

Overview
Regional Meetings on Gonorrhea Control
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February 18, 2009

Background

In 1972, Congress implemented the Gonorrhea Control Program which required enhanced screening of females and increased resources for partner services. During the mid-1970's this program annually supported nearly 5 million screening tests and an estimated 250,000 partner elicitation interviews. As a result of the Gonorrhea Control Program's successful implementation, gonorrhea rates steadily declined over the next 2 decades. By the mid-1990's, limited funding and competing priorities had greatly reduced the size of this program and by 1997, the decades' long decline in gonorrhea rates had ended and national rates have remained relatively flat ever since. Gonorrhea (GC) and chlamydia (CT), two preventable and treatable conditions, have been identified as the main cause of STD related infertility. The national Infertility Prevention Program (IPP) has had a primary focus on chlamydia since its inception in the early 1990s. In the 2009 IPP funding opportunity announcement, CDC strengthened emphasis on gonorrhea control activities in recognition of the need to better address both gonorrhea and chlamydia in the prevention of STD related infertility.

More recently, concerns about persistent elevated gonorrhea morbidity have been escalated by three issues: 1) In 2007, CDC announced that quinolone-resistant *N. gonorrhoeae* (QRNG) strains are now widespread and that fluoroquinolones are no longer recommended for the treatment of gonorrhea. *N. gonorrhoeae* has repeatedly demonstrated its ability to develop resistance to antibiotics and only one class of antibiotics remains an effective treatment. Experts agree that it is only a matter of time before *N. gonorrhoeae* develops resistance to this last class of effective antibiotics. 2) While national gonorrhea rates have remained relatively level for over a decade, CDC reported in 2007 a cumulative increase of 42% in GC incidence rates in 8 western states between 2000 and 2005; highlighting the need for a more focused control effort in these states. Although incidence rates in many areas of the country are not increasing, communities with persistent high gonorrhea rates exist in most states. 3) Gonorrhea rates among African Americans represent a heavy burden of disease and the greatest health disparity for any reportable disease. In 2007, gonorrhea rates were 19 times greater for African Americans than for whites (662/100,000 compared to 35/100,000 respectively). The health disparity for gonorrhea is greater than for any other communicable disease. In June of 2007, DSTDP convened an external consultation on STD health disparities. One clear message from key community stakeholders at the consultation was for CDC to quickly address STD health disparities.

Rationale for Regional Meetings

There is a clear need for enhanced prevention efforts to reduce gonorrhea morbidity, particularly among African Americans. A significant burden of disease persists despite the availability of effective traditional gonorrhea control strategies (targeted screening, partner services, and effective treatment), newer testing technologies, and behavioral

interventions. However control efforts are hampered by a lack of resources, competing priorities, limited experience with implementing effective GC interventions, and the daunting size of the problem. Knowledge gaps exist making it difficult for STD program directors and managers to identify the best approach or gauge the effort needed. Additionally, private health systems, disease burden, risk populations, and existing public health infrastructure vary considerably from jurisdiction to jurisdiction and require program leaders to adapt, tailor, and scale interventions to their particular situation.

In order to address this situation, and maximize opportunities for STD program directors and managers to learn from their peers, CDC will coordinate one-day regional gonorrhea control meetings hosted by the ten IPP infrastructure partners in each of the ten regions. Regional meetings are advantageous because: 1) states in each region have numerous shared issues (resources, capacity, morbidity, infrastructure) and many commonalities exist within regions (e.g. rural low morbidity {plains, N. New England}, rural high morbidity {South}, urban epi-centers {East, Midwest and West}); 2) regional meetings follow the well-regarded 'IPP meeting' model including smaller groups, presentations by CDC and state level STD program staff, and plenty of open discussion; 3) they provide the opportunity for program managers to learn about successful efforts in areas with similar situations and challenges.

Meeting Description

Ten one-day regional meetings will be held to consult and aid states in identifying effective strategies to improving gonorrhea control efforts. The meetings will include a limited epidemiologic and programmatic overview by CDC, reports from state or local program managers on specific interventions and challenges, followed by small group discussions focused on identifying realistic solutions to state and regional challenges. Discussions topics will include assessing local epi and services, outcomes from historic and current interventions (including examples of key program data), insights from published literature, and estimating how much effort is needed. Foundational documents will include the CDC 2001 Gonorrhea Consultation Report, the 2007 Health Disparities Consultation Report, and Funding Opportunity Announcement (FOA) 09 - 902.

The meetings will focus on the following prevention and control strategies: 1) targeted screening based on local epi (as recommended in 09-902); 2.) partner services; 3) access to services; 4) offering gonorrhea prevention services as part of comprehensive STD prevention services; 5) working with providers serving at risk populations; and 6) working with impacted communities (guided by the DSTDP strategic plan and the DSTDP Health Disparities Consultation). These strategies are interrelated and several of them support the broader strategy of targeted screening. These six approaches were selected by a limited review of the literature (including the report from the 2001 CDC External Consultation: Control of N. Gonorrhoeae Infection in the United States) and existing strategies; and a series of informal DSTDP meetings on gonorrhea control. While the formal presentations will be framed by these strategies, the discussion should not be limited to these approaches. CDC proposes to work with each IPP regional coordinator and regional STD directors to tailor each meetings agenda to the need in the region.

Intended Participants

IPP regional coordinators will host regional gonorrhea control meetings during their 2009 and 2010 meeting seasons. The regional meetings on gonorrhea control, while relevant to infertility prevention, are separate from IPP regional meetings and are not intended for all IPP meeting participants. The target audience will include state and large city STD directors, STD program staff involved in gonorrhea control efforts, epidemiologists, and others invited by STD directors or CDC. Prevention Training Centers (PTCs), particularly those developing the STD managers' course should also be included. Responsibility for hosting and planning for the meetings will be shared by DSTDP, the IPP regional coordinator, and STD directors in the region. Kevin O'Connor and Steven Shapiro are the overall leads for the series of meetings. Each regional meeting will be coordinated by Steven Shapiro, a designated DSTDP Program Consultant, and the IPP Regional Coordinator.

Anticipated Outcomes

- Increased understanding of gonorrhea epidemiology, health disparities, and GC's ability to develop antimicrobial resistance
- Increased understanding of gonorrhea control strategies
- Increased knowledge of gonorrhea control activities conducted in the region
- Implementation of cost-neutral, jurisdiction appropriate, evidence-based, and more robust GC control efforts
- Increased GC prevention efforts and reduce GC morbidity prior to the introduction of additional resistant strains of GC

AGENDA FORMAT

A Discussion on Gonorrhea Control in Region __: Optimizing Strategies to Reduce Morbidity

Hosted by DSTDP/CDC and the Region __ IPP Partner

8:30 am	Welcome/Purpose of Meeting	Regional Coordinator/Kevin O'Connor
8:40	National and Regional Gonorrhea Epidemiology	CDC
9 am	Overview: Strategies for Gonorrhea Control	O'Connor
9:45	Questions	
10 am	BREAK	
10:15	State or Local Program Overview (local program director provides update on a GC control activity)	Presenter 1
10:45	State or Local Program Overview	Presenter 2
11:15	State or Local Program Overview	Presenter 3
11:45	Morning Panel Discussion (All morning presenters answer questions from meeting participants)	
NOON	LUNCH	
1 pm	BREAKOUT DISCUSSIONS Breakout option 1: Each breakout group discusses one strategy, based on regional concerns selected during the planning phase. Strategies for discussion include: targeted screening, partner services, access to care, comprehensive services, working with providers, and working with communities. Discussions are intended to identify local challenges and potential solutions. Participants are encouraged to bring local data and reports to share and gain realistic input from others. By the end of the breakout, each participant/jurisdiction should have plans to implement 1 to 3 prevention activities in the next 6 months. Breakout option 2: participants breakout by jurisdiction and discuss challenges and strategies to address gonorrhea in their jurisdiction. By the end of the session each jurisdiction should have specific plans to implement 1 to 3 prevention activities in the next 6 months.	
3 pm	Report Back from Groups	
4 pm	Closing Comments	STD Program Directors

Local Presenters

Invited presenters will be selected by CDC, the IPP Regional Coordinator and STD program leadership during the planning phase. Ideal presenters will be from the region and currently be conducting the GC control activity they are presenting on (*SsuN grantees should be strongly considered*). Local presentations should provide a detailed description of one or two intervention, how and to what extent it is being implemented, at least one year's worth of program data, and any observed challenges and outcomes. Project area presentations are limited to 20 minutes and will be followed by 10 minutes of questions and answers. CDC lead staff should conduct a conference call with STD directors in the region to discuss the agenda and candidates for presentations. Ideally presenters should be from different jurisdictions and should present on different topics. The presentations should to provide a broad overview of activities and challenges in the region or address critical needs identified in the region.

Breakout Sessions

The breakout sessions are the heart of the meeting and will require considerable planning. CDC will develop worksheets for the breakout sessions that will guide attendees to identify significant barriers, solutions/strategies, and to identify 1 to 3 specific action steps that they can take over the next 6 months to implement GC control activities in their jurisdiction. CDC staff will work with the IPP regional coordinator to identify facilitators and note takers. The IPP regional infrastructure partners are tasked with providing summary notes for their region's meeting. CDC Program Consultants will check in with grantees at 3 and 6 months after the meeting to gauge progress on action steps.

Breakout session options should be discussed with STD directors beforehand and they should help guide selection of specific breakout sessions in their region. Also, if directors prefer to breakout by jurisdiction, they should ensure appropriate staff attend and that relevant program and epi materials are available. Once breakout options have been identified, the IPP partners should note the appropriate breakout session when participants are registered for the meeting. Where appropriate, NNPTC staff will be invited to participate.

Literature and Materials

CDC staff should work with the IPP regional infrastructure partners to identify and distribute appropriate literature and other relevant epi and program materials before the meeting. These may include but are not limited to: the 2001 GC Consultation Report, 2007 DSTDP Health Disparities Consultation Report, and the Region IX Guidelines for GC Screening Among Women in FP and Primary Care Sites.