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PREVENTING HIV TRANSMISSION TO MALE INMATES AND THEIR FEMALE PARTNERS 5
By Madina Agénor

EMPOWERMENT THROUGH THE TAWANA PAKISTAN PROJECT 7
By Asma Hussain

FRAMING EATING DISORDERS MATTERS: WHY HEALTH BELIEF MODEL-BASED INTERVENTION PROGRAMS ON COLLEGE CAMPUSES ARE FAILING TO HAVE AN IMPACT 9
By Morgan Kutzman

TOWARD A NEW PARADIGM FOR RAPE PREVENTION 11
By Anne Douglass

UNDERSTANDING COMPLEX HUMANITARIAN EMERGENCIES AND NATURAL DISASTERS ON A CONTINUUM 12
By Asma Hussain

CHIKINGUNYA: A GLOBAL PUBLIC HEALTH CHALLENGE 13
By Hormuz Nicolwala

MOSQUITO SURVEILLANCE 14
By Gayle T. Gross and Tim Link

HEALTH PROMOTION COMES OF AGE 16
By Chinelo Enwonwu

PARTNERING WITH PUBLIC HEALTH OFFICIALS TO CONDUCT COMMUNITY-BASED RESEARCH WITH MEN WHO HAVE SEX WITH MEN IN MASSACHUSETTS 17
By Matthew J. Mimiaga and Sari L. Reisner

A Letter from the Editors

Dear Students,

We have developed this special student issue with students in mind. We, ourselves, are also students and we understand the need to have a publication that is student friendly, where you can submit articles and papers that you have written and articles that are of interest to you. This publication will also be helpful to you to get your feet wet so that later in your career, you can submit and publish your work in journals and other professional publications.

Currently, this issue will be published annually. However, if student interest increases, we will start publishing it biannually. Watch e-mail announcements with the Call for Articles information, and remember to check out our website at www.aphastudents.org.

We hope that you enjoy our first "Student Issue" and that in the future you submit your work for publication.

Sincerely,

Ana Chiapa and Olivia Wackowski
APHA-SA Newsletter Co-Chairs

PREVENTING HIV TRANSMISSION TO MALE INMATES AND THEIR FEMALE PARTNERS

By Madina Agénor, Mailman School of Public Health, Columbia Universtiy

Connecting the Dots between Male Incarceration and HIV Infection in Women

In recent years, the discourse on women and HIV/AIDS has shifted from exclusively addressing biomedical and behavioral issues to incorporating analyses of social and economic determinants, including gender inequality, housing, and unemployment (UNAIDS, 2004; Zierler and Krieger, 1997; Fullilove, 2006). However, one key structural factor underlying women's vulnerability to HIV is often left unaddressed: male incarceration.

Many studies have shown that prisons and jails in the U.S. operate much like revolving doors that allow for the constant flux of inmates between the facility and the community (Leh, 1999; Grinstead et al., 1999). As a result, in addition to raising concerns about the HIV infection risk of inmates, incarceration has important implications for transmission to those living in the communities into which inmates are released, including their female partners (Leh, 1999; Thomas and Sampson, 2005; Grinstead et al., 1999).

Contextualizing the Issue

In 2003, the AIDS rate among U.S. inmates was three times that of the general population (Bureau of Justice Statistics, 2005). While most HIV-positive inmates are infected prior to incarceration, Fullilove points out that correctional facilities represent an "independent risk factor" for HIV/AIDS as a result of the high-risk behaviors and transmission patterns that can occur within prison walls (Fullilove, 2006). For example, in a 2005 study, the Centers for Disease Prevention and Control (CDC) found that becoming HIV positive during incarceration was significantly associated with engaging in unprotected male-male sex, intravenous drug use, and receiving a tattoo (CDC, 2006).

In addition to placing inmates at increased risk of infection, incarceration has profound implications for the HIV vulnerability of members of the broader communities into which inmates are released, particularly their sexual partners (Thomas and Sampson, 2005; Grinstead et al., 1999). For example, the experience of incarceration may lead some men to engage in high-risk behaviors that they were not involved in prior to being "locked up," namely unprotected sex with other men and intravenous drug use, which could in turn increase their sexual partner(s)'s risk of acquiring HIV (Thomas and Sampson, 2005). In addition men's absence from the community as a result of imprisonment may also have an effect on women's HIV infection risk. For example, the scarcity of remaining men may increase their power in sexual relationships, which could in turn heighten women's vulnerability to HIV by making them less able to negotiate condom use and increasing the potential for sexual violence (Thomas and Sampson, 2005).

Tackling the Problem

Given the complexity of the relationship between incarceration and HIV/AIDS, any policy seeking to decrease the risk of transmission to inmates and their female sexual partners must operate on multiple levels by seeking to: (1) decrease the HIV risk of inmates during incarceration; (2) decrease the HIV risk of inmates after release; and (3) decrease the risk of transmission from former inmates to their female sexual partners.

Some specific policy recommendations include:

- Mandating structural changes in prisons and jails that would decrease HIV transmission, such as condom distribution, needle exchange, and routine voluntary counseling and testing (VCT);
- Connecting inmates to community-based resources (e.g. housing) immediately upon release;

- Providing HIV education sessions, case management, and support groups for inmates' female partners;
- Tackling the broader social and economic issues that make the link between incarceration and HIV infection so strong in communities throughout the U.S., namely poverty, housing instability, unemployment, and a lack of educational opportunities.

Moving Forward

Too often, policies and programs that seek to decrease women's HIV infection risk target the women themselves rather than the external factors that increase their vulnerability. The few studies that seek to understand women's vulnerability to HIV within the context of heterosexual transmission continue to emphasize men's sexual behavior and identity as the major factors underlying their risk of acquiring and spreading the virus. However, sexual behavior and identity do not operate in a vacuum and are shaped by social, economic, political, historical, and cultural issues. Thus, we should strive to understand the structural factors, such as incarceration, that increase the HIV infection risk of men in an effort to not only promote their health, but also the health of women, families, and communities.

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EMPOWERMENT THROUGH THE TAWANA PAKISTAN PROJECT

By Asma Hussain, Case Western Reserve University, School of Medicine

My MPH degree required a research component which I fulfilled at the Department of Community Health Sciences in the Medical College of Aga Khan University in Karachi, Pakistan. From January-April 2007, I analyzed data collected from the Tawana Pakistan Project (TPP), a school-based feeding program which took place from September 2002 -June 2005.

TPP addressed the nutrition and school attendance of primary school aged girls in 29 impoverished rural districts across Pakistan. Balanced meals were served to over 410,000 girls in over 4,000 schools by community women who were taught the essential foods necessary for the proper growth of young girls, the preparation of balanced meals, and the use of hygienic practices. This training was provided to 95,000 women. The achievements of the project included the reduction of wasting (the most serious form of malnutrition) and the stunting of growth by 45% and 6%, respectively. In addition, school enrollment increased by 40 percent by the end of the program.

Empowerment was also an integral goal and strategy of this project. "Empowerment" ranges in meaning, from an individual process of taking control for one's life to a political process of granting human rights to disadvantaged people (Strandberg, 2002). TPP's approach included community mobilization which resulted in the empowerment of its people (goal) and it also enabled the project to be successful for the participants (strategy). Although no specific objectives were set prior to the project to measure the level of empowerment that was achieved, its occurrence was evident through the case studies, interviews, and surveys conducted with the program participants.

My study analyzed three sources of quantitative and qualitative information to identify if and how women were empowered: case studies, interview data, and questionnaire data regarding nutrition, cooking, feeding, and certain socioeconomic indicators. I utilized theories of empowerment derived from Dr. Naila Kabeer, a UN author and professor, Margot Breton, a professor who has written many pieces related to empowerment, and Paulo Freire, a Brazilian educator best known for his work, *Pedagogy of the Oppressed*.

Kabeer states that central to the idea of empowerment is the idea of "power," which relates to the ability to make choices (Kabeer, 1999). Kabeer notes that not all choices are equally important to the definition of power (Kabeer, 1999) as some decisions have a more significant impact on one's life. Breton argues that empowering cognitive and behavioral changes do not directly translate to empowerment if these personal and interpersonal changes have no impact on socially unjust situations which affect one's life (Breton, 1984). Freire believed that the idea of "false consciousness" is perpetuated through education and socialization (Critical Pedagogy, 2007) but also believed that groups can recognize and identify their oppression and oppressors, and eliminate false consciousness. This idea is vital to Freire's notion of "conscientization"—the process in which one attains "critical consciousness".

Several case studies I analyzed demonstrated how many women became involved in political work and even stood in elections after their participation in TPP. Here, Freire would argue that critical consciousness has taken place, as these women have gained awareness, stepping outside of their naïve consciousness, to extend their skills outside of Tawana into the political arena. Similarly, Breton would agree that the cycle of change has occurred because the knowledge gained through Tawana has been translated into a concrete social action. Kabeer's theory also becomes applicable here because these concrete social actions are challenging the unequal existing structures. Women are occupying a space unfamiliar to them, one in which males comprise the majority.

However, the application of various theories of empowerment to certain examples do not always produce similar results. For example, the quantitative results I analyzed from the KAP survey indicated that women became more involved in determining what to cook for the family after the TPP. While this increase could be viewed as evidence of empowerment, such that women began taking a larger role in making the decision of what to cook, this increase in responsibilities may also be viewed as a negative change, such that women are burdened with an additional duty. One may argue that these women are simply becoming better at certain assigned societal roles, rather than becoming "empowered". In order to determine which viewpoint may be more accurate and depictive of the situation described through the chart, it would be important to know whether these women were *given* a larger role in this decision-making process or whether they *chose* to become more involved. Similarly, it would be crucial to understand how the women view this change. Therefore, we must know the process which led to this change and the feelings and attitudes which arise from this change in order to determine whether empowerment has occurred.

Theorists do not always agree on the most beneficial way to understand, measure, and define empowerment. Although consensus may never be attained, the best approach is to utilize both qualitative and quantitative data and determine whether they are supportive of each other towards providing evidence of empowerment.

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FRAMING EATING DISORDERS MATTERS: WHY HEALTH BELIEF MODEL BASED INTERVENTION PROGRAMS ON COLLEGE CAMPUSES ARE FAILING TO HAVE AN IMPACT

By Morgan Kutzman, School of Public Health, Boston University

In the United States, 9.3 million adults reported having had suffered from an eating disorder some time in their life.[1] Most every month magazine covers contain stories about a woman who is dying to be thin right next to headlines about dieting secrets. It is no wonder people are confused about eating disorders.

The public tends to perceive Anorexia Nervosa as loss of appetite or a woman's fear of food, which is a gross over simplification of a complex psychological disease. Very few people with Anorexia Nervosa actually have a loss of appetite.[2] Moreover, one fourth of people suffering from the disorders are male.[1] Patients with eating disorders suffer from obsessive thoughts and behaviors resulting from depression or anxiety that lead to starvation behaviors.[3] The medical diagnostic criteria for Bulimia and Binge-Eating disorder do not include the requirement for low body weight.[4] Eating disorders result from a complex pathway of risk factors including genetic, psychological and behavioral.[4] Like eating disorders, heart disease develops from genetic factors, behavioral factors, and psychological factors. However, heart disease is rarely portrayed as an individual's responsibility.[5] Consequently eating disorders are framed as purely behavioral. A frame is a "label the mind uses to find what it knows," [6] which is a powerful tool in public health because the language used by public health practitioners to frame a problem can generate support or lack thereof. The diseases are framed as personal responsibility, which requires public health practitioners to develop interventions that focus solely on individual's behavior change.[6]

The college social environment is complex; many students may feel overwhelmed by the responsibility of being on their own, handling difficult course work, pressure to fit in and find a social group. This can lead to feelings of loss of control, which for some can be fulfilled by controlling weight and restricting diet.[7] The shift in student's social context can be triggering to those already at risk for the development of an eating disorder. Affecting 5-7% of college students the prevalence of the diseases is increasing.[7] Traditional interventions on campuses are based on the Health Belief Model and serve to educate about the diseases.[8] However, education alone does not address the underlying depression, anxiety, or loss of control. A study on an intervention program with college students showed it succeeded at increasing knowledge about eating disorders, but did not correlate with behavior change. Furthermore, at the six month follow up participants had significantly increased their eating disorder related behaviors.[9] In a similar study; educational sessions were preceded by information on perceived body size, and techniques for increasing ones own body image. Minimal effects were observed.[7] A third study resulted in 81% of participants reporting feeling confident about accessing recourses for treatment, yet only one half recommended for treatment followed through.[10] The Health Belief Model caused the three interventions to be focused on individuals' health behaviors. The programs should have provided individuals with motivation to change their behavior.[11] These educational interventions focused on "blaming the individual," and did not include community level factors, therefore had a small effect.[12] Framing eating disorders at the individual level causes interventions on college campuses to focus on changing individuals' behavior without regard to the social context of the diseases.

On college campuses, most of the behaviors associated eating disorders are socially accepted and not recognized as being the development of diseases.[7] When unhealthy behaviors are thought to be the norm in a social group, the urge to conform affects individuals. Interventions based on the Social Norm Theory aim to promote accurate norms of health and safety.[13] High-risk groups, such as freshman, can be targeted with comprehensive programs using positive messages and normative feedback.[14]

When public health practitioners frame eating disorders as an individual issue, individuals' behavior is

targeted. Significantly higher prevalence of the diseases exists on college campuses and interventions are failing to address the social context in which eating disorders occur rendering them ineffective. Social Norm Theory based interventions focusing on increasing awareness about the underlying issues with regard to social factors; may help to decrease the prevalence of eating disorders on college campuses.

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TOWARD A NEW PARADIGM FOR RAPE PREVENTION

By Anne Douglass, The Heller School for Social Policy and Management, Brandeis University

Imagine a community without sexual violence. Law enforcement officials would not warn women to walk in pairs to avoid the latest "groper." Parents would know they could trust the priest, boyfriend, neighbor, and one another with their children. There would be no sleepless nights crying over a child's lost innocence, or our own. What will it take to achieve this vision of a safer community? In 1988, Texas Tech men's basketball coach Bobby Knight told reporter Connie Chung, "If rape is inevitable, relax and enjoy it" (New York Times, 1988). While the myth that women enjoy rape has lost much of its public support, we now must challenge the assumption that rape is inevitable. Sexual violence is all too prevalent, but it can be prevented.

We all know someone who has been sexually assaulted. For example, my mother told me recently of an evening spent with old friends, during which she shared with them the work that I do. To her surprise, one by one her friends disclosed their own personal experiences of rape and sexual assault. We need not be surprised. Just look at the statistics: according to the National Violence Against Women Survey, 1 in 6 American women have been raped. An estimated 1 in 4 girls, and 1 in 6 boys will be sexually assaulted, mostly by people they know and trust (Dube et al., 2005; Tjaden & Thoennes, 2000). Armed with an awareness of the prevalence of sexual violence, we must toss out the old myth that rape is inevitable, and replace it with the knowledge that rape is preventable. Then we can take concrete new steps to put an end to sexual violence.

Over the last 30 years, the rape crisis movement has transformed the landscape for rape survivors by building legal, medical, and psychological supports and protections. But as a society, we still respond to rape as if it were inevitable. The question we ask is "What could the victim have done differently?" We then "prevent" rape by trying to change the potential victim: teaching women self-defense, teaching children about "stranger danger", and urging women to carry mace or whistles. While these can be important strategies for individual protection, they do not prevent rape.

True prevention requires us to ask a new question, "How can we stop people from becoming perpetrators?" This is the question whose answer will help end sexual violence once and for all. Research shows that sexual violence is *learned* behavior. It stands to reason that prevention, therefore, should focus on ensuring that individuals do not learn this behavior. Furthermore, emerging evidence shows that violence-prevention education can change attitudes and behaviors, which can lead to a reduction in sexual violence. Our current, lopsided approach was illustrated in an interview I conducted recently with a pediatrician who revealed that she routinely speaks with college-age girls in her office about consent in sexual relationships, but does not speak with her male patients about these topics. "What would be the appropriate message for boys?" she wondered. According to a 2000 US Bureau of Justice statistics report, over 40% of sexually abused children were abused by peers or older children (Snyder, 2000). If we fail to address sexual relationships routinely and systematically with both girls and boys, we miss a golden opportunity for prevention. Now is the time to develop broad-based community prevention strategies that promote healthy relationships characterized by respect, empathy, and accountability.

The next time you hear a rape case reported, listen for discussion about what could have been done to prevent the perpetrator from becoming abusive. Could his friends have noticed the warning signs of his controlling and violent behavior? Could he have received counseling? Could his community have implemented a sexual violence prevention curriculum? Could he have learned to respect women and hold himself accountable for his behaviors? If all you hear is what the victim had to drink, what time of night she was out, or whether she was walking alone, then we lose the focus on the perpetrator and solutions for prevention. Once we recognize that rape is preventable, then not only will we protect potential victims, we will take bold new steps to stop people from becoming rapists. *See References on page 11*

UNDERSTANDING COMPLEX HUMANITARIAN EMERGENCIES AND NATURAL DISASTERS ON A CONTINUUM

By Asma Hussain, Case Western Reserve University, School of Medicine

Fifteen years ago, the concept of "complex humanitarian emergencies" (CHEs) was developed as a result of the Kurdish refugee exodus with the explicit goal of distinguishing such crises from natural disasters (Toole et al. 2005). A CHE is defined as "…a humanitarian crisis in a country, region or society where there is a total or considerable breakdown of authority resulting from civil conflict and/or foreign aggression; which requires an international response that goes beyond the mandate or capacity of any single agency." CHEs are "characterized by large numbers of civilian casualties," "human suffering of major proportion" and require "a high degree of external political support to enable humanitarian response" (WHO 1994). While natural disasters and CHEs are demarcated into separated categories, they share significant overlap and interplay of many factors. As such they should be viewed as occurring along a continuum rather than as two separate occurrences, especially when their previously distinguishable characteristics begin to blur and both phenomenon coexist.

There are essentially three aspects of CHEs and natural disasters which need to be analyzed in order to understand why they should be viewed as occurring along a continuum: the genesis, health outcomes, and the humanitarian responses to the crisis.

While the genesis of natural disasters typically stem from geological causes, the genesis of CHEs relate to internal or external conflicts. Albala-Bertrand (2000) describes a CHE as one that is derived from an "overt political phenomenon, which takes the form of a violent, entrenched and long-lasting factionalist conflict or imposition with ultimate institutional aims." However, the genesis of a crisis becomes unclear in situations where natural disasters *and* CHEs are occurring simultaneously. Subsequently, the label of the crisis (natural disaster or CHE) also becomes uncertain. This has important implications, as a label of "natural disaster" versus "CHE" may better serve the interests of the affected country in terms of receiving international aid. Indeed, nations may be more willing to respond quickly with humanitarian assistance to populations affected by natural disasters than by conflict (UNHCHR 2006), despite the fact that both types of crises share many of the same health outcomes. These include excess morbidity or mortality, internally displaced persons, human rights violations, breakdown of the public health infrastructure, lack of access to adequate shelter and water, food shortages, the spread of communicable diseases, and a general lack of resources for reproductive and mental health.

In terms of the response of humanitarian agencies, although the relief approaches to both situations may overlap significantly, obstacles faced by aid workers are exacerbated when war prevents them from safely conducting their work, as is often the case with CHEs. Military escorts for humanitarian deliveries may be necessary (UNHCHR 2006). In addition, as conflict persists in CHEs, the effects of the impact also persist, making the emergency itself persist (Vayrynen 1996).

Complex humanitarian emergences and natural disasters are viewed as two separate phenomenon which occur on opposite ends of one spectrum. This approach becomes problematic if for instance, a natural disaster strikes in an area already suffering from a conflict. Or perhaps, an area affected by a natural disaster could quickly begin experiencing internal conflicts as vulnerability of the population increases due to a lack of resources from the original natural disaster. In such cases, defining the genesis and producing a label of the situation becomes more difficult. This simultaneous existence would also complicate administering effective aid. Both CHEs and natural disasters produce similar health concerns but differ significantly in terms of the genesis of the crisis and the response of humanitarian emergencies. Therefore, it is valuable to view both situations on a continuum and understand that one could escalate into another. *See References on page 11*

CHIKINGUNYA: A GLOBAL PUBLIC HEALTH CHALLENGE

By Hormuz Nicolwala, Texas A&M University

A 28-year-old woman with acute joint pains attends a clinic in Switzerland after returning from Mauritius. A 66-year-old man develops severe myalgias in Hong Kong after returning from Africa. These clinical cases define one disease: Chikingunya.

Chikingunya--linked neither to chickens nor the deadly Avian Flu-- in Makonde [Tanzanian dialect] means 'that which bends,' referring to the stooped posture of afflicted patients. This nonfatal viral illness transmitted by the Aedes mosquito, which started as an urban phenomenon, is now sweeping the globe.
The disease resurfaced in Africa, spreading in pandemics to Southeast Asia. The tropical Indian Ocean states faced the worst outbreak of 2006. The CDC has confirmed cases in travelers to USA.
From a global perspective, Chikingunya is a disease in evolution that poses a public health challenge. Implementation of integrated prevention programs in endemic areas is key. Economic support for research and human resources for a sustainable public health infrastructure in developing countries is crucial. Sustained vector reduction through environmental awareness and health education is needed. By reversing prevalent demographic trends, depressurizing urban centers with inadequate sanitation, eliminating global socioeconomic disparities and promoting public health accessibility universally, we can emphatically reverse the current trend in resurgent vector-borne infectious diseases.

Understanding Complex Humanitarian Emergencies and Natural Disasters on a Continuum, Continued:
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MOSQUITO SURVEILLANCE

By Gayle T. Gross, Walden University and Tim Link,
Environmental Sanitarian, City of Dubuque Health Services

During my practicum this summer, I have been assisting the sanitarians at the City of Dubuque Health Services Department with a mosquito/mosquito-borne disease surveillance program that was developed by the Medical Entomology Laboratory at Iowa State University. The monitoring of mosquito populations and mosquito-borne disease is a cooperative project with the Iowa Department of Public Health, the University Hygienic Lab and the Iowa Department of Agriculture and Land Stewardship in Iowa City, Iowa. The program is able to provide public health officials with mosquito population and species information, as well as indicate the presence of mosquito-borne disease in the community. This information serves as an early warning system for both the general public and health officials with information about mosquito populations and the potential for those mosquitoes to transmit disease agents.

This summer, human cases will be monitored, as will mosquito and virus activity in mosquito populations, and virus activity in sentinel chicken flocks. One of the responsibilities of my practicum is to pick up the mosquitoes daily from the New Jersey Light Traps. The traps run from 6:00 pm – 8:00 am daily. We have two traps placed in areas in the northern and southern sections of the city. The insects are placed in a paper cup, stapled and placed in a box, then mailed to the lab at Iowa State University on Friday morning for analyses. The Department of Entomology provides a detailed report the following week on the types of species found. The City also received a sentinel chicken flock that gets blood samples drawn every Friday morning. Chicken blood is collected by drawing blood from the wing with a syringe or sticking the comb or under side of the wing with a lancet. The sentinel chicken samples are sent to the University of Iowa Hygenic Laboratory for testing of arboviral diseases that include West Nile Virus, Eastern Equine Encephalitis, and St. Louis Encephalitis.

The results to date of both monitoring efforts have not shown an incidence of infected mosquitoes. The most prevalent mosquito found has been the Aedes vexans (Meigan) species. The Aedes vexans is one of the most widespread pest mosquitoes in the world. The Aedes vexans is found throughout the United States, including Hawaii and Alaska (Crans, 2007). Even though this type of mosquito has not been documented as a vector of disease, it has been implicated as secondary vector of Eastern Equine Encephalitis and dog heartworm (Crans, 2007).

West Nile Virus is a potentially serious illness that affects the brain and spinal cord. The mosquitoes carry the virus after they become infected from feeding on infected birds. People of all ages can become ill from a single mosquito bite. Symptoms of West Nile Virus include:

1. Fever, headache, and body aches.
2. Some persons may develop skin rash and swollen lymph glands.
3. In 1% of the infections particularly in those persons over age 50, West Nile Virus can cause serious disease, such as encephalitis or meningitis.

Mosquito surveillance is a very effective prevention method to reduce the risk of West Nile and other mosquito-born diseases. Other ways to prevent West Nile Virus, Eastern Equine Encephalitis, and other mosquito-borne illnesses are to:

1. Use insect repellent with DEET, picaridin or oil of lemon eucalyptus.
2. Avoid outdoor activities at dusk and dawn when mosquitoes are most active.
3. Wear long-sleeved shirts, pants, shoes, and socks whenever possible outdoors.
4. Eliminate small collections of standing water around the home. Mosquitoes lay their eggs in standing water in buckets, pool covers, pet water dishes, and inside rubber tires.

Blood Sampling of Sentinel Chicken

New Jersey Light Trap

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HEALTH PROMOTION COMES OF AGE

By Chinelo Enwonwu, Case Western Reserve University

Thousands of delegates and conference participants came together at the 19th International Union for Health Promotion and Education (IUHPE) World Conference to reflect on the principles of the Ottawa Charter on health promotion. Twenty one years after its declaration in 1986 in Ottawa, the world community gathered, once again, in Canada (this time in Vancouver, British Columbia) to reassess the progress made since the health promotion movement began. Building on the theme of the conference "Health Promotion Comes of Age: Research, Policy and Practice for the 21st Century," the keynote/ plenary presentations, oral sessions, debates and dialogues, and poster presentations focused on the tenets of health promotion. These tenets are: creating supportive environments for health, building healthy public policy, strengthening community action through developing personal skills, and reorienting health systems. Issues encompassing global aging, health and development in developing countries, school health promotion, and chronic disease prevention, to mention but a few, were discussed and debated with eagerness and enthusiasm. Not to mention issues about equity in health were amongst the hottest topics.

It was my first time attending an international health conference – a world conference as a matter of fact. I was also presenting my thesis and was highly honored for the opportunity to do so while interacting with delegates from around the world. As a recent Masters of Public Health graduate, this conference served not only as a vacation for me, but as a culmination of my public health studies. Everything that I learned came together as I attended session after session, reflecting on public health issues and possible solutions, as well as on the founding principles in public health like the Alma Ata Declaration, and most certainly the Ottawa Charter. Was it the riveting opening speech by Stephen Lewis, a former UN Envoy, calling upon health professionals to stand up for social justice and equity that renewed my sense of commitment to work public health? Or was it that delivered by Sir Michael Marmot, re-emphasizing the need to examine the "causes of the causes," otherwise known as the Social Determinants of Health, when looking at issues of health? I was "empowered," if you will, by speeches such as these.

The conference was not just about reflection on public health problems and how health promotion can move forward; it was also a celebration of the successes achieved thus far. Twenty one years after the Ottawa Charter was proclaimed, the world community has made great strides in the field of health promotion. The anti-tobacco initiatives, the push for health to be on political agendas, the institutionalization of health promotion policies in some countries like Nigeria, and the recognition of health as a fundamental part of development, are some of the strides we, as the health community, have to celebrate. Yes, they are successes indeed even though more work still has to be done.

I think each and every one of us in public health is called to promote health in some aspect. Our world is in need of active health promoters whether internationally, nationally, or locally. To quote Stephen Lewis (from the conference), "Nothing is more powerful than an idea whose time has come." Health promotion has come of age, especially in this 21st century. Now, more than ever, we are called to be health promoters, to be advocates, and to work for social justice. We are called to sustain the "healthy, vigorous, and growing movement" that was spawned by the Ottawa Charter in 1986.

PARTNERING WITH PUBLIC HEALTH OFFICIALS TO CONDUCT COMMUNITY-BASED RESEARCH WITH MEN WHO HAVE SEX WITH MEN IN MASSACHUSETTS

By Matthew J. Mimiaga, ScD, MPH, Harvard Medical School / Massachusetts General Hospital and Sari L. Reisner, MA, Harvard University Extension School

In the United States, men who have sex with men (MSM) continue to be at increased risk for HIV infection and other sexually transmitted infections (STIs).[1] In Massachusetts, MSM accounted for approximately 40% of all HIV/AIDS cases diagnosed in 2005 and HIV incidence among MSM increased from 292 in 2004 to 315 in 2005. [2] Rates of syphilis among Massachusetts MSM have risen dramatically, with a greater than five-fold increase in infectious syphilis cases among MSM between 2000 and 2005; Quinolone-resistant gonorrhea is also on the rise among MSM, with 66 cases in 2005.

The Fenway Institute (TFI) at Fenway Community Health[3], a freestanding healthcare and research facility specializing in HIV/AIDS care and serving the needs of the lesbian, gay, bisexual, and transgender community in the greater Boston area, and the Massachusetts Department of Health (MDPH) Division of STD Prevention and the AIDS Bureau, have partnered to conduct research addressing these alarming epidemiologic trends among MSM in the greater Boston area. TFI and MDPH have collaboratively launched a number of public health research initiatives aimed at intervening to curb rates of STIs and HIV among MSM in Massachusetts.

In a study using a modified respondent-driven sampling (RDS) method to explore MSM perceptions of barriers and facilitators to HIV/STI screening, TFI and MDPH found that Boston MSM were most likely to be screened for STIs if they had active symptoms or were told by a partner of a recent exposure, and least likely to be screened if they did not consider themselves to be at risk, lacked access to free and anonymous testing, or were not experiencing symptoms.[4-9]

Given that STI transmission can occur irrespective of symptomatology, TFI and MDPH continue to monitor the incidence of both symptomatic and asymptomatic STIs and HIV among Fenway Community Health MSM patients.[10-11] As part of a separate STI surveillance program to screen asymptomatic health center patients over a one-month period (March 2007), of the total 114 MSM who were screened for gonorrhea/ Chlamydia with nucleic acid amplification tests (NAATs), 11.4% tested positive for an STI.

To support STI prevention efforts, TFI and MDPH designed a toolkit to help clinicians overcome barriers and provide information about recent STI trends and risk factors. “Prevention and Management of Sexually Transmitted Diseases in Men who Have Sex with Men: A Toolkit for Clinicians” (2005) covers topics including how to conduct a risk assessment, CDC recommended STI screening guidelines, risk reduction counseling, partner management strategies, and useful resources and referrals.

In response to the need for an effective approach to notify sexual partners of those recently diagnosed with HIV/STIs, TFI and MDPH launched a mixed methods study involving three samples of MSM (men who present for STI testing, men recently diagnosed with HIV, and individuals referred through the RDS method of social networking). Direct person to person notification was found to be the most commonly preferred method of partner notification (PN), followed by assistance from a third party (i.e. medical provider, MDPH or Fenway). Many participants indicated that the greatest obstacle in PN is the difficulty in contacting partners, typically due to anonymous sexual encounters. To explore potential alternate methods of PN, TFI conducted an innovative internet PN study which documented broad acceptance of Internet PN by at risk MSM, regardless

of HIV serostatus, including a willingness to receive or initiate PN related e-mail.[12-16]

The use of crystal methamphetamine ("meth") and its association to risky sexual behaviors has been well-documented.[17-21] A TFI/MDPH study is currently investigating crystal meth use and risky sexual behavior among Massachusetts MSM who utilize MDPH mobile van services. Findings from this project will help inform MDPH programs that focus on improving sexual health and health care for men who utilize van services, as well as assist in the design of effective behavioral interventions for this population which target crystal meth use and high risk sexual behaviors.

TFI's vibrant, nationally-recognized research and evaluation program is an exemplary model of community-based research. The longstanding collaboration between TFI and MDPH continues to result in innovative projects which not only address broad public health concerns including communicable diseases and drug abuse, but which also continue to inform effective programming and interventions to improve health outcomes for MSM in Massachusetts.

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