"How do we change someone's behavior? Their pattern? The person has to want to."** Another discussion group participant suggested, **"We need to develop strategies to work effectively with circuit parties."** Other participants reported that some MSM, particularly those who know they are HIV+ demonstrate a casual attitude towards having syphilis. **"'If it's syphilis we just get medication,'"** said one clinic staff person to illustrate his point. A number of participants also discussed the attitudes of health care providers who serve

MSM populations as a challenge to syphilis prevention and control. **"I heard of some providers who feel it's un-loyal if they report their patients,"** one DIS said. **"Patients feel it's their right not to be reported,"** added another. **"We need to explore some more of these unknowns, the ones who are not reporting,"** said a DIS supervisor. **"How do we get to the unknowns?"** he wanted to know.

Although a great deal of the discussions focused specifically on MSM, some participants also expressed concern that this change in program focus might be problematic. **"We have to make sure we move to other at risk groups, such as prostitutes,"** cautioned one health department official. **"We have to work in this area like it was MSM, and watch for high incidence of other high risk behaviors, like drugs and prostitution."** And another community agency partner said later, **"The form we have to use is just focused on MSM. It's too much focus on MSM for the community health centers clients."**

And in Seattle, again, in large part, the identified challenges and barriers to achieving syphilis elimination were associated with characteristics and behaviors of the at-risk populations in Seattle. **"Client promiscuity,"** one clinician cited as a challenge to syphilis elimination. **"They think it's their right to have sex with anyone they want to,"** a DIS staff person complained. A clinician declared, **"We have a revolving door. The behaviors never change."** In addition to the Internet facilitating the meeting of anonymous partners, substance abuse and mental health problems were also described as contributing to risky sexual practices, thereby challenging the success of syphilis elimination. **"Access to [drug] treatment is excessively limited,"** a clinician reported. **"They really do need some public assistance to get treatment."** Still another clinician discussed the prevalence of depression in the at-risk populations. **"We don't have anywhere to refer them,"** he said. **"Many of them have no family support."** A senior health department manager introduced the ability of some at-risk MSM to travel substantial distances for sexual encounters as a challenge. **"People are getting on the plane and going to LA and San Francisco,"** he said. Several discussion group members described the attitudes of some MSM towards partner notification as a barrier to syphilis elimination. **"MSM don't name partners,"** a DIS said. **"They feel it's their right that they don't have to do anything."** A health department official admitted, **"I would have to say that PN has only been modestly effective."** Several group members also noted the challenge posed by the fact that many clients, particularly those who are also HIV+, place little significance on a syphilis infection. One clinician explained, **"They [HIV+ persons] are already really challenging. If you get too confrontational they get offended and we never see them again. It's a balancing act."** And another summed it up this way, **"The effect of being HIV+ means syphilis is no big deal."** According to a DIS staff person, **"The MSM community is not interested in the public health aspect [of syphilis]."** She went on to illustrate her point, **"'I've already been harassed enough by the hostile straight society.'"**

6.2.2 Inadequate Access to Health Care

In North Carolina, and particularly in Robeson County, with its large geographical distances, transportation for economically disadvantaged persons is a significant barrier to accessing health care**.** To provide STD services, DIS regularly have to drive clients their clinics across large distances, ultimately limiting the number of persons they are able to bring in for care in a day. According to one discussion participant, **"DIS are also taxi drivers,"** because in addition to shuttling persons to and from the health department, to facilitate client-acceptance of partner services, often the DIS are compelled to make other stops for clients along the way. In addition to providing client transportation, Robeson County DIS also identified several other challenges they experience in their syphilis prevention and control efforts. These challenges include: more reticent and resistant clients in terms of naming partners; adapting to intervening with men-who-have-sex-with-men; intervening with commercial sex workers who are **"getting younger and younger particularly among the Native Americans,"** and intervening with clients who are struggling with other family issues.

Several DIS participants felt that establishing rapport often means addressing other social issues first. A number of participants noted the difficulty in prioritizing needs of different populations in different settings with limited resources to apply to these identified needs. Another noted challenge to syphilis elimination and STD prevention and control in general, is the lack of adequate clinical facility space as well as the lack of sufficient STD treatment and services staff. **"Our actual physical space is the first thing that comes to mind,"** one Robeson County Health Department official said, adding that even if they were to get more staff there would be no physical room to expand clinical services. Other Robeson County Health Department staff, however, maintained their case for increasing local STD staff, describing the lack of staff

as a chronic barrier to care due to the travel distances required to contact partners and the limited number of available clinic hours for persons to receive care.

In the more urban sites, access to health care was also cited as a challenge to syphilis elimination. In Boston, for example, one DIS participant said, **"Find a spot where you can screen patients."** Discussion group participants noted that in the Boston area health department STD clinics are not always the predominant source of STD care. "**A shift in the government is sending negative messages to gay men,"** an MSM Sexual Taskforce member said. **"You have to think about the source."** Another member added, **"Sexuality has become a political issue and created a barrier to [syphilis] elimination."** Limited public funds have resulted in clinic closings. **"If we had funds we could do it [STD testing] every day all day here,"** one AIDS service organization manager said. **"I would love to see us do more testing for syphilis. There are so many related issues."** And where clinics are available syphilis testing is often not free, so as one participant observed, **"STD testing means insurance issues."** In addition to the challenge presented by the lack of care for syphilis the quality of care for MSM was also noted. **"Develop GLBT-friendly provider relationships,"** one participant suggested.

6.2.3 Inadequate DIS Training and Performance Accountability

Boston area participants also discussed inadequate DIS skills as an important barrier to implementing effective syphilis prevention and control services, particularly when it comes to working with Internet-based organizations. In addition to the fact that DIS staff often lack access to computers, three challenges to successful Internet interventions were described: a prominent lack of DIS skill to intervene effectively with MSM populations, a need for a standardized Internet intervention training program, and the need to maintain a strong commitment to Internet client/customer privacy.

In New York, the inadequacy of training for Partner Notification staff, particularly as it relates to cultural competence/sensitivity to MSM groups, was frequently cited as a challenge to syphilis elimination. **"Partner notification is the best way to find new cases,"** one health department official said. However, in the words of another official, **"If anything is misunderstood in the community it's PN [partner notification]."** Several discussion group participants identified unrealistic client expectations of the health department and patient distrust of the health department as challenges. **"It's a government agency,"** one clinic staff participant observed. **"A lot of them [patients] are afraid to give contacts because they are HIV+ and they are breaking the law by having unprotected sex,"** added another clinic staff person. Several discussion group participants said that some private providers are advising patients not to use the health department's PN services. As one DIS staff person put it, **"Private providers are telling patients not to talk to the health department."**

In Miami too, according to a majority of participants, a general challenge to syphilis elimination centers around issues associated with DIS staffing and the provision of partner services. Chief among these is the inadequate DIS training and preparation for changing populations at risk for syphilis. **"The training modules are out of date,"** said one DIS staff person. **"Here we are trilingual,"** said another. **"But it's more than that."** In addition to training and skills development needs, several health department participants described substantial challenges to retaining good DIS staff. **"Retention, retention, retention,"** stressed one DIS supervisor. **"We've got to keep our DIS. The thing is keeping them here and motivated. It's a war going on right now. You got to give them training when they ask for training. We've got to compensate them and stroke them."** Another manager added, **"Sometimes within the system it's broken. "Does the management know how to handle this?"** Several discussion group participants talked about DIS performance accountability as a barrier to achieving syphilis elimination. **"We stopped looking at the individual numbers,"** said one DIS. **"Because it's not a numbers thing. But that doesn't fit into the DIS evaluation because it doesn't count the education."**

6.2.4 The Health Department Image and Stigma of STDs

Closely associated with the provision of traditional Partner Services, is the image of health departments as perceived by communities and groups affected by infectious syphilis. In explaining the STD stigma issue, one Miami community agency participant said, **"There is stigma with doing outreach in the Black community. They're not wanting to have anything to do with STDs, particularly in the Black community."** And as already noted, in another example, some Boston participants reported that it is common for MSM to decline health department delivered partner services due to distrust of the government.

Another significant challenge to syphilis elimination in North Carolina generally and Robeson County specifically is the more conservative social context, particularly in the rural communities. A number of NC discussion group participants described the effect of abstinence-only health education models on STD and HIV prevention. **"Some teachers and principals don't want to hear it [syphilis, STDs, HIV],**" reported one community-based organization participant. "**You still have some parents who don't want you to talk about it around their kids,"** another said. One way the Robeson County Health Department has been able to address this challenge has been through the involvement of the faith-based community in their efforts. **"Syphilis Elimination is a very non-traditional ministry for many denominations,"** said a community clergyman. However, summarizing the common goals the Healing Lodge and the Robeson County Health Department share, he added, **"We would like to see our people healed.**" The Church was often cited as a crucial link to the North Carolina and Robeson communities. **"When you come to the rural south you can't ignore the church,"** a community participant said.

6.2.5 Syphilis Elimination in the Context of HIV/AIDS

The challenge of doing syphilis elimination work in the context of the HIV epidemic was noted by a number of participants. In a discussion with an STD program official, the official said, **"I find it challenging to work with HIV bureaus. It's a double-edge sword I'd have to say. HIV is process-oriented and STD is task oriented."** In Seattle, one senior health department official described CDC's Division of HIV/AIDS Prevention PEMS project as a substantial challenge to achieving syphilis elimination. **"Make sure you write that down,"** she said regarding her description of the impact of implementing PEMs on syphilis elimination.

In Boston, a community member said, **"Peoples' attitudes toward safe sex are HIV-centric."** Another added, **"Folks are not thinking of other STDs."** Reiterating this particular point, another participant said, **"The worried well for HIV are not the same as the worried well for syphilis."** There are also challenges within the way STD and HIV organizations talk about the epidemics. **"For HIV,"** according to one Boston community member, **"You say 'get tested' for syphilis you say 'get screened'."** A New York City health department official observed, **"Just trying to use the same language, the terminology, is a barrier."** And another official remarked, **"We need to clarify the risk reduction messages especially when it comes to oral sex. Public opinion is going to look for a hierarchy that permits oral sex. "** According to several discussion group participants the persistent controversy regarding what is safe and what is not safe needs to be clarified and resolved. According to one community participant, **"The condom has taken on this mythical demeanor."** And another admitted, **"I worry about disease fatigue."**

6.2.6 Funding, Contracts, and Grant Guidance

Inadequate funding for community partners was also highlighted as a barrier. **"We need implementation dollars for SAG members,"** one community based partner said. Related to inadequate funding are also the lack of flexibility in funding guidance, as well as project officer bias and the lack of public health training of some project officers. **"The project officer needs to have a logic model approach,"** one New York community partner declared. Harder-to-reach populations require more creative and innovative approaches that are often not allowed in the current funding guidance some community partners explained. **"The criteria for how the funds are distributed need to be without politics,"** recommended another community partner. Local area contract rules and regulations were described as a challenge to syphilis elimination. **"One of the problems has been in re-negotiating the existing contracts,"** said a community agency partner. **"The third party contract administration is the impediment,"** concluded another.

7 Recommendations for the 2005-2010 Syphilis Elimination Plan

7.1 Summary of key findings

<table>
<tr><th colspan="2">Recommendations for the 2005-210 Syphilis Elimination Plan</th></tr>
<tr><td><u>Common Themes</u>
• Access to quality STD health care
• Prevention program integration and social service support
• Partnerships with communities and providers
• Partner services and DIS skills
• Behavioral interventions and cultural competence
• Evidence-based program planning and evaluation</td><td>1. <u>Robeson County, NC</u>
2. Develop a rapid syphilis test.
3. Employ multi-disciplinary and integrative public health approaches.
4. Institute jail screening.
5. Partner with community-based organizations, including churches.
6. Support training and staff development for health department line-staff and CBO partners.
7. Partner with other social and civic institutions, including police departments, correctional facilities, and political institutions (e.g., school boards, state legislatures).
8. Promote political will for and civic commitment to the effort.
9. Conduct active syphilis case-finding.
10. Conduct regular and frequent epidemiology analyses.
11. Require highly mobile and flexible STD intervention staff.
12. Provide for sustained syphilis intervention efforts.
13. Incorporate behavioral interventions.
14. Intervene early with youth.</td></tr>
<tr><td><u>Boston, MA</u>
1. Develop a national agenda and standardized approaches for Internet-based interventions, including regular monitoring.
2. Review and evaluate, and re-design the role of DIS-delivered partner services with new and emerging populations at risk for syphilis.
3. Incorporate client-centered approach principles into Partner Services.
4. Promote GLBT-friendly provider relationships.
5. Partner with HIV/AIDS bureaus and agencies and integrate syphilis elimination with HIV prevention.
6. Develop regional collaborations for and approaches to syphilis elimination.
7. Tailor interventions to: geography, demographics, and sexual orientation.
8. Increase sharing of “best practices” between STD programs.
9. Expand public information campaigns for syphilis elimination to include lifestyle messages and positive images of affected populations.
10. Build improve community relations with affected communities.
11. Increase funding flexibility to facilitate more rapid response to changing epidemics.
12. Ensure program accountability based on number of new cases found.
13. Require a designated syphilis elimination coordinator.
14. Focus on risk behaviors not the specific STD.
15. Increase screening.
16. Reduce “the scare factor.”
17. Link syphilis elimination to reducing health disparities.
18. Foster more political will for syphilis elimination.</td><td><u>New York, NY</u>
1. Develop partnerships with affected communities and private providers;
2. Increase investment in applied STD research (e.g. rapid syphilis test, microbicides, behavioral demonstration projects);
3. Develop extant project knowledge and promote on-going staff knowledge and skills training;
4. Integrate STD program activities with other public health efforts (e.g. HIV, Hepatitis);
5. Provide clear program evaluation guidance and specific objectives;
6. Organize and deploy rapid response teams for case management;
7. Assign DIS to specific private provider offices;
8. Increase public information to promote testing;
9. Increase private provider STD/syphilis training;
10. Increase program collaboration across health jurisdictions;
11. Expand access to clinical care (e.g. Saturday clinics);
12. Promote private provider-supported PN services;
13. Employ a multi-disciplinary, multi-perspective approach to elimination;
14. Increase access to health care;
15. Address social distrust of the government;
16. Include a full-spectrum of interventions (individual, community-level, and structural); and
17. Directly fund CBOs. and
18. Use caution with social labeling.</td></tr>
<tr><td><u>Miami, FL</u>
1. Provide on-going DIS staff training & skills development;
2. Hire more DIS & resolve DIS pay disparities;
3. Promote flexible DIS comp time policies to provide more outreach;
4. Develop interventions to address changing sexual risk patterns;
5. Promote client-centered programs;
6. Conduct public information campaigns;
7. Encourage pre-emptive or early interventions to at risk groups;
8. Increase partnerships;
9. Increase training for external partners;
10. Increase flexible resource allocation to respond to epidemics;
11. Conduct sentinel surveillance of other at-risk groups;
12. Provide sustainable programs;
13. Increase use of technology (e.g., Internet-based preventions);
14. Develop guidance for PN services across international jurisdictions;
15. Promote integration of prevention activities;
16. Encourage strategically-planned and data-driven programs;
17. Share “best practices” from among local programs;</td><td><u>Seattle, WA</u>
1. Promote syphilis asymptomatic screening for syphilis in persons at risk
2. Encourage and train all providers to take sexual histories for their patients
3. Enhance access to drug treatment and mental health services
4. Provide on-going outreach to at-risk and potentially at-risk populations
5. Develop Internet-based prevention and control interventions
6. Support community-level interventions to promote healthier social norms
7. Improve collaborations between health departments, hospitals, and private providers
8. Facilitate the exchange of “best practices” between local programs
9. Increase community awareness and knowledge of syphilis
10. Promote and support a syphilis prevention and control research agenda
11. Support program evaluation and advance evidence-based program</td></tr>
</table>

Recommendations for the 2005-210 Syphilis Elimination Plan	
18. Improve community perceptions of health department STD clinic; 19. Incorporate a business-practice model in SE program planning.	design 12. Support the use of spinal taps for diagnosing syphilis in HIV+ persons. 13. Encourage increased case interview time to improve case investigations.

7.2 Issues raised

7.2.1 Access to Quality STD health Care

In large part the discussion group participants recommended that the 2005-2010 syphilis elimination plan ensure more access to quality STD prevention and control services, such as increased screening and treatment and more client-centered STD health education. **"Ensure more time per patient to allow for proper investigation,"** one Seattle-based DIS suggested. **"Provide more training in conducting sexual histories,"** a Seattle clinician offered. "And train clients to ask their providers for better assessments of their needs. Educate clients to be better consumers." Another discussion group DIS recommended, **"Have specialists in the area of syphilis to improve staff skills and training."** There was broad consensus calling for the development of a rapid test for syphilis. In the words of one Robeson County staff person, **"You can sell that!"** A number of participants said that a rapid syphilis test is crucial to improving outreach screening, enabling the health department to bring health services to the people instead of having to always bring the people to the health department.

7.2.2 Prevention Program Integration and Social Service Support

Program integration was frequently recommended for the new syphilis elimination plan, integrating STD program activities with other public health efforts (e.g. HIV, Hepatitis). Participants said that syphilis elimination campaigns should not only raise awareness of other STDs in the affected communities, but also address the other social factors such as drug use and economic hardships that contribute to the transmission of STDs. As part of an integrative model health department staff could be cross-trained, reducing **"compartmentalization"** in STD programs. As an example, **"HIV is another STD,"** one Seattle said. **"The increased HIV testing benefited the STD program."** Another Seattle DIS person reported, **"Increase screening and expand venues, and include Chlamydia and gonorrhea."** Across the discussion groups there was consensus regarding the importance of having a designated syphilis elimination coordinator who can facilitate the development and maintenance of public health intra-agency, inter-agency, community, and regional partnerships for a more comprehensive approach to STD and HIV prevention in general and syphilis elimination in particular**. "Partnership is a key part of this,"** one Boston state STD program management official said**.** Partnerships should also be nationwide as warranted and promote sharing of 'best practices' across programs. **"You need system changes that lead to a comprehensive program,"** he added.

In addition to instituting the means for increasing access to STD health care, a number of discussion group participants also recommended that the new plan support the development of more comprehensive social services, such as mental health services and drug treatment to achieve syphilis elimination. **"We need a means to deal with some of these issues, such as depression and sexual risk,"** one clinician said. **"We need places to refer people."** Another health department person observed, **"With syphilis there are no key stakeholders."** Another staff person said, **"It makes community mobilization for syphilis difficult. Couple it with something else, such as men's health."**

7.2.3 Partnerships with Communities and Providers

Participants usually described partnerships with affected community members, community-based organizations, and political and civic institutions as being essential for an effective syphilis elimination effort. According to one North Carolina participant, **"Community taskforces enable tailored efforts, screening and education."** A number of North Carolina participants cautioned that any syphilis elimination intervention, including outreach and jail screening, needs to be conducted in partnership with affected communities and relevant agencies and institutions. **"Gone are the old days of the blitz,"** a state

official said. **"Now we prepare areas [communities] for the intervention. CBO partnerships have been key, key, key,**" the official added in explaining North Carolina's successes towards eliminating syphilis.

For New York officials too developing partnerships with affected communities and their relevant private providers was a critical recommendation. **"Health departments need to reach out to CBOs,"** one NYC community partner said. "**Directly fund CBOs,"** another partner suggested. Partnerships can lead to the employment multi-disciplinary, multi-perspective approaches to syphilis elimination, and according to another community partner partnerships can help to, **"Provide a full spectrum of interventions, individual, group, and community level,"** thereby increasing public information regarding syphilis, syphilis testing, and access to health care in general.

For working with private providers a number of recommendations were offered. One DIS person recommended **"Empower patients and private providers to do their own field services [PN]."** Another discussion group participant said, **"Teach doctors how to ask the right questions."** A health department official called for the establishment of **"Health Alert network."** There was a recommendation to limit the use of such labels as "MSM." In the words of one community partner, **"It is so stigmatizing for me."**

In general, most of the discussion group participants recommended that the new plan continue to support community involvement and organizational partnerships, and they called for establishing and maintaining partnerships with private health care providers specifically. **"Improve collaborations between health departments, hospitals, and private providers,"** a Seattle STD clinician said. Community-level interventions, conducted in partnership with affected community-based agencies and institutions, were seen as critical to promoting healthier social norms. **"Work with the majority gay community,"** advised a health department staff person, **"To somehow make that rabid sexual behavior of the core group not socially acceptable to who want to dabble in it."** Finally there was a general call for increased efforts to mobilize political will for public health efforts aimed at improving the health status of GLBT communities as well as other communities of persons at-risk. **"There has to be a reason for why we take on this additional work,"** an AIDS service organization staff person said.

However, an essential first step to delivering services to those populations at risk for syphilis is improving community perceptions of the health department. **"We have to address the perception that the health department is not the sex police,"** counseled one DIS. **"The health department could sponsor civic activities and promote awareness and testing to improve the health department's image,"** suggested another.

7.2.4 Partner Services and DIS Skills

There were also recommendations regarding the role of DIS and the provision of Partner Services. In Miami, for example, in addition to hiring more DIS and improving their salaries, many of the discussion group participants called for ensuring on-going training and skills development for DIS. **"Invest more in DIS to improve DIS quality for the new patients who are educated,"** said one health department official. **"Sufficient training and qualified staffing,"** said a Miami community agency partner. **"You have to have a good strong base."**

Some participants also stressed that DIS must be allowed to work flexible hours to provide more client-friendly outreach (e.g., evening hours). Also some DIS participants called for the new plan to specifically provide guidance for conducting partner services across international boundaries. **"The best thing we can do is ask the person to make sure his significant other gets treatment,"** a DIS complained. **"The patient has to take the bulk of the responsibility of informing partner."** In Massachusetts too there was interest in assisting STD patients to do self-referral of their partners. One Boston area DIS participant said, **"We need a program to address those who are willing to do self-referrals for patients. How do we help them talk to their partners?"**

A number of participants expressed a desire that the new plan provide for the review, evaluation, and perhaps re-design of DIS-delivered partner services with new and emerging populations who are at risk for syphilis. Some discussion group participants recommended the application of client-centered approach principles for syphilis partner services. **"I still see a problem with trust,"** one DIS staff person said

regarding relationships with clients and private providers, and he recommended that the new national plan address this challenge. As a possible solution, some discussion group participants suggested skilled DIS staff be deployed in rapid response teams for case management or be assigned to specific private provider offices where at-risk populations seek care.

7.2.5 Behavioral Change Interventions and Cultural Competence

In addition to having a rapid test, discussion group participants also repeatedly emphasized that the elimination of syphilis could best be achieved using integrative models that involve multi-disciplinary approaches that are biomedical, epidemiological, social, and behavioral. According to a North Carolina health department official, without behavior change for the high risk populations, **"It [syphilis] will rear its ugly head again."**

Essential to the provision of effective behavioral change interventions is the cultural competence of these interventions. There was widespread agreement across the discussion groups that syphilis elimination interventions be tailored to respective geographical and cultural settings where they are being delivered. **"Meet them [clients] where they're at,"** a DIS participant said. Greater awareness of syphilis, social marketing of syphilis prevention and control efforts, and networking of partners were all deemed important by the participants, however, these efforts should be carried out consistently, and as one participant noted, **"People need to become comfortable with the advertisements."** Public information campaigns for syphilis elimination ought to include lifestyle messages and positive images of affected populations, a number of community partners said. **"Reduce the scare factor,"** a community participant suggested. **"Using a communication vehicle that gay men use that leads to risk behaviors and make it more risk reducing,"** a member of the Boston area MSM Sexual Taskforce suggested. Other discussion group participants suggested a focus on risk behaviors not the specific STD. One state official called for more interventions targeting medical providers. Placing less confidence in behavioral interventions targeting the at-risk groups, the official said, **"We can change health care seeking behavior and provider behavior."** And with respect to the intervention settings, one participant recommended a "third space" approach, **"Not a club or public sex environment,"** he said**. "But a walk-in center, maybe a cyber café, where people can get information."**

In order to develop more effective culturally competent interventions to address changing sexual risk patterns (e.g., MSM circuit parties, anonymous partnering) discussion group participants suggested making use of partnerships with client-specific community-based organizations and key health care providers. **"We have to talk to our providers,"** a Miami-Dade County health department official said. **"We could increase their training by providing them with the CDC guidelines."** Other participants urged more behavioral science training for staff to improve risk reduction and promote health care-seeking health information campaigns aimed at populations at risk for syphilis. **"We need behavioral interventions,"** said one clinic staff person. **"To ascertain the risk 'tipping point.'"** A DIS said, **"We need to develop innovations to deal with anonymous sex partners."** According to a number of participants a better means of delivering these behavioral interventions are likely to involve the increased use of technology. **"We can use the Internet to reach our populations. We can create some pop-ups [advertisements],"** advised one health department staff person. And across the discussion groups participants recommended that the new plan encourage the sharing of "best practices" from local STD programs. **"Promote local interventions,"** recommended a health department discussion group participant.

7.2.6 Evidenced-Based Program Planning and Evaluation

A number of discussion group participants emphasized the need for program planning guidance and requirements in the 2005-2010 syphilis elimination plan. One community partner said, **"Make sure your goals are clear and involve your partners early."** Another community agency partner suggested, **"[Have] a planning consortium involving key partners and the community to do the planning and implementation. We need to have first of all what are the priorities. How will we distribute the funds?" s**he asked. According to the discussion group participants, elements of a good planning process include: 1) integrating prevention programs (e.g., HIV with STD); 2) developing data-driven activities supported by surveillance data; 3) building in flexible resource allocation; and 4) establishing sustainable program interventions.

Participants recommended more funding flexibility to facilitate more rapid response to changing epidemics as well as ensuring program accountability is based upon number of new cases found. **"Since the epidemic changes quickly funding needs to be that flexible too,"** a state official said. It was also suggested that syphilis elimination be linked to reducing health disparities, with close monitoring of the epi data for emerging epidemics among other at-risk groups. In making the case for more flexible programs, a health department official said, **"The world seems to be more faster now. Patients change quickly. The structure should allow some flexibility."** Another aspect of good program planning as determined by a number of the participants has to do with pre-emptive or early intervention activities. **"Focus on catching the problem before it starts,"** one community based agency partner advised; and another recommended, **"We need to get to the kids."** There was broad consensus across the discussion groups that the new plan should encourage ongoing outreach to at-risk and potentially at-risk populations, as well as maintenance of sentinel surveillance of groups with behavioral risk if not syphilis morbidity. **"Require regular data analyses locally,"** one health department official said. **"If we waited for our data to get to the state then it would be a big delay."**

Discussion group participants frequently requested that program evaluation guidance be included the future syphilis elimination plan, guidance that includes specific objectives. There was a common call for more applied research and program evaluation to be featured in the new plan. **"More research and evaluation coordinated at a central level,"** as a senior health department official put it. **"Evaluate community resource allocation,"** suggested another. **"More investment in applied research, such as quick and easy syphilis diagnostics. And microbicides as opposed to condoms,"** recommended still another. In general the participants recommended that the new plan encourage evidence-based syphilis elimination program design and the subsequent sharing of "best practices" across STD project areas. For example, participants wanted to see methods for addressing social distrust of the government included in the new plan.

There was universal agreement that the key to eliminating syphilis is a profound commitment to sustaining the effort at the local, state, and national levels. **"What gets harder is keeping momentum and enthusiasm,"** one state official said. State and national partners need to secure and ensure funding for the effort. **"It would be a huge blow to the community if we cut back on staff and CBO support,"** another state official cautioned. At the local level, there was consensus that STD staff should be highly mobile and flexible, and adaptable. According to one participant, **"STD staff could be required to move and work hours other than eight to five. It's not an option to say no,"** the participant concluded.

8 Core Values for Syphilis Elimination

8.1 Summary of findings

<table>
<tr><th colspan="2">Core Values for Syphilis Elimination</th></tr>
<tr><td><u>Common Themes</u>
• Commitment to individual & public health
• Cultural competence
• Respect for staff and client diversity
• Client confidentiality
• Partner Services
• Access to health care
• Evaluation & accountability
• Access social support services
• Staff training
• Patient education
• Human dignity
• Client-centered methods
• Commitment to partnerships</td><td><u>Robeson County, NC</u>
• Commitment to the health of the community
• Human dignity
• Client confidentiality
• Increased access to health care
• Links to social support services
• Involvement of faith-based organizations
• Reduced health disparities
• Cultural competence and sensitivity
• Ethnic and cultural diversity
• Social tolerance
• Flexibility
• Performance-driven program planning and management</td></tr>
<tr><td><u>Boston, MA</u>
• Support for the individual’s personal motivation towards health and well being
• Merging public health with profitability
• Cultural competence and sensitivity
• Respect for social diversity
• Confidentiality and respect for privacy
• Increased access to and acceptability of care (including hours of operation)
• A client-centered approach to disease intervention
• A harm reduction approach to disease intervention
• A syphilis elimination plan based on epidemiology
• Commitment to quality care regardless of sexual orientation
• Commitment to staff training and development, and supervision
• Reduction in health disparities
• Improved partnerships with local health departments</td><td><u>New York, NY</u>
• Increased access to health care services particularly to the under- and uninsured;
• Equitable distribution of STD fiscal resources across affected communities;
• Commitment to Partner Services;
• Continuing education and professional development for DIS staff;
• Patient education;
• Commitment to using the Internet for interventions
• Human dignity
• Client-centered approach
• Respect for innovation
• Limit the use of social categorization & social labeling (e.g., MSM vs. gay)</td></tr>
<tr><td><u>Miami, FL</u>
• Commitment to education of staff and clients
• Holistic approach to health
• Access to healthcare
• Cultural sensitivity & cultural competence
• Respect for individual clients
• Staff ethnic & cultural diversity
• Community & external provider participation in program planning & implementation
• Ethics
• Professionalism
• Commitment to follow-up & follow-through
• Confidentiality
• Efficient & effective use of resources</td><td><u>Seattle, WA</u>
• Respect
• Cultural competency
• Accessible health care
• Honoring sexual health
• Partner Services
• Sexual history taking
• Sustained intervention efforts
• Individual commitment to the public’s health
• Program evaluation
• A balance between the individual’s health and the community’s health
• A quality STD program infrastructure
• Collaboration between public health programs</td></tr>
</table>

9 CDC's Role for Syphilis Elimination

9.1 Summary of key findings

<table>
<tr><th colspan="2">CDC's Role for Syphilis Elimination</th></tr>
<tr><td><u>Common Themes</u>
• Leadership and maintenance of efforts
• Increasing resources
• Sharing 'best practices and facilitating technical assistance
• Standardizing interventions and training
• Increasing accountability
• Developing a research agenda
• Promoting Partnerships</td><td><u>Robeson County, NC</u>
1. "Keep up the momentum";
2. Develop and make available a rapid syphilis test;
3. Provide funding for innovative projects, staff training and hiring, and for incentive gifts for communities;
4. Increase CDC visibility at the local level by conducting site visits and provide feedback to the projects, including guidelines and recommendations for program activities;
5. Promote information sharing, using such tools as instructional web-sites, teleconferences, web-casts;
6. Coordinate the development of strategies to reach the hardest to reach populations at risk for syphilis;
7. Develop partnerships at the local and national levels, promoting integration with such groups as maternal and child health organizations, and correctional institutions;
8. Lead efforts to expand MSM social and behavioral research (e.g., the impact of youth vs. more mature adults, social class, and ethnicity) to ensure more culturally competent interventions targeting these groups;
9. Launch a Congenital Syphilis Elimination Campaign;
10. "National party to celebrate our successes"; and
11. Support a nation-wide media campaign.</td></tr>
<tr><td><u>Boston, MA</u>
1. Standardize the Internet intervention effort;
2. Provide an FTE for Internet intervention development;
3. Regularly monitor STD data and provide national indices reports to STD programs;
4. Clarify risk reduction; messages (e.g., oral sex and risk for HIV, syphilis transmission);
5. Ensure sharing of "best practices" between state and local programs;
6. Increase access to technical assistance for state and local programs;
7. Sponsor annual STD program directors' meetings;
8. Conduct syphilis elimination site visits;
9. Develop and make available a rapid syphilis test that can also be used at home;
10. Promote collaboration between STD and HIV agencies and providers and develop a shared agenda for reducing health disparities;
11. Target provider behaviors to increase quality of care for STDs; and
12. Support and fund staff training and development.</td><td><u>New York, NY</u>
1. Improve communication between CDC HIV & STD programs;
2. Increase regular feedback from CDC to local programs;
3. Support the promotion of "best practices" among programs, (e.g., sponsoring inter-project area site visits;
4. Fund more clinic and DIS staff;
5. Support extended clinic hours;
6. Support more training for DIS staff;
7. Reinvent/redefine priorities & standards for PN interviews;
8. Increase interaction with & technical assistance;
9. Develop a universal message of syphilis elimination applicable to all health departments;
10. Develop a plan to assist CBOs to move from public to private funding;
11. Provide fiscal support to CBOs for syphilis elimination activities; and
12. Promote evidence-based practice.</td></tr>
<tr><td><u>Miami, FL</u>
1. Increase funding;
2. Support more staff training and skills development;
3. Support more applied STD prevention and control research;
4. Increase funding for PN staff salaries;
5. Promote evidence-based practice;
6. Develop guidance for PN services across international jurisdictions;
7. Facilitate the sharing of "best practices" across local programs (e.g., support site visits);
8. Emphasize STD reporting compliance to health care providers;
9. Promote increased collaboration and integration between local programs (e.g., syphilis testing in HIV care settings);
10. Encourage program innovation to meet new STD prevention and control challenges; and
11. Support increased screening
12. Provide standards to increase program accountability.</td><td><u>Seattle, WA</u>
(not directly addressed during the discussion groups)</td></tr>
</table>

9.2 Issues raised

9.2.1 Leadership and Maintenance of Effort

Discussion group participants were also invited to describe what they believe the role of CDC should be in syphilis elimination. First and foremost the participants urged that CDC **"keep up the momentum."** Participants cited a variety of ways CDC could sustain the energy and enthusiasm for the effort which ranged from funding for staff hiring and training and support for CBO grantees to more frequent technical assistance and fact-finding site visits. One local health department official suggested, **"Come see what we're doing."** Along with these site visits participants urged that CDC provide feedback to the sites more regularly. Participants also called for CDC to lead in promoting increased collaboration and integration between local programs (e.g., syphilis testing in HIV care settings); as well as encourage program innovation to meet new STD prevention and control challenges and increase syphilis screening. Ideas for improving the provision of this feedback also included increased reliance on innovative technologies such as video-conferencing and web-casting. In general participants saw CDC as having a leadership role in establishing revised priorities and standards for partner notification interviews and services in particular.

And in its leadership role, discussion group participants felt that CDC should further promote collaboration between STD and HIV agencies and providers and lead the development of a shared agenda for reducing infectious syphilis and other health disparities**. "People pay attention [when CDC speaks] and the more we can leverage this the better,"** an AIDS service organization manager said. However, another community partner cautioned, **"Overly rigid models that are expected to be implemented locally often don't work because of local differences."** Also of particular importance is the need for CDC to improve the clarity of risk reduction messages associated with sexually transmitted infections.

A number of discussion group participants recommended that CDC sponsor a national celebration of the successes achieved collectively thus far in the syphilis elimination effort. And building on this particular success, others suggested that CDC lead a national campaign to specifically eliminate congenital syphilis.

9.2.2 Increasing Resources

Many of the discussion group participants recommended that secure increased funding for syphilis elimination activities. In addition to calls for more funding for **"More workers out in the field," "More cars," and "More funding for Saturday clinics,"** participants wanted to see more funding for applied research. **"Increase funding for STD research,"** said another. **"Let's do something different than what we've been doing."** Another offered, **"Money could be put aside for smaller projects for individual cities."** Other participants suggested that increased funding be directed towards hiring more staff and enhancing salaries. **"Increase funding for salaries,"** another health department staff person said. **"To keep experienced people on staff."** One community agency participant recommended that increased funding be allocated to hire a community liaison. **"To monitor community organization activities,"** he said. And another community agency partner emphasized, **"Yes, more money but more money with accountability, such as improved tracking systems."**

9.2.3 Sharing "Best Practices" and Facilitating Technical Assistance

The discussion group participants also frequently emphasized CDC's role as a facilitator and coordinator of the sharing of best practices from local programs. **"Best practices should be shared between programs,"** one Miami-Dade participant advised. **"CDC could create a jury to review programs and announce such programs so people can have access to this information."** Similarly a DIS staff person said, **"Take what advantages we have and really bring it home."** According to one health department official, **"CDC can support thinking and acting outside of the box."**

In addition to sharing "best practices", discussion group participants urged CDC to ensure access to technical assistance for state and local programs. One state official in Boston suggested that CDC sponsor annual STD program directors. These meetings would address a broad range of STD issues, including syphilis elimination. A number of participants called for CDC to be more directly and regularly interactive with local programs as it relates to syphilis elimination particularly in the areas of evidence-based technical

assistance. Moreover, there were recommendations that CDC support more on-going training for DIS staff to improve the quality of Partner Notification services. **"Include case studies that are effective,"** one DIS staff person recommended regarding the DIS training.

9.2.4 Standardizing Interventions and Training

It was also recommended that CDC support more staff training and skills development. In particular participants saw the value of CDC's role in standardizing the Internet intervention efforts and even providing staff for nationwide Internet intervention development. In addition to training for Internet interventions, discussion group participants recommended that CDC support and fund staff training and development across a variety of key areas, including cultural competence and more client-centered approaches to Partner Services.

9.2.5 Increasing Accountability

Establishing and improving accountability requirements and processes was generally viewed as a CDC responsibility. **"Promote evidence-based practice,"** said one a clinic staff person. **"Emphasize reporting compliance,"** said another. **"There needs to be consequences for doctors not reporting."** A number of participants wanted to see more technical guidance and assistance from CDC in support of syphilis elimination. **"Develop international PN strategies,"** requested one DIS. **"Conduct more site visits,"** recommended a community partner. **"CDC should have a higher visibility,"** added another community agency partner. **"Certainly it would be advantageous to CDC with the guidelines."** Regularly monitoring STD data and providing national indices reports to STD programs were also recommended for CDC action.

9.2.6 Developing a Research Agenda

A number of participants called for CDC to lead in the development of both a biomedical and behavioral applied research agenda. There was also a universal call for CDC to develop and provide a rapid syphilis test. Some went on to add that such a test should be designed for use at home. CDC should also lead in seeking new strategies aimed at reaching "the hardest to reach" persons who are at risk for syphilis for example. Participants recommended that CDC lead efforts to expand MSM social and behavioral research (e.g., the impact of youth vs. more mature adults, social class, and ethnicity) to ensure more culturally competent interventions targeting these groups. Others recommended that behavioral research should target health care providers to increase the quality of care for STDs in private medical settings. **"STD clinics are not the be all end all any more,"** said one DIS staff person.

9.2.7 Promoting Partnerships

CDC's leadership role was identified as essential in promoting improved communication and collaboration between STD and HIV programs at the national level. As an example, one community partner called for CDC to **"develop a plan for moving CBOs from public to private funds,"** that would ultimately benefit both STD and HIV prevention. CDC's efforts to encourage partnerships at the local, state, and national levels between health departments and a variety of health, social service, and civic institutions were often described as critical.

10 Conclusions

Findings from the Syphilis Elimination Listing Tour provided some insight into the achievements, concerns and hopes of a diverse group of high morbidity areas (HMAs) with regards to the Syphilis Elimination Effort (SEE). The main finding from this work was the high degree of commitment to, and enthusiasm for, the SEE and desire of professionals, communities and individuals to see the effort succeed. We found little evidence from the field of vacillation or wavering support for the SEE. In contrast, respondents unanimously felt that the SEE should remain a key strategic activity for the CDC and affected local health departments.

Since its launch in 1999, the SEE has resulted in substantial gains and benefits to those working at the local level. Most sites have observed substantial reductions in disease incidence among heterosexual minorities, and in congenital syphilis cases. There have also been gains in the improvements of partnerships with communities and private providers; greater public and professional awareness of syphilis; expansions in access to STD health care; and improvements in the quality of partner services. These gains suggest that the benefits of the SEE far outreach those of traditional vertical, disease-specific interventions. In contrast, the effort has impacted on a wide range of sexual health related services and interventions. These "collateral gains" were especially evident in those areas which were most severely affected by hyper endemic levels of heterosexual syphilis, and which benefited from investment of financial and other resources (e.g. RRT deployments, Program Assessments etc). In this regard, the SEE should be seen not only as fulfilling its primary function of reducing disease incidence, but also as having improved sexual health capacity at the local level.

Local areas have learned a number of lessons from the SEE implementation. Key among these are the importance of integrating prevention programs, conducting epi-analyses, implementing data-driven programs, collaborating with community stakeholders, ensuring robust and ongoing public education campaigns are in place, and providing training to health department staff and external partners. These emerging lessons were consistent across sites, and confirmed the need for an ongoing process of reflective learning to be built into future SEE efforts. Suggestions for facilitating the exchange of ideas and strategies include: placing evaluations and relevant information on the SEE website, facilitating meetings between SEE coordinators, and the wide dissemination of reports and resources on SEE methods.

However, despite the gains and the positive responses to the programs, local colleagues identified a number of barriers which are likely to hinder the success of future SEE activities. The changing disease epidemiology and the appearance of new populations at increased risk for syphilis are challenging programs to re-configure their interventions and realign prevention partnerships. Changing expectations of STD clinic attenders, and changing relationships with private providers (with occasionally strained relationships with the Public Health Departments) have required a reconsideration of the historic roles and relationships between health departments and their stakeholders. The growing problem of HIV/AIDS among minority and underserved populations, many of whom are at risk of syphilis, presents challenges for STD programs to work collaboratively with this and other disease prevention programs. Finally, in an era of decreasing resources, tough decisions will need to be made on what are the prevention priorities at the local level. In some areas, legitimate questions have been raised about the relative prioritization of current syphilis elimination activities and efforts. Any future revision of the SEE plan should take into account these changing contexts, and be able to provide practical and implementable solutions.

Given the context of these challenges, the reframing of SEE efforts is timely and appropriate. Local programs reiterated the need for clear guidance and leadership to be provided by the CDC, in addition to ongoing advocacy and support (financial and otherwise) to the national effort. A greater emphasis on *more effective implementation* was also called for, so that local programs could be assisted to deliver more effective syphilis prevention interventions. Whether this is achieved through a greater emphasis on training and staff development, or better monitoring or evaluation, it is clear that local programs now require a distillation of which interventions are best applied, in which situations, and with which communities. Whilst local innovation has been key to the SEE's success in many areas, there remains a strong role for central coordination of the effort, with CDC providing assistance with capacity building and technical assistance.

For the first time, we explored some of the core values which should underpin future SEE activities. For many respondents, syphilis incidence remains a predictor of a community's ill-health, degree of marginalization, and lack of social-cohesion. It is therefore imperative that any effort to eliminate this disease takes into consideration the wider socio-political and economic realities facing underserved populations in our country today. Recurrent themes of respect, cultural sensitivity, confidentiality, dignity, and client-centered approaches were repeatedly mentioned by respondents. So too was the need for a long-term commitment from CDC to continue to prioritize this program.

There are limitations to this work. Our methodology provided insights into the range of experiences, attitudes and aspirations for the SEE in selected high morbidity areas. These views may contrast to areas experiencing low or no syphilis morbidity at this time. All of the visited sites during this tour currently receive syphilis elimination funds and are more likely to be informed about the SEE and have more considered views of SEE activities. Although we attempted to obtain a diverse mixture of perspectives within focus groups, certain constituencies may have been under- or un-represented in these discussions. Further more detailed work will be required.

Nevertheless, our findings provide some insight into the social, behavioral and bio-medical contexts influencing the transmission of syphilis in high-morbidity areas in the US today. In the absence of any formal evaluation of the SEE, the results also provide a framework for considering future directions for the SEE. Finally, the findings should also be interpreted within the context of other consultation activities being hosted by the CDC Division of STD Prevention during 2005. The findings from this, as well as other consultations, will be taken into consideration in reframing the future directions

11 Appendix 1. Topic Guide

INTRODUCTION

1) **Welcome and introductions**
   a. *All participants*
   b. *Chair and recorder*

2) **Purpose of the key informant interview**
   a. *To obtain first hand experience of the social, behavioral and biomedical contexts influencing syphilis transmission in the US*
   b. *To consult with sites on the future directions for the SEE program*
   c. *To initiate discussions on local issues and concerns which should ideally should be taken into consideration in the development of any new SEE strategic plan*

3) **Explain what will happen to the results of the interviews.**
   a. *All data are confidential*
   b. *Notes will be taken*
   c. *Aggregate summary combined with reports from other sites*

4) **Explain the structure of interview**
   a. *Structured discussion*
   b. *Interview will be in 3 sections*

SEE IN ACTION AT THE LOCAL LEVEL

5) **Overall, what gains have been made in syphilis elimination in your area since 1999?**

6) **What do you think are some of the key factors which have helped you to achieve these outcomes?**

7) **What, if any, are factors which may have hindered the successful achievement of these goals.**

8) **What key lessons have you learnt about the making syphilis elimination a success at the local level over the past 5 years?**

THE FUTURE OF SYPHILIS ELIMINATION

9) **What would you like to different or new in a new national syphilis elimination strategy for 2005 -2010?**

10) **Thinking of syphilis elimination in the future, what are some of the key principles that should underscore any new syphilis elimination effort?**

11) **Thinking of syphilis elimination in the future, what are some of the key activities that should underscore any new syphilis elimination effort?**

12) **What sort of role would you like to see CDC play in any future SEE effort?**

13) **What sort of role would you like to see HMAs/ program areas play in any future SEE effort?**

14) **What sort of relationship would you like to see between CDC and local program areas in the future?**

GETTING INVOLVED

15) **In what ways would you like to see local program areas being involved with future Syphilis Elimination Efforts**

16) **What sort of communication with the center is important for you and how would you like to be kept abreast of SEE efforts?**

CLOSURE

17) **Are there other points that you would like to cover as far as the future of syphilis elimination is concerned?**

Thanks very much for your participation