

**CENTERS FOR DISEASE CONTROL AND PREVENTION**  
**National Center for HIV/AIDS, Viral Hepatitis,  
STD and TB Prevention**



**Strategic Realignment of Funding to Support Priorities in  
Sexual Health and STD Disparities Among  
Racial and Ethnic Minorities**  
**July 8, 2010**  
**Atlanta, Georgia**

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**Record of the Proceedings**

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**CENTERS FOR DISEASE CONTROL AND PREVENTION**  
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**STRATEGIC REALIGNMENT OF FUNDING TO SUPPORT PRIORITIES IN**  
**SEXUAL HEALTH AND STD DISPARITIES AMONG**  
**RACIAL/ETHNIC MINORITIES**

**July 8, 2010**  
**Atlanta, Georgia**

**Summary Report**

The Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) convened the Legacy Funding Realignment Consultation. The proceedings were held on July 8, 2010 in Building 19 of the Tom Harkin Global Communications Center at the CDC Roybal Campus in Atlanta, Georgia.

**Opening Session**

**Dr. Donna Sweet** is the co-Chair of the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC). As the Chair of the Workgroup for the Legacy Funding Realignment Consultation, she opened the meeting by welcoming the participants to this important event.

**Dr. Kevin Fenton** is the Director of NCHHSTP. He also welcomed the Workgroup members and noted that the Consultation is of critical importance to both CDC at the agency level and NCHHSTP at the National Center level. Since his appointment as the Director of NCHHSTP in 2005, Dr. Fenton has provided leadership to strengthen the focus on health disparities and promote health equity. He highlighted key changes NCHHSTP has made since that time to achieve these goals.

NCHHSTP has been building on its existing strategies to reduce the tremendous disparities in HIV, viral hepatitis, STDs and TB in the United States. NCHHSTP traditionally focused on and made a commitment to document disparities by reviewing surveillance data and other research. Over the past five years, however, NCHHSTP has taken a more proactive approach to ensure that health equity is incorporated into all of its programs and target populations.

NCHHSTP also has placed more emphasis on applying a social determinants of health (SDH) approach to address health disparities. The SDH approach has allowed NCHHSTP to (1)

broaden its focus on determinants of disparities and health inequities; (2) consider health system factors in a more strategic manner; (3) utilize a more systematic approach to identify social, cultural and economic factors that drive disparities; and (4) align research, policies and programs across the four NCHHSTP divisions to reduce social and structural determinants of health.

Dr. Fenton confirmed that the Workgroup's input during the Consultation would play a critical role in helping NCHHSTP to improve its current activities and priorities, realign its existing SDH and health equity efforts, and clarify its future directions. The Consultation also would provide an opportunity for the NCHHSTP Division of STD Prevention (DSTD) to obtain external advice on its investment to the Tuskegee University legacy initiative.

The Workgroup would be asked to formulate recommendations to NCHHSTP on priority areas for future investment, potential strategies to increase the health impact of this funding, and possible areas to realign resources to meet NCHHSTP's new directions and priorities in SDH and health equity.

Dr. Fenton described the two major imperatives that are driving NCHHSTP's new directions and priorities at this time. First, the global economic crisis has dramatically decreased NCHHSTP's ability to leverage new resources for its prevention programs. As a result, existing resources must be used as effectively and efficiently as possible.

Second, investments across all NCHHSTP programs must be fully aligned with CDC's strategic priorities established by Dr. Thomas Frieden, Director of CDC. Most notably, Dr. Frieden issued a strong directive to all CDC programs to strategically allocate resources to increase health impact and reduce health disparities.

Dr. Fenton concluded his opening remarks by thanking the Workgroup members for taking time from their busy schedules to attend the Consultation and contribute their expertise to helping NCHHSTP realign the Tuskegee legacy funding. Dr. Fenton opened the floor for introductions. The Participants' Directory is appended to the summary report as [Attachment 1](#).

## Overview of the Consultation

Dr. Hazel Dean is the Deputy Director of NCHHSTP. She presented a comprehensive overview of the Tuskegee legacy funding to set the stage for the Workgroup's deliberations on CDC's strategic realignment of this investment to support priorities in sexual health and STD disparities among racial/ethnic minorities.

President Clinton issued an apology on behalf of the nation in 1997 for the U.S. Public Health Service *Tuskegee Study of Untreated Syphilis in the Negro Male*. He made a firm commitment to provide Tuskegee University with necessary funding to establish a Center for Bioethics in Research and Health Care.

The overall goal of the funding was to support the establishment of a center with a strong emphasis on bioethics in research involving human subjects, particularly in African American (AA) communities. Over the past 12 years, CDC's cooperative agreement with Tuskegee has supported the development and implementation of the Tuskegee University National Center for Bioethics in Research and Health Care. CDC has allocated ~\$20.3 million to Tuskegee since that time to support this effort.

Tuskegee's cooperative agreement funding of \$2 million per year ended in September 2009, but CDC provided a one-year extension of ~\$1.6 million to support additional activities through September 2010. However, CDC has determined that continued funding for this project would need to be competed because no Congressional language exists to justify eligibility status to a single grantee. As a result, CDC convened the Workgroup to provide external guidance on the strategic realignment of funding to support priorities in sexual health and STD disparities among racial/ethnic minorities.

CDC initiated the cooperative agreement with Tuskegee 12 years ago, but the focus on health disparities among AAs is still an important issue at this time. Most notably, AAs historically have experienced a disproportionate burden of STDs and accounted for 49% of all new HIV infections in 2006. In 2008, AAs accounted for 49% of all reported chlamydia cases, 49% of all reported syphilis cases, and 71% of all reported gonorrhea cases. The STD/HIV disparities in AAs primarily have been exacerbated by several SDH factors, including poverty, limited access to quality health care, healthcare seeking behaviors, illicit drug use, and residence in communities with high STD prevalence rates.

To help CDC in addressing these issues, Dr. Dean emphasized that the Workgroup would be charged with achieving three key objectives during the Consultation: (1) identify opportunities in the future to accelerate the impact on health disparities through programs, policy, research and public health ethics; (2) make recommendations to CDC regarding the potential use of funding; and (3) articulate key principles in the areas of programs, policy and research to be considered in the development of a new funding opportunity announcement (FOA) to allocate resources.

Dr. Dean clarified that the Workgroup's input would be relevant to and consistent with CDC's four priority goals. The "strategic realignment" goal aims to reduce health disparities and promote health equity. The "strategic partnership expansion" goal aims to strengthen collaborations with diverse groups that have a strong interest and competency in STD health disparities and public health ethics activities and research to support the effectiveness and impact of the legacy investment. Partners in this effort include Historically Black Colleges and Universities (HBCUs), other academic institutions and non-governmental organizations. The "community participation and engagement" goal aims to engage a wider group of academic and community stakeholders in determining the appropriate use of funds to assure the greatest benefit and impact on the lives and well-being of AA communities. The "accountability" goal aims to critically examine programs and identify opportunities to optimize investments, eliminate redundancy, and achieve greater health impact.

CDC expected the Workgroup to provide recommendations in response to four key questions.

1. What criteria should be used to realign the funds?
2. How should these funds be directed to accelerate the impact on STD disparities?
3. How should CDC ensure that the principles of public health ethics inform and guide efforts to reduce STD disparities?
4. What institutional or organizational partnerships should be developed to effectively implement strategies to reduce STD disparities among racial/ethnic minority groups?

Dr. Dean concluded her overview by describing CDC's next steps after the Consultation to realign the legacy funding. CDC would use the Workgroup's recommendations to develop and release an open and competitive FOA for organizations to take advantage of key opportunities to reduce health disparities and advance public health ethics. CDC expects to award funding to one or more organizations to achieve this goal.

In response to the Workgroup's request, Dr. Fenton confirmed that NCHHSTP would provide the Workgroup with information on its entire budget along with individual funding levels for the HIV, viral hepatitis, STD and TB programs. In the interim, however, he highlighted the allocations of the NCHHSTP budget.

Of NCHHSTP's total Congressional appropriation of \$1 billion, ~70% is allocated to domestic HIV prevention, ~15% (or ~\$158 million) is allocated to STD prevention, ~14% is allocated to TB prevention, and ~2% (or ~\$20-\$24 million) is allocated to viral hepatitis. Of DSTDP's \$158 million budget, \$20 million is allocated to the Syphilis Elimination Effort and \$2 million is allocated each year to the Tuskegee legacy activities.

In response to the Workgroup's question, Dr. Fenton clarified that DSTDP is not directly benefiting from American Recovery and Reinvestment Act (ARRA) dollars. However, the NCHHSTP Division of HIV/AIDS Prevention (DHAP) will receive ~\$30 million from the "Prevention and Public Health Fund to Jumpstart Community-Based Prevention Programs." NCHHSTP will explore opportunities with the DHAP investment to develop comprehensive HIV prevention activities.

NCHHSTP also is collaborating with CDC colleagues in the National Center for Chronic Disease Prevention and Health Promotion to try to leverage resources from Community Transformation Grants that are funded by the Prevention and Public Health Fund. NCHHSTP hopes that these grants will facilitate opportunities to integrate sexual health promotion activities over time.

The Workgroup made general observations in two key areas in response to Dr. Dean's overview. First, the Workgroup commended CDC on its new focus on social and structural determinants of health, but the members emphasized the critical need for CDC to also consider social attitudes and the political environment.

Additionally, the Workgroup consultants stated that CDC's strategic realignment of funding to support STD and sexual health disparities would not be successful unless changes are made to



the existing social and political culture, particularly among policymakers and other key decision-makers.

The Workgroup consultants went on to further state that these changes should include widely implementing evidence-based STD prevention programs, launching a national conversation to normalize sexual health dialogue across the United States, and developing metrics to demonstrate the impact of advocacy and sexual communications on normalizing sex-related discussions.

Second, CDC's new FOA to strategically realign funding should have a stronger emphasis on community engagement, e.g., community-based participatory research (CBPR). CBPR has a long and effective history of (1) involving communities in the decision-making process; (2) changing cultural norms, attitudes and beliefs among local elected officials, policymakers, legislators and community/grassroots leaders; and (3) facilitating changes in local policy.

Community health centers (CHCs) that are funded by the Health Resources and Services Administration (HRSA) may play a critical role and could serve as leaders in using the realigned funding to prevent STDs, conduct community engagement, and test and treat clients. CHCs could play a critical role in decreasing STD disparities in healthcare settings.

Dr. Fenton was pleased that the Workgroup's initial observations were consistent with CDC's goal to take a bold, different, exciting and innovative approach to realigning the legacy funding. The realignment of the legacy funding in DSTDP also could serve as a model for restructuring NCHHSTP's other cooperative agreements in the HIV, viral hepatitis and TB programs. Dr. Fenton confirmed that CDC would thoughtfully consider the Workgroup's recommendations in four key areas in developing the new FOA: science, policy, affected communities and programs.

### **Overview of the Division of STD Prevention (DSTDP) Priorities**

Dr. Cathleen Walsh is the Acting Director of DSTDP. She presented data to support DSTDP's prevention activities. DSTDP's prevention goals focus on STD-related HIV transmission, adverse pregnancy outcomes, STD-related cancer, and impaired fertility. DSTDP recognizes the importance of addressing health disparities, strengthening local capacity, addressing the effects of social determinants, and enhancing local infrastructure in order to accomplish these goals.

CDC data show that compared to other racial/ethnic groups, primary and secondary syphilis (P&S) rates dramatically increased among AA males 15-19 years of age in the United States from 1999-2008. The same data set also showed tremendous disparities in gonorrhea among AAs compared to other populations.

Chlamydia is the most commonly reported notifiable disease in the United States with >1.2 million cases reported in 2008. However, CDC estimates that the burden of infection is closer to 2.8 million cases annually due to substantial underreporting caused by the asymptomatic nature of chlamydia. The direct medical cost of chlamydia is \$678 million per year.

By age, the burden of chlamydia is highest among sexually active adolescents and young adults. Sexually active persons 14-24 years of age have ~3 times the chlamydia prevalence than sexually active adults 25-39 years of age. By gender, sexually active females 14-19 years of age have the highest chlamydia prevalence. By race/ethnicity, chlamydial infection is more commonly reported in non-Hispanic blacks than non-Hispanic whites.

The 2005 Wiesenfeld, *et al.* study reported societal challenges to STD prevention. In terms of providers' knowledge, attitudes and screening practices of STDs, primary care physicians had limited knowledge of STDs with only six of ten providers correctly answering 75% of questions on common STD scenarios. General practitioners cited several reasons for low screening rates: lack of awareness of disease prevalence in their communities; perceptions that their patients are not at risk; an inability to offer confidential services to adolescents; and a belief of chlamydia being a non-urgent and easily treatable medical condition.

Challenges to STD prevention at the individual level include a low perception of risk among adolescent girls. Among sexually experienced females 14-19 years of age, 89% perceived little or no risk for STDs, but 74% reported a previous STD, risky behavior or symptoms. Among low-income minority adolescents 14-19 years of age, AAs were 84% less likely to perceive themselves as susceptible to both pregnancy and STDs compared to whites. A recent STD diagnosis in this population did not increase the likelihood of perceived susceptibility for a single or dual sexual outcome.

DSTDP is conducting a number of activities to address these challenges. DSTDP's disease-specific priorities for syphilis include enhancing social marketing campaigns and building local capacity to prevent syphilis in HIV-infected persons, men who have sex with men (MSM), pregnant women and minority populations. The Prevention and Public Health Fund could provide DSTDP with greater opportunities to achieve these goals. DSTDP also is developing and evaluating rapid diagnostic tests for syphilis to treat persons with positive results at point of care.

DSTDP's disease-specific priorities for chlamydia include assuring that chlamydia screening and appropriate partner services are accessible for sexually active women of reproductive age, particularly those who obtain health care in public health settings. DSTDP also is strengthening and supporting efforts to reach youth (or the population at highest risk) through multifaceted and tailored campaigns.

DSTDP, MTV, the Kaiser Family Foundation and Planned Parenthood have partnered with the media to launch the successful "Get Yourself Tested, Get Yourself Talking" (GYT) Campaign. The goals of the GYT Campaign are to normalize conversations around sexual health, safety

and testing; raise awareness of STD prevalence and prevention methods among adolescents and young adults; and normalize routine STD testing.

The components of the GYT Campaign include public service announcements and videos as well as segments for mobile phones; a website with digital toolkits, posters, banners, logos and postcards; and strategies to generate dialogue about STD testing with healthcare providers and sex partners.

DSTDP continues to address new and ongoing challenges to STD prevention. In terms of disease-specific challenges, DSTDP recognizes the need to monitor the uptake, implementation and impact of human papillomavirus (HPV) vaccination from both biological and behavioral perspectives. Additional challenges faced include antibiotic-resistance to gonorrhea, while maintaining a balance among multiple competing infections (*i.e.*, syphilis, chlamydia, gonorrhea, HPV, herpes and trichomonas).

DTDSP also sees the value of identifying effective partnerships and resources at the local level to bridge the gap between new opportunities emerging from health reform and traditional public health roles and responsibilities. Health reform demands a shift in the focus of prevention from strictly providing clinical care to assuring access to quality comprehensive STD prevention and developing data systems to monitor STD prevention at both local and national levels.

DSTDP will provide leadership in enhancing local capacity to assure that evidence-based techniques and strategies are implemented and evaluated; efforts are tailored to complement the needs of communities; and emphasis is placed on policy and structural approaches whenever possible to have a greater population impact on the underlying causes of STDs.

In response to the Workgroup's request, Dr. Walsh presented additional details on DSTDP's budget. Of DSTDP's total budget of \$158 million, \$115 million is for extramural activities primarily conducted by state and local health departments and \$43 million is for intramural activities conducted by CDC staff. By initiative, ~\$20 million of DSTDP's budget is allocated to syphilis prevention in high morbidity areas (SEE), ~\$10 million is allocated to HIV, ~\$30 million is allocated to chlamydia and other infertility prevention programs, and the remaining funds are allocated to the control of syphilis and all other STDs. SEE grantees are required to share at least 15% of their awards with CBOs.

## **Overview of Challenges and Opportunities in STD Disparities in the United States**

Ms. Jo Valentine is the Associate Director for Health Equity in DSTDP. She described the major challenges and opportunities for STD disparities in the United States. CDC defines "health equity" as the fair distribution of health determinants, outcomes and resources within and between segments of the populations regardless of social standing. Ms. Valentine reminded the Workgroup of the CDC data that Dr. Walsh presented to demonstrate tremendous disparities in chlamydia, gonorrhea and P&S syphilis among AAs in the United States from 1999-2008.

DSTDP is well aware of multiple social determinants other than individual behaviors that contribute to STD disparities in AA communities, such as racial and sexual orientation inequalities, high uninsured rates, low educational attainment and high incarceration rates. DSTDP also is aware of the need to target STD interventions to multiple areas of influence at individual, public policy, interpersonal, community and institutional/organizational levels.

CDC has been applying lessons learned from the Syphilis Elimination Effort (SEE) to the same populations that acquire other STDs. Key lessons learned from SEE include:

- Providing high-quality STD services.
- Integrating syphilis elimination with other STD/HIV prevention and control programs.
- Adopting a holistic approach to eliminate syphilis that considers the social determinants of disease transmission.
- Applying surveillance outcomes, research findings and other data gathered from the local level to develop evidence-based strategies.
- Developing flexible syphilis elimination activities to respond to rapidly evolving epidemics at the local level.
- Including Internet-based prevention and control strategies.
- Engaging and collaborating with communities and local private providers.

The 1993 Hatch, *et al.* paper defined four levels of “community participation:” (1) advise and consent; (2) endorse and cooperate; (3) advise, guide, support and execute; and (4) define, decide, design, analyze and interpret. CDC aims to achieve the fourth level to ensure that communities are engaged as full partners throughout the entire decision-making process

In 2007, DSTDP drafted an STD Disparities Action Plan with three key component goals in addition to providing a comprehensive DSTDP approach to reducing STD disparities. The three component goals are: (1) improving STD prevention research capacity, (2) improving program capacity, and (3) promoting internal and external collaborations with key stakeholders, organizations and affected community leaders to promote sexual and reproductive health and reduce STD disparities. A number of activities to reduce STD disparities are currently underway, including the HBCU STD Training and Community Outreach Project, a project with the National Medical Association to conduct the healthcare provider sexual history-taking project to reduce the risk for STDs among AA MSM, and the CDC interagency agreement with the Indian Health Service to provide technical support for STD prevention and control among Native American populations.

## Overview of NCHHSTP’s Public Health Ethics Activities

Dr. Frederick Bloom is the Deputy Associate Director for Science in DSTDP. He described NCHHSTP’s public health ethics activities. The NCHHSTP Public Health Ethics Team (PHET) was chartered in 2007 with representation from all four divisions. PHET functions as a liaison

between the CDC Public Health Ethics Committee (PHEC) and NCHHSTP; serves as a resource to NCHHSTP for public health ethics; increases awareness and knowledge of public health ethics; serves as a public health ethics advisory body.

Representatives of the four NCHHSTP divisions who serve on PHET have discussed a broad range of public health ethical issues, including the ethics of collecting and sharing laboratory data for surveillance or possible research purposes; stigmatization of hepatitis C in the workplace and the ethics of existing guidelines on hepatitis C and unprotected sex; HIV confidentiality versus criminality for HIV-infected persons; and the U.S. male circumcision policy.

To date, PHET has provided public health ethics materials to CDC's new Ethics Teams in other National Centers; submitted case studies to support CDC's ethics training courses; co-hosted a CDC-Tuskegee public health ethics fellow; and collaborated in mentoring an ethics summer intern from Emory University.

### **Charge to the Workgroup**

Dr. Dean charged the Workgroup with providing advice and guidance to CDC on the following:

1. What criteria (e.g., morbidity, age, gender, risk or region) should CDC use to realign funds to effectively improve the sexual health of racial/ethnic minorities that are disproportionately affected by STDs? Examples of issues for the Workgroup to consider in responding to question 1 include:
  - How should the criteria be applied to ensure an appropriate allocation of resources?
  - Should certain criteria be more heavily weighted than others?
  - If a combination of criteria is used, what should be the balance between designated criteria?
2. How should funds be directed to accelerate the impact on STD disparities? Examples of issues for the Workgroup to consider in responding to question 2 include:
  - To provide direct services (e.g., screening and treatment, risk reduction counseling, or drug treatment)?
  - To support research (e.g., individual behavioral, biomedical or structural interventions)?
  - To develop and implement policy interventions (e.g., legal, regulatory, partnership and communication)?
3. How should CDC ensure that the principles of public health ethics inform and guide efforts to reduce STD disparities?
4. What institutions and organizations should partner with CDC to effectively implement strategies to reduce STD disparities among racial/ethnic minority groups? Examples of issues for the Workgroup to consider in responding to question 4 include:

- What types of institutions or organizations should be eligible to apply for these funds (e.g., state and local health departments, academic institutions, non-governmental organizations)?
- How should CDC assure community participation in these efforts?

In response to the Workgroup's requests, Drs. Dean and Barrett confirmed that CDC would distribute two resources: (1) maps to illustrate geographic regions in the United States with the highest burden of STDs and (2) the "Principles of the Ethical Practice of Public Health" created by the Public Health Leadership Society in 2002.

The Workgroup made three key suggestions outside of the four overarching questions Dr. Dean posed. First, CDC should capture data to document the role of the healthcare delivery system in STD prevention and control at the local level. For example, uninsured persons or individuals with no ability to pay have no access to STD services in many jurisdictions. CDC should require grantees of the new FOA to collect local data on this social determinant.

Second, CDC should require grantees to develop innovative strategies to use the realigned funds to make STDs a priority in communities. Third, CDC should craft the new FOA language with sufficient flexibility to address diverse abilities, infrastructures and resources of grantees at this time.

Dr. Fenton asked the Workgroup to consider two additional questions during its deliberations. Is funding available from other CDC entities, federal agencies or external initiatives to add to the realigned funds and build a broader health disparities research agenda? What innovative strategies (*i.e.*, matching funds) could be implemented to expand competition of the new FOA to the local level?

### Workgroup Deliberations

The Workgroup's advice and guidance to CDC on four overarching questions are outlined below.

1. *What criteria (e.g., morbidity, age, gender, risk or region) should CDC use to realign the funds to effectively improve the sexual health of racial/ethnic minorities that are disproportionately affected by STDs?*
  - **Morbidity.** Funding should be allocated to high-morbidity areas and should follow epidemics in terms of specific diseases and burden of disparities. The top two STDs that should be prioritized are: (1) syphilis due to its important role in acquiring HIV and the complexity in treating this disease and (2) chlamydia due to its impact on young AA women.
  - **STD Prevention Plan.** Applicants should be required to submit a local STD Prevention Plan that accurately captures the needs and priorities of local providers and the broader community and describes a comprehensive approach to sexual

health that values the diversity of sexual expression and honors family-centered approaches to sexual health education.

- **Partnerships.** Applicants should demonstrate strong and established partnerships with CHCs, local health departments, and organizations that serve target populations to facilitate a comprehensive and coordinated community-wide effort, integrating STD prevention and care, and enhancing existing infrastructures. Moreover, the partnerships should help to improve the sexual health of target populations by providing the full spectrum of education, prevention, screening and treatment.
- **Health Equity.** Health equity should be an additional criterion to ensure that the realigned funds are integrated into communities with a high burden of concomitant diseases, particularly HIV, and the same target populations. CDC should give a clear mandate to its HIV grantees to increase their focus on STD issues.
- **Public Health Ethics.** Applicants should honor the source and history of the realigned funds (*i.e.*, the ethical framework related to the Tuskegee syphilis study).

At the conclusion of the discussion on question 1, the Workgroup selected its top five criteria for CDC to use in realigning the legacy funds. (*Editor's Note:* The criteria are not ranked from most to least importance.)

1. The significance and impact of the proposed project in reducing disparities; the relevance of the proposed project to current problems; and the ability of the proposed project to address barriers.
  2. Innovation and novel methods described in the application to implement a comprehensive sexual health framework that values the diversity of sexual expression.
  3. Submission of an innovative and significant STD Prevention Plan that highlights established partnerships with the local community (e.g., Ryan White Programs, CHCs, AA church groups, AIDS service organizations, and youth-serving organizations).
  4. Ability to engage disproportionately affected communities to clearly define the "community," accurately describe the needs and priorities of the community, and obtain endorsement from the community.
  5. Accountability of HIV grantees to integrate STD prevention into their programs.
2. *How should funds be directed to accelerate the impact on STD disparities?*
- **Multifaceted Intervention Strategies.** Funds should be allocated to support "twin" interventions that are conducted at the same time (*i.e.*, service and policy interventions) in order to leverage results.
  - **Evaluation.** Interventions should be evaluated to demonstrate their effectiveness. The evaluation component should include baseline data on STDs in the target community (*i.e.*, syphilis rates among AA MSM) and the effectiveness of the grantee's project in decreasing these rates over the three-year funding cycle. Grantees should be required to document specific reasons if their projects did not accelerate the impact on STD disparities over the three-year funding cycle.
  - **Innovation.** The allocation of funds should support novel methods to normalize sexual communications, change sexual attitudes, beliefs and treatment at the local level, and launch efforts to de-stigmatize sex.

- **Priority focus on Service and Policy Interventions.** Funds should be allocated to service and policy interventions. CDC should partner with the National Institutes of Health and the Agency for Healthcare Research and Quality to fund long-term research on STD disparities. Efforts should be made to use research dollars to support strong community advocacy due to negative perceptions and the stigma associated with STDs.
  - **Health Communications and Media Development.** Funds should be allocated to launch aggressive and up-to-date media campaigns to educate impacted communities about the importance and seriousness of STDs in the current environment.
  - **Direct Funding to Community-based Organizations.** Health departments should be required to engage and share their legacy funds with CBOs. Due to the historical mistrust of health departments, CBOs have much better and more open lines of communication with affected communities and should serve as the lead for these activities. States should not serve as a “pass-through” to allocate funds to local communities that are disproportionately impacted by STDs as the entities often face restrictions that could dilute sexual health messages to target populations.
  - **Engaging Community Health Centers.** Funds should be allocated to applicants with established partnerships with CHCs to educate and train physicians in these settings and more rapidly improve the quality of STD treatment. However, a partnership with a CHC should not serve as an advantage to receiving an award because many jurisdictions do not have CHCs. An example of the FOA language addressing CHCs could read: “Relationships with CHCs should be considered.”
  - **Commitment to Health Equity and Public Health Ethics.** Funds should be allocated for grantees to implement an ethical framework to advance health equity.
  - **Conduct Community-Based Participatory Research.** Funds should be allocated for grantees to support community engagement to inform program standards and better address health disparities.
  - **Compile and Disseminate “Best Practices.”** Funds should be allocated for best practices to be compiled and disseminated, such as a CHC with high STD screening rates. The best practices should serve as successful models for other programs to replicate across the country.
  - **Provide for multi-year project periods.** Individual funding awards should range from \$100,000-\$250,000 annually for a minimum of three years for grantees to build an infrastructure, establish partnerships, conduct interventions, and evaluate activities to accelerate the impact on STD disparities.
3. *How should CDC ensure that the principles of public health ethics inform and guide efforts to reduce STD disparities?*
- **Public Health Ethics Plans.** Applicants should describe a strategy to use public health ethics to hold their states accountable to using the realigned funds to meet the needs of affected communities.
  - **“Principles of the Ethical Practice of Public Health.”** The ten “Essential Public Health Services” should be incorporated into the FOA language.



- **Evaluation of Public Health Ethics Efforts.** Applicants should be required to describe a detailed process to address and evaluate public health ethical issues in their proposed projects. CDC should provide several resources to ensure that applicants are held accountable to conducting public health projects with an ethical basis, including:
    - CDC-sponsored webinars or face-to-face training courses to help applicants in responding to the public health ethical questions in the FOA.
    - CDC should make efforts to broaden the availability of its online public health ethics course.
    - CDC should include a link in the FOA to the “Principles of the Ethical Practice of Public Health.”
    - CDC should include a link in the FOA to the elimination of racial/ethnic health disparities study that was written by Dr. David Satcher, the former U.S. Surgeon General, and published in 2001 in the *Yale Journal of Health Policy, Law and Ethics*.
  - **Public Health Ethics Criteria in the FOA.** To preserve recommendations addressing public health ethics, NCHHSTP should instruct the review panel to evaluate and score applications based on the following criteria outlined in the FOA:
    - Does the proposed project have the capacity to help reduce the incidence of STDs in the populations at risk?
    - Is the proposed project universal, confidential, targeted to all-comers, and equal-handed to all groups?
    - Is the proposed project consistent with the principle of public health ethics to provide all patients infected with STDs access to quality care with the best approach, in the least offensive manner, and with the smallest number of barriers?
4. *What institutions and organizations should partner with CDC to effectively implement strategies to reduce STD disparities among racial/ethnic minority groups?*
- **Institutions with credibility with affected communities and populations.** Applicants should reflect the target community ideally, but the experience and success of the applicant in serving the community should take precedence regardless of race/ethnicity or other demographic factors. The applicant should clearly define the community, document an effective relationship with the community, and demonstrate the community’s concurrence with the proposed project.
  - **Ensure majority support to Community-based Organizations.** If local health departments are eligible to apply for funding, CDC should require these agencies to allocate no less than 75% of their awards to CBOs. This requirement should be explicitly stated in the FOA.
  - **Addressing Human Sexuality and Sexual Health.** Applicants should demonstrate a willingness and capacity to address and change attitudes and norms regarding sexuality and sexual health at the local level.
  - **Community Advisory Boards.** The establishment of a Community Advisory Board (CAB) should be a condition of funding to ensure that grantees receive external input from the community on a periodic basis. The CAB should truly reflect and represent

the community and should be charged with reviewing the grantee's performance in implementing all components of the proposed project, such as programs, public health ethical issues and partnerships. A clear plan to establish and retain the CAB over the time should be described in the application, including its organizational structure and composition of members.

- **Diversity of Eligible Applicants for the FOA.** CDC should not sole-source these funds. Applicants should be encouraged to build a coalition with existing resources in the community, such as an Education and Training Center, a CHC/local health department for STD testing and clinical care, and a CBO. However, grantees should be given sufficient time to build strong linkages with the coalition of partners. HBCUs should not have an advantage in receiving funds solely on the basis of their status as an HBCU. Applications submitted by HBCUs should be held to the same standards and evaluated with the same rigorous criteria as applications submitted by non-HBCUs.
- **Emphasize Partnerships.** Applicants should be encouraged to establish partnerships with the following entities: faith-based CBOs, mental health agencies, community college networks, the National Medical Association, and Minority HIV/AIDS Research Initiative grantees. These partnerships could increase the role of minority and junior researchers in conducting CBPR on STD disparities.

### Summary of the Workgroup Deliberations with NCHHSTP Leadership

Dr. Fenton rejoined the meeting at the conclusion of the deliberations for the Workgroup to highlight its advice and guidance to CDC in response to the four questions. For question 2, he noted that the Workgroup advised CDC to direct funding to the following areas to accelerate the impact on STD disparities:

- Projects that conduct community engagement (e.g., CBPR).
- Projects with demonstrated capacity to accelerate the impact on STD disparities in communities at greatest risk.
- Projects with the ability to partner with other federal agencies, collaborate with CHCs, and implement novel methods and innovation.
- Projects designed with a strong evaluation component to demonstrate the efficacy of interventions over a three-year funding cycle, apply lessons learned, and broaden the pool of interventions to reduce STD disparities.

In response to Dr. Fenton's question regarding the distribution of funding, the Workgroup advised CDC to require applicants to allocate the bulk of their awards (*i.e.*, 80%-85%) to the programmatic component. This approach would require projects to have the greatest focus on decreasing the incidence of STDs in target populations.

In response to Dr. Fenton's question regarding the public health ethics fellow, the Workgroup fully supported the retention of this position to honor and acknowledge the legacy and history of

the Tuskegee syphilis study. However, the Workgroup agreed that DSTDP should support an “STD-specific” public health ethics fellow only. CDC’s emergency preparedness, chronic disease and other programs should be responsible for supporting an equal portion of this position if the fellow will be utilized outside of DSTDP.

The Workgroup also raised the possibility of including language in the FOA for the public health ethics fellow to be available to all grantees and their partners (beyond Tuskegee and other HBCUs) to serve as a resource and provide technical assistance. In the new FOA, the public health ethics fellow could be funded to address the historical distrust and stigma associated with STDs in the AA community as a result of the Tuskegee syphilis study.

### **Closing Session**

Dr. Sweet thanked the Workgroup members for contributing their valuable expertise and diverse perspectives to help CDC in developing and releasing the new legacy funding FOA. She confirmed that the summary report of the Consultation would be distributed to the Workgroup members for review and comment.

Dr. Sweet also thanked Dr. Fenton for his leadership in convening the important Consultation to realign the legacy funding. She hoped the Workgroup’s recommendations would play a key role in improving the lives of the most vulnerable populations that are impacted by STD disparities.

Dr. Fenton thanked the Workgroup members for providing CDC with bold and innovative recommendations to realign the legacy funding. He emphasized that CDC greatly appreciated the Workgroup’s passion, energy and continued commitment to decreasing health disparities.

Dr. Fenton also acknowledged CDC staff for their outstanding efforts in planning, organizing and arranging the Consultation: Hazel Dean, Margie Scott-Cseh, Norman Hayes, Eva Margolies, Jo Valentine, and Sharnell Wilson.