IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

IHIPC
Illinois HIV Integrated Planning Council

ILLINOIS HIV INTEGRATED PLANNING COUNCIL NEWSLETTER

Winter 2018 Volume 1, Issue 4

FROM THE CO-CHAIRS

Hi, everyone.

I am pleased to announce that Mike Benner and I, Co-chairs of the Illinois HIV Integrated Planning Council (IHIPC), were selected to represent Illinois at a series of "Establishing Synergy for Integrated Planning Leadership" meetings sponsored by the National Alliance of State and Territorial AIDS Directors (NASTAD). Jurisdictions with already-established integrated HIV prevention and care planning bodies were invited to apply, and 12 were selected through a competitive process. At the first meeting, held October 25-26, 2018 in New Orleans, the health department and community co-chairs of the 12 selected jurisdictions came together to learn and share best practices for strengthening their integrated planning processes. The meeting culminated with each pair of co-chairs developing a four-month action plan for implementation back in their jurisdiction. Mike and I will be informing the IHIPC of that plan and working with our committees on various tasks and activities. We will be meeting with the other jurisdictions again in March to report on our progress and to develop a more long-term strategic plan. We will be sure to keep you posted!

Janet Nuss, IHIPC Health Department Co-chair

Mike Benner, IHIPC Community Co-chair

IN THIS ISSUE:

CALENDAR OF UPCOMING EVENTS

February 7:
National Black HIV/AIDS Awareness Day

February 21:
IHIPC Webinar
The registration link will be posted closer to the meeting date.

March 26-29:
STD Counselor Training
Sangamon County Health Department
Contact Lesli Choat at lesli.choat@illinois.gov for more details.

TRAINING UNIT UPDATE

The HIV Training Unit is finalizing the training schedule for 2019 and will distribute it. We will be offering a new course next year, "HIV Navigation Services," which will include Motivational Interviewing. Also, to clear up some confusion, "Foundations of HIV Prevention" will have a new name: "Introduction to HIV Prevention." We look forward to seeing you in our classes! If you have any inquiries about HIV trainings in 2019, please contact Jamie Burns at jamie.burns@illinois.gov.

SNIPPETS OF INFORMATION

Our webpage transition is complete! Find all IHIPC documents, meeting schedules, and meeting registration links/recordings at http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg.

The HIV Surveillance Unit has produced a new 'People who Inject Drugs' factsheet, including data through 2017. View the factsheet here.

GETTING TO ZERO

The first draft of Illinois' **Getting to Zero Plan** (www.gtzillinois.hiv/draft) was released on December 3, 2018 in honor of World AIDS Day. Visit https://gtzillinois.hiv/ or email us at info@GTZIllinois.hiv for more information.

How you can get involved:

1. Review the draft plan and provide comments through January 18, 2019
2. Take the survey at www.gtzillinois.hiv/survey
3. Connect on social media: #GTZIL2030

IHIPC UPDATE

Thanks to everyone who participated in the October 29-30, 2018 in-person meetings of IHIPC. Our face-to-face meetings are truly a great opportunity to network and garner input from our community partners. Approximately 80 people, including some who participated remotely via webinar, attended each meeting.

As always, we designated a portion of our meetings for assessing HIV community services and needs at the state, regional, and local levels. The regional HIV care and prevention lead agents, IDPH HIV Section Program leads, and IHIPC liaisons all provided brief reports from their respective areas about issues, needs, challenges, and successes pertaining to HIV. An overview of Illinois' 2017 Youth Risk Behavioral Surveillance (YRBS) survey results and a more detailed analysis of the sexual minority responses were presented. This was followed by thoughtful group discussion about the causation behind some of the disparities in the responses and implications for program planning and direction. The Integrated Planning Needs Assessment Work Group then provided an overview and solicited input from the group on plans for needs assessment activities to be conducted in 2019 and 2020.

In furtherance of its responsibility to keep the planning council updated on the State's HIV epidemiologic profile, the HIV Section presented a 2018 report of Illinois' progress in meeting the National HIV/AIDS Strategy (NHAS) Indicators and Illinois' Statewide HIV Care Continuum and Unmet Need Analysis for 2017. These documents along with other presentations from the meeting are available at the following link: https://www.regonline.com/october2018ihipcmeetings. The HIV Section Epidemiologist also prepared Unmet Need Analyses for each of the eight HIV care/prevention regions in Illinois (available here).

The meeting concluded with a very productive and meaningful community discussion about viral suppression. Viral suppression is defined as "having less than 200 copies of HIV per milliliter of blood." HIV medicine can make the viral load so low that a test cannot detect it. When people living with HIV are virally suppressed or have an undetectable viral load, their HIV is under control. Getting and keeping HIV under control is the best thing people living with HIV can do to stay healthy. This open discussion focused on the challenges and struggles clients and case managers experience with clients staying in care and achieving or remaining virally suppressed. The information gleaned from this discussion was invaluable and should be used by the planning council and state, regional, and local program planners to enhance client/community education and outreach, and to guide program changes/improvements.

As a reminder, all webinar and face-to-face meetings of IHIPC are recorded and maintained in our online archive for a minimum of 12 months. Links to the recorded meetings/webinars and associated slides and meeting handouts are available on the IHIPC webpage under "Resources" at the following site: http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg .

Submitted by Janet Nuss, HIV Community Planning Administrator, IHIPC Coordinator/Co-chair, IDPH

THE GRAYING OF HIV: NEW CASES AMONG PEOPLE OLDER THAN 50

This article contains excerpts from "The Graying of HIV: 1 in 6 New U.S Cases are People Older Than 50", published by the Washington Post. To view the full article, click here.

Thousands of people 50 and older are diagnosed with HIV each year in the United States, a development that has significant consequences for the health care and social support they need and the doctors, counselors, and others who provide it.

The phenomenon has various medical and social roots. Erectile dysfunction drugs such as Viagra, for example, have extended men's sex lives. And older heterosexuals, particularly women beyond child-bearing years, may not be in the habit of using condoms for safe sex. Older people tend to be sicker when the infection is finally discovered. They usually have other health conditions that accompany aging and are often hesitant to reveal their illness to family and friends. Many never dreamed they were at risk of contracting the virus, and some have outmoded ideas of a disease that long ago became manageable through advances in medication.

Yet health care providers still do not routinely consider HIV when treating older patients, despite guidelines that call on them to screen through age 64, researchers and physicians say. They may be reluctant to ask about an older person's sex life and sometimes attribute HIV symptoms to age-related issues such as heart disease.

Overall, this graying population has not been studied much — especially compared with people who acquired HIV when they were younger and have been aging for decades with the infection, aided by improved antiretroviral therapy. While the older, newly diagnosed group includes more heterosexuals and more women, it generally reflects the overall HIV universe: mostly gay men, some straight men and women, and intravenous drug users. It is mostly minority, as well.

A big difference for older people, however, is the shock of receiving an HIV diagnosis later in life. That is especially true for heterosexuals, mostly women, who thought they were in monogamous relationships and must confront the idea that a partner likely has been having sex with someone else.

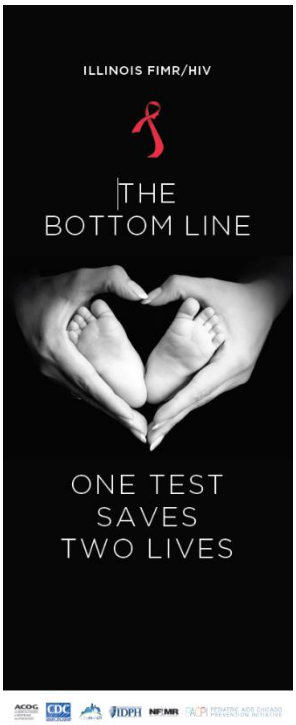
Older people who feel stigmatized worry that family, friends, neighbors, or caregivers will shun them at a time when they often have a heightened need for social support, especially if a spouse or partner has died, some experts said. The diagnosis and social isolation can lead to depression, which can cause people to stop taking their medication.

But a 2015 study of HIV-positive women older than 50 found that many eventually transition from shock, disbelief, and a sense of doom, to growing acceptance. The diagnosis also prompted them to take better care of their physical and mental health, to leave toxic situations, and to engage in more meaningful activities, says Christina Psaros, a Harvard Medical School psychologist. "With age came knowledge and understanding of what it means to live with HIV and how to . . . cope effectively," she wrote in the journal Aging and Mental Health.

If there is a silver lining for older people with HIV, it is how serious they become about protecting their health. Older people are generally much more adherent to drug regimens than younger ones and are more likely to accept HIV as a chronic, controllable condition.

GETTING TO ZERO: PERINATAL HIV IN ILLINOIS

Illinois is making dramatic progress against HIV. New HIV cases have dropped by 35 percent from 2006 to 2017; mother-to-child HIV transmission has been nearly eliminated; and there are fewer than 1,000 annual cases in Chicago for the first time in two decades. However, not all groups are benefiting equally. HIV disproportionately impacts communities of color, with Blacks being most affected by HIV across all stages of the disease – from new infections to death. Black gay men are experiencing an increase in HIV cases, particularly among youth.



Despite these advancements, "near elimination" of Perinatal HIV is not enough, and the IDPH HIV Program continues making investments to further reduce HIV transmission among women throughout their life. Black women account for more than 75 percent of women who are newly diagnosed and women who are living with HIV. Illinois saw no perinatal HIV transmission in 2015-2016; **however, there were four reported cases in 2017.**

***Getting to Zero:* Illinois's Ending the HIV Epidemic Strategy** reinforces IDPH's commitment to perinatal HIV elimination and has provided HIV leadership with an infrastructure assessment and valuable consumer and stakeholder recommendations. All of these establish priorities, improve perinatal prevention programs, and ensure timely access to PrEP for prevention and HIV care for those mothers living with HIV.

To further cement IDPH's commitment to eliminating perinatal HIV, the IDPH HIV and Women's Health Programs jointly supported **HB2800,** which mandates Opt-out, Repeat Third Trimester HIV Testing (RTTHT). The bill was passed in August 2017. The Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG) both support RTTHT, as Illinois is deemed as having a sufficient Perinatal HIV Prevalence (= or > 1 percent) to warrant repeat testing. Repeat HIV testing normalizes routine HIV screening at multiple touchpoints during pregnancy.

To better support this new testing mandate, the IDPH HIV Section continues to support the Perinatal HIV Hotline, which provides 24/7 education, reporting, clinical guidance, linkage to third trimester testing, and timely treatment for pregnant women and their families. IDPH has developed frequently asked questions (FAQs), webinar trainings, educational posters, and updated data collection forms to complement this work. IDPH is also working with Illinois Perinatal Regional Network Administrators to assess capacity and develop seamless implementation practices for their respective patients and clinics. **Early detection, the hallmark of HIV testing, is essential for preventing mother-to-child transmission.** Administration of antiretroviral drugs among pregnant women for four weeks can yield an undetectable viral load and facilitate a low risk delivery, even vaginally. Repeat testing, education, and case management also support HIV specialty OB/GYNs to facilitate low-risk deliveries for HIV positive women.

Elimination of Perinatal HIV also requires wraparound support services for moms and families, which IDPH proudly supports through Perinatal Enhanced Case Management. Services include direct connection to medical appointments and housing, emotional support, transportation, and other critical needs. Staff skills cover trauma informed care and ensure the clients are cared for before, during, and after pregnancy.

A very special thank you to IDPH's Perinatal HIV stakeholders, especially Perinatal AIDS Chicago Prevention Initiative, Northwestern, and the Perinatal Regional Network Administrators.

Submitted by Eduardo Alvarado, HIV Section Chief, Illinois Department of Public Health

BEST PRACTICES: ENHANCED CASE MANAGEMENT

The following summarizes best practices for perinatal case management through the Perinatal AIDS Chicago Prevention Initiative (PACPI) for pregnant women living with HIV. The perinatal case management program is based on a model of intensive case management. In addition, it maintains established tracking systems to ensure no mother or infant is lost after identification, up to six to 18 months postpartum.

PACPI serves approximately 100 mothers living with HIV/AIDS, and their families, on an annual basis. In 2017, 94 mothers received PACPI services, 42 of whom were delivering mothers. Fourteen of the delivering mothers were diagnosed with HIV either during their pregnancy or at labor and delivery, while the remaining 28 mothers knew their status prior to entering PACPI's care. Seven of the 94 mothers had an AIDS diagnosis.

1. Linkage to Care: Linkage to Care is a key component to perinatal case management, ensuring that each client knows one of the top goals is linking them to optimal care now and for the future. Clients are linked to a specialty HIV OB/GYN care center during pregnancy, and also to specialized infectious disease pediatric providers for infants after birth.

2. Building rapport and trusting relationships with clients: The perinatal case managers have the remarkable ability to meet each client where they are, engendering trust in a highly emotional and vulnerable environment. The client and case manager build necessary trust through weekly interactions, which can include monitoring adherence to medication and medical appointments. This is done through home visits, calls, or texts.

3. Facilitate communication between clients and their health care providers: Perinatal case managers remind clients it is their right to ask their service providers questions about their care and health. They help clients understand there are no irrelevant questions they can ask their health care provider and they have a right to answers.

4. Postpartum: The case manager will meet with the client to advise them on how to discuss health decisions with their provider, such as modifying their antiretroviral medications to a more preferred regimen after having the baby. The case manager will remain a support system to the client six to 18 months after the birth of the baby as the postpartum period poses a challenge to medication adherence for many moms. They will also do contraceptive counseling with clients, empowering the client to have a conversation with their health care provider about their contraceptive needs.

5. Infant follow-up and postnatal prophylaxis: The perinatal case manager will ensure the client understands the medicine the baby should receive and how to administer it. The case manager will also work with them to ensure they are attending all necessary medical appointments for the baby after birth and discharge from the PACPI enhanced case management program.

6. Plan for their future needs: The perinatal case manager will work to connect clients to necessary resources to remain healthy and have successful outcomes. Resources include medical care, housing, employment, food, public benefits, health insurance, etc.

Submitted by Erie Crawford and Allie Effrein, Perinatal AIDS Chicago Prevention Initiative

NORTH AMERICAN HOUSING AND HIV RESEARCH SUMMIT

In August, the ninth North American Housing and HIV Research Summit was held in Washington, D.C. This Summit was an opportunity for researchers to put forth their findings on best practices, not only in HIV housing, but also other current HIV-related research that is showing promise.

Sessions ranged from this year's theme of "Structural Intervention and Ending the Epidemic" to data integration for housing service coordination, the opioid epidemic, and U=U (Undetectable= Untransmittable). Presenters included our colleagues from the AIDS Foundation of Chicago and a few other Illinois-based researchers.

Of particular interest was how other communities are moving forward and linking Department of Housing and Urban Development (HUD) and Housing Opportunities for Persons with AIDS (HOPWA) services with Health Resources and Services Administration (HRSA) Ryan White Part B housing services. Although each program has its own set of guidelines and data collection standards, headway is being made to create a more fluid transition between the two.

Best practices for use of funding was discussed, with all relating back to how housing is a key determinant in treatment of the most vulnerable populations living with HIV, and those most at risk of HIV acquisition. Much of this ties into the Getting to Zero (GTZ) premises of pre-exposure prophylaxis (PrEP) and U=U: keeping those at risk *PrEP' d*, and keeping those living with HIV continually engaged in treatment.

With IHIPC and GTZ, we in Illinois appear to be above the curve of many of our colleagues in the planning of using housing as an HIV intervention. There are other areas in the country (including within our own state) that we can turn to for best practices models.

Submitted by Mike Benner, IHIPC Community Co-Chair, Greater Community AIDS Project

THE FORUM: GET ON UP!

On October 13th, The Forum, a conference geared towards addressing HIV and other health disparities that affect the Black population in the Midwest, was held in St. Louis, Missouri. The conference was hosted by Williams and Associates, Inc., a non-profit organization in St. Louis that addressees minority disparities across a variety of health and social categories.

The conference began with a celebration of culture and community. Participants were greeted with open arms, and young men demonstrated components of the lesbian, bisexual, gay, and transgender (LBGT) Ball culture. Discussion continued with reinforcement of the conference theme "Get On Up!," a message that empowers community members and public health advocates to combat health disparities and social inequities in the Black community.

Conference sessions were all specifically geared toward unique aspects of the Black community and included topics relevant to issues of concern such as sex trafficking of Black girls and women, toxic masculinity, trauma and coping, and disproportionately high rates of sexually transmitted infections (STI) in predominantly Black communities. Topics of particular interest were "Silent Killers in the African American Community," a session that revealed how the top ten causes of death among Blacks are exacerbated by factors such as lack of health care access, medical mistrust, and other priorities that affect daily life such as housing, employment, food security, etc.; and "Navi-'gay'- ting the Scriptures," a discussion about the intersectionality of faith, the Black Community, and LGBT individuals through Black Queer Theology.

Keynote Speaker Dr. Kimberly Parker of Texas spoke about PrEP for HIV prevention engagement among Black women and shared profound ideas about how historic and present oppression and cultural practices in the Black community can affect women's decisions to use HIV and STI prevention methods. Using PrEP as an example, related barriers included not being able to or not wanting to engage in quarterly appointments with medical professionals, not feeling that PrEP is for them as it is strongly advertised as a drug for gay men, and the belief that recognizing vulnerability to HIV and STIs may be seen as a sign of weakness or lack of trust and commitment to a partner. She also stressed that although health education is important, these beliefs and practices ultimately guide decision making processes. Her message is a reminder to always think holistically about the needs, history, and beliefs of a client, and to recognize that HIV and STI interventions should always reflect the client's priorities and values.

Overall, The Forum was a great, collaborative experience for participants to learn and candidly share ideas about unique strengths and challenges related to health and wellness in the Black community. The conference's overarching messages are applicable to the work of the IHIPC as we continue to strategically plan to combat health disparities and social inequities among communities most impacted by HIV.

Submitted by Marleigh Andrews-Conrad, Illinois Department of Public Health, HIV Community Planning Specialist

PLANNED PARENTHOOD: DEVELOPING AND IMPLEMENTING PrEP

This article contains excerpts from "Developing and Implementing PrEP at Your Local Health Center," published by Women's Healthcare: A Journal For NPs. The article was written by several representatives of Planned Parenthood of Illinois. To view the full article, click here.

Pre-exposure prophylaxis (PrEP) is the use of antiretroviral medication by HIV-negative individuals to reduce their risk of acquiring HIV. Advanced practice registered nurses (APRNs) working in reproductive health clinics, sexually transmitted infection clinics, obstetrics and gynecology practices, and other primary health care settings are particularly well positioned to discuss PrEP with their patients and prescribe the medication when indicated.

With the hope of encouraging APRNs to be more proactive in prescribing PrEP and, even more, helping them set up a PrEP program in their own practice venue—the authors share their experience in developing and implementing a PrEP program at 16 affiliates of Planned Parenthood of Illinois (PPIL).

Training and Support of Clinicians:

As part of their training, clinicians were asked to review Medical Standard and Guidelines for PrEP and to attend a 90-minute presentation on PrEP. The presentation was provided by PPIL's PrEP champion. The presentation included a case study with multiple-choice questions that generated discussion and allowed the clinicians to apply information from the protocols and algorithms. PrEP education included identifying candidates for PrEP, counseling, prescribing, and required follow-up. The clinicians were reminded that most patients are unaware of PrEP, and as clinicians, they are responsible for discussing PrEP as part of a comprehensive HIV prevention strategy.

Upon completion of the PrEP presentation, the clinicians were free to implement PrEP into their practice. Providing routine education and screening for PrEP was encouraged. However, the clinicians exercised their own judgment and comfort level in terms of whether they chose to prescribe PrEP themselves or refer patients to another PPIL provider to do so. The PrEP champion was always available to answer questions and provide support.

Evaluation Process and Results:

PPIL implemented evaluations at four, 12, and 18 months using electronic health record (EHR) data, one-on-one meetings between the clinicians and the PrEP champion, and clinician surveys. Along the way, these evaluations provided valuable insights. Early on, some clinicians needed and were provided with more information about the PrEP protocol, as well as guidance on initiating the conversation about PrEP with patients who might not consider themselves vulnerable to HIV. One year after implementing PrEP services, the clinicians reported that they had received appropriate training, but that they gained complete confidence in themselves and the process only after seeing a patient for whom they prescribed PrEP. They reported that the more times they prescribed PrEP, the easier it became to do so. During the first year, 18 (75 percent) of the PPIL clinicians reported prescribing PrEP, and all 24 expressed interest in prescribing PrEP.

Recommendations:

Based on their experience at PPIL, the authors created a robust list of recommendations for developing and implementing a PrEP Program. View these recommendations and other PrEP resources used by PPIL in the full article .

USPSTF CALLS FOR OFFERING PrEP TO ALL AT HIGH RISK OF HIV

This article contains excerpts from "Task Force Calls for Offering PrEP to All at High Risk for HIV," published by The New York Times. To view the full article, click here.

An influential government task force has drafted a recommendation that would for the first time urge doctors to offer a daily prophylactic pill to patients who are at risk for contracting HIV. The recommendation would include all men and women whose sexual behavior, sex partners, or drug use place them at high risk of contracting the virus that causes AIDS.

The United States Preventive Services Task Force's (USPSTF) draft recommendation gave an "A" grade, the highest possible, to the regimen, known as PrEP, for pre-exposure prophylaxis. If approved, it would greatly expand access to the $20,000-a-year drug regimen, since most private health plans are required under the Affordable Care Act to cover the full cost of the preventive services recommended by the panel.

"This is definitely fantastic news and validates everything science has been saying all along," said Dr. Aaron Lord, a physician at New York University School of Medicine who co-founded the PrEP4All Collaboration, which aims to expand access to PrEP for all Americans. "We've known this is a very effective medication for quite a while, and feel we could be a lot further along in using it to reduce infections. The potential is absolutely tremendous."

More than a million people in the United States are living with HIV, and 40,000 new people are infected every year. Yet only a minority of those at risk for HIV in the United States currently use PrEP, according to the Centers for Disease Control and Prevention, which estimates that of 1.2 million Americans eligible for the medication, only about 78,360 people used it in 2016.

The panel's new draft recommendation reiterated its call for physicians to screen all patients aged 15 to 65 years for HIV but, for the first time, it also proposed physicians offer PrEP. Groups at risk include:

- Men who have sex with men and who have a sex partner living with HIV, or who were recently infected with another sexually transmitted disease, or who do not use condoms consistently.
- Sexually active heterosexual men and women whose sex partner is living with HIV, or who don't use condoms consistently with a partner who is at high risk for HIV or whose HIV status is not known, or who recently had syphilis or gonorrhea.
- People who inject drugs and share needles or other drug equipment, or whose sexual behavior puts them at risk.
- Sex workers and sexually active bisexual men and transgender women and men should also be considered for PrEP, the draft says.

USPSTF Draft Recommendations available online:

The USPSTF's draft recommendations for "Prevention of HIV: Pre-Exposure Prophylaxis" can be viewed here. The draft recommendations were open for public comment until December 26, 2018. USPSTF will post final recommendations after careful consideration of public comment feedback.

For more information about free PrEP for Illinois residents, please go to www.PrEP4Illinois.com .

HIV IS NOT A CRIME

This article contains excerpts from "The National Movement to Decriminalize HIV Rights across State Lines," published by the AIDS Foundation of Chicago. To view the full article, click here.

Chris Wade is more than just your average HIV advocate. His longstanding work and organizing in downstate Illinois contributes to education and advocacy for the rights of people living with HIV. He attended HIV is Not a Crime National Training Academy (HINAC) in Indianapolis in June 2018, which trained advocates from all over the nation to talk about the criminalization of people living with HIV. Chris was interviewed and shared his experience:

What was your experience attending HINAC?

Ending HIV criminalization has always been dear to my heart. It can happen to anybody at any point in time. So, the fact that we're looking at modernization and repeal of these HIV laws as well as the intersections happening within intracommunity spaces experienced by people of color and transgender individuals is so important.

Speakers from Colombia, Canada, Mexico, and all over came to talk about their HIV criminalization experiences with topics ranging from immigration, sex work, and the military. The Black United Leadership Institute group was always great to be around to connect and uplift national work from Black-identified HIV advocates. They held a pre-conference before HINAC to train and encourage capacity-building on a national scale, which is a great addition from years past. I appreciate spaces where I can see where people are at with their local advocacy efforts and experience diverse representation.

How do you feel like you'll take back the knowledge and experience gained at HINAC?

I appreciated the time HINAC built out for advocates from each state to come together and strategize to eliminate bad HIV laws. Illinois attendees, including myself, all sat around a table and talked about next steps and coalition-building, incorporating information we heard from advocacy groups from places like California and North Carolina.

I want to go back to my local community and document their needs for HIV decriminalization support. From that, I want to connect with partners and begin creating state-wide engagement strategies that may work to evolve these laws. With more education and awareness targeting the community and state legislators, I think we can stop the unfair criminalization of people living with HIV. I think we're starting to see Illinois advocates are investing in efforts to stop these discriminatory laws by bringing local community partners and individuals to the table.

Is there anything else you'd want people to know about this conference?

Historically, you've got people who've been doing this work for a long time . There's a lot to learn from this model, but I keep finding that there's still a lot of work we must do. We need more young and not-so-young folks to help shape this model to best support people living with HIV into positions of empowerment.

Submitted by Chris Wade, Central Illinois FRIENDS of PWA, Director of Prevention Services

CENTER ON HALSTED INTRODUCES CDPH/IDPH RECIPROCAL HIV COUNSELING AND TESTING TRAINING DELIVERY PROGRAM

In November 2017, the Center on Halsted (COH) in Chicago became an Illinois Department of Public Health (IDPH)/Chicago Department of Public Health (CDPH)-approved training agency. Melvin Laureano, COH's Manager of HIV/HCV Services, assisted Jill Dispenza, the Director of HIV/AIDS & STD Services, in writing the curriculum and leading the in-house training of new staff. This exciting certification program ensured that the COH was providing intensive training while allowing for the flexibility to train staff as they were hired by COH. COH's curriculum includes online trainings, hands-on practice, and multiple in-person shadowing opportunities. All COH Health Educators are also trained as counselors on the State of Illinois AIDS/HIV & STD Hotline – 1-800-AID-AIDS (243-2437); (TTY) 1-800-782-0423; TEXT 872-243-1004; get2zero@centeronhalsted.org; http://www.centeronhalsted.org/HIV.html

New, COH-trained Health Educators include Anaïs Cotillas, Andrew Foxhoven, Derrick Little, and Zachary Hudson, with Jill Dispenza on the left and Melvin Laureano on the right.

Derrick Little, Health Educator, recently spoke of his experience regarding the training COH provided: "It was immensely meaningful to be trained at COH by COH staff as this process allowed me to not only learn and understand vital components of my position, but it also offered me the chance to foster and sustain relationships – specifically mentorship relationships – with my coworkers. This training model assists COH in making our work more community-based and also helped me feel affirmed and valued at work." COH's clients have already benefitted from the counseling skills and support of our new HIV testing staff.

Below are links to some of the online modules that COH uses to orient and train new health educators:

- **IDPH Office of Health Protection Data Security & Confidentiality Guideline Training:**
- **IDPH CTR Programs Forms Training**
- **IDPH HIV Home Study Modules**
- **Oregon Health Department Training Modules (HIV Prevention Essentials Modules 1-8)**
- **CDC Care & Medication Adherence Trainings**
  - *Online adherence trainings for Peer Support; HEART; Partnership for Health; and SMART Couples*
- **National LGBT Health Education Center Learning Modules**

Submitted by Jill Dispenza, Center on Halsted, Director of HIV/AIDS & STD Services

STD SECTION UPDATE

Syphilis Is Back

In August 2018, Pfizer launched a new website called SPHYILIS BACK. All are encouraged to visit the site and share its resources with clients. The website found at this link: https://syphilisback.com/ .

The website also includes syphilis data, including the following:

- Nationally, there was a 74 percent increase in syphilis cases in 2016 compared to 2012.
- In 2016, there was one new person infected with syphilis every 20 minutes.
- Across the nation, syphilis is found in seven times more men than women.
- 58 percent of all syphilis cases are in men who have sex with men (MSM).
- Syphilis is five times more likely to occur in Blacks than any other race or ethnicity.
- The number of cases of congenital syphilis increased by 87 percent in 2016 compared to 2012.

Illinois saw a 50 percent increase in syphilis from 2013-2017, and the HIV/syphilis rate remains around 50 percent.

Experts Brace for More Super-Resistant Gonorrhea

This article contains excerpts from "Experts Brace for More Super-Resistant Gonorrhea," published by the University of Minnesota's Center for Infectious Disease Research and Policy. To view the full article, click here.

In late March, an ominous report from England's public health agency described a case of gonorrhea that was resistant to both components of the dual antibiotic therapy of azithromycin and ceftriaxone—the only remaining recommended treatment for gonorrhea.

The infection, which was also resistant to a slew of other antibiotics, was quickly dubbed "super gonorrhea" by the press. It was the first reported case in the world of gonorrhea with combined high-level azithromycin resistance and ceftriaxone resistance. It's not a matter of if gonorrhea will become resistant to the currently recommended antibiotic treatment, but when.

Sexually transmitted disease (STD) experts and public health officials are particularly concerned about pharyngeal gonorrhea, not only because it's easily transmittable and could be spreading silently, but also because it doesn't always respond to the recommended treatment regimen. "Pharyngeal cases of gonorrhea tend to be a little harder to treat, meaning that sometimes people can show signs that they've had their infections cleared at other sites, but still have signs of gonorrhea in their throat after treatment," said Sancta St. Cyr, MD, a medical officer in the US Centers for Disease Control and Prevention's (CDC's) Division of STD Prevention.

Submitted by Lesli Choat, Illinois Department of Public Health, STD Counseling and Testing Coordinator

Interested in having your HIV planning news shared with the IHIPC membership and community stakeholders? Feel free to send your submissions for the newsletter to janet.nuss@illinois.gov.