

NASTAD HIV PREVENTION BULLETIN

JUNE 2002

**Focus on Viral Hepatitis Among MSM and IDUs
Adolescent and School-Based Health:
Hepatitis B in API Youth
The Manager: Achieving Empowerment
Calendar**

Focus on Viral Hepatitis Among MSM and IDUs

Hepatitis A, B and C are common in the United States among individuals at risk for or living with HIV, due to shared routes of transmission and shared populations at risk. Increasingly, HIV/AIDS directors are responsible for administering viral hepatitis prevention programs in health departments, and HIV/AIDS programs are serving populations at risk of or infected with viral hepatitis. Previous issues of NASTAD's *HIV Prevention Bulletin* have focused on viral hepatitis: the February 2001 issue featured a primer on viral hepatitis; the September 2001 *HIV Prevention Bulletin* provided a rationale for integration and profiled jurisdictions integrating viral hepatitis programs and services into HIV/AIDS programs; and the March 2002 issue illustrated HIV, viral hepatitis and substance abuse integration occurring at the federal level through the "Multi-Center" initiative (see update on this initiative below). You can access these issues of the *HIV Prevention Bulletin* online at the NASTAD website by clicking on the following link: http://www.nastad.org/pub_viralhep.asp?publication_category_id=4&publication_subcategory_id=1.

Although viral hepatitis [types A, B and C] has gained attention in recent years, lack of resources, awareness and political support has limited the implementation of full-scale hepatitis prevention programs. While hepatitis C is the most prevalent and potentially deadly type of viral hepatitis, hepatitis A and B also affect many of the same populations at risk for HIV. Illicit drug users and men who have sex with men (MSM) are at increased risk for hepatitis A; researchers have reason to believe that while the incidence of hepatitis A is decreasing overall in the United States, it is increasing among MSM. Likewise, hepatitis B, a sexually transmitted and blood borne infection, poses a risk for MSM, persons with multiple sex partners, and

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NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS

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**2002 National Institute of Health (NIH) Consensus
Development Conference on Management of Hepatitis C**

The NIH Consensus Development Conference on Management of Hepatitis C will be held June 10-12 in Bethesda, Maryland. The purpose of this conference is to update the NIH hepatitis C treatment guidelines that were developed by the consensus panel in 1997. These guidelines were widely disseminated and recognized as the standard of care. At the conference, experts will present the latest hepatitis C research findings and then members of an independent, non-Federal consensus panel will draft an updated statement based on the current research. The consensus statement will address a number of questions, including whether active drug users should be treated for hepatitis C.

The consensus panel's draft statement will be posted to the Consensus Program Website, <http://consensus.nih.gov>, on Wednesday, June 12, 2002. For those who cannot attend the conference, the program will be available via web cast over the Internet at <http://videocast.nih.gov>.

For more information about the conference, please visit the following website:
http://consensus.nih.gov/news/upcoming/hepc/hepc_info.htm

injection drug users. However, unlike hepatitis C, there are safe, effective vaccines available to prevent hepatitis A and B. The existence of these vaccines has done little to curb hepatitis A and B among MSM and other adult populations at high risk. This month's *HIV Prevention Bulletin* includes information on hepatitis A and B vaccine, provides an overview of the CDC National Immunization Program (NIP), outlines the different funding streams available from the CDC Division of Viral Hepatitis (DVH), discusses the challenges to hepatitis C prevention among IDUs, and profiles HIV/AIDS programs reaching IDUs with viral hepatitis prevention programs and services.

Epidemiology of Hepatitis A & B Among MSM

Recent outbreaks of syphilis among MSM prompted public health officials to conduct regional meetings in the fall/winter 2001, aimed at addressing the implications of this rise in reported

STDs among MSM. Driven partially by a concern that these outbreaks signaled a rise and return to high risk, unsafe sexual behavior, these regional conferences were designed to raise awareness of the concurrent outbreaks, shared risk factors and potentially shared interventions that might reduce the number of new infections in MSM populations. Hepatitis infections among MSM are associated with similar risk behaviors as HIV and other STDs, and information about hepatitis infections in MSM were included in these regional meetings. Just as important, it was determined that addressing sexual health of MSM must include hepatitis as well, since hepatitis A and B are clearly sexually transmitted in MSM populations.¹

Hepatitis A and B have long been identified as infections that disproportionately affect MSM. Recommendations for the management of hepatitis infections in MSM were suggested long before vaccines for hepatitis A and B were available. These recommendations were based on identified risk factors for hepatitis infections that were common among MSM. For example, safe sex messages that suggested using a condom correctly

and consistently is a message developed as a part of HIV prevention. However, handling a used condom can put a person at risk for hepatitis A, spread through oral-fecal contact. In addition, certain sexual practices, “tossing salad” or “rimming” for example, are also activities that can put a person at risk for hepatitis A.

Hepatitis B, which is known to be 100 times more infectious than HIV, is commonly referred to as the only vaccine preventable STD. Roughly 15% of all new infections of hepatitis B are in individuals who report MSM behavior.²

2002 STD Treatment Guidelines Published

In May 2002, CDC released updated guidelines for the treatment of patients who have sexually transmitted diseases. The new guidelines highlight the need to immunize adults at risk for hepatitis A and B. The guidelines state that MSM who are sexually active should be screened annually for HIV, chlamydia, syphilis and gonorrhea and should be vaccinated against hepatitis A and B.

The new 2002 STD Treatment Guidelines are available for download at both the CDC Division of Sexually Transmitted Diseases (DSTD) website: <http://www.cdc.gov/std> and the Morbidity and Mortality Weekly Report (MMWR) website: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm>. Hard copies of the guidelines will be available for delivery in mid-to-late July; you can submit an order request online at <http://www.cdc.gov/std/treatment/default.htm>.

These guidelines join a growing list of resource documents supporting the integration of STD, HIV, and hepatitis services.

The good news is that in the U.S., rates of new infections for both hepatitis A and B have fallen to historically low levels. This is in part due to vaccination programs for infants and children, and changes in behavior among other high-risk groups. Unfortunately, these changes in rates do not appear to be occurring among MSM. National surveillance systems do not routinely collect information on sexual orientation or sexual behavior. However, male to female ratios of new infections have been steadily increasing, and ongoing outbreaks of hepatitis A in major metropolitan areas would seem to suggest that MSM continue to be a source of new infections, despite recommendations for immunization against these two infections since the availability of a licensed vaccine.³

What is striking is what we have learned about health seeking behaviors among MSM. Recent studies of MSM have indicated that a large majority of MSM have health insurance, have regular visits with a primary health care provider, and would pay for a vaccine if suggested by their health care provider. A majority also report that they are unaware of the vaccines, and are unaware of their risk for infection. Additionally, a majority report that their provider is aware of their sexual practices that put them at risk for hepatitis A and B infection.⁴

Unfortunately, despite safe and effective vaccines (hepatitis A vaccine has been available since 1996, and vaccines for hepatitis B since 1981), rates of immunization have continued to be low. A recent study of young MSM determined that rates of immunization for hepatitis B are at the same level they were in the first years of vaccine availability.⁵ Twenty years later, MSM are chronically under vaccinated against the hepatitis B virus. Reasons for the under utilization of this safe and effective vaccine are unknown.

What we do know is that those behaviors, which place MSM at risk for hepatitis A or hepatitis B infection, continue to occur. We know that the vaccines are safe and effective, and that the use of the vaccine in MSM populations are increasing, but are still unacceptably low.⁶

It is believed that a large majority of MSM seeks health care on a regular basis. This may be in part due to the HIV epidemic. A group so highly associated with an infection for 20 years may be hyper-sensitized to health and health behaviors, though it is not known if MSM have more positive health seeking behaviors than the general public. However, like the general public, the majority of MSM do not use public health venues as their primary source of health care. A large percentage of MSM have health insurance, and a large majority would accept the vaccine if it were recommended to them by their health care provider.⁷

We have yet to determine if MSM of color are accessing health care in the same way that the majority of MSM access health care. It is also not known if MSM of color have the same rates of insurance coverage as white MSM. It is quite possible that using public health sites to access MSM of color may be a reasonable approach to accessing a sub-population that is under-insured and medically underserved.

The current interest in integrating STD and HIV has generated a grass roots effort to promote comprehensive sexual health care to MSM, and to advocate for hepatitis vaccinations as a part of health care. However, it is not known if a hepatitis vaccination can be linked to health interventions that seek out infected individuals as the point of intervention. Hepatitis vaccine interventions seek out those who are susceptible. These may not be the people presenting at public health clinics, or the people historically targeted for intervention by a public health infrastructure that focuses on contact

tracing and 'know your status'. Finally, we must ask if there is an additional stakeholder in this effort. If a majority of MSM have health insurance and seek regular health care, do business managers of doctor's offices hold the key to reimbursement by becoming savvy to methods to bill insurance plans without 'outing' their patient?

Outbreak management, such as immunizing in gay bars, bathhouses, or in mobile vans, have an immediate public service/public perception effect, but little long term effect on the rates of new cases of acute vaccine preventable hepatitis infections in the MSM. The standard public health response (free vaccine clinics) may not be the answer for long-term management of this infection in MSM. High rates of infection continue to be reported despite repeated efforts to engage the MSM community. The institutionalization of HAV and HBV vaccine as a part of routine, standard health care for MSM is necessary.

In conclusion, hepatitis A and B vaccines have been developed and have been recommended for routine use in the MSM community for years. The vaccines are safe and effective, and further, have flexible dosing schedules. Hopes for a vaccine against HIV are on the horizon, yet studies that measure rates of vaccination have yet to demonstrate an effective means for administering a three dose, flexible scheduled, effective vaccine. Should hepatitis B vaccination efforts be a model for the HIV vaccine of the future?

¹ Centers for Disease Control and Prevention. Update: HIV Incidence Among Young Men Who Have Sex With Men---Seven U.S. Cities, 1994-2000. MMWR - Morbidity & Mortality Weekly Report 2001; 50(21): pp. 440-445.

² Goldstein, Susan T.; Alter, Miriam J.; Williams, Ian T.; et al. (2002) Incidence and Risk Factors for Acute Hepatitis B in the United States, 1982-1998: Implications for Vaccination Programs. The

Journal of Infectious Diseases, Vol. 185, pp. 713-719.

³⁻⁷ Makellar, Duncan A.; Valleroy, Linda A.; Secura, Gina M.; et al. (2001) Two Decades After Vaccine License: Hepatitis B Immunization and Infection Among Young Men Who Have Sex With Men. American Journal of Public Health, Vol. 91, No. 6, pp. 965-971.

When HIV Prevention Messages are Not Enough: Preventing Hepatitis C among Injection Drug Users

Twenty years into the HIV/AIDS epidemic, HIV prevention messages for injection drug users (IDUs) have reached the drug using community. Recommendations to use a new, sterile syringe for each drug injection and not to share syringes with others have been heard by IDUs across the United States, despite serious funding and political constraints. Although effective HIV prevention for IDUs has been difficult to implement in most of the United States due to structural barriers (i.e. laws restricting needle exchange programs, paraphernalia laws), in many jurisdictions where there are options for IDUs to obtain clean syringes (e.g., pharmacies, needle exchange programs), the prevalence of HIV among IDUs has remained low or decreased.^{1,2}

In the mid to late 1990's, HIV prevention programs for IDUs slowly began to find that their hard work in fighting the transmission of HIV had been countered by the transmission of another, silent blood borne virus: hepatitis C (HCV). HCV is characteristically asymptomatic, so infected individuals often don't learn their status until as many as 15 to 20 years after infection, when they begin to experience symptoms of chronic liver disease. HCV had silently and covertly spread, unchecked, among IDU populations. Studies have found that 60-90% of IDUs who report injecting for 5 or more years are infected with HCV.

So, especially in injecting drug populations where HIV infection remained low, is the prevalence of HCV so high? CDC suggests that the apparent rapid acquisition of HCV among IDUs is likely caused by a high prevalence of chronic HCV infection among IDUs, which results in a greater likelihood of exposure to an HCV-infected person.³ It also appears that HCV is far more infectious than HIV, and therefore easier to transmit. In fact, research suggests that in order to prevent transmission of HCV among IDUs, the message to not share needles and syringes is insufficient. Investigators have found that a significant proportion of HCV infections can be attributed to sharing contaminated drug preparation equipment, or "works." One study in Seattle, Washington found that 54% of HCV infections were attributable to sharing cookers and cotton.⁴ This finding underscores the importance of access for IDUs, as researchers in IDU communities have long understood that IDUs don't share because of social reasons or because they want to, they share because they do not have access to their own equipment.

Steve Koester, Ph.D., an Associate Professor at the University of Colorado at Denver and visiting Behavioral Scientist at CDC's Division of Viral Hepatitis (DVH), further highlights the issue of access in the context of the significant economic barriers that impact the lives of many IDUs. Dr. Koester explains that impoverished, addicted IDUs, suffering from heroin withdrawal routinely engage in "drug sharing". Drug sharing is the process by which IDUs will buy drugs with others, prepare the drugs [this applies to tar heroin] by cooking them, and then use a syringe to accurately measure the drug solution to ensure an even split of the drugs. As he explains, most IDUs share drugs solely for economic reasons; an injector may not have enough money for drugs, but by combining resources with another injector the two can purchase the amount of drugs needed. Dr. Koester further reveals that it is through this process of drug

sharing that blood borne viruses such as HCV can unknowingly be transmitted. The injectors may be careful to not share syringes for injection, but if they are using a contaminated syringe to measure and split the drug solution, the blood borne virus may be transferred to the other injector.

Understanding the context and the reasons for risk behavior of IDUs is critical to the development of effective HCV prevention programs for IDUs. In the absence of rational public policies for drug users, HIV and HCV prevention programs must work hard to understand the reality of the injectors' world in order to develop effective prevention programs. IDUs should be centrally involved in generating appropriate, realistic solutions to preventing the spread of HIV and HCV. Reaching IDUs, especially new initiates, with effective HCV prevention messages is vitally important: studies have found low HCV prevalence among young injectors and new initiates, in stark contrast to the high prevalence of HCV among older, long time IDUs.⁵

So given limited research, what is the best HCV prevention message? Dr. Koester recommends the following four messages: 1) Avoid sharing anything including syringes, drugs and drug preparation paraphernalia (water, cottons and cookers); 2) Try to divide shared drugs before preparing them into solution; 3) Always use a brand new, sterile syringe to inject and to prepare, divide and distribute shared drugs; 4) If a sterile syringe is unavailable, always bleach a syringe before using it to prepare drugs into solution and to divide and distribute the solution. And most importantly, work with drug users in developing responses to the risks embedded in the process of preparing and injecting drugs- they're the experts.

It is important to remember that although this message may seem overwhelming and complicated, especially in light of the realities of

IDUs' lives, fifteen years ago prevention researchers thought that it would be impossible to teach IDUs not to share syringes. Education, information, and increased options for safer injection will make a difference in hepatitis prevention, just as they did with HIV/AIDS prevention.

¹ Des Jarlais, Don C.; Rodrigues, Darlene & Smetka, Suzette (2001) Hawaii's Statewide Syringe Exchange Program: 2001 Evaluation Report.

² Des Jarlais, Don; Marmor, Michael; Friedman, Patricia; et al. (2000) HIV Incidence Among Injection Drug Users in New York City, 1992-1997: Evidence for a Declining Epidemic. *American Journal of Public Health*, Vol. 90, No. 3, pp.352-359.

³ Centers for Disease Control and Prevention. Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. *MMWR - Morbidity & Mortality Weekly Report* 1998;47(No. RR-19): pp. 1-39.

⁴ Hagan, Holly; Thiede, Hanne; Weiss, Noel S.; et al. (2001) Sharing of Drug Preparation Equipment as a Risk Factor for Hepatitis C. *American Journal of Public Health*, Vol. 91, No. 1, pp. 42-46.

⁵ Thorpe, Lorna E.; Ouellet, Lawrence J.; Levy, Jennie R.; et al. (2000) Hepatitis C Virus Infection: Prevalence, Risk Factors, and Prevention Opportunities among Young Injection Drug Users in Chicago, 1997-1999. *The Journal of Infectious Diseases*, Vol. 182, pp. 1588-1594.

Lessons From the Field: HIV/AIDS Programs Respond to Viral Hepatitis Among IDUs

The following stories illustrate viral hepatitis prevention interventions and services tailored to IDUs.

Positive Health Project—"One Hit Kit"

*Jason Farrell, Positive Health Project, Inc., NYC
Marcia Bisgyer, Safety Works, Inc., NYC*

Positive Health Project, Inc., a NYC HIV prevention/harm reduction agency that receives funding from the New York State AIDS Institute, and Safety Works, a distributor of harm reduction program supplies, collaborated with researchers from the Yale University School of Public Health to develop and conduct a survey measuring perceived risk, injection behavior and hepatitis C virus (HCV). Three other syringe exchange programs from Los Angeles, Connecticut and Wisconsin also participated in the project. The goal of the study was to determine possible strategies to reduce the risk of HCV infection related to the use of drug injection equipment and drug injecting practices.

Positive Health Project's study consisted of a survey including participants from its site in NY and participants from Los Angeles, Connecticut and Wisconsin syringe exchange programs. The survey found that participants were less educated about HCV than HIV and believed that the risk reduction techniques they used for HIV would protect them against other blood borne diseases. The survey also found that participants were unaware of the dangers associated with the re-using or sharing of water (as soon as a used syringe is dipped into a water bottle, the water and bottle become contaminated and should no longer be used), of the importance of using clean paraphernalia, and of eliminating skin contact with blood.

To address and help change these risky injection practices, project collaborators created the "One Hit Kit." This kit contains one cooker, one cotton, one sealed 5 ml vial of water, one alcohol pad to clean the injection site and one gauze pad to stop the flow of blood from the injection site. Also included is a palm card which clearly outlines nine steps to a safe injection. All items are sealed in a plastic bag and labeled "use once." Injectors reported that they were much more likely to use injection equipment only once after they were educated about the risk of contracting HCV. For more information about the survey, Positive Health Project services, and hepatitis educational materials, please contact Jason Farrell at jfarrell@phpnyc.org.

Integrating Viral Hepatitis into Services for IDUs: The New Mexico Experience

The New Mexico Department of Health HIV/AIDS program received funding in 2001 from the Division of Viral Hepatitis (DVH) at CDC to develop a Viral Hepatitis Integration Project (VHIP). One of the primary objectives of New Mexico's program is to integrate viral hepatitis services into harm reduction and syringe exchange programs for IDUs. New Mexico has statewide syringe exchange through the Department of Health; there are 26 syringe exchange sites, which serve approximately 6,000 individuals annually. Services offered at the syringe exchange programs (SEPs) include one-for-one syringe exchange and disposal, HIV counseling and testing, hepatitis testing and immunization, education on harm reduction principles, proper vein care, and referrals to drug treatment programs.

The New Mexico Hepatitis Program has successfully integrated hepatitis C counseling and testing into the SEPs. There are approximately 19,700 persons listed in the hepatitis C registry in New Mexico; sixty-four percent of persons are

from District 1, which includes Bernalillo County (Albuquerque). Karen Gonzales, hepatitis C coordinator for New Mexico, reports that integrating hepatitis C testing was a smooth process, largely because the risk factors for HIV and hepatitis C are so similar. If a person tests positive for hepatitis C, the Hepatitis Program offers hepatitis A and B testing and immunizations.

On April 1, 2002 the program began the purchase and distribution of adult hepatitis vaccine for SEP sites, public health STD clinics, and to support public health outreach initiatives. Hepatitis A and B vaccine is available to high-risk populations based on a Viral Hepatitis Testing and Immunization protocol. This protocol was developed based on the incidence, prevalence, risk factors, and other characteristics unique to viral hepatitis in New Mexico.

The New Mexico Hepatitis Program is currently providing viral hepatitis training for harm reduction staff. The program is also beginning a social marketing campaign, targeting IDUs, designed to increase awareness and use of services for viral hepatitis. This project will be focus on Bernalillo and Rio Arriba counties with a control group in San Miguel County. Three contract nurses have also been hired to support an increase in hepatitis testing and immunization at SEP sites and in STD clinics.

For more information on hepatitis in New Mexico, please visit their website: <http://www.healthlinknm.org/nmhepline/index.html>.

Overview of the National Immunization Program

While it is clear that high-risk adults should be immunized against hepatitis A and B, there are currently no federal grant programs that specifically provide hepatitis A and B vaccine for

adults. Traditionally, state immunization programs have focused their efforts on following the CDC's "Recommended Childhood Vaccine Schedule," which provides guidance on the immunizations infants and children should have by a certain age. These recommendations are often further reinforced in states by mandatory vaccine laws that require children to be immunized against certain diseases in order to attend school. This unique partnership has allowed for a very effective system of immunizing infants and children in the United States.

The CDC National Immunization Program (NIP), is the federal program responsible for providing leadership for the planning, coordination, and conduct of immunization activities nationwide. NIP was established in 1992 to increase higher immunization coverage and the protection of children younger than age two; however, a national immunization program has been in place in the United States since 1963, when Congress established the Immunization Grant Program.

The mission of NIP is to prevent disease, disability, and death in children and adults through vaccination. Priorities of the NIP include reducing vaccine-preventable diseases, raising immunization coverage levels, and further improving vaccine cost effectiveness. The program operates in the 50 states, 6 Pacific Island jurisdictions, Puerto Rico, the Virgin Islands, and in six large cities: Chicago; District of Columbia; Philadelphia; New York City; Houston; and San Antonio.

NIP provides vaccine to the states through two federal programs: Section 317 of the Public Service Act and the Vaccines for Children Program (VFC). VFC is an entitlement program that provides vaccines free of charge to VFC-eligible children through public and private providers. VFC-eligible children include: children under 18 who are eligible for Medicaid; children without

health insurance; Native American and Alaskan Native children; and children with health insurance that does not cover immunizations, provided that they seek care at a Federally Qualified Health Center. Section 317 funds have no eligibility requirements; this program is authorized under Section 317 of the Public Service Act. NIP allocates Section 317 funds indirectly to jurisdictions by providing them with an account at CDC through which they can purchase vaccine. In 2002, VFC and Section 317 funds provided by NIP amounted to nearly \$1 billion. In 2001, NIP administered \$373.8 million in federal grants to 64 state, local and territorial public health agencies for program operations and the purchase of vaccines not covered by private insurance or the VFC program. An additional \$897.3 million was provided to the VFC in 2001.

State, territorial and local immunization programs use these federal funds to purchase vaccine and maintain an immunization infrastructure to assure service delivery, conduct surveillance of vaccine coverage and safety, and sustain and improve vaccination levels. Immunization grantees are provided technical assistance through site visits and routine communications by program consultants at NIP.

States have the option to determine their own vaccine supply policies. States may have a universal program, which provides public vaccine to all children, a quasi-universal program, which serves most children with a few exceptions, or a non-universal program, which relies on public sector purchases of vaccine for non-VFC eligible children.

Providing hepatitis A and B vaccine to adults at-risk is a challenge for NIP and state immunization program managers for several reasons. First, immunization program managers are trained to ensure that every eligible child receives the required immunizations. This is complicated by

the fact that there are continuously new, expensive vaccines added to the recommended childhood vaccination schedule. Additionally, vaccine "need" has never been clearly defined, making it difficult for NIP to conduct planning, make budget requests, and allocate funding. There is also competition from other adult immunization programs, such as influenza. And finally, immunization program managers may be reluctant to expand their program, for example by providing hepatitis A and B vaccine to STD clinics this year, and then find that the program is not sustainable and must be discontinued next year.

NIP is, however, well aware of the need for an adult immunization program. NIP reports that each year in the United States, \$10 billion is spent treating adults for vaccine-preventable illnesses (e.g., influenza, hepatitis B), and each year over 30,000 people die from diseases that could have been prevented. In April 2001 a sub-group of the Advisory Committee on Immunization Practices (a Federal advisory committee whose role is to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the Director of the CDC on recommended immunizations) Adult Workgroup, began the development of an adult immunization schedule. This schedule is designed to provide a summary of immunization recommendations for adults. It is currently under review and expected to be published later this year.

In addition, the Institute of Medicine (IOM) released a report in 2000, "Calling the Shots: Immunization Finance Policies and Practices," which examined the roles and responsibilities of federal and state governments in supporting immunization programs and services. The IOM report recommended that Congress increase the annual Section 317 vaccine budget by \$50 million per year to meet residual needs for high-risk adolescents and adults under the age of 65 who do not qualify for other federal assistance. The IOM further recommended the development of a

comprehensive adult immunization program within each state.

NIP is encouraging immunization program managers to work with HIV/AIDS and STD program managers to help determine the need for hepatitis A and B vaccine for at-risk adults. HIV and STD programs need to collaborate with immunization program managers and articulate their need for vaccine. There are possible opportunities that immunization programs may have to provide vaccine; for example, there are currently vaccine supply shortages for certain required vaccinations. The immunization funding year runs on the calendar year, so programs should spend all their resources by the end of 2002. If a shortage remains throughout the year for some of the expensive vaccines, this could be an opportunity to use the untapped funds to buy additional hepatitis A and B vaccine. Although it is not possible at current budget levels for NIP to provide all HIV/STD providers with hepatitis vaccine, there is strong interest in maximizing opportunities and increasing vaccination rates where possible.

Division of Viral Hepatitis Funding Streams

The Division of Viral Hepatitis (DVH), which is located in the National Center for Infectious Diseases (NCID) at CDC, provides funding to state and local health departments and national non-profit organizations to support viral hepatitis integration activities. The three primary funding streams are: Viral Hepatitis Integration Projects (VHIP), Viral Hepatitis Education and Training Projects (VHET) and the Epidemiology and Laboratory Capacity (ELC) cooperative agreement.

Fifteen state and local health departments are funded under the VHIP cooperative agreement, which focuses on the integration of viral hepatitis services with existing HIV, STD, corrections and substance abuse programs. These demonstration projects are designed to determine the feasibility of integrating viral hepatitis prevention (immunization, testing, counseling, medical referral) into existing public health programs. DVH has utilized several different models, such as HIV/AIDS prevention, STD clinics, drug treatment, and correctional health. These programs are developing materials for use by other programs. DVH also funds three Indian Health Service VHIP's. Visit <http://www.cdc.gov/ncidod/diseases/hepatitis/partners/index.htm> and click on "The Liver Works" to learn more about their viral hepatitis integration projects.

Ten national and regional non-profit organizations are funded under the VHET cooperative agreement. The objective of these projects is to test, disseminate and evaluate viral hepatitis educational materials and messages, and to develop programs for health professionals relative to the prevention and control of viral hepatitis. Projects under development include NASTAD's Resource Guide for HIV/AIDS programs on viral hepatitis integration (http://www.nastad.org/pro_viral_hepatitis.asp?menu=pro), and the National Minority AIDS Council's viral hepatitis prevention materials for MSM and IDUs of color. For information about these and other VHET projects, please visit <http://www.cdc.gov/ncidod/diseases/hepatitis/partners/index.htm> and click on "Stay in the Loop."

The ELC cooperative agreements support the funding of a state hepatitis C coordinator position. A hepatitis C coordinator serves as a liaison with other public health programs such as HIV/STD, immunizations, substance abuse, and corrections.

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QUICK FACTS ABOUT HEPATITIS A AND B VACCINE

Hepatitis B vaccine has been available in the United States since 1982. It is a very effective and safe vaccine; there are no live viruses in the vaccine. The vaccine is usually given in a three-shot series intramuscularly. The second and third dose should be given one month and six months after the first dose, respectively.

Persons recommended for hepatitis B immunization include:

- Sex partners of persons infected with hepatitis B virus
- Men who have sex with men
- Persons who have had a sexually transmitted disease (e.g., gonorrhea, syphilis)
- Persons with multiple sex partners
- Injection drug users
- Household contacts of persons infected with hepatitis B virus
- Persons whose job exposes them to human blood
- Kidney dialysis patients
- Travelers to countries where hepatitis B is common
- All persons 0-18 years of age, should be started at birth

Hepatitis A vaccine has been available in the United States since 1995. It is also a very safe and effective vaccine and does not contain live viruses. It is a two-shot series that should be given intramuscularly. The second dose should be given six – eighteen months after the first dose.

Persons recommended for hepatitis A vaccination include:

- Household contacts of persons infected with hepatitis A virus
- Sex partners of persons infected with hepatitis A virus
- Men who have sex with men
- Travelers to countries where hepatitis A is common
- Illicit drug users, both oral and injecting
- Persons living in counties, communities or regions of the United States with consistently elevated rates of hepatitis A

Hepatitis A and B vaccine can be given at the same time. In addition, there is a new option called Twinrix, which is combined hepatitis A and B vaccine that is licensed for use in persons older than age 18. Twinrix is distributed by GlaxoSmithKline Biologicals and is an intramuscular, three-shot series.

Goals of the coordinator position include helping to successfully integrate hepatitis C into existing prevention programs, ensuring medical referrals for hepatitis C infected individuals, supporting hepatitis C surveillance efforts, ensuring laboratory capabilities for hepatitis C testing, conducting trainings for health professionals and organizations on hepatitis C, and evaluating the effectiveness of hepatitis C prevention activities. To date, 48 jurisdictions have received ELC funding.

The ELC cooperative agreement also provides funding for seven hepatitis C surveillance projects, five of which are in different locations from states with hepatitis C coordinators. The purpose of these grants is to assist grantees in the development, implementation, and evaluation of surveillance systems to identify persons with chronic hepatitis B virus and hepatitis C virus infection. A detailed map of the United States illustrating DVH's FY 2002 integration activities [is attached](#).

Update on the "Multi-Center" Initiative

The CDC National Center for HIV, STD and TB Prevention, National Center for Infectious Diseases and National Immunization Program are collaborating with the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment to conduct a "Viral Hepatitis Vaccine Assessment for High Risk Adults." The goal of the needs assessment is to determine the amount of hepatitis A and B vaccine needed to immunize high-risk adults. Although high-risk adults have long been recommended for vaccination against hepatitis A and B, millions of high-risk adults seeking care in public health care facilities go unvaccinated each year due to limited vaccine availability and limited integration of hepatitis prevention services in HIV, STD and substance abuse treatment programs. CDC states

that this assessment is, "a first step in the development of a national strategy to address this problem."

HIV/AIDS directors, STD directors, hepatitis C coordinators and hepatitis B coordinators received a letter in May 2002, signed by the directors of the four centers, requesting their assistance with this needs assessment. The letter asks them to meet with the immunization program manager in their state by June 15, 2002, to help determine the number of high-risk adults that should be vaccinated, as well as the amount of vaccine and infrastructure needed to integrate hepatitis A and B immunization programs into existing services (e.g., HIV clinics, STD clinics, corrections). The immunization program managers were asked to gather the data from each program, calculate the numbers using a CDC formula, and return the information to the National Immunization Program by June 30, 2002.

The unmet need for hepatitis A and B vaccine in correctional settings (e.g., jails, prisons) and substance abuse treatment programs will also be included in this needs assessment. The data to estimate these numbers are collected from states by the National Institutes of Justice and the National Institute of Drug Abuse, respectively, and these numbers will be added to the state-generated data.

For more information about the "Viral Hepatitis Vaccine Assessment for High Risk Adults," please contact Laurie Schowalter at lschowalter@nastad.org.

Adolescent and School-Based Health: Hepatitis B in API Youth

Fifty percent of the 1.25 million people with chronic hepatitis B virus (HBV) infection are Asians and Pacific Islanders (API), even though only 4.5% of the U.S. population is API. During the 1990s rates of HBV infection among API children were 17 times greater than that of white American children. Most of these children are immigrants or children of immigrants and are at greater risk because in many Asian countries, around 10% of the population are HBV carriers. Transmission of hepatitis B frequently occurs perinatally or during childhood through close personal contact with blood or the bodily fluids of infected individuals, such as contact between open wounds. Hepatitis B is not spread by contaminated food or water, as with other types of hepatitis. The current rate of new infections among unvaccinated API children is estimated to be 0.5% to 1.0% per year, which is about 30 times the risk in U.S. white children. Most of these new infections occur within the household from blood to blood exposure.

The CDC Advisory Committee on Immunization Practices (ACIP) encouraged providers to consider hepatitis B vaccination of API children starting in 1982, months after the first hepatitis B vaccine (HepB) was first licensed in the United States. In 1995, it was recommended that all children under age 11 who were, or whose parents were, born in countries where hepatitis prevalence is greater than 2%, including Asia, Africa, and parts of South America be vaccinated. Catch up recommendations were also recommended for all U.S. children ages 11 and 12 years. The ACIP guidance for API hepatitis B vaccination became sequentially stronger and broader until HepB was recommended for all children (API and non-API)

up through 18 years of age in 1998. By 1995, almost 90% of API children born after 1993 had received their three-dose HepB series, but only 10% of those API children born before 1993 had received HepB. There are about one million API children in the United States born before 1993, with 80% residing in 12 states—California, New York, Hawaii, Texas, New Jersey, Illinois, Washington, Florida, Virginia, Massachusetts, Maryland, and Pennsylvania. In these states extra catch-up efforts are indicated.

Currently 69% of all API American children 2-18 years of age have received their three-dose series of HepB. Most of the remaining API children who have not received the HepB are 9-18 years of age. In addition, most children under middle school age will be required to be vaccinated to enter middle school because 31 states and the District of Columbia have instituted middle school HepB requirements. However, those children who are now in high school have very low vaccination rates (below 40%) and need to be vaccinated at this time. The National Task Force on Hepatitis B, Focus on Asians and Pacific Islanders, is a CDC funded task force working on this issue. The National Task Force's hepatitis B vaccination API catch-up coverage goal is that 90% of all API children (2-18 years of age) in the United States will receive the three-dose HepB series by 2004.

Dr. Gary Euler, the CDC Project Officer of the National Task Force, makes the following recommendations:

- Continue efforts to educate, motivate and vaccinate with HepB in high schools where 30% or more of the students are API. Many of these high school aged youth have missed their vaccinations because laws were not in effect when these youth were in middle schools in 1998 and 1999.
- Consider implementing high school HepB regulations as soon as possible in states that do not have middle school HepB regulations.

- In areas where there are high API populations, health departments can band together with education agencies and schools for educational prevention interventions. There are model programs in Chicago, Detroit, Los Angeles, and NYC.
- Continue to provide hepatitis B vaccination education and motivation to providers of immunization services to API adolescents. Promote use of hepatitis B vaccination tracking/reminder/recall systems targeting API adolescents, hepatitis B vaccination standing orders for API adolescents, and free hepatitis B vaccination services for children whose parents can not afford to pay fees for hepatitis B vaccination services (e.g., office visit fees for a vaccination, vaccine administration fees, or doctor visit fees for a vaccination visit). Promote the provision of special evening and weekend office hours for vaccination clinics. Promote the use of interpreters for all targeted API parents who speak an API language in the home.
- Continue to enroll all providers who provide immunization services to API adolescents into the Vaccines for Children (VFC) program. The Centers for Medicaid and Medicare Services administers the Vaccines for Children program, which provides physicians with a certain number of free vaccines. Health departments can also train and ensure that VFC enrollment providers use and implement VFC services correctly.

For more information on the National Task Force on Hepatitis B, contact Dr. Gary Euler at gle0@cdc.gov. Additional information on hepatitis B in the API community can be found at the Asian Liver Center's website at <http://liver.stanford.edu>.

Reference: Euler, GL. The Epidemiology of hepatitis B vaccination catch-up among AAPI children in the United States. *Asian American & Pacific Island Journal of Health* 2001, 9:pp. 154-61.

The Manager

Achieving Empowerment

“Empowerment” is a familiar term in the world of HIV/AIDS programs and services. Indeed, achieving empowerment is a major goal both for individuals and for communities. But, is it a possibility for HIV/AIDS programs managers as well? The answer is an emphatic “yes” according to Peter Block, author of *The Empowered Manager: Positive Political Skills at Work* (Jossey-Bass Publishers, 1987).

Dimensions of empowerment

In the context of work life, the author identifies three distinct dimensions of empowerment. “To feel empowered means several things,” he states. First, “we feel our survival is in our own hands...that we take responsibility for our situation. No one to blame, no matter what the circumstance; we are the ones who have essentially put it all together.” In this sense, empowerment for HIV/AIDS managers is very similar to empowerment for their clients.

Second, “we have an underlying purpose. Work is something more than paying the mortgage. Granted, we work because we have to, but if we are going to put in time, we have a goal or vision of something worthwhile.” Working in the HIV/AIDS field is certainly worthwhile, but it is can be easy to lose a sense of clarity in terms of specific goals or visions.

Finally, “we commit ourselves to achieving that purpose...the act of commitment is to decide to fulfill the purpose of this job and not to wait until conditions are more supportive. The commitment needs to be made regardless of who our boss is, or how business is going, or how alone we seem to be

in our purpose.” In short, knowing one’s goals or visions is not sufficient for empowerment – action must follow.

Taking action

In turn, seeing empowerment through into action involves three key practices, writes the author: “be your own authority”, “encourage self-expression,” and “make commitments.”

The first of these is to “be your own authority” by identifying one’s source of control as being internal rather than external. Of course, this applies not only to the manager, but also to those who are being managed. “If we ask people to take responsibility for their own actions...this means that we as managers have to give up some of our control, de-emphasize the power we have over the people under us, and acknowledge that while the captain may choose direction, the engine drives the ship.”

One approach to “being your own authority” is to review an organizational chart, and then to invert the usual pyramid structure. When this happens, the people that one manages are no longer viewed as being “below” the manager in a hierarchy; rather the manager becomes a source of support for those who provide front-line services. If your organization is not very hierarchical, you might try “flattening” the organizational chart, reflecting the interconnectedness of all those who work together.

Another approach is to alter the nature of supervision from “oversight” to “advice.” “Let the role of the supervisor be consultative and by invitation only...if a subordinate has clear goals and accountability, [this approach] has worked.” The process of supervision can also be altered by: empowering staff members to evaluate both their own performance and that of the larger unit; by introducing self-managing teams; and by

encouraging subordinates to call meetings. One can also “see that assignments become a two-way contract” by coordinating the work of both parties – and following through on whatever you promise for your part.

It can seem questionable, or even unwise, to relinquish traditional modes of supervision. But, the author notes, such changes are ideally carried out within a larger context of empowerment. In the next edition of *The Manager*, we will examine the other two major practices related to empowerment – encouraging expression and making commitments as well as the importance of committing to the overall goal of empowerment.

Recognizing the need to support HIV/AIDS program staff members in their management challenges, the NASTAD HIV Prevention Bulletin offers “The Manager” column to bring to our readers’ attention key works by professionals in the field of management. “The Manager” encourages readers to send in ideas for topics to be covered in this column. Please e-mail suggestions to nastad@nastad.org, fax them to 202-484-8092, or mail them to “The Manager,” NASTAD, 444 N. Capitol St., NW, Washington DC 20001.

Community Planning Calendar

Following are listings of meetings, conferences and other key dates that may be of interest to those working on HIV prevention or community planning. Their inclusion does not necessarily indicate endorsement by NASTAD; please see contact information for additional details about each activity.

July 7-12, 2002

XIV International AIDS Conference, Barcelona, Spain. The theme for this conference is "Knowledge and Commitment for Action." For more information, visit: <http://www.aids2002.com>.

July 10-12, 2002

National Leadership Summit to Eliminate Racial and Ethnic Disparities in Health, Washington, DC. Sponsored by the Office of Minority Health. For more information, call (888) 516-5599 or visit: <http://www.summitt.omhrc.gov>.

August 9-11, 2002

The 7th Annual African American Leadership Conference on HIV/AIDS, Louisville, KY. For more information please call (800) 420-7431 or (502) 574-5600.

September 9-11, 2002

U.S.- Mexico HIV/AIDS Border Conference, Tucson, AZ. For more information, visit: <http://www.elrio.org> and log on to "Border Conference."

September 19-22, 2002

2002 United States Conference on AIDS, Anaheim, CA. For more information, visit: <http://www.nmac.org/usca2002>.

September 26-28, 2002

National Conference on Health Care and Domestic Violence, "Prevention and Response Strategies: Pushing the Envelope", Atlanta, GA. Sponsored by the Family Violence Prevention Fund's National Health Resource Center on Domestic Violence. For more information, visit: <http://www.endabuse.org/health>.

December 1-4, 2002

4th National Harm Reduction Conference, "Taking Drug Users Seriously", Seattle, WA. For more information, visit: <http://harmreduction.org/conference/4thnatlconf.html>.

January 27-30, 2003

National Hepatitis Coordinator Conference, San Antonio, TX.

If you have an idea or program relative to any of these topics that you would like to include in the Bulletin, please contact Nyedra Booker (e-mail: nbooker@nastad.org, phone: 202/434-8090).

LET US KNOW WHAT YOU THINK!

NASTAD welcomes feedback to issues presented in our newsletter. To submit commentary, please e-mail us at nastad@nastad.org.

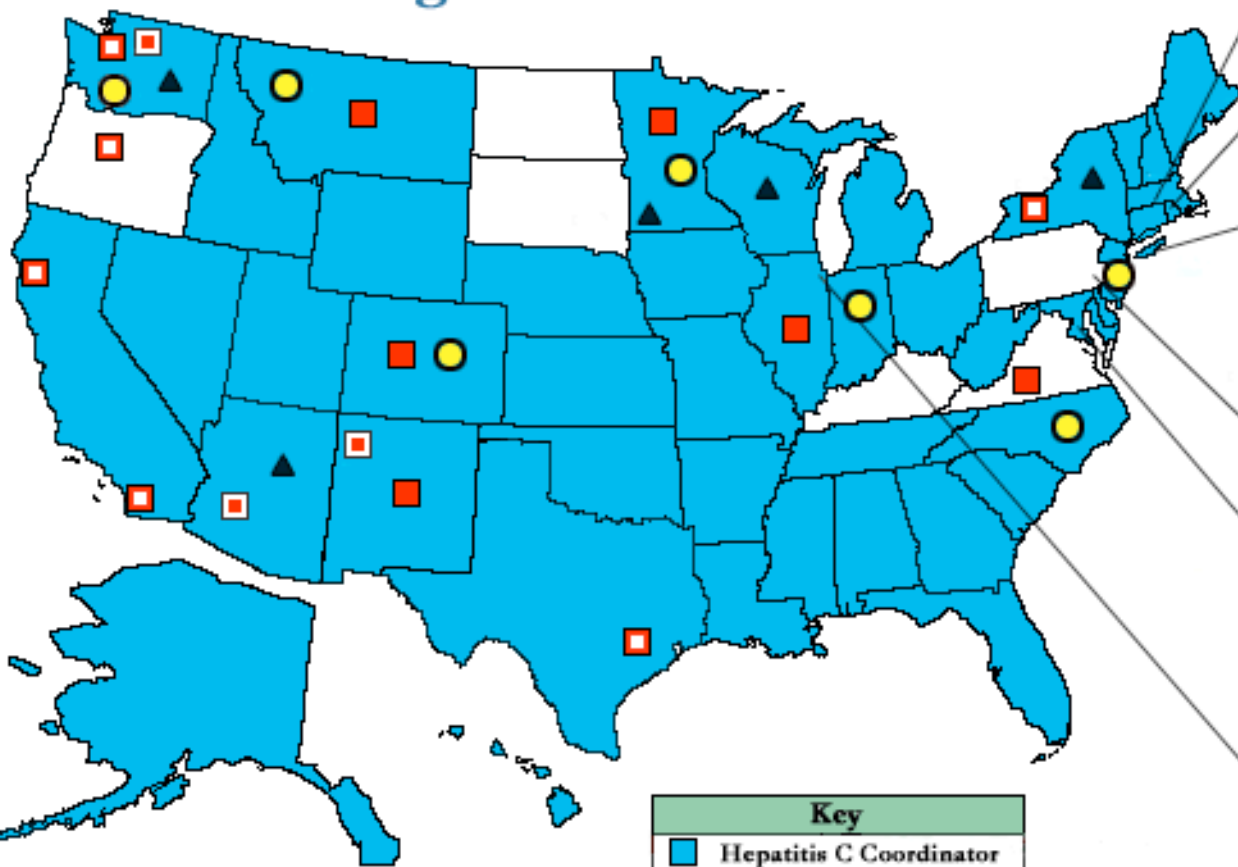
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Electronic versions of *the Bulletin* are posted, along with other information on both NASTAD's prevention and care projects. <http://www.nastad.org>

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CDC Funding for Viral Hepatitis

Integration Activities FY 2002



Massachusetts

- ▲ Surveillance
- VHIP

Rhode Island

- HCV Coordinator
- VHIP

New York City

- HCV Coordinator
- VHIP
- VHET
- ▲ Surveillance

Philadelphia

- HCV Coordinator

Washington D.C.

- HCV Coordinator
- VHET
- VHET
- VHET

Chicago

- HCV Coordinator
- VHET

Key

- Hepatitis C Coordinator
- State H.D. VHIP
- L.H.S. VHIP
- City/County H.D. VHIP
- VHET
- ▲ Surveillance Demo

HCV - Hepatitis C Virus
 VHIP - Viral Hepatitis Integration Project
 VHET - Viral Hepatitis Education and Training
 H.D. - Health Department


 Puerto Rico