THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION

OF

GAY STD SERVICES

Volume 2 #2 October, 1980

This Newsletter is published by the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). Suggestions for articles on STDs in gay people, questions about the venereal diseases, and inquiries about membership [Associate/Corporate membership--$250/year; Gay or Nongay Group Medical Practice--$50/year; Gay or Nongay Individual Physician or other Practitioner--$25/year; Gay STD Service--$20/year; and Individual (not in above categories)--$10/year] may be addressed to: Mark Behar, Chairperson, NCGSTDS, 1637 N. 21st Road, #9, Arlington, VA 22209, or by phoning 703/525-0812. Please credit the Coalition when reprinting items from this Newsletter.

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CDC's Fellowship Program

The Center for Disease Control (CDC) is offering fellowships for Visiting Associates, Visiting Scientists, Staff Fellows, and Guest Researchers for the purpose of encouraging and promoting research, studies, and investigations related to health. These fellowships may be provided to secure the services of talented scientists for a period of limited duration. While research may be interpreted as covering more than laboratory research, it does not include program administration or evaluation, administration of grant activities, nor does it include program operations to apply the results of research in disease control. Fellowships for Visiting Fellows are to provide and encourage training for research.

These programs afford the CDC the privilege of employing or utilizing, either full or part-time, promising and distinguished citizens and non-citizens who are either ineligible or unavailable for career employment. The resulting interchange of information and ideas about the approaches to research, investigations, and studies are of mutual benefit to the Fellow and the CDC staff. For more information about specific programs, write to the Center for Disease Control, Atlanta, GA 30333.

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Multiple Copies of Newsletter Distributed

Beginning immediately, NCGSTDS member services will be receiving 5 copies of each Newsletter to better facilitate communications of information and business with individual staff members.

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Address Corrections

Revised mailing lists are tentatively scheduled for distribution to members with the next Newsletter (volume 2 #3). They will include the addresses of all members and friends except those requesting confidentiality. If your address has recently changed, notify the Coalition before November 1 to be included on the list.

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"Telesessions"

Twelve representatives of VD service providers from around the country, including NCGSTDS members from Chicago, Boston, Los Angeles, and Tucson, were hooked together in a conference telephone call September 16 to answer questions concerning the marketing of the hepatitis B vaccine to gay clientele by a "moderator" from Telesessions, a marketing research firm in New York. Although it could not be confirmed, the conference call was believed to be initiated by representatives from Merck, Sharp & Dohme, the drug company that will be producing the vaccine. More such "telesessions" with other clinics are expected soon. *****

NCGSTDS Semiannual Meeting at APHA

The next meeting of the NCGSTDS will be held Sunday, October 19, 1980, from 3-6 pm at the Gay Public Health Worker's Caucus Hospitality Suite at the Leland House Hotel, 400 Bagley Avenue (under the names of Ron Vachon and Jeanne Brossart) in Detroit, Michigan. The meeting coincides with the 108th annual meeting of the American Public Health Association.

Dr. James Curran, MD, MPH, Chief, Operational Research Branch of the CDC's VD Control Division will be attending to discuss a CDC sponsored "working" meeting of a small number of gay STD service providers to establish a gay STD research "priority list" to help influence the allocation of funding monies from granting agencies. The meeting is tentatively scheduled for summer, 1981 in Atlanta. Details elsewhere in this Newsletter. Other agenda items include: review of the "STD Task Force on Healthful Guidelines for Recreational Sex;" reports from members; National Gay Health Coalition's 4th Annual National Gay & Lesbian Health Conference in Houston (details elsewhere); and decision about sponsoring an STD-III Symposium, among other things. As always, the proceedings of the meeting will be recorded on cassette tape and be made available to Coalition members. Details in the next Newsletter.

The Gay Caucus has rented the Hospitality Suite from October 17-23, and will also have a booth at the Exhibition Hall. Volunteers are needed to staff both the Suite and the Booth.

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STD Journal Now Received

The Coalition now subscribes to the quarterly journal of the American Venereal Disease Association, Sexually Transmitted Diseases, and will be able to more directly notify members of significant findings. Subscriptions to STD are available directly from the J.B. Lippincott Co., East Washington Square, Philadelphia, PA 19105 for $28/year ($14/year for students and medical residents). One of the benefits of membership in the American VD Association (AVDA) ($22/year membership fees) is receipt of STD. Membership inquiries may be addressed to the AVDA, William O. Harris, MD, P.O. Box 200, Naval Regional Medical Center, San Diego, CA 92134.

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STD Clinic Management

Yehudi Felman, MD, of the New York Department of Health, wrote an editorial in the latest issue of Sexually Transmitted Disease (STD; volume 7:3) entitled "organization and Management of the Clinic for Treatment of Sexually Transmitted Diseases," that deserves the serious attention of all STD service providers. He describes some of the notorious problems that public clinics are plagued with, along with several guidelines on how clinics should be operated to represent "...the best that public health can provide." Reprint requests may be addressed to: Dr. Yehudi M. Felman, Bureau of VD Control, New York City Department of Health, 93 Worth Street, Room 806, NY, NY 10013. The article is enclosed for your review with this issue, without author's permission.

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4th Annual National Gay & Lesbian Health Conference

The National Gay Health Coalition (NGHC) announced that Houston, TX will be the site of the 4th Annual National Gay & Lesbian Health Conference, at its meeting in Philadelphia, September 28. The final authority for the Conference was given to the National Gay Health Education Foundation (NGHEF), who will select the dates and guide and assist Houston gay representatives to assure an exciting, appealing Conference. [The NCGSTDS has not decided whether an STD Symposium will accompany the Conference at it did in 1980, or whether a

(Continued)

4th Annual National Gay & Lesbian Health Conference, continued

a Symposium will indeed be sponsored in 1981.]

The first three Conferences were respectively held in Washington, DC (1978), New York (1979), and San Francisco (1980). The NGHEF was encouraged to solicit a 1982 Conference site now, to facilitate earlier planning. Gay organizations in other cities are encouraged to consider sponsoring the convention in 1982. If interested, they should contact the NGHEF immediately with a rough draft of their ideas and plans, and submit to: NGHEF, 80 S. Elliott Place, Brooklyn, NY 11217.

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Philadelphia: Lavender Health

Plans are now underway to establish gay STD and comprehensive health care services for gay men and women in Philadelphia, according to Drs. Walter Lear and John Whyte. A $15000 grant earmarked for the gay & lesbian health project from the CDC to the City of Philadelphia has been announced, and a large grant from a major private business is pending. The major part of the clinic's services should be underway by this winter.

In the meantime, a search is underway for the clinic's executive director, whose salary will be $15000 + fringe benefits. The clinic's board of directors will consider two half-time positions, however, so that a male and female would share the salary and responsibilities. Resumes of application for the executive director(s) are now being accepted by Walter Lear, 206 N. 35th Street, Philadelphia, PA 19104.

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Journal of Homosexuality: Special Offer for NCGSTDS Members

The special expanded issue of the spring, 1980 issue of the Journal of Homosexuality (JH; volume 5:3) containing synopses of papers from the Conference on Current Aspects of STDs-I Symposium, June, 1979 in Chicago, is now available directly from the Coalition at a special reduced rate.

In a special arrangement with the publisher, the Coalition will sell copies of this special, invaluable issue for $8 to Coalition members, and $9.95 (regular price) to nonmembers. Thirty percent of this purchase price will be donated to the Coaltion. Thus, your purchase of this special issue will benefit the Coalition also. In order to take advantage of this offer, you must send your remittance directly to the NCGSTDS, 1637 N. 21st Road, #9, Arlington, VA 22209. Sorry, no billing or credit cards. The Coalition will be selling the special issue of JH at the October APHA meeting in Detroit.

Titles of the papers summarized are: "Epidemiology of gonorrhea infections in gay men" (Ostrow, Shaskey, Steffen, Altman); "Epidemiology of pathogenic Neisseria in homosexual men" (Janda, Bohnhoff, Lerner, Morello); "The sexual transmission of parasitic infections in gay men" (William); "Nongonococcal urethritis: general considerations and specific considerations for homosexual men" (Holmes); "Nonspecific proctitis" (Bolan); "Epidemiology of hepatitis B infection in gay men" (Schreeder, Thompson, Hadler, Berquist, Maynard, Ostrow, Judson, Braff, Nylund, Moore, Gardner, Doto, Reynolds); "Chronic type B hepatitis in gay men: experience with patients referred from the Howard Brown Memorial Clinic to the University of Chicago" (Baker); "Future directions in research on STDs in homosexual men--Keynote Address" (Holmes); "Physician attitudes and other factors affecting the incidence of STDs in homosexual males" (Sandholzer), and "Factors adversely affecting research in STDs among gay men" (Ostrow).

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Ideas for Expanded Services

Increased financial support from clients more often corresponds with the addition of new services rather than the refinement of existing STD programs and services. Refinement and improvement of existing services should never take a back seat to expanding services, however the cost of expanding services in terms of money, time, and energy often makes such plans impractical, in spite of their expected benefits.

Several preventative medicine projects, although not necessarily directly related to STDs are concerned with keeping clients aware of and responsibile for their health (laudable goals for STDs as well as general health & well being), and are relatively inexpensive to the provider.

*****Hypertension screening involves the acquisition of a blood pressure cuff & stethescope, and an inservice concerning the proper technique for BP testing, hypertension criteria, the pathophysiology & consequences of high blood pressure, and who to refer clients to if they don't have a private doctor. Patients may be screened while waiting for STD testing. Those found to have elevated BP readings, are referred for appropriate medical followup. It should be noted that single men comprize one of the high risk groups for hypertension, and that black men are at especially high risk. Hypertension screening may be a good oportunity to involve the black gay community in a preventative medicine awareness project associated with your clinic. *****Blood testing of black patients for sickle cell trait and the accompanying education about sickle cell disease is another way to involve the black gay community in the affairs of your clinic. It should be noted however, that knowledge about sickle cell trait is considerably more important for black people who want to have children, than for those who don't. *****Hemoccult screening involves the purchase of the hemoccult guaic cards, wooden sticks, & developer solution (a package, costing approximately $26/100 cards--the patient may be asked to pay for the cost of the materials, i.e., 26¢ per test) along with an appropriate inservice to describe the usefulness of the test: it detects the presence of invisible (occult) blood in the stool from such causes as hemmorhoids, cancer, ulcer or other gastrointestinal diseases that may cause unobserved bleeding from the rectum.

*****Another outreach for extension of services to a sorely neglected group (especially in the realm of STDs)--lesbians. Although exclusively gay women are at considerable lesser risk for acquiring gonorrhea & syphilis, vaginitis is a very persistant and serious problem, and herpes can be transmitted by female-to-female sexual contact, among other diseases. Why not involve the women already working in your clinic in surveying the health needs and desires of the lesbian community and then implement those ideas? Separatism need no longer plague the gay-lesbian movement! The problems with conventional medical care that drove gay men to develop their own STD programs in the early '70's also exist with the lesbian health care now. Rather than duplicating health care services needlessly especially with the limited financial resources available, let's unite to provide sexual health care for both gay women and men at the same facilities.

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Recently Published Gay Medical & STD Articles

Szumeness, et al. (Report of the preliminary results of the New York hepatitis B vaccine study.) New England Journal of Medicine, 303:15, October 9, 1980. [Exact reference not available at the time of this printing. Details of this exciting study will be reviewed in the next Newsletter.]

Whyte, J., & Capaldini, L. Treating the lesbian or gay patient. Deleware Medical Journal, 52:5, May, 1980, pp. 271-80.

Babb, R.R. Sexually transmitted infections in homosexual men. Postgraduate Medicine, 65:3, March, 1979, pp. 215-18.

Christopher Street. Guess what's hit the fan. Volume 4:12, pp. 16-23. [Reviewed on p. 7 of this Newsletter.]

More articles on page 7. ***** ***** *****

The Management Process in Outline

This artilce is designed to encourage thought and suggest specific variables that should be considered when organizing a new VD program or in evaluating the management processes of an existing program. It is modified from MacKenzie, R. Alec, "The management process in 3-D --a diagram showing the activities, functions, and basic elements of the executive's job. Harvard Business Review, November-December, 1969, also reprinted in The Journal of Nursing Administration, November, 1979, pp. 30-33.

Management may be defined as achieving objectives through others in an organized way. Three major elements that comprize the management process are: 1)ideas, which create the need for conceptual thinking to formulate notions; 2)things, which create the need for administration, to manage the details of executive affairs; and 3)people, who create the need for leadership, the ability to influence others to accomplish the desired goals. A person may be a great leader (able to inspire others to action), but a lousy administrator or manager (unable to organize and execute a plan of action). The following outline attempts to organize certain important managerial principles. Modify according to the needs of your clinic.

I. Continuous Functions
   A. Analyze Problems--Gather facts, ascertain causes, develop alternate solutions (e.g., cost-effectiveness; services provided; constructive criticisms)
   B. Make Decisions--Arrive at conclusions & judgements (e.g., staffing)
   C. Communication--Ensure understanding with staff, clients, & other concerns.

II. Sequential Functions Include Planning, Organization, Staffing, Direction, & Control
   A. Plan--Predetermine a course of action. This requires you to:
      1. Forecast--Establish where present course will lead
      2. Set the Objectives--Determine the desired end result
      3. Develop Strategies--Decide how & when to achieve goals
      4. Program--Establish priority, sequence, & timing of steps
      5. Budget--Allocate resources; keep in auditable form
         a. Income Sources--Client donations; fundraising; grants
         b. Expenses--payroll, malpractice insurance, bills
      6. Set Procedures--Standardize methods
      7. Develop Policies--Make standing decisions on important, recurring matters
   B. Organize--Arrange & relate work for effective accomplishment of objectives by:
      1. Establishing Organizational Structure--Draw up organizational chart
      2. Delineating Relationships--Define liaison lines to facilitate coordination
      3. Creating Position Descriptions--Define scope, relationships, responsibilities, & authority
      4. Establishing Position Qualifications--Define qualifications for persons in each position
   C. Staff--Choose Competant People for Positions in Organization by:
      1. Selecting--Recruit qualified people for each position
      2. Orienting--Familiarize new people with the situation
      3. Training--Make proficient by instruction & practice
      4. Developing--Help improve knowledge, attitudes, & skills
   D. Direct--Bring About Purposeful Action Toward Desired Objectives by:
      1. Delegating--Assign responsibility & exact accountability for results
      2. Motivating--Persuade & inspire people to take desired action
      3. Coordinating--Relating efforts in the most effective combination
      4. Managing Differences--Encourage independent thought & resolve conflict
      5. Managing Change--Stimulating creativity & innovation in achieving goals
   E. Control--Ensure Progress Toward Objectives According to Plan by:
      1. Establishing a Report System--Determine what critical data are needed, how, & when. E.g., financial audits, client demographics, morbidity, & documentation with adequate medical records.
      2. Developing Performance Standards--Set conditions that will exist when key duties are well done

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The Management Process, continued

3. Measuring Results--Ascertain extent of deviation from goals & standards; use of self- and client-evaluations
4. Taking Corrective Action--Adjust plans; counsel to attain standards; replan and repeat entire cycle.
5. Rewarding--Praise, renumeration, discipline. E.g., parties, token gifts of appreciation.

III. Other Factors to Consider
- A. Concerns with the Physical Plant of Your Facility--Heating/air-conditioning; electricity; phone & phone recorded messages; floor plan for patient flow, comfort, confidentiality; etc.
- B. Equipment & Medical Supplies--Purchasing
- C. Interagency Affiliations
  1. City, State, Federal, Private--For lab services, epidemiology, funding, professional support
  2. Local Gay Community--Bars, bathhouses, organizations, motorcycle & athletic clubs, religious groups, gay businessperson's associations, gay newspapers, and the unaffiliated
  3. Outreach Services--Bars, baths, mobile van VD testing
  4. Contact with Other Gay STD Service Providers--Through organizations such as the NCGSTDS, NGHC, NGTF, Gay Caucus of the APHA, etc.
  5. Local Universities & Medical Schools--For faculty & medical student/resident /PA/nurses/etc. training in STDs.
  6. Other Concerns--Drug companies, publishers, etc.

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CDC Sponsored Meeting

The VD Control Division of the Center for Disease Control (CDC) will be sponsoring a "working" meeting of 6-8 gay STD service providers (clinicians, researchers, administrators) in the summer of 1981 in Atlanta, to establish a gay STD research priority list to aid CDC, NIH, NIAID, and other officials in the allocation of research monies. James W. Curran, MD, MPH, Chief of the Operational Research Branch of the CDC's VD Control Division, will be a guest at the Coalition's meeting in Detroit to discuss this project.

Those actively involved as gay STD service providers (MDs, PAs, RNs, MPHs, PhDs, researchers, administrators, etc.) are requested to submit and briefly justify a rough draft of gay STD research priorities to the Coalition, by January 3, 1981. Meeting participants will be selected from those who demonstrate a genuine interest in establishing such priorities. A five page set of program guidelines for VD project grants for research, demonstrations, and special public information & education (Section 318(b) of the PHS Act, September, 1980) from the US Department of Health and Human Services (formerly Health, Education, & Welfare) (Public Health Service, Center for Disease Control, Bureau of State Services, VD Control Division, Atlanta, GA 30333) is included with this Newsletter for your review.

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Howard Brown Memorial Clinic Announces New Executive Director

The Board of Directors of Chicago's Howard Brown Memorial Clinic (HBMC) recently announced the appointment of Harley E. McMillen as Executive Director. Previously employed in Missouri, Florida, and Washington, DC, Harley has a strong background in administration and grants writing skills which will benefit HBMC, one of the largest gay STD services in the country. His "extracurricular" interests involve a strong association with the gay community: he is president of a gay motorcycle club and has a part time job as a bartender in a gay bar, and he is a member of the gay Tavern Guild and the Metropolitan Businessman's

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HBMC Announces New Executive Director, continued

Association of Chicago. Such affiliations can help to mobilize community support for the Clinic, which sees approximately 1200 client-visits/month.

What are Harley's plans for the Clinic? He hopes to begin a dialog with community lesbians in the hopes of acquiring sufficient women for staffing lesbian health services [important for all clinics to implement!--Editor]. He also hopes to improve the patient flow and privacy by remodeling the existing Clinic. Other plans involve outreach to attract other gay professionals to work as volunteers, to expand into areas of drug & alcohol abuse, and to develop educational programs that emphasizes preventative health care. "I'm very excited about the job...!" he stated. [From press releases.]

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Intestinal Parasites

The September, 1980 issue of the New York based magazine, Christopher Street (volume 4:12, pp. 16-23) has an outstanding review of the intestinal parasite epidemic in an article entitled, "Guess what's hit the fan." An accompanying article entitled, "A visit to the parasite lab," describes the reporters visit to the laboratory to donate a laxative-induced purged specimen of stool. Although the causitive organism for amebiasis (Entamoeba histolytica) is the major focus, other parasites are mentioned--Giardia lamblia, Dientamoeba fragilis, and others. Most importantly, the article describes the mode of transmission, and the difficulty of diagnosis and treatment, especially with the popularity of certain forms of sexual expression (especially oral-rectal). Parasitologist Asa Chandler, and Drs. Lawrence Downs and Dan William were interviewed for the article. [Dr. William is an active member of the NCGSTDS, and works with the New York Gay Men's Health Project.] Readers are urged to obtain this issue.

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More Recently Published Gay Medical & STD Articles

Altshuler, K.Z., Burchell, C. Jerome, E.K., Kessler, D.R., Owen, W.F., Manahan, W.D., & Peske, E.D. Roundtable: Facing homosexuality's medical issues (a 6 part series in 3 issues). Patient Care--the Practical Journal for Primary Physicians, Volume 14:15, 16, 17, September 15 & 30, and October 15, 1980.

Kapla, W.J. Treating homosexual patients. [Mentions self-administered digital rectal examinations for the discovery of condylomata acuminata.] The Western Journal of Medicine, June, 1980, 132:6, pp. 524-25.

Murray, E.D., Benfari, M.J.F., Coppola, S.R., Hughes, M.D., Feng, W.C., Medeiros, R.M., & Kunz, L.J. New options for diagnosis and Control of gonorrheal urethritis in males using uncentrifuged first voided urine (FVU) as a specimen for culture. American Journal of Public Health, Volume 69:6, June, 1979, pp. 596-98.

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New Clinic in Houston Joins NCGSTDS

The Coalition welcomes The Montrose Clinic, 3317 Montrose, #1090, Houston, TX 77006 as its newest member, serving the gay community of Houston.

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Coalition Members Present Papers at APHA

Two Coalition members will be presenting papers on STDs at the 108th Annual Meeting of the American Public Health Association in Detroit. Mark Behar, Chairperson of the NCGSTDS, was originally scheduled to speak on "The Role of Physician Assistants and Nurse Practitioners in the Staffing and Administration of Community Venereal Disease Programs," however will be speaking instead on "Healthful Guidelines for Recreational Sex," discussing Task Force recommendations on reducing the acquisition and spread of the sexually transmitted diseases. This will begin at 8:30 am, Tuesday, October 21 (place to be announced). At 9:00 am, David Ostrow, MD, PhD, and Norman Altman, MD, from Chicago's Howard Brown Memorial Clinic, and Ralph Burke will be speaking on "Evaluating Outreach Programs to Identify and Control STDs in the Gay Male Population." A discussion will follow at 9:30 am, moderated by Ron Vachon, PA, formerly of Boston's Fenway Community Health Center, and currently president-elect of the Caucus of Gay Public Health Workers. The Caucus is sponsoring the session.

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New Gonorrhea Test

A new testkit which enables health practitioners, clinics, and small hospitals with limited laboratory facilities to make their own presumptive diagnosis of gonorrhea, has been developed by Orion Diagnostica of Helsinki, Finland under the name Biocult-GC. The easy to perform test allows cultivation of specimens immediately after collection. For further information, write to: Orion Diagnostica, P.O. Box 19, SF-00101, Helsinki 10, Finland.

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New Plastic Urethral Swab

A sterile, disposable polystyrene urethral swab (innoculating loop) is rapidly replacing the more uncomfortable Q-tips and the more expensive Calgiswabs for culturing gonorrhea. They are available from Scientific Products, who imports them from Denmark. The cost? Approximately $40/case of a thousand (1979 prices; compare with approximately $150 for a 1000 calcium alginate (Calgiswabs) swabs on thin, flexible aluminum shafts).

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Next Issue of Newsletter

The next issue of the Official Newsletter of the NCGSTDS will be the December-January issue. Please send literary contributions & news by December 13 for consideration for Volume 2 #3. Due to academic considerations of the Chairperson, Coalition business & correspondence may be delayed during the period November 24 through January 10. Please be patient!

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[End of Newsletter Volume 2 #2]

Organization and Management of the Clinic for Treatment of Sexually Transmitted Diseases

DURING THE PAST 30 YEARS the concept that sexually transmitted diseases (STD) require special handling and treatment has become widely accepted. The stigma attached to sexually transmitted diseases, their easy communicability, and their serious health consequences have brought about the general recognition that free public STD clinics, open to any patient regardless of age or ability to pay, are a necessity if these diseases are to be controlled. This recognition has led to the establishment of such clinics by state and municipal health departments in every large city in the United States.

Despite the widespread availability of these free public clinics, certain factors tend to limit their use by the very population they are designed to serve. Many of these factors are characteristic of public clinics in general; they include long waiting periods, indifferent and impersonal treatment by clinic staff, language barriers, inconvenient clinic hours, and drab, sometimes even dilapidated, clinic settings. However, some of the reasons why patients avoid public STD clinics are unique to this type of facility and are well known to specialists in venereology. Many patients fear that confidentiality and anonymity, both for themselves and their sexual partners, will not be preserved. Apathy, indifference, and occasional hostility towards STD patients on the part of some clinic staff members, who sometimes feel that these infections represent a just punishment for sexual "indiscretions," discourage many patients seeking care. Gay patients are often made even more uncomfortable by clinic staff members who have an aversion towards homosexuals. Physicians working in the clinics may compound these problems by neglecting to examine oral and anal sites or by making assumptions about a patient's sexual preference. Privacy for undressing is often nonexistent. This, plus a lack of female physicians, discourages women from attending venereal disease clinics.

On the basis of New York City's experience and those of other large cities discussed in papers by Dans,[1-3] I propose the following guidelines for public STD clinics. Although it may not be possible for every local or state health department (including New York City's!) to put all of these guidelines into effect, they still represent the services that a properly organized and managed STD clinic should be prepared to offer in the 1980s.

(*1*) STD clinics should be located in an area where they are accessible to high-risk groups of patients. This means that every large city should have at least one STD clinic easily accessible to the local gay community as well as to indigent heterosexual men and women. It is most important that clinic hours be scheduled during evenings as well as weekends, so that working people will be able to attend. A strictly 9-to-5 STD clinic is totally unsuitable if we are to reach the population that we are presumably trying to serve. It is truly amazing how few major cities in the United States have Saturday hours at STD clinics; this situation is quite unlike that in Great Britain, where almost every major city has at least one STD clinic that is open on Saturday mornings. It is also important that STD clinics be easily reached by public transportation.

(*2*) Well-designed facilities ought to feature certain basic amenities: privacy in examining rooms, pleasant waiting rooms stocked with literature related to STD, adequate clerical intake areas and storage space, air conditioning, reasonably comfortable chairs for patients, and a basic atmosphere of cleanliness and neatness. STD clinics do not have to be palaces, but they do have to convey the message that we think our patients are important enough to maintain for their care a facility that appears respectable. Patients should not have to stand endlessly in corridors because there is no other place for them.

(*3*) Adequate personnel, both clerical and professional, should be provided, as well as a line of authority that sees that all personnel working exclusively in the STD clinic report to one central authority, preferably a physician-in-charge or a non-physician clinic manager who, in turn, reports to a physician clinic director.

If clerical personnel report to one supervisor, nursing to another, physicians to a third, and laboratory personnel to a fourth, it is very difficult to establish

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The opinions expressed in this editorial are those of the author and do not necessarily represent those of the New York City Health Department.

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a harmoniously functioning clinic. In cities with more than one STD clinic, all STD clinics' physicians-in-charge should report directly to the Director of Venereal Disease Control in the central office of the city's health department. The Director should be responsible for the entire operation of all public STD clinics in the city and have the authority to issue directives controlling all aspects, both professional and nonprofessional, of clinic services.

It can be quite useful in large STD clinics to have a nonphysician clinic manager who is responsible for ordering supplies and medications, for custodial and security services, and for the administration of the nonmedical aspects of the clinic. This concept was introduced into New York City in 1973 in a "model clinic," for the express purpose of eliminating many of the administrative bottlenecks that characterized New York City's STD clinics, and it proved to be successful.

Many cities in the United States have found themselves unable to attract truly qualified physicians to work in STD clinics because of low salaries and lack of interest of physicians in STD. The best approach to overcoming this problem lies in staffing STD clinics with physician extenders (physicians' assistants and nurse-practitioners) as primary professionals for direct delivery of health care. These personnel should work under the supervision of a physician clinic director and as many physicians as are necessary for adequate staffing. Due weight must also be given to hiring a reasonably well-motivated clerical staff. The impressions that patients form from their treatment by the clinic clerks can make or break the community's impression of the clinic as a whole. Furthermore, the clerical staff is responsible for a good deal of the record-keeping, and errors in this area can be serious when attempts are made on the part of clinic management to plot trends and gather information.

(*4*) The clinic should have the capacity to diagnose and treat properly all sexually transmitted diseases, not just syphilis, gonorrhea, and nongonococcal urethritis. Specifically included should be trichomoniasis; herpes progenitalis; condylomata acuminata; candidiasis; genital molluscum contagiosum; scabies; pediculosis; and sexually transmitted enteric diseases, especially amebiasis and giardiasis, but also salmonellosis, shigellosis, and hepatitis B. A well-equipped clinical laboratory, staffed by adequately trained laboratory technicians, is essential. The laboratory should have the capacity to perform darkfield examinations, smears and cultures for detection of *Neisseria gonorrhoeae*, wet-mount preparations for trichomoniasis, Tzanck smears for herpes, and examination of stools for amebiasis and giardiasis. Serologic testing for *Chlamydia* and specific treponemal tests for syphilis, such as the fluorescent treponemal antibody-absorption (FTA-Abs) or microhemagglutination *Treponema pallidum* (MHA-TP), must also be available. Physicians must be trained in the proper performance of bimanual pelvic examinations of female patients, so that the diagnosis of pelvic inflammatory disease can be reliably made.

(*5*) Clinics should be designed so that, when possible, the services are brought to the patient, rather than requiring the patient move endlessly from room to room for interview by a clerk, venipuncture, history taking and physical examination, gram stain, culture, treatment, case-finding interviews, etc. This concept was also instituted in the "model clinic" with great success, particularly in motivating patients to return for follow-up. Express lanes such as those found in supermarkets can be set up for returnees who are coming only for results of laboratory tests, additional medication, follow-up serology, or test-of-cure cultures. Furthermore, these lanes can also be used to separate high-priority patients, such as patients with acute pelvic inflammatory disease, pregnant women, and patients with generalized eruptions.

(*6*) Telephone follow-up of all test results should be available to patients within 48 hr.

(*7*) Case finders, professionally trained for this purpose, should be stationed on the clinic premises to trace contacts of patients with syphilis, gonococcal pelvic inflammatory disease, infections with penicillinase-producing *Neisseria gonorrhoeae*, and other high-priority patients. Public health nurses also can and should be trained to perform these duties. The nurse-venereologist concept has been quite successful in Great Britain, and deserves a better trial in the United States.[4] It has proved successful in Boston.[5]

(*8*) Venipuncture and other laboratory testing can be performed by a microbiologist, technician, nurse, or STD casefinder. The decision as to which personnel should perform venipuncture should be made by the physician who is director of the clinic.

(*9*) The chart system should provide ready access to patients' records, not only those in the clinic last attended by the patient, but also those in other clinics in the same city, as well as in the central office of the Venereal Disease Control Bureau (or its local equivalent). Such a system, instituted as part of the "model clinic," has proved to be of great value. However, with recent improvements in computerized record-keeping, it should be possible to use a computerized medical record. This is already done with the CDC epidemiologic contact investigation form 2936 used nationwide in contact tracing.

(*10*) Educational sessions should be held regularly for both patients and clinic personnel. Patients, while

in the waiting room, could benefit from a short presentation by a member of the professional staff describing sexually transmitted diseases and the importance of finding contacts.[6] Moreover, continuing medical education for the medical staff should be an integral part of the clinic's operation. The best way of insuring high professional standards is by recruiting talent from a local medical school or large hospital. This concept is now being introduced by the Venereal Disease Control Division of the Center for Disease Control (CDC) in several large cities across the United States in their new STD Training and Treatment Centers. This program features a pooling of resources between the CDC, a local medical school, and the local health department's STD clinic for the purpose of continuing medical education for all health professionals (including private physicians) interested in STD. If this concept proves successful, as I am certain it will, it will demonstrate the need for and the benefits from such programs at all STD clinics, especially in the area of improving relationships with physicians in the community by offering a continuing medical education program in STD that is not easily obtainable elsewhere.

The steps I have outlined in this editorial should be within the reach of most local health departments. If they have not already been instituted, it is because of not only a lack of resources, but also a lack of commitment. Unfortunately, STDs are not considered to be of paramount importance in schools of public health, health departments, or medical schools. As a result, training of physicians and future physicians, as well as of public health professionals, suffers greatly. It is difficult to believe that control of a group of diseases that annually affect more than ten million people in the United States should receive such grudging support. Yet, unfortunately, such is the situation in many cities in this country. To the old principle that STD clinics should be free and confidential, we must add the maxim that STD clinics should be an example of the best that public health can provide.

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GUIDELINES FOR VENEREAL DISEASE PROJECT GRANTS FOR RESEARCH, DEMONSTRATIONS, AND SPECIAL PUBLIC INFORMATION AND EDUCATION (Section 318(b) of the PHS Act)

I. INFORMATION

A. Background and Purpose

Venereal disease (VD) control requires early effective treatment of infected patients and their sexual partners and improvements in the knowledge and health-seeking behavior of persons at risk. These guidelines govern the preparation, review, and award of grants for applied research*, demonstrations, and special public information and education programs as authorized under Section 318(b) of the Public Health Services Act. Note that public information and education activities may be funded under these guidelines if they are of national scope, developmental in nature, or best carried out by an agency which is not eligible for a grant for carrying out ongoing venereal disease control programs. Regulations governing the award of these grants are expected to be published in 42 CFR Part 51b-Project Grants for Preventive Health Services. A Notice of Proposed Rulemaking which adds a new subpart to these regulations was published on July 17, 1980. Final regulations are expected to be published during November, 1980. (Separate guidelines are available for grants to State and local health agencies to carry out basic venereal disease control programs authorized under Section 318(c), and with respect to the public information aspects of control programs, Section 318(b) of the Act).

B. National Program Goals

1. To develop, improve, apply, and evaluate methods for the prevention and control of syphilis, gonorrhea, and other sexually transmitted diseases (STD) through demonstrations and applied research.

2. To develop, improve, apply, and evaluate methods and strategies for public information and education about syphilis, gonorrhea, and other STD's.

3. To support particularly deserving public information and education programs at the community level which cannot be supported through other grant programs.

C. Eligible Applicants

Official health agencies of any State, political subdivisions of any State, the District of Columbia, any United States Territory, or any other public or nonprofit private entity are eligible to propose

*Applied research as used in this context means the process of developing and evaluating operational approaches and solutions to practical venereal disease control problems by formulating appropriate models and hypotheses and testing them in the field.

[From: The US Department of Health and Human Services, Public Health Service, Center for Disease Control, Bureau of State Services, Venereal Disease Control Division, Atlanta, GA 30333.]

applied research, demonstrations, and public information and education activities which are designed to contribute to improved venereal disease control. United States Territories include: Puerto Rico, Virgin Islands, Guam, Trust Territory of the Pacific Islands, Northern Mariana Island, and American Samoa.

II. APPLICATION PROCEDURE

A. Forms

Application for grants must be made on project application forms which may be obtained from the Director, Procurement and Grants Office, CDC or PHS Regional Offices.

B. Consultation

Consultation and assistance in developing applications and proposal plans is available from the Venereal Disease Control Division, CDC, or from PHS Regional Offices.

C. Budget Information

Applications shall be submitted for a 1-year budget period and a 1- to 5-year project period. There are no matching or cost participation requirements for this program. However, for new applications, anticipated expenditure for the activity by the applicant must be reflected in the narrative portion of the application. For continuation applications, information must be provided in the narrative for any expenditures made in the program by the applicant during its most recent annual accounting period. In addition, estimates of support for the next budget period for which grant support is requested must be provided. Only budget items for which Federal support is requested will be shown on budget pages of the Form PHS 5161-1. Both financial and direct assistance (i.e., "in lieu of cash") may be requested. Information which justifies or explains budget items must be included in the narrative.

D. Submission of Applications

Information about the timing and routing of applications may be obtained from the Procurement and Grants Office, Center for Disease Control, Atlanta, Georgia 30333.

Continuation applications must be submitted for each budget period throughout the duration of the project period.

E. Program Narrative

In addition to certain budgetary information described in II.C. above, each application must include a narrative description of the background and need for project grant support, the objectives of the project, the activities which will be undertaken to accomplish the objectives (including the timing of such actio s), the methods which will be used to evaluate the work, the anticipated application of findings to the national venereal disease control effort, and any other information which will support the request for grant assistance.

III. REQUIREMENTS OF AN APPROVED PROGRAM

A. Assessment of the Need for the Project

1. A review should be undertaken of the problem in venereal disease control which the application addresses to determine the need for the project.

2. A review should be undertaken to establish the appropriateness and feasibility of the project and transferability of positive results to other areas.

B. Objective Setting

1. Objectives should be specific, measurable, and realistic.

2. Objectives should relate to National Program Goals.

3. Both long-term objectives (for the project period) and short-term objectives (for the 1-year budget period) should be developed.

C. Planned Activities and Method of Operation

Planned activities should be clearly related to project objectives. The method of operation should describe in detail how the applicant intends to proceed toward the project objectives, especially where the activity is unusually complex, where several activities are interdependent, where specific support systems and procedures must be developed, and where there is no clear precedent for the particular approach to be employed. The description of methodology should include an assessment of any possible effect, both positive and negative, that conduct of the proposed initiative might have upon the established venereal disease control program in the immediate locality.

D. Evaluation

A plan must be developed which clearly describes the methods for evaluating the proposed initiative. The evaluation plan should also include any proposed activity output measures to be collected and the forms or specific data collection instruments to be employed.

IV. CRITERIA FOR AWARDING GRANTS

Priority for funding new grants will be based on the following factors:

A. The potential for immediate and direct benefit of the project in the national venereal disease control effort.

B. If the proposal intends only to evaluate an existing disease prevention and control approach, public information and education strategy, or diagnostic or treatment practice, the extent to which the questions to be answered substantially differ from those which can be answered by routine program evaluation.

C. The need for the proposed applied research, and assurances that it does not replicate prior work or currently ongoing applied research by others.

D. The extent to which the budget request is reasonable and consistent with the intended use of grant funds.

E. The extent to which project objectives are specific, measurable, realistic, time phased, and related to the National Program Goals.

F. The extent to which the method of operation is logical, relates to project objectives, and describes how the applicant intends to proceed, particularly with activities that are complex, interrelated, or unprecedented.

G. The extent to which the application includes an assessment of any possible effect, both positive and negative, that the conduct of the proposed initiative might have upon the established venereal disease control program in the immediate locality, and the extent to which possible negative effects will be avoided or minimized. Applications for grants to demonstrate improved methods to provide services will receive special consideration if they show an integration and coordination of services between public venereal disease control programs and federally supported primary care and service programs providing care to medically underserved populations at high risk for venereal disease.

H. The extent to which the application includes a comprehensive and realistic plan for the evaluation of the project, specifying the measures and instruments of measurement to be used.

V. CRITERIA FOR CONTINUATION AWARDS

Continuation awards will be based on the availability of funds, and:

A. The extent of documented progress toward achievement of previous established short- and long-range objectives; or,

B. The extent to which modifications in short-term objectives, methods of operations, or plans for evaluation are justified and consistent with purposes for which the original grant was approved.

VI. REPORTING REQUIREMENTS

A. Narrative progress reports will be submitted as required for individual projects, generally no less frequently than every 3 months. Narratives should address progress being made in achieving project objectives, problems which have been encountered (and methods used or changes being made to resolve problems) and other information which, in the grantee's opinion, may be useful to the Center for Disease Control (CDC) or the Public Health Service.

B. A final narrative report will also be required, generally within 90 days after the end of the month upon which the project is terminated. The narrative should include a summary of the project as originally proposed, plus any changes made during the course of its conduct and a complete description of the findings, conclusions, and recommendations relative to the national venereal disease control effort.

C. All of the above reports and the annual expenditure report are to be submitted to the Director, Venereal Disease Control Division, Bureau of State Services, Center for Disease Control.

VII. SPECIAL PROGRAM REQUIREMENTS

Applications that involve the use of individuals as human research subjects must follow HEW and PHS policies on protection of human subjects.

VIII. USE OF GRANT FUNDS

A. Grant funds may be used for the costs associated with organizing and conducting applied research, demonstrations, and special public information and education programs.

B. Grant funds may be used to reimburse individuals asked to be participants in applied research. Such reimbursement, however, must be justified as necessary and reasonable. Furthermore, a schedule of reimbursements must be submitted for specific approval by the Grants Management Officer.

C. Grant funds may not be used to supplant funds supporting existing venereal disease control services.