



**National Guidelines for Internet-based
STD and HIV Prevention:
Accessing the Power of the Internet for Public
Health**

Guidelines for Internet-based Partner Notification

Guidelines for Internet Outreach

Guidelines for Health Communications

March 2008

Executive Summary

Accessing the Power of the Internet for Public Health: Guidelines for Internet-based STD/HIV Prevention, hereafter referred to as *The Guidelines*, is a user-friendly document developed to aid health departments and community-based nonprofit organizations use the Internet as a tool for the control and prevention of STDs including HIV. *The Guidelines* focus on three distinct types of Internet activities: Internet-based Partner Services (IPS), Outreach, and Health Communications. These three activities were chosen based on their current use in the field (IPS), and the overarching nature for which other online activities derive (Outreach and Health Communications). While IPS is a discrete interaction with a trained Internet-Disease Intervention Specialist, STD/HIV outreach and health communication activities carried out online are intended to be broad reaching.

Internet-based Partner Services (IPS)

Rooted in traditional Partner Notification, IPN is the process of using the Internet to conduct or enhance the method of notifying a person of their potential exposure to an infectious disease. As trends in sex-seeking opportunities adapt to new technological advances, IPN is particularly useful in contacting individuals that may otherwise be unreachable except for screen names, e-mail addresses, or other Internet aliases. Measures to ensure confidentiality, ethics, and computer security are essential precursors to conducting IPN. *The Guidelines* present several issues, and possible solutions, to consider prior to attempting IPN.

It should be noted that *The Guidelines* have adopted the term *partner services* as a replacement for the term *partner notification*. This was done for two reasons. Foremost, the term partner services encompasses a broader definition, one that captures the broad array of services being offered beyond partner notification, such as the provision of referrals, follow-up, testing for other STDs including HIV, vaccination for hepatitis, etc. Additionally, the term is being used so that this document is consistent with the new, Centers for Disease Control and Prevention (CDC) partner services document, which integrates guidelines for partner services for HIV and other STDs into a single set of recommendations and replaces the CDC's 1998 *HIV Partner Counseling and Referral Services Guidance* and the Partner Services module of the 2001 *Program Operations Guidelines for STD Prevention*.

Internet-based Outreach

Careful observation of the culture of the online community is crucial for online outreach. Each Internet community may have different clientele with unique STD/HIV risk behaviors, or varying standards for permitting health educators and health messages on their website or online community. As such, it is important to create guidelines for online outreach specific to your individual program or agency to ensure consistency in approach. *The Guidelines* offers tips on creating an online identity and suggests elements to be included in your program or agency-specific guidelines.

Health Communications

STD/HIV-related health communications on the Internet should be a complementary activity to IPS and outreach. At the very least, every program or agency needs to have a website. The passive health-information seeker may be more inclined to view health information on a website than to engage in dialogue with an actual person from a health department or community-based organization, either in person or online. Having a well-developed website for your program or agency can also add credibility to other online activities, such as IPN and outreach. In addition to tips on developing a website, *The Guidelines* highlight traditional health communications tools, such as banner ads, and expands to include emerging technologies to be considered, such as mobile devices and audio/video. *The Guidelines* also provides examples of how these tools can be translated for use in a virtual environment.

The virtual environment is fluid, constantly shifting, and changing. Websites popular today may lose their core audience and become cliché tomorrow. However, equipped with the basic elements outlined in *The Guidelines*, your program or agency will have the necessary skills to remain relevant in the realm of Internet-based STD/HIV prevention activities.

Introduction

Background

Access to the Internet is ubiquitous in the United States and research has shown it to have an impact on sexually transmitted disease (STD) transmission. As the use of the Internet and other technologies continues to grow, many program areas turned to the National Coalition of STD Directors (NCSD) and the Centers for Disease Control & Prevention (CDC) for guidance on how to use the Internet as a tool for the control and prevention of STDs including HIV.

Because of these requests for direction, an effort was initiated to bring together all those who are conducting STD prevention online to create guidance based on their successes and their mistakes. In acknowledging their collective knowledge and experience, the wheel was not reinvented but rather a document was created that will help other programs initiate and conduct successful Internet efforts and avoid common mistakes.

Objectives

In creating this document, NCSD, CDC, and its many partners had two objectives. First, this is an important, initial effort to document what is known nationally about promising practices for using the Internet for the control and prevention of STDs. Second, this is an important first effort to establish a baseline of operating procedures that will help assure consistency in the quality of services and management of risk related to these services. The aim is to create a useful and user-friendly document that is helpful to state public health departments and community-based nonprofit organizations that want to begin using the Internet or want to expand or improve their current Internet efforts.

Levels of Guidance

Because the use of the Internet for the control and prevention of STDs is still new, there is a limited amount of evidence to suggest any one approach or procedure is better than any other. Every organization using the Internet is having different degrees of success and, as far as we know, continuing to learn and adapt approaches as needed.

The guidelines included in this document represent two levels of practice. We chose these levels because we believe we have enough experience in some areas to recommend preferred practices. In other areas, there are too many options to choose from and still more options being created all the time.

- **Framework Level:** Preferred practice for the way to approach something; lays a foundation based on good experience. This level applies to the guidelines included for Internet Partner Services and Internet Outreach.

- Recommendation Level: Optional practices based on initial exploration or experience; a place to begin from or move toward. This level applies to the guidelines included for Health Communications on the Internet.

Guidelines Development Process

A work group led by NCSD and the CDC's Division of STD Prevention (DSTD) planned and coordinated the guideline development process. The content for these guidelines was developed with the participation and input of a wide range of professionals who work in STD and HIV control and prevention across the United States. Stakeholders with various levels of Internet-based STD/HIV prevention knowledge and experience were invited to the table in order to ensure that the document was written for a broad audience in the most comprehensive and cohesive way. Invitees represented those programs with the most experience and expertise in this field, those programs that wanted to develop and implement their own programs but did not know where to begin, and those programs with little or no knowledge of and/or experience with the Internet and how it could be used as a prevention tool. Approximately 30 invitees from 20 different jurisdictions participated in a 3-day meeting in Washington DC, June 27-29, 2006. The focus of the initial meeting was to develop the key concepts, approaches, practices, and procedures that would be included in the guidelines. Following the preliminary meeting, participants convened in small working groups to further develop the detailed content for the guidelines. Protocols were outlined and developed and a smaller group of participants was reconvened in Washington DC for two days, January 10-11, 2007, to fill in gaps, make additional decisions, and outline future steps. Finally, various contributors spent countless hours writing, compiling, and editing the documents. Draft versions of the documents were shared with programs with little or no Internet-based prevention experience for comments and feedback. Responses from the programs were incorporated when applicable and possible. This is a living document that was put through a rigorous review by a medical editor. Prior to the release of the final document it will be vetted to staff in the Office of the Director of the Division of STD Prevention at the CDC and approved by the Board of the National Coalition of STD Directors. What you have before you is the incredible work of many dedicated individuals.

The completed guidelines are the property of NCSD. NCSD will make them available through its website and is committed to updating them regularly, based on lessons learned and as new information about the Internet and other technologies emerge. Questions about the guidelines and the process by which they were created should be directed to NCSD.

Acknowledgements

Guidelines for Internet-based STD/HIV Prevention, 2007

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1. Introduction

This section of the Internet Guidelines makes recommendations for conducting Internet-based partner services (IPS), which includes Internet-based partner notification (IPN), for both STDs and HIV, in virtual settings, such as through e-mail, instant messaging (IM) and in chat rooms. STD and HIV IPS has been combined into a single set of recommendations, because, while programs may have different approaches to Internet-based STD/HIV work, certain basic programmatic and staff requirements are necessary for the work to be effective. It should also be noted that this document uses the term “partner services (PS)”, including IPS, as adopted by the recently revised CDC guidelines for HIV-STD partner services.¹ The term “Partner Services” is broad and encompasses services beyond partner notification (PN); such as STD testing and vaccination recommendations. Moreover, the term acknowledges that persons with STDs often need the same array of services as persons with HIV and that creating distinctions between the two does not serve the best interests of public health or the individuals involved.¹

The recommendations in this section are based on program experience²⁻⁸, lessons learned from pioneers in the field of IPS, and input from several state health departments and community-based nonprofit organizations. Most of the data driving these guidelines are based on using IPS for infectious syphilis cases. Although these guidelines can easily be modified to include other STDs – such as Chlamydia, gonorrhea, or HIV – and indeed some programs are already using IPS for these infections, the data are not currently available to warrant global guidelines for all STDs.

IPS adheres to the same standards and ethics as traditional PS, and the recommendations presented in this document should be used in conjunction with the CDC’s STD Program Operations Guidelines⁹ and the CDC’s HIV Counseling, Testing, and Referral Guidelines.¹⁰⁻¹¹ Principles from both documents apply directly to IPS.

For those jurisdictions that plan to implement IPS, these guidelines are intended to assist program managers in developing their IPS activities. For those jurisdictions that have already developed specific policies for IPS, these guidelines are intended to enhance existing practices. Agencies may have internal policies or electronic barriers, such as firewalls, that may impede implementation of Internet-related activities. It is recommended that agencies review state and local laws and health department or agency policies and consult with information technology (IT) departments prior to implementing IPS activities.

2. Background

PS, as traditionally conducted, has been endorsed by the CDC and National Coalition of STD Directors (NCSD) as an effective public health strategy to reduce STD and HIV transmission and associated morbidity. PS attempts to inform people of their potential exposure to STDs, and to refer them into care, thereby breaking the chain of infection and reducing morbidity.

The Internet is a powerful medium for communication and, as such, is a valuable tool for facilitating STD/HIV PS. Research has shown the Internet to be a venue for STD transmission¹²⁻¹⁴ as well as for disease control and health promotion.¹⁵⁻¹⁷ Access to the

Internet has become nearly universal for most Americans,¹⁸ and program areas and health departments have been encouraged to incorporate the Internet into their prevention efforts.¹⁹ With the rise of Internet-based social networking, dating, and sex sites, anecdotal evidence suggests that increasing numbers of men who have sex with men (MSM) as well as other high-risk populations are meeting online to arrange anonymous sexual encounters. As a result, individuals who are newly diagnosed with STDs/HIV may know only the screen names and/or e-mail addresses of their sex partners.

The Internet represents a relatively new medium for conducting PS. IPS is the process of using the Internet to conduct or enhance the process of notifying a person of their potential exposure to an infectious disease. IPS should augment traditional methods of PS, specifically provider referral, where appropriate. Partner-locating information is sometimes limited to an e-mail address or screen name/profile on an Internet site, making the use of the Internet the only viable option for providing appropriate STD/HIV partner services in these cases.

Tip from the field

Both the Division of STD Prevention and the Division of HIV Prevention at the U.S. Centers for Disease Control & Prevention encourage the use of the Internet for STD/HIV prevention including IPS.

See the September 13, 2005 Dear Colleague Letter:¹⁹

<http://www.cdc.gov/std/DearColleague9-13-2005.pdf>

2.1 Types of Partner Services

Three primary strategies can be used to notify partners of possible exposure to STDs or HIV infection: Provider, Self, or Contact referral. Often, more than one strategy may be used to notify different partners of the same infected patient. The strategy will depend on the particular patient, the particular STD, and partner circumstances. For example, a patient with an STD may feel that he or she is in a better position to notify a main partner, but would prefer that the Disease Intervention Specialist (DIS) notify other partners.⁹

2.2 Principles of Partner Services

Current national STD and HIV program guidelines share core principles for the provision of STD partner services and HIV partner counseling and referral services, and these principles remain applicable when using the Internet for PS. Listed below is the set of principles as described in the newly revised Guidelines for HIV-STD Partner Services.¹

- **Client-Centered:** All steps of the partner services process should be delivered in a client-centered manner, i.e., tailored to the behaviors, circumstances, and special needs of the person being served.

- **Confidential:** The confidential nature of partner services is essential to its success. This also applies to special protections for data collected as part of the process.
- **Voluntary and non-coercive:** Participating in partner services is voluntary for both the infected person and his or her partners and cannot be conducted in a coercive manner.
- **Free:** There is no charge to infected persons or their partners for partner services.
- **Evidence-based:** Partner services activities should be evidence-based to the extent possible and require knowledge, skill, and training.
- **Culturally, linguistically, and developmentally appropriate:** Partner services are to be delivered in a nonjudgmental manner appropriate to the cultural, linguistic, and developmental characteristics of the person being served.
- **Accessible and available to all:** Partner services must be accessible and available to all infected persons regardless of where they are tested or diagnosed and whether they are tested confidentially or anonymously. Due to the chronic nature of HIV infection, it is also necessary to assure that partner services for HIV are available in an ongoing manner.
- **Comprehensive:** Partner services are part of an array of services that are integrated to the greatest extent possible for persons with HIV or other STDs and their partners.

2.3 Field Experiences

Following are descriptions of experiences from project areas that have developed and implemented IPS programs. These jurisdictions saw an increase in Internet sex partners and adapted their programs to meet the needs of their patients and to address this new venue. Often the only locating information available to the DIS was an e-mail address or screen name. These programs developed procedures and protocols for IPS, learned what worked and what didn't, and paved the way for others. If these sex partners had not been contacted via the Internet, they would not have been notified of their possible exposure to an STD.

San Francisco, California

In 1999, San Francisco conducted a case control study of 7 early syphilis cases that were linked to an online chat room. The mean number of partners per index case was 5.9, and locating information for the sex partners was limited to screen names. Using the Internet to conduct PN resulted in 42% of the named partners being notified and confirmed as having been tested.²

In 2003, San Francisco reported that 20.9% of 151 syphilis cases were able to provide only e-mail addresses as locating information for a total of 44 sex

partners. Using the Internet, San Francisco Department of Health staff were able to locate 15 (34%) of the Internet sex partners and confirm that they were screened and treated, if necessary.³ San Francisco had more success reaching those contacts who were first contacted by the original patient (OP) (26/44), with a follow-up by the DIS, as compared to the DIS making first contact.

Los Angeles, California

Two cases from Los Angeles were reported in a 2004 *Morbidity and Mortality Weekly Report* (MMWR) and exemplify how IPS can be an effective, patient-centered approach to PN. In Los Angeles, a high percentage of MSM who were diagnosed with syphilis reported meeting sex partners online. The first case cited an OP who reported 134 male Internet sex partners. He was able to provide the DIS with 111 e-mail addresses and 23 telephone numbers for PN. The Los Angeles County Department of Health Services (LACDHS) sent e-mails to all 111 contacts; 29 persons (26%) responded to the e-mail and were contacted by local DIS.⁴

In the other syphilis case, the LACDHS asked the OP to send an e-mail to his 16 male Internet-sex partners. Of the 16 sex partners, the OP sent e-mails to 13, notifying them of their exposure to syphilis and indicating the health department's desire to refer them to STD clinics for testing and treatment, if necessary. Seven (44%) responded and made arrangements to be tested; suggesting that OP involvement in PN via e-mail may improve partner-response rates.⁴ This MMWR also reported that instant messaging (IM) can have similar success for PN.

Philadelphia, Pennsylvania

In 2000, the city of Philadelphia experienced a significant increase in primary and secondary syphilis cases. Through active case management, two infected individuals identified anonymous sex partners met through the Internet chat rooms. These individuals could only provide e-mail addresses for former sex partners. A protocol was developed and implemented to conduct IPS. All DIS, as well as clinical and support staff, were informed of these efforts to insure proper responses to calls generated from IPS. One IPS case resulted in a 60% (3/5) response rate from partners, suspects, and associates. A second investigation resulted in a 40% (2/5) response rate from suspects and associates.⁵

Minnesota

The Minnesota Department of Health also experienced increased cases of syphilis among MSM. Investigation of these cases revealed a cluster of 176 individuals at risk for HIV, syphilis, gonorrhea, and/or Chlamydia infection. In this cluster, 61% (108) of the individuals stated they used the Internet to meet sex partners. Of these, 50 were locatable only by an e-mail address or screen name. Seven (14%) were out of jurisdiction (OOJ) cases. The remaining individuals

were sent e-mails from the health department. Of those contacted, 60% (32) responded to IPS efforts and 26% (13) did not respond at all.⁶

Chicago, Illinois

Howard Brown Health Center (HBHC), a community-based organization (CBO) in Chicago, conducted a comparative analysis of PN initiated via the Internet versus PN via the telephone, the latter being the traditional method of PN. A retrospective case audit was performed for all syphilis cases interviewed by HBHC DIS between January 2005 and September 2006. During that time, there were 304 cases of syphilis followed by HBHC, and these cases produced 368 sex partners. All were included in the overall analysis. IPS was initiated for 190 partners (52%) and telephone PN was initiated for the remaining 178 (48%). Telephone PN was significantly more likely to result in contact between the exposed individual and the DIS. When the analysis was restricted to only those partners contacted regardless of method, there was no significant difference in final disposition (whether or not partners were brought in for testing and treatment, if necessary). Of the 190 sex partners that were contacted through IPS, 30 were found to be infected and brought to treatment and 121 who may not have otherwise had any contact with HBHC, or known of their potential exposure, were provided counseling and referral services.⁷

Boston, Massachusetts

In a national IPS study performed by The Fenway Institute, Fenway Community Health looked at the acceptability of IPS among MSM. A total of 1,848 MSM were recruited online via an Internet sex partner-seeking website between October and November 2005. This study recommended that health departments using IPS use clear and culturally sensitive language when communicating via e-mail. Participants attached a high level of importance in receiving a variety of information in notifications: e-mails informing them that they had sex with someone infected with an STD, linking them to education about the STD, linking them to information on where to get tested for the STD, triage to public health specialists familiar with the STD, as well as access to phone numbers or links to a customer service representative to confirm the e-mail's authenticity. More than 92% of participants reported that they would use IPS in some capacity (i.e., use the department of public health to notify sexual partners using IPS, notify sexual partners themselves via IPS, or do both) to inform their sexual partners if they were to become infected with an STD in the future. The study concluded that IPS should be considered an acceptable tool to decrease rising STD and HIV rates among MSM who use the Internet to meet sex partners.⁸

Based on the above examples, when the only locating information available for a sex partner of an infected individual is an e-mail address or screen name, conducting IPS can result in partners being notified, then responding to notifications, and, ultimately, being tested and treated for STDs. Additionally, when used after other methods of contact have

failed, IPS can increase the chance of eliciting any sort of a response. IPS, therefore, should be viewed as an additional tool for effective and patient-centered PN, and not a separate or different practice.

Tip from the field

IPS should be viewed as an additional tool for PN and not a separate or different practice.

3. Before You Begin

3.1 Legal Authority

Before implementing IPS, programs should adhere to applicable state/local laws, regulations, or statutes. A program should assure that policies and procedures developed (e.g., IPS methods, patient confidentiality, ethical conduct of employees) are in compliance with these laws, regulations, and statutes. The HIPAA Privacy Rule allows protected health information to be disclosed by those public health authorities who are mandated to notify individuals of their potential exposure to a communicable disease in an effort to prevent the further spread of disease during the course of a public health investigation. Prior to beginning IPS, programs should review which STDs fall under this rule.²¹

3.2 Confidentiality and Ethics

All PS activities must adhere to standards of confidentiality and ethics. These standards do not change with IPS. Agencies conducting IPS are expected to have a confidentiality policy that specifically covers Internet communication with patients and should include consequences for violations of the policy. These confidentiality agreements should extend beyond staff conducting IPS and includes IT staff and any other staff that may view or have access to confidential information. Such agreements should include statements about the consequence of personal use of health department accounts, e-mail addresses, and health department profiles, as well as statements related to IT access to confidential e-mail or IM. Prior to implementation, agencies need to ensure their HIPAA compliance, use of firewalls, security of wireless networks (if used), and that a policy about permitting staff to conduct IPS from their home computers or laptops is in place. See **Appendix A** for examples of confidentiality agreements.

Screen names, e-mail addresses, HIV status, and/or any personal information are considered to be identifying information and as such are held to the same levels of confidentiality as a patient's first name and surname. Printed documents, such as logs, reports, or transcripts containing screen names or e-mail addresses are to be stored in locked areas. Under no circumstances should staff share any information about IPS patients with anyone other than affiliated PS staff. E-mail groups and list serves should not be used for PS because patient confidentiality cannot be maintained.

Tip from the field

Amend confidentiality agreements to include e-mail addresses, screen names, and other potentially identifying information.

Staff members need to be trained on IPS policies including what information can be shared and/or discussed over the Internet with infected patients and their sex partners. Some programs require all outgoing e-mails to have a legal disclaimer. See **Appendix B** for an example.

Reasonable efforts should be taken to ensure that e-mails are sent to the intended recipients. The ubiquity of free, password-protected e-mail accounts, screen names, and IM accounts help minimize concerns that erroneous individuals be contacted through IPS. It is important to acknowledge that the potential exists for someone to share an e-mail account or screen name with another person (if they are a couple, for example), but anecdotal evidence from experienced programs have found this not to be the case with the vast majority of e-mail addresses and screen names that are reported to them.

Common concerns about protecting confidentiality

Programs that are new to IPS or newly considering implementing IPS often have concerns about ensuring patient confidentiality and the possibility of breaching confidentiality. The primary concern is that sending an e-mail – especially from an organization that uses the acronym ‘STD’ in their email address, for example, DCSTD@dc.gov – will unwittingly breach confidentiality if anyone other than the intended recipient of the letter views either the letter or the return e-mail address of the sender. However, few, if any, programs that have been conducting IPS (more than 13 years of combined experience) have experienced these hypothetical scenarios due to the ubiquity of free e-mail accounts, eliminating the necessity of a shared e-mail address. Sending an e-mail carries the same risks as leaving a letter on a doorstep. The same risks exist for both modes of communication, but the public health benefit of notifying someone of their possible exposure and infection outweighs the small possibility that confidentiality will be breached.

Furthermore, descriptive details elicited during the DIS interview with the infected patient (such as race, height, weight, unusual identifying characteristics) should be sufficient to determine that the correct sex partner is being contacted. DIS should also obtain detailed descriptive information about the partner’s Internet profile (such as age, height, weight, HIV status, interests, number and type of pictures, and the town and state the profile is listed in) as well as the accuracy of the information listed. If IPS results in the anonymous partner calling the DIS, use of the descriptive information in the profile, along with the information provided by the OP, may be used to verify that the DIS is talking to the correct person. With IPS, the experience reported by many STD programs is that patient confidentiality can be maintained in the same way that confidentiality is maintained when conducting PN via the telephone.

3.3 Access to the Internet and Computer Security

In order to conduct IPS, employees will need approved access to Internet sites that are traditionally blocked including, but not limited to, social networking, dating, or sexually explicit sites, in addition to the standard resources required as written in the CDC STD Program Operations Guidelines.⁹ Access to websites, IM programs, and other communication technologies are essential.

It is critical that IT managers/staff and current program policies and procedures be consulted regarding issues of security, access to sexually explicit websites, etc. prior to implementation of IPS. Potential barriers that may prohibit effective IPS are lack of computer access in clinics, lack of Internet access, lack of computer/Internet knowledge, slow Internet connections, firewalls protecting Internet-enabled computers from gaining access to sexually explicit websites, and local policies restricting the use of the Internet by state and local employees. Procedures securing computer equipment and software used for IPS should be established as well. Anti-virus and anti-spyware software should be kept up-to-date and used at all times on computers used for IPS. Some programs may require a non-networked computer, that is, a computer with Internet access that is separate from the internal network in order to protect servers and to alleviate IT networking concerns. See **Appendix C** for a sample protocol for the use of a stand-alone computer with Internet access.

3.4 Engagement of Appropriate Stakeholders

Engagement of key stakeholders can determine the success or failure of an IPS program. Important stakeholders include, among others, the state Health Commissioner, the Health Department Medical Director, the Health Department Information Technology Director, the Legal Department, persons who will conduct the IPS, STD/HIV Program Managers, DIS, and the at-risk communities themselves. Some stakeholders simply need to be made aware of a program's intention to proceed with IPS; others should be involved in the creation of IPS policies.

Health departments and CBOs conducting PS (hereon referred to as health departments but including all other programs that provide PS) should inform other health department programs, all partnering agencies, community clinics, CBOs, and agencies that service impacted communities that IPS is now offered through the health department. Ongoing communication with these agencies is critical. Often patients will call these agencies to confirm that the attempt to reach them is valid and the verification can expedite the time the patient takes to respond to the e-mail notification.

Health departments should also notify all private health care providers of this new approach to PS. Many individuals may contact their private physician long before making any attempt to contact the health department. Private physicians can help validate IPS as a new activity used by the health department. Given that many STD cases are diagnosed in private settings, special emphasis on effective collaboration with private providers is crucial and mutually beneficial for health care providers, health departments

and patients. Some health departments provide in-service training regarding the health department's IPS work to hospitals, health centers, and private providers to help them understand PS.

4.0 Evaluation of Internet Partner Services (IPS)

As with traditional PS, IPS quality assurance and monitoring must be conducted through frequent, routine, and standardized evaluation. However, IPS is unique in that (1) staff will have the ability to access adult-oriented websites and (2) a written record of all communication between DIS and those they contact will exist. In some program areas, the ability of staff to access sexually explicit websites at work may not be widely understood or recognized as an effective means of conducting disease intervention and may bring unwanted public and/or political fallout. Organizations conducting IPS activities should have mechanisms in place to ensure that the program is meeting its goals and objectives and that all related program policies and procedures are being followed. Evaluation and quality assurance measures are critical to the success of any disease intervention initiative. STD programs should assess and evaluate their efforts on the Internet, not only to quantify successes but to avoid any potentially harmful/unintended consequences.

Logic models are an effective way of clearly outlining the steps and desired outcomes of IPS and may help in developing evaluation protocols. For examples of logic models, see **Appendix D**. The CDC recently released a valuable evaluation manual specific to STD programs, "Practical Use of Program Evaluation among STD Programs".²¹ We recommend that STD programs use the manual to guide evaluation efforts including the development of a logic model.

Tip from the field

Obtain a copy of the manual:

Practical Use of Program Evaluation among STD Programs

<http://www.cdc.gov/std/Program/pupestd.htm>

4.1 Documentation

Documentation is vital to the evaluation of PS, and therefore to IPS as well. Quality assurance activities can include various data collection forms or secure, password-protected databases, including contact and referral logs, activity report forms, and activity observation tools. See **Appendix E** for a sample log.

Agencies may want to consider collecting printed or electronically stored transcripts of IPS activities, including e-mails or IMs sent and/or received, when feasible (some websites restrict the ability to cut and paste or otherwise save chat room or messaging text, one way to circumvent this barrier is "printscreen", a keyboard option located in the

upper right hand corner of PC keyboards, and then “Paste” in a document). Transcripts can be used for qualitative analysis or to determine factors that influence the high-risk behaviors of individuals online. Monitoring this information will inform evaluation efforts, ensure that protocols and guidelines are being followed, and indicate when program modifications are necessary.

Process measures are those activities that are conducted during implementation of a program and include such things as developing program-specific guidelines and providing IPS training to relevant staff. Outcome measures capture the end effect of your efforts and include items such as the number of individuals contacted, number who responded to IPS, number referred to services, number tested, number who test positive for the infection they may have been exposed to, and/or number of individuals treated. These measures should be captured by staff on interview record forms.

Below is a list of some of the ways in which IPS programs can be evaluated for quality assurance and effectiveness.

- Require consistent and accurate data collection
- Develop an evaluation and quality assurance process for compiling and analyzing data and for documenting and reviewing outcomes
- Provide IPS staff with evaluations and feedback
- Develop a means for patients to provide feedback
- Define methods for assessing progress toward stated process goals/outcome objectives
- Develop an ongoing system for program improvement

4.2 Special Considerations Regarding Documentation

Many programs have faced various challenges documenting IPS cases and efforts. Different programs document their IPS efforts in various ways. Additionally, not all areas use STD Management Information System (STD*MIS; a free database application provided by the CDC to state and local STD control programs for use in managing their disease control programs).

4.2.1 The Creation of Logs Specific for IPS

Tracking Internet partners through STD*MIS is possible, although it requires that data be entered in a unique and timely manner. We have included examples on how Massachusetts and Washington DC track Internet partners through STD*MIS in **Appendix K**. It is recommended that programs create a separate log or spreadsheet that will allow investigation of Internet partners to be initiated and tracked until either enough locating information is obtained to put into STD*MIS or investigation ceases. An example of such a log/spreadsheet is located in **Appendix E**.

Tip from the field

In addition to documenting IPS efforts in STD* MIS, some program areas have created additional forms to monitor IPS. See **Appendix E** for an example.

5. Getting Started

While there are common considerations that cover all PN, including IPS, there are also some unique considerations that must be addressed before implementing IPS as listed below. Refer to **Appendix F** for a more complete checklist.

It is important to remember that the websites where patients meet sex partners and from which IPS is being conducted do not have a public health mission. Most of them are private businesses whose primary mission is to generate revenue. It is possible that a health department or CBO presence will be perceived as a threat to that mission. When conducting IPS through a website, it is important to be aware that you are a member of the community and are subject to the rules and regulations of the website. It is imperative to be aware of such rules and regulations pertaining to IPS prior to joining the site.

Rules and regulations regarding Internet interventions will vary from site to site. Some websites will allow one type of Internet effort and not another, for example, they will allow passive outreach, but not IPS. Other websites may require separate profiles for IPS and outreach and will state that they should not be used interchangeably. Being aware of the rules and regulations for each website and following those policies will help to ensure that Internet efforts that are conducted within private businesses are preserved.

5.1 Creating Profiles, Screen Names, and E-mail Addresses

At this stage it should be determined what computer stations and Internet accounts will be used to send and receive e-mails for IPS. Jurisdictions that have already implemented IPS use a dedicated department e-mail account, work-specific e-mails, or have established state profiles for IPS communication. For example, Howard Brown employees who conduct IPS directed at sex partners with e-mail addresses each use their own specific work e-mail addresses, such as employeeX@howardbrown.org. On sites that require profiles (e.g., Manhunt), Howard Brown uses the profile name HBHCinChicago. Washington DC uses the same moniker, dcSTD, for all Internet-based efforts including screen names, profile names, and e-mail addresses (see **Appendix G**). Personal e-mail accounts and profiles should never be used for IPS.

When creating a profile, the official health department logo should be used as the account picture and other identifying information should be filled out respective to ISP/website protocol for health departments. Some websites may require certain information be contained within your profile. For example, Manhunt recently created a

standard logo for all profiles conducting IPS or outreach in order to provide a validation of legitimate health-related profiles (see **Appendix H**).

Programs need to be aware that different websites have different options that may help maintain or potentially breach confidentiality. For example, on www.bgclive.com (Black Gay Chat), after creating a profile, it is necessary to choose "My Account Options" and then choose "Turn Who I Recently Visited Off." Otherwise, when an Internet partner's profile is viewed, it will document the health department's visit on that individual's profile.

Tip from the field

IPS should be conducted from designated department e-mail accounts and profiles, and never from personal e-mail accounts or profiles.

Sometimes an e-mail can be sent to an individual within the website. This type of e-mail system is called a proprietary e-mail system and is used by sites such as Manhunt, Adam4Adam, Men4Now, and MySpace.

Anecdotal evidence from experienced programs has found that including specific disease information in proprietary e-mail systems is safe and acceptable to the recipients. In general, proprietary e-mail systems are password-protected, and members of websites designed specifically for sex seeking typically have individual accounts. If members choose to share an account with another person, it is typically because they are in a relationship and looking for group sexual encounters.

5.2 Staffing

Staffing for IPS is dependent upon the organizational structure, program size, STD morbidity, and appropriateness of using IPS for target populations. IPS must be conducted by staff members, typically DIS, who are trained in traditional PN techniques (i.e., have taken courses such as Introduction to STD Intervention and Advanced STD Intervention) and have experience conducting traditional PS. An experienced DIS who is already well-versed in traditional PS methods, protocols, and principles will ensure that basic PS practices are adhered to while conducting IPS.

Other important qualities for DIS implementing IPS should include familiarity with computers, the Internet, and with social networking sites (SNS). DIS should also be acquainted with online populations, including the language, etiquette, and culture of chat rooms and other current, popular sites. They should have experience with the language and culture of the populations offline (e.g., African-Americans, youth, or MSM). Professionalism and the ability to separate personal from professional activities are essential.

Given that IPS is a new area for disease intervention, the STD program manager may want to establish this function as a lead position, using an experienced DIS. As increased

use of this new venue for disease intervention increases over time, this function may become routine for all DIS within a program.

Tip from the field

Massachusetts Department of Public Health's STD Division has found that having one experienced DIS conduct IPS was preferable to having all DIS perform IPS. They believe that centralizing this function will assist with quality assurance.

5.3 Training

Effective implementation of IPS comes from the combination of a good candidate, appropriate supervision, and a comprehensive training program. For IPS to be successful, STD/HIV programs will need to provide staff with additional training specific to using the Internet for PS. DIS should be provided with ongoing support because this area is still developing, new technologies are emerging, and websites are constantly changing.

Following is a list of trainings that may be necessary to implement IPS:

- Health department-specific IPS policies and procedures. Some examples include:
 - Revising the interview format to include questions about on-line partners.
 - Setting up online profiles.
 - Reviewing standardized online correspondence and discussing any additional interaction between DIS and patients.
 - Going over scenarios other programs have experienced doing IPS.
- Basics of the Internet – including but not limited to: types of web-based networks (Internet service providers, websites, chat rooms, IM services, etc.) and Internet terminology and iconography.
- Training on chat rooms including chat room terminology and etiquette and finding relevant chat rooms and named partners.
- Cultural competency training, including how and why people use the Internet for sex seeking.
- Internet safety and confidentiality - IPS staff should understand the different security and confidentiality levels of the various modes of online communication, such as e-mail (including proprietary e-mail) and IM.
- Hands-on website experience.

New IPS staff should spend time exploring websites frequented by target populations in order to gain familiarity with how these sites work and to understand these sites from a public health perspective. Surfing the Internet should be an ongoing activity, as more websites will be pulled into the process once all DIS begin asking all patients about Internet partners.

5.3.1 Training for Adjunct Staff

Other program staff should also attend trainings on IPS as needed. For example, all staff answering phones should be instructed on how to answer calls from patients contacted via the Internet. Front-line staff, such as reception or check-in staff at STD clinics, should also know how to interact with patients contacted through IPS.

5.4 Supervision

Effective supervision will reduce the likelihood of error, demonstrate the program's commitment to quality assurance, and reduce risk of misuse of the Internet.

Supervisors should have access to all exchanges made between DIS and the initiated partner, as well as interview records and IPS logs. Supervisors should maintain a list of all IPS-related passwords and screen names. Additionally, support regarding specifics of online interactions should be offered regularly, such as during DIS meetings.

6. Implementing Internet Partner Services

6.1 Original Interview

As with traditional PS, the index patient, also known as the original patient (OP), is an individual who has a laboratory-confirmed STD and, based on program policies, will be interviewed by DIS and offered PS services.

The CDC's Program Operation Guidelines states:

“While interviewing the patient, the DIS should make every attempt to enlist the patient as a resource, making it clear that the information the patient provides will be confidential and very helpful to the DIS, the patient, and the patient's partners. The DIS can incorporate elements of patient-centered counseling by acknowledging and treating the patient as a partner in reducing additional STD in their community. The partnership should be clear to the patient.”⁹ (Partner Services section, p. PS-5)

<http://wwwdev.cdc.gov/std/Program/partners.pdf> or
<http://wwwdev.cdc.gov/std/Program/partner/3-PGpartner.htm>

During the interview, DIS should ask OPs whether or not they meet sex partners online. If the OP meets partners through the Internet, ask for the websites used and for

screen names, e-mail addresses, and regular descriptive and locating information for all partners. It may be helpful to prompt the patient by naming a few popular sex venues, including websites, bathhouses, and public sex venues, to let the patient know that the DIS is familiar and comfortable with such venues. For case management and future disease surveillance purposes, it is important to acquire the OP's own screen names and e-mail addresses. This will assist in case management as partners name back the OP in cluster interviews. Furthermore, in future cases, if the OP's screen name is provided as a partner, complete locating information will already exist in the database and IPS will not need to take place—traditional PN can instead be initiated.

6.2 Initiating Contact Using IPS

Prior to initiating IPS, DIS should attempt to obtain the geographic location of the individual they are trying to contact. This is often listed in the individual's online profile. Knowing the geographic location of the sex partner allows the DIS to provide appropriate referral information (i.e., clinic locations, clinic times). If a partner can be located based on an address or telephone number, those avenues should be used prior to conducting IPS. IPS is traditionally conducted if other methods fail to elicit a response or if it is the only information available. Some programs are looking to use IPS concurrently, such as contacting a partner by phone, while simultaneously trying to contact the same person through IPS. Data regarding this practice are not yet available.

6.2.1 Out-of-Jurisdiction Considerations

E-mail addresses and screen names with an identified geographic location outside of a program's jurisdiction will require that an "out of jurisdiction" (OOJ) field record be initiated. Because the Internet does not adhere to jurisdictional boundaries, traditional methods of handling OOJ contacts may need to be adjusted when conducting IPS. Geographic boundaries are not often able to be adhered to in IPS. Rather, it is important to discuss the situation with the STD program in the jurisdiction in which the partner is known or alleged to reside to understand that jurisdiction's protocols for handling IPS. Until more is known about the standards of practice in each state, or national guidelines are developed for OOJ IPS, these situations will need to be handled on a case-by-case basis. In areas where patients and partners frequently cross jurisdictions, it is recommended that STD programs in these areas work together to develop standard protocols for addressing OOJ-IPS partners. For example, the New England states have formed a regional agreement with Massachusetts serving as the lead project area and performing IPS for all states except for New Hampshire, which has its own IPS program. In these circumstances, Massachusetts sends an e-mail to the OOJ partner on behalf of the applicable jurisdiction. The e-mail contains the contact information of a DIS in the relevant jurisdiction (where the partner resides). Massachusetts will then create a file for this case but will not enter it into STD*MIS. Rather the partnering state should enter the case into their case management system.

In other areas, Washington DC, for example, the health department will contact the OOJ and will transfer the case, if the jurisdiction is able to conduct IPS. If not, DC will

offer to conduct IPS on behalf of the jurisdiction. Additionally, DC will discuss IPS with the OP in order to determine confidentiality. With the jurisdiction's permission to proceed and with the consent of the OP, DC initiates IPS and signs any correspondence with the DC DIS contact information.

6.3 Types of Notifications

6.3.1 Notification via DIS

This notification strategy allows DIS to take responsibility for notifying partners for whom they have an e-mail address, screen name, or IM account.

Currently, there are two ways in which e-mails notifying potentially infected partners of their exposure are written. The first way mimics traditional PN referral letters and is more conservative and lacks specific exposure information. These messages stress the importance for immediate communication between the potentially infected individual and the DIS due to “an urgent health matter” (see **Appendix H** for traditional e-mail examples). The second method is more specific and provides more detailed information about why the partner is being contacted. These messages state that the partner may have been exposed to an STD and urge the partner to contact the DIS or to seek medical care ASAP. This method is typically used only on websites with proprietary e-mail systems or on sex or dating sites and not for IPS sent to general e-mail accounts; although a few programs, such as DC, use this type of language for all IPS (see **Appendix I** for alternative e-mail examples).

In general, initial IPS messages should consist of a brief message encouraging the partner to contact the DIS either by e-mail, telephone, or face-to-face.

Subsequent attempts to contact the partner may include, where appropriate, additional information to increase the sense of urgency; request for the individual's consent to receive information via IPS, disease-specific exposure information, etc.

At a minimum, all IPS messages must include the following information: name, program or health department affiliation, office address, office phone number, and times the DIS can be reached in the office. It may also be helpful to mention that leaving a message on voicemail is confidential, if this is indeed the case. All correspondence should include directions on how the patient can confirm the contacting individual's identity, such as including the name of a supervisor and his/her telephone number. Additional referral information may be included, such as: instructions to present the IPS message at a medical care location, as well as the names, addresses, and phone numbers of testing and treatment sites, and the hours of service.

All IPS letters should be sent from a health department/CBO e-mail address or profile. The ability to confirm that the IPS is not a hoax but a real and urgent matter is very important for the patient. Whenever possible, messages should be accompanied by an automatic request for notification when the message is read.

Programs must also determine the allowable number of times a patient may be contacted. Experienced programs recommend no more than three attempts to initiate contact with the patient. Some websites have policies regarding the number of times a health department or CBO may contact their members. Manhunt's policy is that no more than two attempts to initiate communication with a patient be made per disease exposure event (see <http://www.ncsddc.org/docs/FinStgdWorkingManhunt.pdf>). It is important to remember that each situation may require different strategies (see **Appendix J** for a detailed description of when DC sends IPS e-mails).

San Francisco has reported great results, anecdotally, by having computers in the interview rooms. If a patient mentions that he/she meets partners on an Internet site on which the health department has a profile, the DIS will immediately log on to that site and ask the patient to help the DIS find their sex partners. DIS then offer to send an IPS e-mail to all sex partners via the city clinic's profile without mentioning the OP, though, on occasion, the OP will want to send IPS emails to their partners from their personal profiles. They have found that this approach helps to normalize the use of the Internet as a way to find partners.

6.3.2 Notification From The Original Patient

6.3.2.1 Personal IPS

This notification strategy allows for the infected individual to notify their partners of their exposure to an STD via IPS. With assistance from DIS, infected patients will receive support and guidance about how to contact their sex partners on the Internet. Patient-initiated IPS messages should include the name and contact information of the DIS to contact at the health department. Some health departments have found IPS to be more successful when the OP makes first contact with named partners, with follow-up by DIS, as compared to the DIS making first contact.

6.3.2.2 Via Third-Party Sites

Third-party websites, such as InSpot.org, allow patients to notify their partners, anonymously or not, of a possible exposure to an STD. There are limited outcome evaluation data available on these third-party notification sites, currently most data are web usage statistics; however, these sites have potential to improve or increase PS for STDs such as Chlamydia and gonorrhea, which often do not fall within the purview of PS. Los Angeles County launched InSpotLA in December 2005. In 2006, the first full year of regular operation of the website, a total of 9,916 e-cards were sent to 15,984 recipients. Broken out by infection, most of the e-cards sent were about crabs and scabies, followed by Chlamydia, gonorrhea, and HIV. The great majority of e-cards (83.7%) were sent anonymously, but nearly as many (80%) also contained a personal

message; 24.5% of e-card recipients clicked through to the inSPOTLA website to receive more information.²²

Sites such as InSpot.org make it very easy for people to notify their partners on their own for STDs for which DIS don't traditionally get involved. However, for STDs such as HIV and syphilis, the DIS model is still recommended because there is no way of verifying that a partner was actually notified, or that the individual sending the notification even has a laboratory-confirmed STD.

6.4 IPS Patient Follow-Up

It is currently within the purview of each jurisdiction to establish policies on IPS follow-up. The following are suggested procedures to consider.

- When a partner calls or comes to the clinic, ask how he/she was notified of his/her potential exposure. If the individual was notified via IPS, the DIS may not have the real name of the individual. DIS should ask the individual for his/her Internet screen name or e-mail address, then search the case management data system, e.g., STD*MIS (**Appendix K**). Once the DIS confirms the identity of the individual through other locating information obtained from the original patient, update the field record. Do not delete the screen name or website from AKA section.
- Print and attach to the field record all IPS correspondence with the date and time sent.
- Some individuals may consider seeking services from private medical providers. When individuals respond with this plan, the DIS should offer to contact the private medical provider on behalf of the patient. Often, the DIS is able to get an individual's case expedited for medical care in the physician's office. It also allows the DIS to reiterate the recommended examination, testing, and treatment protocols with the private medical providers. Health departments will want to be sure that private medical providers are following recommended STD treatment guidelines and are properly treating exposed individuals.

6.5 Special Considerations

6.5.1 Instant Messaging

There will be occasions when an investigator has only an individual's screen name associated with a specific IM program. If it is not possible to send a private e-mail, the DIS needs to determine if the use of IM is an appropriate mechanism for providing PS since there are numerous variables that can potentially breach a partner's confidentiality. For example, IM conversations can be viewed by website owners and managers as well as health department IT staff. Or IMs can go straight to a cell phone. Additionally, some IM programs will sit on a computer desktop whether or not the account user is present.

This means that anyone can see an IM when it pops up on the computer screen and, therefore, anyone can respond to the IM as well.

7.0 Future of IPS

As new technologies become available and are adopted by the general public, the field of public health will want to adjust the way in which we conduct business, prevent the spread of disease, and reach our target populations. There will be many future technologies that will facilitate sex seeking and currently there are two technologies, mobile phones and social networking sites (SNS), that health departments and program areas should begin to think about and consider using for IPS. However, to date, there is no published evidence or knowledge about how to conduct IPS via these mediums.

7.1 Cell Phones

Much like the Internet, mobile phone use has become commonplace in the US. Currently, 73% of adults, 77% of young adults, and 63% of teens own cell phones²³ and 33% of cell owners use the text-messaging features on their phones.²⁴

Moreover, cell phones are replacing landline telephones. A report released in April 2007 by the CDC found that about 15.8% of American homes did not have landline telephones but most of those households had at least one working wireless telephone. Half of those Americans living in households with only wireless phones are less than 30 years of age. Wireless-only adults are more likely to be living in poverty. They are also more likely to be men, Hispanic, and living in the South.²⁵

It can also be expected that Internet access via mobile devices will become more prevalent over the next few years. dotMobi is the first Internet domain developed solely for Internet access through mobile phones. Backed by leading Internet and mobile organizations, .mobi allows users to bypass the constraints of operators, handsets, and geography to effectively reach their audience.²⁶ In fact, .mobi has recently announced that 650 city names will be available to city governments in an effort to offer important city information to citizens and tourists. The city sites will be ideal for sharing news information, giving business updates, promoting culture and events, and accessing local attractions, services, and transportation.²⁷

Mobile technologies like cell phones are changing the way in which we contact people, which has relevancy for PN. Currently, we are unaware of any programs or health departments in the US that are using cell phones specifically for PN; however, there is one published case out of the UK. In 2001, a letter to the editor in the journal *Sexually Transmitted Infections* described a clinic patient presenting for STD testing at a health clinic due to a text message sent to him from his girlfriend. The text message included the woman's clinic number and a diagnosis of trichomoniasis. As a result, the man was able to receive appropriate treatment. This case suggests that mobile phones and text messaging should be considered for PN.²⁸

7.2 Social networking sites (SNS)

SNS have gained widespread popularity in both the US and worldwide. In 2007, the Pew Internet and American Life Project reported that approximately 55% of teens between the ages of 12 and 17 use online SNS such as MySpace (www.myspace.com) and Facebook (www.facebook.com). Forty-eight percent of these teens reported accessing these sites on a daily basis or more often.²³ MySpace is by far the most popular SNS with 85% of the respondents reported having a MySpace profile. And it's not just teens; 20% of adults have also created a profile on a SNS site²³ and the numbers continue to grow. From 2005 to 2006, MySpace alone saw a 367% year-over-year growth rate in profiles created.²⁹

Needless to say, SNS can be another online venue for sex seeking. Anecdotally, we know that people are finding sex partners on these sites, and that people testing positive for STDs are naming partners for which the only information they have is a SNS profile. However, at the writing of these guidelines, we know of no health department or program that has actually conducted PN on a SNS, but there are program areas that are starting to think about the specifics and logistics of conducting IPS on these types of sites.

8.0 Summary

Internet Partner Services (IPS) provides a unique set of tools that can facilitate the contact of potentially infected individuals. Currently, IPS is most valuable in contacting individuals that may otherwise be unreachable through screen names, e-mail addresses, or other Internet aliases. In most jurisdictions, IPS is being used as a supplement to traditional PN but, as experience grows and as the technology evolves and is employed by public health, IPS has the potential to become the preferred method of PN.

The need for guidance in regards to IPS has been well established; both the Division of STD Prevention and the Division of HIV Prevention at the CDC encourage the use of the Internet for STD/HIV prevention, including IPS.

These guidelines have been created to assist program managers in the development of their IPS activities or to enhance any existing guidelines. Developed from program experience and lessons learned by state departments and nonprofit CBOs, these guidelines provide a foundation to build on and are not prescriptive. It is anticipated that each jurisdiction will use this guidance as a foundation in the creation of local guidelines that can address their needs, capabilities, policies, and procedures. Before implementing IPS, programs must adhere to applicable state/local laws, regulations, and statutes.

The content of these guidelines provide guidance on how the Internet can be best used to contact individuals exposed, or potentially exposed, to an STD/HIV. Current national STD and HIV program guidelines provide a set of shared principles for the provision of STD partner services and HIV counseling and referral services. These principles remain in effect and applicable when using the Internet for PN.

Documentation, program evaluation, process measures, outcome measures, and other forms of data collection and program review are critical to the long-term success of IPS.

The guidelines address concerns such as confidentiality, ethics, computer security, staffing, training, and supervision. It is understood that there are significant barriers to the use of IPS in some jurisdictions that make IPS a unique challenge. Obstacles such as approved access to Internet sites that are traditionally blocked and the engagement of key stakeholders exist. With the development of these guidelines it is hoped that these obstacles will be overcome. In addition to this guidance, consistent and informed supervision will help to ensure that many of these concerns are addressed.

To ensure that partner notification is effective in its mission to reduce STD and HIV transmission, public health must employ new technologies as they are adopted by the general public. These guidelines will help to ensure that your use of the Internet for PN is as effective and productive as possible.

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Glossary of Acronyms

AKA	Also known as
CBOs	community based organizations
CDC	Centers for Disease Control & Prevention
DSL	digital subscriber line
DIS	Disease Intervention Specialist
EDG	Employee Development Guide
FAQ/A	Frequently Asked Questions/Answers
GLI	Group Level Interventions
HC	health communications
HERR Guidelines	CDC Guidelines for Health Education & Risk Reduction Activities
HIPAA	Health Insurance Portability and Accountability Act
IM	Instant Message or Instant Messaging
IO	Internet Outreach
I&R	Information and Referral
IT	Information Technology
ILI	Individual Level Interventions
IOP	Internet Outreach Programs
IPN	Internet Partner Notification
IPS	Internet Partner Services
ISP	Internet Service Providers
ISIS	Internet Sexuality Information Services
LGV	<i>Lymphogranuloma venereum</i> (an STD)
MSM	Men who have sex with men
MMWR	Morbidity & Mortality Weekly Report (CDC)
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i> infection
NCI	National Cancer Institute
NGOs	Non-governmental organizations
NCSD	National Coalition of STD Directors
OP	original patient
OOJ	out of jurisdiction
PN	Partner Notification
POG	Program Operating Guide
PCRS	Partner counseling and referral services
PS	Partner Services
SNS	social networking sites
STD*MIS	STD Data Management Information System

For a more comprehensive list of acronyms used on the Internet please click:

<http://www.gaarde.org/acronyms/>

APPENDIX A

Examples of Confidentiality Agreements

Example #1 – Howard Brown Health Center

PLEDGE OF CONFIDENTIALITY

It is the goal of Howard Brown Health Center (HBHC) to provide our clients (anyone seeking care or services with or through HBHC) with professional, competent and quality care and education in a respectful, affirming atmosphere. As an employee, consultant, auditor or volunteer of HBHC, you have a responsibility to maintain a sense of concern and professionalism while performing your duties. In the execution of this duty, you must be sensitive to the comfort, sensitivities and confidentiality of the client.

The comfort and confidentiality of our clients is of primary concern to HBHC. The professionalism of our staff is necessary to maintain the comfort and trust we have built through the years. Courts and health care professionals maintain that upholding patient confidentiality is an absolute necessity. Federal Courts guarantee absolute privacy regarding all STD medical records. Furthermore, sexual health histories may not be subpoenaed by any court. Breaches of confidentiality regarding the aforementioned data may be punished by dismissal. As an employee, consultant, auditor or volunteer of the HBHC, it is imperative that you follow all Federal, state and local confidentiality laws.

In addition to the legal confidentiality laws, as an employee, consultant, auditor or volunteer of HBHC, you must also abide by the following:

- Some of us, in the context of our duties, advise, within the clinical setting, appropriate and inappropriate behavior as it pertains to physical and/or mental wellness. In the context of this document, clinical setting includes all areas and/or physical space in which you perform your assigned duties.
- We do not, and can not, be “moral custodians”, nor do we have policing rights.
- Do not discuss clients or client data with unauthorized persons.
- Discuss clients or client data only to conduct legitimate business, and such discussions should take place only in a manner(s) and location(s), which affords absolute privacy.
- Do not discuss clients or patients outside of HBHC for any reason.
- Make no reference to a client visit to HBHC should you meet a client elsewhere.
- Preserve the confidentiality of friends who are HBHC clients as you would any HBHC client.
- Never acknowledge the presence or absence of clients to any caller.
- Respect for clients is mandatory as a representative of HBHC.
- Client confidentiality is respected and maintained by all staff and other members of the Howard Brown Health Center’s workforce after concluding their working relationship with Howard Brown Health Center.

**BREACH(ES) OF CONFIDENTIALITY WILL NOT BE TOLERATED AND IS
GROUNDS FOR IMMEDIATE DISMISSAL.**

We guarantee our clients absolute confidentiality of their records. Any client requesting a copy of their records must follow the HBHC Policy of Chart Access. No person shall be permitted to view client medical, mental health, or case management records, unless written documentation of permission by the client involved is provided.

Your signature below confirms that you have read, understand and accept to follow the Howard Brown Health Center's Pledge of Confidentiality.

Signature: _____

Name: _____

Date: _____

Example #2 – San Francisco Department of Health

CONFIDENTIALITY AGREEMENT

USE OF DPH RECORDS AND INFORMATION SYSTEMS

Individuals with access to the records and information systems (Internet, e-mail, telephone, pager, fax machines, etc.) of the San Francisco Department of Public Health have a legal and an ethical responsibility to protect the confidentiality of medical, financial, and personnel information, and to use that information and those systems only in the performance of their jobs. The following rules apply to information that you receive or send from any source, including computer, paper, telephone, and facsimile.

Confidential information may not be accessed, discussed, or divulged in any form except as required in the performance of your duties. Sharing confidential medical information is allowed within DPH among medical professionals in order to provide medical care to a patient.

You may not use any DPH information system for any type of personal use. Use the following test: "Is my use of this information system enabling me to provide better service, or to perform my duties more effectively or less expensively?" If the answer is no, then your use of the information or system is unnecessary and/or inappropriate.

Be aware that most DPH information systems maintain records of what is viewed and/or sent by whom. You may be asked to justify why you viewed or released specific information.

You may be given a user ID and a password to enable you to view computerized information. Under no circumstances may you disclose your User ID or password other than to your supervisor or to IS staff. If you suspect someone else has knowledge of your password, you must immediately notify your supervisor and the divisional IS Manager.

The hardware, software, and data used in the DPH information systems are the property of DPH. All software installed on a DPH computer must be authorized in writing by IS and must be licensed to allow installation on a DPH computer. DPH has the right to review and remove personal or unlicensed software and data on any DPH computer.

If you, inadvertently or intentionally, misuse or improperly disclose your user ID or password, misuse or improperly disclose confidential information, use DPH information systems for personal reasons, or install personal or unlicensed software or data on a DPH computer, you may lose access to the computer system, be subject to disciplinary action up to and including termination, be reported to the appropriate licensing board, and/or be subject to civil or criminal liability.

I understand that I have no privacy right in the information in my DPH computer or the information that I access or send via my computer or other DPH equipment. I acknowledge that my use of DPH information systems and equipment may be monitored.

PRINT NAME

DIVISION

SIGNATURE

SSN

Appendix B

Example of a Legal Disclaimer

*****Notice*****

This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to which they are addressed. If you have received this e-mail in error please notify the sender. This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this e-mail.

Appendix C

Protocol for the use of a stand-alone computer with DSL line

Reasons for a specifically dedicated computer:

Research has shown that people are not only using the Internet for seeking sex partners but that these online behaviors are often antecedents to very risky offline sex behaviors, including increases in anal sex and a decrease in condom use. Activities such as online outreach, partner notification, and health communications are additional public health tools for STD/HIV prevention and education.

Approved activities:

-  Access to sexually explicit websites and content on the Internet
-  Access to chat rooms
-  Access to social networking sites
-  Use of instant messaging programs
-  Use of web-based e-mail programs

Unacceptable activities:

-  Gambling
-  Dating
-  Downloading non-work-related music or videos
-  Illegal activities

Computer access:

-  Researchers whose work specifically relates to the Internet (or other technologies) and STD/HIV prevention may use the dedicated computer
-  The computer will be password protected
-  All researchers with access to the computer will have to sign a form agreeing to use the computer only for the approved activities
-  The computer will be maintained on a unique server that has no connection to the main server
-  The computer will have virus protection that will be regularly updated.

APPENDIX D
Logic Models
Logic Model Template

Goal/Situation:

Inputs

Activities

Outputs

----- **Outcomes** -----
Short Intermediate Long

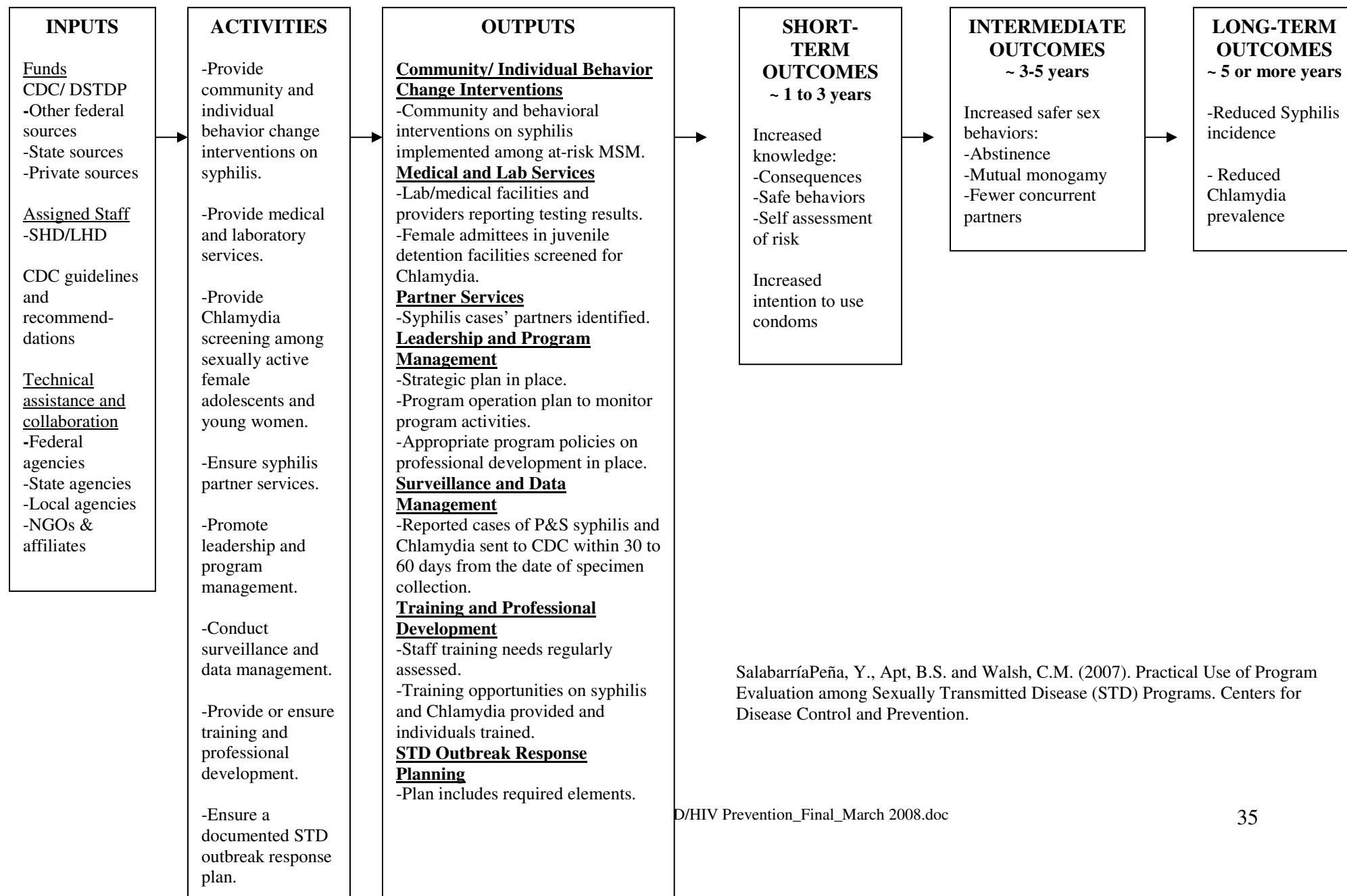


Guidance

Value Proposition

Logic

Logic Model for State X Comprehensive STD Prevention Systems (CSPS) Program



APPENDIX E

Example of Documentation Log

INTERNET PARTNER NOTIFICATION LOG SHEET

Your Name:
Initiation Date:

DIS # & State:
OP Id # and Disease:

Partner #	E-Mail Date	Website Name	Partner's E-Mail	E-Mail Script #	AM Logon Time	PM Logon Time	Notes/Outcome of Activity	Disease Verification (3 rd E-mail)	Closure Code
1									
2									
3									
4									

APPENDIX F

Check list for creating guidelines for online/Internet partner notification

- ☐ Determine who will need to be involved with the creation of the guidelines
 - ___ Health Department Medical Director/Administrator
 - ___ Health Department Security Coordinator
 - ___ Health Department Information Technology (IT) Director
 - ___ Legal Department
 - ___ Management Information Systems (MIS) Director
 - ___ STD Epidemiologist
 - ___ STD Area Managers
 - ___ STD Program Managers
 - ___ HIV Program Managers
 - ___ STD Disease Intervention Specialist (DIS) representative
 - ___ External Partners (community-based organizations [CBOs] working with affected communities, Website owners, etc.)
- ☐ Determine who will be covered by the guidelines
 - ___ A specific department (e.g., STD/HIV program)
 - ___ A city or county health department
 - ___ The entire state department of health
- ☐ Determine technological and staffing needs
 - ___ Do you need to hire someone new or are there existing staff members who can work on Internet/online projects such as partner notification online?
 - ___ How much of this staff member's time will be dedicated to online projects – 5 – 100%?
 - ___ Should this staff member come to the position with the necessary knowledge or can they be trained on the job?
 - ___ Is there someone who has the time to supervise this staff member?
 - ___ Is there at least one computer that can be dedicated to this purpose?
 - ___ Creation of a dedicated e-mail account?
 - ___ Approval obtained for unrestricted access to the Internet?
 - ___ At least one IT contact working with staff member?
- ☐ Sections of guidelines
 - ___ Introduction/Purpose
 - ___ Involved personnel
 - ___ Description of responsibilities of all involved personnel
 - ___ Competencies required of personnel conducting online partner notification
 - ___ Training
 - ___ Confidentiality
 - ___ Standard Operating Procedures of conducting online partner notification including templates and examples
 - ___ Adverse Events or Emergencies

- ___ Documents and Documentation
- ___ Evaluation

Details within each Guideline section

- ☐ Introduction/Purpose
 - ___ Statement of purpose, i.e., who, what, when, where, why
 - ___ Description of chat rooms, instant messaging, listservs, websites, etc., as well as passive vs. active outreach
- ☐ Personnel intimately involved with the online partner notification
 - ___ Primary employee conducting online partner notification
 - ___ Secondary employee to cover if primary employee is out of the office
 - ___ Supervisor
 - ___ IT employee for guidance and technical support
- ☐ Description of responsibilities of all involved personnel
- ☐ Competencies required of personnel conducting online partner notification
 - ___ Demonstration of good judgment and performance of responsibilities related to partner notification
 - ___ Cultural Competency
- ☐ Training (some examples/suggestions)
 - ___ Introduction to STD Intervention (ISTDI)
 - ___ Information Security Training
 - ___ Internet Partner Notification and Referral Services Training
- ☐ Confidentiality
 - ___ Description of how confidentiality will be handled and maintained
 - ___ Description of how a patient's identity will be confirmed
 - ___ Confidentiality agreement signed by all involved parties including IT and front-desk staff
- ☐ Standard Operating Procedures of conducting online partner notification including templates and examples
 - ___ Creation of step-by-step procedures on how to conduct online partner notification
 - ___ Creation of documentation forms and logs
 - ___ Creation of e-mail language, number of attempts made in a certain time frame, etc.
 - ___ Creation of referral resources
 - ___ Templates of e-mails, forms, logs, etc.
- ☐ Adverse Events or Emergencies
 - ___ Description of how adverse events or emergencies will be handled

___ Who will handle adverse events or emergencies?

☐ Documents and Documentation

- ___ List of all documents to be used including copies
- ___ Where documents will be stored
- ___ When and who will review documents
- ___ Documents should include, at minimum, the following:
 - ___ original patient case number
 - ___ e-mail or screen name of partner
 - ___ website where partner was met, if possible
 - ___ real name of partner if obtained
 - ___ disposition of the case
 - ___ dates & times e-mails were sent
 - ___ responses received
 - ___ turn-around time or time frame for completion

☐ Evaluation

- ___ **Process Evaluation** (ongoing evaluation while program is being developed and implemented)
 - ___ During development and implementation, meet on a regular basis with the team involved and ask the following questions:
 - ↳ What is working?
 - ↳ What should be improved?
 - ↳ How should it be changed?
- ___ **Outcome Evaluation** (assessing the degree to which the program has met the objectives, or the degree to which the program has been of use to the target population)
 - ___ Outcome evaluation should be conducted yearly to gauge the impact of the program. Ask the following questions:
 - ↳ What has happened?
 - ↳ Who was affected?
 - ↳ What was the most effective aspect of the program?
 - ↳ Was it cost-effective?

Appendix G

Examples of Screen Names and Profiles

<u>Organization</u>	<u>Screen/Profile Name</u>	<u>Email address</u>
San Francisco City Clinic	SFCityClinic	johnd@sfdph.org
Massachusetts Dept. of Health, STD Division	DivofSTDMA	Varies
Howard Brown	HBHCinChicago	johnd@howardbrown.org
Washington, DC STD Control Program	dcSTD	dcSTD@dc.gov

Required Manhunt Logos for Health-Related Profiles



Example 1: Massachusetts Department of Health, Division of STD Prevention Partner Notification Profile

MANHUNT.net

close [x]

DivofSTDMA

Offline

MANHUNT CARES

PARTNER NOTIFICATION PROFILE

Jamaica Plain,
Massachusetts

Division of STD Prevention: Partner Counseling and Notification

If you have received an email from this account, it is because someone you had sex with requested our help notifying you that they tested positive for an STD. Please read the e-mail I sent you for further information.

If you would like to confirm that this is a real profile, please call the Manhunt Health Liaison at 866-424-9999 ext 8945.

Please note that this profile is also used to contact individuals outside of Massachusetts.

Division of STD Prevention
Massachusetts Department of Public Health
State Laboratory Institute
305 South Street
Jamaica Plain, MA 02130

WHEN: Ask Me
WHERE: Ask Me

ETHNICITY: Ask Me
STATUS: Ask Me

INTO:

99 | 7 ' 11 | Ask Me | Ask Me / Ask Me | Ask Me



click any photo to enlarge

EMAIL BLOCK ADD BUDDY 🗑️

last login: 2 days ago

Example 2: Washington, DC STD Control Program
Partner Notification Profile

MANHUNT.net

close [x]

dcSTD

Offline

MANHUNT CARES

PARTNER PROFILE
NOTIFICATION

Washington,
District of Columbia

Washington, DC STD Control Program: Internet Partner Notification
If you received an unsolicited email from me, it's because someone you met online has recently been diagnosed with a laboratory-confirmed sexually transmitted disease (STD).
Please read the e-mail I have sent you for details about this possible STD exposure and next steps.
To confirm this is a real profile, please call the Manhunt Health Liaison at 866-424-9999 ext. 101.
Please note that this profile is also used to contact individuals outside of Washington, DC.

Southeast STD Clinic
Washington, DC Department of Health
1900 Massachusetts Ave, SE Bldg. 8
Washington, DC 20003
8:15am-3:15pm Mon-Fri
Metro stop: Stadium-Armory

WHEN: Ask Me
WHERE: Ask Me

ETHNICITY: Ask Me
STATUS:

INTO:

99 | Ask Me | Ask Me / Ask Me | Ask Me


click any photo to enlarge
EMAIL **BLOCK** **ADD BUDDY** 😊
last login: 4 days ago

Example 3: Legacy Community Health (Houston, Texas) Outreach Profile



ProjectCORE1

close [x]

Offline

MANHUNT CARES



OUTREACH PROFILE

Houston,
Texas

Cyber Outreach Health Educator! Ask me a question.

Syphilis is on the rise in Houston. It can be spread through oral sex, regardless of position. And symptoms can go unnoticed!! Find out how to protect yourself better!! I also have information on all STD's, as well as other issues like Bareback, PnP, Drugs, and other health related issues!! Here is an opportunity to ask questions you may have to a real Health Educator, free of charge! No holds barred!!! (Thanks to the profile graciously donated by Manhunt.net)

Feel free to Email, Responses are guaranteed!!

WHEN: Ask Me

WHERE: Ask Me

ETHNICITY: Ask Me

STATUS: Ask Me

INTO:

99 | Ask Me | Ask Me / Ask Me | Ask Me





click any photo to enlarge

EMAIL

BLOCK

ADD BUDDY

👤

last login: Over 2 weeks ago

APPENDIX H

Sample e-mails - Traditional language

Day 1 of Investigation

E-mail - 1st attempt

To: SexKitten@sexsite.com

From: StarDIS@ncsddc.org

Subject: URGENT HEALTH MATTER

My name is John Investigator, and I am with NCSD. I have urgent and confidential health information to discuss with you. I can be reached at my office at (555) 234-5678. Please contact me as soon as possible. Thank you, John Investigator.

Day 3 of Investigation

E-mail - 2nd attempt

To: SexKitten@sexsite.com

From: StarDIS@ncsddc.org

Subject: HEALTH DEPARTMENT MATTER

My name is John Investigator and I work with NCSD. I attempted to contact you on 01/01/04; I have some very important health information to share with you. This is a very urgent matter, and because of the confidential nature of this information, it is vital you contact me. Please call me at (555) 234-5678. I can be reached at this number from 8am to 5pm, Monday through Friday or you can contact me using my e-mail address StarDIS@ncsddc.org or my cell phone at (555) 255-5888. To assist you in confirming my identity, I have included my supervisor's name and phone number: Josefina Boss, Program Manager, (555) 234-5679. Please do not delay in contacting me.

John Investigator

Disease Intervention Specialist

NCSD

South Central District Office (555) 234-5678

If no response after Day 4, the DIS should discuss the situation with their supervisor. Attempt to re-interview the original patient for additional locating information, and/or consider having the original patient attempt to notify the partner. The original patient can explain that a representative from the health department will be contacting him/her with important health-related information, plus provide the DIS name and office number.

Appendix I

Sample e-mails - Alternative language

E-MAIL 1

Day 1 of investigation

Dear <<screenname>>,

My name is John Doe, and I am from the Washington DC Department of Health, STD Control Program. I'm emailing you because someone you met online was recently diagnosed with a laboratory-confirmed sexually transmitted disease (STD).

You need immediate medical attention because this person identified you as a sexual partner during the infectious period of this STD. For confidentiality reasons, I cannot tell you anything about the person you had sex with, including when it occurred.

Please call me at 202.XXX.XXXX, and I can tell you more about the specific infection and where you can go to be tested and treated for free.

If I'm not there when you call, I will call you back. Be sure to leave a number and time when I can reach you. My voicemail is private, confidential, and password-protected.

I check my voicemail and email at the beginning and end of each business day (8am-4:30pm, M-F).

If you want to check that this email is real, call the Division of STD Prevention at 555-555-5555 and ask to speak with our Medical Epidemiologist, Dr. J. Doe. You can also <<call Website/ISP Administration at XXX.XXX.XXXX>> to confirm the legitimacy of this <<Website/ISP] account.>>

Thank you,

John Doe, [credentials]
Disease Intervention Specialist (or other title)
STD Control Program, Washington, DC Department of Health
Email: dcSTD@dc.gov

E-MAIL 2

Day 6 of Investigation

Dear <<screenname>>,

I noticed that you read my first email, but I didn't hear back from you.*

I have important information about the specific STD you have been exposed to and want to give you a couple of ways to get this important information:

1. You can call me at 202.XXX.XXXX and I can tell you more. My voicemail is private, confidential, and password-protected.
2. You can email me (at this email or at dcSTD@dc.gov), and let me know that it's okay to give you more details about this STD in writing. Just put "I agree" in the subject line.

Remember, I check my voicemail and email at the beginning and end of each business day (8am-4:30pm, M-F).

[If you want to check that this email is real, call the Division of STD Prevention at 555-555-5555 and ask to speak with our Medical Epidemiologist, Dr. J. Doe. In addition, you can email me at my work address: dcSTD@dc.gov. You can also <<call Website/ISP Administration at XXX.XXX.XXXX>> to confirm the legitimacy of this <<Website/ISP>> account.]

Thank you,

John Doe, [credentials]
Disease Intervention Specialist (or other title)
STD Control Program, Washington, DC Department of Health

If it is not known if the individual read the email (i.e. Adam4Adam), the first line will need to be modified: "A few days ago I sent you an email, and I didn't hear back from you."

If it can be confirmed that the partner has not deleted the first email (which has verification information), then the verification information should not be included in Email 2.

National Guidelines for Internet-based STD/HIV Prevention_Outreach_Draft_02-11-2008_for review.doc

E-MAIL 3

Day 11 of Investigation

Dear <<screenname>>,

As you know, I've tried to reach you twice now about your exposure to a laboratory-confirmed STD. Although I respect that you don't want to contact me to find out which specific infection you may have been exposed to, my hope is that you have visited your medical provider and let them know I've been in contact with you.

Remember, with many STDs, you need to be treated for your exposure, regardless of your STD test result.

This will be my last unsolicited email to you regarding this specific exposure. However, in the future if you are exposed to another laboratory-confirmed STD, I may be contacting you again.

Finally, if you decide to call me (202-XXX-XXXX) or email me (dcSTD@dc.gov), I want to emphasize that our communication is strictly confidential.

Thank you,

John Doe, [credentials]

Disease Intervention Specialist (or other title)

STD Control Program, Washington, DC Department of Health

Appendix J

Description of Washington DC's timeframe for sending IPS e-mails

A series of emails has been created to initiate Internet Partner Notification (IPS) in a standardized manner. The IPS DIS will commence by sending E-mail 1. If there is no response, E-mail 2 shall be sent after five days; likewise, E-mail 3 shall be sent five days later. Only three unsolicited e-mails shall be sent per disease exposure. If the partner expresses interest in no further communication, E-mail "Negative Response" shall be sent. If a partner expresses interest in learning more via e-mail, E-mail "Positive Response" shall be sent. If the interested partner has not responded within one week after E-mail "Positive Response" being sent, E-mail "Positive Response Follow-up" shall be sent. In many situations, partners may attempt to call the IPS DIS, at which point the IPS DIS shall refer to previous training to handle telephone communication.

APPENDIX K

Documenting IPS in STD*MIS

Example - Massachusetts

Documentation Requirements

- The DIS will document all Internet activity.
- DIS must document all work with the date, time and description of each interaction on the Internet PN Log Sheet.
- All e-mail documentation should be kept in a case file.
- Internet PN must be entered and kept up-to-date in STD*MIS (see below).

Entering Internet Screen names into STD*MIS

This section of the policy seeks to address sexual contacts of infected individuals who are known to the infected patient by their screen names or e-mail addresses only. This flexible approach is based on how much information is available about a partner and serves as a systematic way to maintain accurate records of not just names, addresses and phone numbers, but also screen names. In this way, we can perform searches for individuals by their screen names and/or e-mail addresses when no other information is available.

- Individuals who are only known by their screen name are entered into STD*MIS as: Internet, screen name (For example, Internet, Sexyperson.) Both the first and last names should be updated when more information becomes available.
- Screen names are entered into the Also Known As (AKA) section. AKAs should never be changed or deleted. New screen names must be added as needed. (It is important to note that individuals can be searched for in STD*MIS by their AKA only- no other information about first or last names is needed to perform a search.) If the individual is not currently in the STD*MIS system, we can add them and open a new Field Record.
- Screen names pertain to specific Internet sites. These sites (Manhunt, AIM, Yahoo, etc.) must be noted in the Notes section of the Field Record. Individuals may change their screen names frequently, so it is essential that the date of the last known use of the screen name be noted in the Notes section. (For example: MH “Sexyperson” 4/19/06, Yahoo “SexyP” 4/19/05, AIM “SexyPER” 4/19/04.)
- The way we currently manage missing locating information remains the same. For example, if we know a client’s first name and address, this individual is entered into the system as “John UNK.” Now, with this new system for entering names into STD*MIS, sexual contacts will be entered into the system as “Internet, screen name,” or, if we know the client’s first name, “John Internet.”
- Case dispositions should be entered into STD*MIS with the following codes (STD*MIS does not allow numbers to be entered after letter codes; this can be noted in the case file):

<u>Code</u>	<u>Description</u>
A*	Preventative treatment (not infected - confirmation of examination and/or treatment)
C*	Infected, brought to treatment (infected - confirmation of examination and/or treatment)
L1**	Patient states examination and/or treatment (not infected - no provider confirmation)
L2**	Patient states examination and/or treatment (infected - no provider confirmation)
J**	Informed of disease exposure - no further contact with MPDH (located, received specific STD exposure info, no further contact with MDPH)
H1	E-mails read but never responded (located but refused to respond, did not receive specific STD disease information)
H	E-mail(s) not read (unable to locate)
* Infers direct contact with DIS	
** Infers e-mail or phone communication without disclosure of identifying information	

Example – Washington DC

Within 72 hours of the Original Interview, the investigating (Ix) DIS will record in the OP's STD*MIS file that the OP had a "PARTNERS INTERNET" risk factor. Internet partners are recorded as contacts of the OP; if a partner is not listed in STD*MIS (after a search using the FIRST NAME, LAST NAME, and AKA fields), a patient record is created for him/her. The Ix DIS should then complete a Field Record for the partner with all information pertaining to the Internet partner (including physical descriptions, identical spelling of e-mail addresses, sex venues, etc.). The Ix DIS will then assign this partner to the IPS Coordinator (writing the IPS Coordinator's Worker Number STD*MIS number in the Field Record).

For data entry, Ix DIS should follow this format:

Individuals who are only known by their screen name (internal e-mails) or e-mail address (external e-mails) are entered into STD*MIS as FIRST NAME: "<<SCREENNAME@WEBSITE or e-mail address>>", LAST NAME: "INTERNET". Both the first and last names should be updated when more information becomes available. The screen names will be entered followed by the website. Note: For long screen names or e-mail addresses, simply enter as much of the name that will fit into the space (20 characters).

Examples for Internal Emails:

Website	Screenname	STD*MIS Entry
Manhunt.net	SWEATYnDC	SWEATYNDC@MANHUNT.NET
Adam4Adam.com	SWEATYnDC	SWEATYNDC@ADAM4ADAM.COM
Manhunt.net	HOTnSWEATYnDC	HOTNSWEATYNDC@MANHUNT.COM
Adam4Adam.com	HOTnSWEATYnDC	HOTNSWEATYNDC @ADAM4ADAM.COM

Examples for External Emails:

Website	Screenname	STD*MIS Entry
Gay.com	SWEATYnDC	SWEATYNDC@GAY.COM
Yahoo.com	SWEATYnDC	SWEATYNDC@YAHOO.COM
Gay.com	HOTnSWEATYnDC	HOTNSWEATYNDC@GAY.COM
Yahoo.com	HOTnSWEATYnDC	HOTNSWEATYNDC@YAHOO.COM

In addition, screen names and e-mail addresses are entered into the AKA section. AKAs should never be changed or deleted. New screen names must be added to the AKA section as needed. (It is important to note that individuals can be searched for in STD*MIS by their AKA only—no other information about first or last names is needed to perform a search.) If the name of the Internet partner becomes known at a later date, it is important that the screen name is moved to the AKA section because it will allow for the individual to be searched in the future under his/her screen name.

Individuals may change their screen names frequently, so it is essential that the date of the last known use of the screen name be noted in the Notes section (e.g., “SWEATYnDC@MANHUNT 4/19/06”).

The way we currently manage missing locating information remains the same. For example, if we know a client’s first name and address, this individual is entered into the system as “JOHN UNK.” Now, with this new system for entering names into STD*MIS, sexual contacts will be entered into the system as “<<SCREENNAME@WEBSITE>> INTERNET” (or “<<EMAIL ADDRESS>> INTERNET”) or, if we know the client’s first name, “<<FIRST NAME>> INTERNET.”

For data entry, IPS DIS should follow this format:

Within the Field Record, under “EVENTS”, the IPS DIS shall choose the last option: “INTERNET PARTNER NOTIFICATION”. In the “INTERNET PARTNER NOTIFICATION” screen, there are a series of Y/N fields. The first field, “IPS”, indicates whether the individual is an Internet partner. The remaining 13 fields, “IPS_L1a through IPS_L4” allow for further explication of the “L” disposition that is designated for an Internet partner (see Dispositions below).

Case dispositions should be entered into STD*MIS with the following codes (STD*MIS does not allow numbers to be entered after letter codes; this can be noted in the case file):

<u>Code</u>	<u>Description</u>
A	Preventative treatment
B	Refused preventive treatment
C	Infected, brought to treatment
D	Infected, not treated
E	Previously treated for this infection
F	Not infected
G	Insufficient information to begin investigation
H	Unable to locate
J	Located, refused examination
K	Out of Jurisdiction
L	Other*
L1	Informed of specific STD exposure (2nd e-mail, phone call, in-person communication)
a.	Informed of specific STD exposure, claims preventive treatment
b.	Informed of specific STD exposure, refuses preventive treatment
c.	Informed of specific STD exposure, claims to be infected and treated
d.	Informed of specific STD exposure, claims to be infected and not treated
e.	Informed of specific STD exposure, claims to be previously treated
f.	Informed of specific STD exposure, claims to not be infected
g.	Informed of specific STD exposure, no further contact
L2	Informed of an STD exposure (first e-mail)
L3	Not informed of STD exposure
	Refused—E-mails not read even though patient logs in
	Refused—Patient blocks IPS screen name
	Not known if e-mails are read
	Unable to locate (Patient has not logged in during Field Investigation period.)
L4	Insufficient information to begin investigation (Screen name does not exist.)

*The L disposition will be used for Internet disposition codes, provided the Internet partner does not have any physical locating information (i.e., name and/or address). If physical locating information is acquired at any point throughout IPS, traditional disposition codes (A-K) shall be used.

Data Entry into the Proposed STD*PAM

In the proposed STD*PAM software, data entry will follow the same format. However, an additional, “Internet Partner” Disposition Code (e.g., “WI”) will be added to differentiate Internet partner dispositions from traditional partner dispositions:

<u>Code</u>	<u>Description</u>
A	Preventative treatment
B	Refused preventive treatment
C	Infected, brought to treatment
D	Infected, not treated
E	Previously treated for this infection
F	Not infected
G	Insufficient information to begin investigation
H	Unable to locate
J	Located, refused examination
K	Out of Jurisdiction
L	Other
W	Marginal Partner Dispositions
WI	Internet Partner Disposition
WI1	Informed of specific STD exposure
WI2	Informed of STD exposure
WI3	Not informed of STD exposure
WI4	Insufficient information to begin investigation

In addition, another question will be added to the field record to indicate the type of Provider (DIS) Referral. The choices will be:

Telephone
In-person
E-mail
E-card



Guidelines for Internet Outreach

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1. Introduction

This section of the Internet Guidelines makes recommendations for conducting STD/HIV prevention outreach and recruitment activities on the Internet and through virtual settings, such as chat rooms, social networks, bulletin boards, e-mail groups, and other online communities. For the purposes of this document, outreach is defined as a virtual interaction between an STD/HIV prevention professional, such as an outreach worker, and a person or persons at risk for STDs or HIV for the purposes of providing STD/HIV related: health information and education, referrals and access to services, recruitment for testing and treatment, and support for reducing risk behaviors.

In the field of HIV and STD prevention, outreach has been an important method for information and service delivery, particularly among those populations that do not access the traditional health care system or are considered hard-to-reach.¹⁻³

Outreach activities meet the clients where they are (both physically and behaviorally), helps to create a credible and trusting relationship between program staff and clients, and allows for health and risk assessments. These activities provide accurate and relevant health information, referrals to services, and testing and treatment, which ideally results in behavioral change. Similarly, Internet-based or online outreach meets at-risk populations where they are, in this case virtually, and is an additional means of providing health information, risk reduction materials and messages, and referrals to services, thereby promoting and supporting positive behavioral changes.

Few studies have been conducted specifically on the impact or effectiveness of either street or online outreach. Programs should consider the following when determining whether or not to conduct online outreach: cost effectiveness, feasibility, acceptability, and replicability.⁴⁻⁵ Despite this, certain basic programmatic and staff requirements are necessary, as determined by those with the most experience conducting online outreach.⁶⁻¹² The following recommendations should be used in conjunction with the CDC's HIV Health Education and Risk Reduction Guidelines¹³ (HERR); CDC's Program Operations Guidelines for STD Prevention¹⁴; and CDC's HIV Counseling, Testing, and Referral guidelines¹⁵⁻¹⁶.

These guidelines have been developed for agencies and/or programs that intend to implement Internet outreach or to enhance existing guidelines in departments where guidance is in place. Some agencies/programs may have more in-depth guidance or specific policies on the use of the Internet for health outreach and education. Additionally, agencies/programs may have internal policies or electronic barriers, such as firewalls, that may impede the implementation of Internet-related activities. It is recommended that agencies review state and local laws and agency/program policies and consult with IT departments prior to implementing Internet outreach.

2. Background

The Internet has become a means for finding both health information and sex partners. Finding health information online is one of the most common functions of the Internet. About 80% of American Internet users have used the Internet to search for

health information and this number has remained stable for the past 4 years. Over 60% of these users go online to find information on a specific medical condition and 11% report seeking sexual health information. About 58% of health information seekers say the information they found in their last search affected a decision about how to treat an illness or condition and 55% say the information changed their overall approach to maintaining their health or the health of someone they help take care of. Also, 54% say the information led them to ask a doctor new questions or to get a second opinion from another doctor.¹⁷⁻¹⁹ Not only are people using the Internet as a source of health information; the information they obtain is influencing the actions that they take.

The Internet is also a well known venue for finding sex partners. People who use the Internet for seeking sex partners are more likely to report high risk behaviors, such as: unprotected anal intercourse, anonymous sex, drug use, multiple sex partners, group sex, and trading sex for money or drugs.²⁰⁻²⁵

Because the Internet is both a tool for gathering health information and for finding sex seekers, it has been posited to be a tool for outreach as well.²⁶⁻²⁹ Additionally; online sex-seeking populations have indicated that health workers should be allowed in chat rooms and that they would listen to what the health workers had to say.²⁷

Trained health educators and outreach workers can provide a variety of services through the Internet, including prevention education, risk-reduction counseling, referrals to reliable web-based information, and local resources such as testing and treatment sites, recruitment into prevention and care programs, promotion of positive health-seeking behaviors, and support for online communities at risk. Tailored health messages can be delivered to groups via encounters in chat rooms/social networking sites and postings on bulletin boards or to individuals during one-on-one private sessions and e-mail. Such interactions do not require an appointment, can vary in duration and intensity, and meet people where they are - online.

It is understood that the medium of the Internet is constantly changing and that this consistent state of flux presents unique challenges. It is our hope that this document will be a useful tool in the development of new and innovative Internet interventions and that it will assist programs in overcoming the challenges of working with populations in an electronic environment.

3. Principles of Outreach

3.1 Cultural and Linguistic Competency

Internet outreach should always be conducted in a culturally and linguistically competent manner. A key element of any successful STD/HIV prevention program is an understanding of the community within which prevention activities take place, which includes the linguistics or language of the community members and the capacity to communicate with them in meaningful terms. It is important to not only understand the beliefs, attitudes, behaviors, norms, and values of a population, but also to be able to understand and convey information to them in their “language”.

Cultural Competence

“Cultural competence is defined as the capacity and skill to function effectively in environments that are culturally diverse and that are composed of distinct elements and qualities. Cultural competence begins with the STD/HIV professional understanding and respecting cultural differences and understanding that the clients' cultures affect their beliefs, perceptions, attitudes, and behaviors.”

CDC's Guidelines for Health Education and Risk Reduction Activities, April 1995

<http://www.cdc.gov/hiv/resources/guidelines/herrg/index.htm>

Online communities, just like offline communities, will have their own ‘culture’. This includes a unique language; one abundant with abbreviations, acronyms, and inferences. And within the Internet there are a variety of different online communities, which will generally have different cultures and languages from one another, that is, an adolescent-focused site will have a very different feel than a site targeting older men-seeking-men (MSM) or a community of adult ‘swingers’. It is essential for outreach workers to learn and understand the culture and language of the target populations before engaging in outreach activities.

Linguistic Competence

“The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences.”

Georgetown University's Center for Child & Human Development, [National](#) Center for Cultural Competence, November 2004

<http://www.ncccurricula.info/linguisticcompetence.html>

Spending time on Internet sites popular with the target population or where members of the target population congregate will help outreach workers gather information and learn about the population. Conducting a community assessment, as outlined in Section 4.1, may also help program planners and staff better understand the community in which they are conducting Internet outreach. It is also recommended that periodic assessment or quality assurance activities be conducted to ensure the ongoing cultural competence of the program.

Tip from the field

Just like offline communities, online communities have their own ‘culture’ and vernacular.

Staff members that perform STD/HIV prevention activities on the Internet are expected to be culturally competent and skilled at providing health education messages to the specific, online population that is being targeted. This competence includes an awareness and understanding of health-education messages and a strong awareness and

comfort level with communication that may be sexually explicit or conform to community standards that could be in conflict with the personal ethics or values of the outreach worker. It is recommended that staff participate in cultural competency training with regards to the specific population being targeted prior to conducting Internet outreach activities. The staff's level of cultural competency should be reviewed periodically during an Internet outreach program. Quality assurance measures should be instituted to assess the cultural competency of staff performing these activities.

3.2 Client Centered

A client-centered approach strives to provide an environment of empathy, unconditional positive regard, and acceptance. Workers should be encouraged to accept their clients where they 'are' at the moment and provide support. Being supportive to the client while providing education is key to the overall success of outreach in online communities.

Client-Centered Counseling

“Counseling conducted in an interactive manner, responsive to the individual patient's needs and requiring an understanding of the unique circumstances of the patient including behaviors, culture, knowledge, and social and economic status.”

CDC's Guidelines for Health Education and Risk Reduction Activities, April 1995
<http://www.cdc.gov/std/program/partner/ApJ-PGpartner.htm>

3.3 Confidentiality and Privacy

All Internet outreach must adhere to standards of confidentiality and ethics. Agencies conducting Internet outreach are expected to have a comprehensive confidentiality policy that specifically covers Internet-related and electronic client-identifying information. The confidentiality agreement should include consequences for any violation of the policy. The confidentiality agreement should extend beyond outreach workers and must include the organization's Information Technology (IT) staff and all staff that may view or has access to sensitive information. It should be acknowledged that private website managers and the IT staff of those sites will also have access to all conversations conducted on their website and are not bound by the confidentiality policies of public health organizations. Prior to the implementation of Internet outreach, agencies should consider compliance with the Health Insurance Portability and Accountability Act (HIPAA), use of firewalls, security of wireless networks (if used), and whether to permit staff to conduct Internet outreach from their home computers or portable laptops.

HIPAA Privacy Rule and Public Health

Guidance from CDC and the U.S. Department of Health and Human Services

Morbidity and Mortality Weekly Report

April 11, 2003/ 52; 1-12

<http://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm>

Screen names, e-mail addresses, HIV status, and any personal or sexual information are considered to be identifying information and must be held to the same level of confidentiality as a client's first name and surname. Printed documents, such as logs, reports, or transcripts, containing screen names or e-mail addresses are to be stored in locked file cabinets. Under no circumstances should outreach workers share any information about one cyber client to anyone else, whether it is in the 'virtual world' or in the 'real world.' For e-mail groups and listservs, it is recommended that member e-mail addresses not be shared with any other members.

See **Appendix A** for examples of confidentiality agreements.

Tip from the field

All staff with access to information that may identify a client (e-mail addresses, chat room names, etc.) should sign a confidentiality agreement. This includes outreach workers and extends to other agency staff, such as the IT staff.

3.4 Ethics and Safety

Staff members that utilize the Internet for outreach are expected to identify themselves to the community in which they are working quickly and professionally by giving clients their name (or screen name), job title, and agency affiliation. Not professionally identifying oneself may be interpreted in the online world as lurking, spying, or some sort of possible entrapment. Staff members should be very cautious about how much personal information they give online, protecting their personal information at all times.

Staff should never share or use their personal e-mail address or screen names nor should they give out the web address of a personal profile or webpage to conduct Internet outreach. Staff should never share their personal information such as a personal telephone number, home address, or any other individual contact information.

At no time should staff ever use a relationship made while conducting Internet outreach to pursue personal, sexual, or illegal activities in any way. Staff should never misrepresent themselves or mislead by role (i.e., if they are not medical providers, then they should not give medical advice to individuals online).

Safety protocols should include procedures on handling abusive or slanderous clients met on the Internet. Staff should be trained to know how, when, and where to defer these clients. These procedures may include disengaging from online activities, blocking or ignoring abusive individuals, or referring difficult clients to a supervisor.

3.5 Approaching Your Audience

There are several approaches Internet outreach workers can take when attempting to engage a community or encourage individuals into a one-on-one discussion. There are two approaches that are currently in practice; an ‘active’ and a ‘passive’ approach.

An active approach is generally more aggressive than a passive approach and can involve techniques that entice users to communicate in private or Instant Messaging (IM) sessions. The most common technique involves posting health-related messages regularly and openly in public chat sessions and inviting other users in the public chat room to enter into a private one-on-one interaction. Be aware that if your approach is too aggressive, online communities and website owners may view your presence as intrusive. It is extremely important to always remember that when you are in a chat room or other social/sexual networking site you are there as an invited ‘guest.’ To be culturally competent you should always respect members of the website and abide by the social norms that have been established by the community. An overly aggressive approach can lead to your organization and potentially all organizations being banned from the website in the future. Staff should always be aware of this and be respectful of the cultural/social variations and group norms of different online communities. Tolerance levels will vary from room to room and website to website.

Tip from the field

Aggressive outreach can cause chat room members to leave the chat room or website and go elsewhere.

A more passive approach would involve simply sitting in a chat room without having introduced oneself or posting any chat dialogue. This approach may be less effective in terms of reaching significant numbers of people in a cost-effective manner. Some individual members of online communities may view this approach as ‘lurking’ in a room; other communities may require that outreach workers remain passive.

Since building trust in any online community is of the utmost importance and is a key element in the success of Internet outreach, it is recommended that outreach workers

always introduce themselves in a professional manner when entering a chat room or social/sexual networking site unless directed otherwise by the website owners or community standards. This introduction should identify the Internet outreach program and the outreach worker's purpose, and could include an invitation to IM or e-mail for a private one-on-one chat. See **Appendix B** for an example of a one-on-one chat. Because new users will enter the room after the initial introduction, outreach workers should re-introduce themselves regularly. The frequency of re-introductions should be limited to one every 10-15 minutes depending on the level of activity in the chat room.

Recommendation

Always introduce yourself in a professional manner upon entering a chat room or social/sexual networking site.

Many online communities that are 'profile-based' will provide profiles for outreach workers to use. When logging on most profile-based communities, such as Manhunt.net, your presence will be automatically announced and your profile will be listed as being 'online'. Once you are listed as being 'online' you become available to answer questions via e-mail, chat, or IM. See **Appendix C** for examples of Screen Names and Profiles.

Some Internet outreach workers may choose to actively contact online clients they suspect, from reading profiles or chat room conversations, are practicing high-risk behaviors. Although it is tempting to reach out to people who are engaging in high-risk behaviors, individuals must be actively ready to change, otherwise outreach may be ineffective, as posited by Stages of Change Theory.³⁰ Engaging individuals before they are ready will cause them to ignore you at best, and at worst, place a negative mental barrier to your message and possibly your organization, now and in the future. Instead, think of an outreach worker's presence in a chat room or on a website as a subtle reminder to members that risky behaviors can be harmful to one's own health and that outreach workers will be able to serve as a reliable resource should members move to a stage where they are ready to make a change. Moreover, being too aggressive during outreach can threaten trust and rapport-building and will often be met with negative feedback from the online community. Should there be significant complaints regarding outreach on any given site, it is possible that all outreach workers, not just your agency, could be banned from the site or chat room. This approach can also hurt an agency's reputation in the community, potentially leading to complaints from community members or lack of trust in the agency's other programs and services. *These guidelines do not recommend using this approach.*

4. Getting Started

There are many similarities between conducting virtual outreach and outreach in more traditional street and community settings.

Many websites contain virtual elements or features that mirror venues or aspects of venues in traditional settings. Public chat rooms and social networking communities are analogues to community centers, bars, or other areas where public conversations can take place. IM is analogous to one-on-one or private communication. Both elements (public chat and private IM) have the potential to be used for risk reduction, counseling, or other individual-level interventions (ILI).

Just as in traditional settings, some personal information in a profile is public, while other pieces can be kept private but, generally speaking, profiles are the public portion of a person's persona. Many websites allow members to 'lock' or keep private certain pieces of personal information, including pictures, text, and personal interests.

When joining a website, it is recommended that you take some time to acquaint yourself with the community you are now a member of; read through profiles, examine the search features, go into the chat room, and listen before interacting within the community.

In addition to reviewing the community for content and its general culture, time should be spent learning the features of the site. Acquaint yourself with how to use the e-mail system, chat rooms, instant messaging, search, and the other features of the site.

For further assistance with getting started see **Appendix D**; a checklist of creating guidelines for Internet-based outreach.

4.1 Community Assessment

Prior to designing and/or implementing an Internet outreach program or joining a website for the purpose of Internet outreach, it is recommended that agencies assess the community to learn more about the attitudes, behaviors, language, community norms, and values of the targeted population(s). Assessment activities can be informal or formal. An informal assessment may include feedback from staff, anecdotal observations of potential Internet venues, and consultations with community leaders, gatekeepers, and client advisory boards. A formal assessment might include online surveys, interviews, or focus groups.

A community assessment may assist in the following ways:

- Defining the purpose and scope of your Internet outreach program.
- Establishing appropriate program goals, objectives, and activities.
- Defining and learning more about the target population.
- Identifying online venues that will help you to reach the target population.

- Identifying social attitudes, behaviors, perceptions, and vernacular of the community.
- Providing the basis for evaluation as part of formative and summative studies of interventions.
- Establishing community-based support for the proposed activities.

It is recommended that periodic assessment or quality assurance activities be conducted to ensure the ongoing involvement of the target community and to ensure that the program is meeting the needs of the community. The CDC's 'Health Education and Risk Reduction Guidelines' (HERR)¹³ provide more information about community assessment for health education programs.

When considering conducting Internet outreach, an agency should be aware of what other community-based organizations and similar agencies are doing on the Internet. Questions to ask could include:

- What agencies are already online?
- What online venues are currently being served by those agencies?
- What methods are being used by the agencies in the venues (outreach, health communication, and/or partner notification)?

Agencies should also communicate with the state or local health department to coordinate efforts as much as possible. To minimize over-saturation within a venue or an area, one ideal scenario would be to have an experienced point person in each agency that collaborates with other agencies and organizations.

Tip from the field

Useful websites for information on conducting community assessments:

[HIV Health Education and Risk Reduction Guidelines - Community Needs Assessment](http://www.cdc.gov/hiv/resources/guidelines/herrg/gen-con_community.htm)
http://www.cdc.gov/hiv/resources/guidelines/herrg/gen-con_community.htm

University of Florida/IFAS Extension Electronic Data Information Source
<http://edis.ifas.ufl.edu/FY501>

4.2 Choosing a Population to Target

About 70% of all U.S. adults¹⁸ and 87% of U.S. teens¹⁹ are online. With millions of websites and billions of web pages, targeting the best website or chat room to conduct your outreach is extremely important. Internet outreach should be cost effective and directed towards populations at increased risk of becoming infected with STDs/HIV or, if already infected, of transmitting the infection to others. Some research has shown that individually focused interventions, such as street outreach, can be cost effective when

targeted toward high-risk, STD-prevalent populations, such as MSM, but not for low-prevalence populations. For low-prevalence populations, structural interventions, such as condom availability, may be more cost effective.⁵

Disease Intervention Specialists (DIS) often ask STD patients about sex partners met through the Internet; therefore, local surveillance data may help to identify appropriate online venues where the target population can be reached. Agencies should also review local health department surveillance data for pertinent information to ensure that appropriate populations are targeted. Agencies should define the specific population to be served and determine the general needs of this population. Based on the information gathered, the agency can then make an educated decision as to what specific online venues are best suited for Internet outreach and what time of day is best for conducting the work. Additional information about where high-risk individuals go online should be obtained from community assessment activities prior to, during, and after program implementation.

Because the Internet is an ever-changing environment, online venues or times for reaching a specific population online may change frequently. Therefore, flexibility and the monitoring of Internet trends are very important.

4.3 Working In Online Venues

Before an organization actually goes online, they are strongly encouraged to develop formal guidelines and trainings on how to conduct Internet outreach that is specific to their program and locale. Organizations should conduct a needs assessment (formal or otherwise) and contact experienced programs to share information and obtain guidance from those that have already successfully conducted Internet outreach. For contact information on organizations with experience, visit or contact the National Coalition of STD Directors (NCSD) at their website - www.ncsddc.org.

In addition to formal guidance, organization-level policies for Internet use should be reviewed. Clear separation between the personal use of the Internet and work use should be established and documented prior to the implementation of any program that utilizes the Internet. Additionally, outreach staff may need specialized training.

Similar to street and community outreach, it is imperative that agencies make every effort to establish contact with, and to obtain permission from, website owners or the management of the online venue, prior to conducting outreach. Some sites may require that you establish an official relationship with them before you conduct outreach on their site. Go to the NCSD website for an example of guidelines for working with Manhunt.

Agencies should recognize the limitations within each venue. For instance, some websites may permit agencies to set up an online profile and exchange e-mails with its members, but may not allow agency staff into member chat rooms. Bulletin board monitors may allow agencies to post event announcements, whereas a social network may prohibit unsolicited e-mail but will allow chats with members. Finally, many websites prohibit public health entities from providing any kind of services on their site.

Establishing an official relationship with the website where outreach is to be conducted is the ideal situation. Contact and/or permission may not be granted or communication with the venue may be impossible to establish. In this situation, it is the program supervisor's decision on whether to proceed.

Tip from the field

Most programs that conduct online outreach have, at one time or another, been removed, blocked, or had their profile deleted or their account revoked from a website.

When working through online venues, programs should be aware that they are in a public environment that is owned and hosted by a private company. In most cases, outreach workers will be invited guests, in other cases outreach workers may be seen as intruders. Every effort should be made to ensure that a positive relationship is formed with both the members in the venue and the venue owners and employees.

Online outreach workers should remember that users are generally online for purposes different than their own and that health messages may not always be welcomed. Considering that you are a guest in a venue that most likely will be part of a private business, your tone and behavior should be welcoming and understanding. Aggressive behavior will generally be met with conflict.

Unlike outreach in the real world, outreach and communication online is subject to sudden disconnection. It is possible to be blocked by an individual member or by the venue itself. Be aware that outreach workers can be blocked and banned from a venue abruptly and without notice or warning.

4.4 Accessing Adult Sites

To conduct Internet outreach, employees must have access to websites with sexually explicit material. Online outreach will be more successful if outreach workers are empowered to meet people where they are. It can safely be assumed that high-risk sex behaviors will take place on sex-positive websites. Giving employees access to adult sites can be a sensitive issue for some agencies. To ensure that problems are avoided, outreach programs should work with their IT department to determine how online outreach workers can get past firewalls and other security systems as well as to assist in the creation of clear guidelines that grant access to sites with sexually explicit content. Agency guidelines should define what sites are to be accessed, when, and for what purpose. See **Appendix E** for Suggested Rules or Code of Conduct for workers in this area. Also refer to section 3.4, Ethics & Safety, for additional information.

To ensure access to sexually explicit websites, some programs have an individual computer or a network that is dedicated for Internet outreach. This computer or network is separated from the agency's primary computer or network. A configuration such as this can help to protect the primary server or network from viruses and hackers while providing a confined access point where sexually explicit websites can be reached.

4.5 Website Terms of Service

Most websites will have Terms of Service that usually include rules of conduct, regulations, privacy policies, and more. It is important that agencies conducting Internet outreach read and understand these Terms of Service and any other guidelines or binding agreements where prevention activities are conducted. Usually, signing up to join a site implies agreement with the site's Terms of Service. It is within a website administrator's authority to remove someone from a chat room/website or to terminate an account for a violation of their Terms of Service.

Websites typically post frequently asked questions (FAQ) that will guide users and outline appropriate behavior in the venue. For example, a FAQ could include guidelines on how to introduce oneself to another member, direct a question or response to a specific user, or how to report a disruptive user.

Tip from the field

Health workers posting health messages may be thrown off websites and blocked for violating the Terms of Service of a website.

5. Program Implementation

The CDC's 'HIV Health Education and Risk Reduction Activities Guidelines' (HERR)¹³ list a number of core elements that should be considered in a health education and risk reduction program and evaluation activities. These core elements also apply to Internet outreach and are listed below, in chronological order, with a few minor changes.

5.1 Recommended Internet Outreach Program Core Elements

- Conduct community assessment activities.
- State realistic, specific, measurable, and attainable program goals and objectives.
- Identify methods and activities to achieve specific goals and objectives.
- Clearly define staff roles, duties, and responsibilities.
- Define the populations to be served by: geographic locale, risk behavior(s), gender, sexual orientation, age, and race/ethnicity.

- Assure that educational materials and messages are relevant, culturally competent, and language/age-appropriate.
- Consult with IT staff to ensure program capability with network and firewalls, enable access to online venues, and support confidentiality measures, like password-protecting computers.
- Include professional development for all program staff.
- Include a written policy and personnel procedures that address stress and burnout.
- Include written procedures for the referral and tracking of clients to appropriate services inside and outside of the agency.
- Provide for collaboration with other local service providers to assure access to services for clients.
- Assure confidentiality of persons served.

5.2 Frequently Asked Questions and Answers (FAQ/A)

Giving out factual information on HIV, syphilis, and other STDs, as well as risk/harm reduction and sexual health information is important to the success of any Internet outreach program. In addition to training on these topics, staff may want to use a list of frequently asked questions (FAQ). Not only can a FAQ ensure the accuracy and consistency of information disseminated online, but it can also make Internet outreach easier. When an online client asks a FAQ (e.g., what are the risks of oral sex?), outreach workers can simply cut and paste answers into the chat, IM session, or e-mail. For examples of FAQ documents, see **Appendix K**.

5.3 Referral to Resources

The primary objective of many Internet outreach programs is to refer clients to web-based informational and educational resources and local service providers. Agencies should maintain an up-to-date resource guide for online resources and local area service providers, including: health care agencies, support groups, and prevention services providers. It is important to collaborate with community hotlines for crises or emergencies that may occur during Internet outreach. Agencies should have a list of appropriate referral sources, including: suicide or crisis hotlines, child protective services, and agencies working in domestic violence. These types of events should be documented on an incident report and given to appropriate supervisors.

5.3.1 Recommended Types of Resources

The following resources are suggested for Internet outreach. It may be necessary to expand this list for your community needs.

- STD and HIV information, testing, and treatment
- Mental health information and counseling services
- Substance abuse information, counseling, and treatment
- Sexual health and safe sex information

- Domestic violence information and resources
- Rape Crisis Centers
- Family Planning Resources
- Sexual addiction information and resources
- Youth-oriented information and resources
- Transgender information and resources

Internet-outreach workers should be well-versed in and knowledgeable about these resources so they can readily refer online clients to them. Referrals to resources should be appropriate to the clients' needs and should be documented and tracked when possible. If online clients have given Internet outreach workers permission to contact them after the initial contact, it is recommended that staff follow-up with the clients to see if they reviewed or used the resource(s) given. Follow-up interchanges should be documented including when there is a denial of permission for further contact.

5.4 Recruitment into Other Prevention Programs

Conducting Internet outreach can be an excellent tool for recruiting clients for STD/HIV testing, treatment, and other prevention interventions³¹. It can also be used to recruit individuals to participate in advisory boards or focus groups or to complete surveys for quality assurance or research.

5.5 Follow Up

Following up with online clients may help to improve the likelihood that they will obtain the information and services they need. Well-documented follow up also helps support Internet outreach by proving its impact or effectiveness. It is recommended that Internet-outreach workers ask for the client's permission to follow up with them via e-mail or IM, and ask if the staff member can save them to their buddy list (if available). Ideally, quick follow up with each client is desired; however, follow up may be difficult with clients that frequently change screen names or do not login often. Follow up as a performance indicator for staff is not advised due to these and other issues.

5.6 Evaluation of Internet Outreach Program and Activities

Organizations conducting Internet outreach should have mechanisms in place to ensure that the program is meeting its goals and objectives, that factual health-related information is being delivered appropriately, and that all related program policies and procedures are followed.

Logic models are an effective way of clearly outlining the steps and desired outcomes of a program. These tools also help with program evaluation by providing specific elements in the program to assess. For examples of logic models, see **Appendix F**. The CDC recently released a valuable evaluation manual specific to STD programs, 'Practical Use of Program Evaluation among STD Programs'.³¹

We recommend that STD programs use this manual to guide their evaluation efforts, including the development of a logic model.

Tip from the field

Obtain a copy of the manual:
Practical Use of Program Evaluation among STD
Programs <http://www.cdc.gov/std/Program/pupestd.htm>

Quality assurance can include various data collection forms or databases, including contact and referral logs, activity report forms, and activity observation tools. For examples, see **Appendices G-J**. Agencies may want to consider collecting printed or electronically stored transcripts of online activities and e-mails when feasible (some websites restrict the ability to cut and paste or otherwise save chat room or messaging text). These transcripts can then be used for qualitative analysis purposes or to determine factors that influence high-risk behaviors online. Program modifications can then be made based on this analysis.

Ongoing participation from the target population, through individual and group interviews, client advisory boards, client satisfaction surveys, and other quality assurance measures, will help assure that Internet outreach programs are accepted by the community.

Process measures, such as the number of individuals that were educated, number referred to services, or time spent in interactions can be captured by staff using logs or databases.

Outcome measures can be determined through the development of a logic model and the community assessment process. The data collected could serve as baseline and formative evaluation. Outcome objectives could include the number of individuals from the target population successfully linked to other services, the amount of disease identified after individuals are tested, or behavioral changes seen in profiles or through follow-up assessment activities.

Below is a list of some of the ways in which an online outreach program can be evaluated for quality assurance and effectiveness.

- Develop a process evaluation.³¹
- Require consistent and accurate data collection procedures.
- Supervisors should periodically provide outreach staff with evaluations and feedback on performance.
- Develop a means for clients to provide feedback or grievances.
- Designate staff responsible for evaluation and quality assurance activities, for compiling and analyzing data, and for documenting and reviewing findings.
- Define methods for assessing progress toward stated process goals/outcome objectives.

- Include mechanisms for measuring the use of referral services.
- Provide findings for program modifications.

5.7 Staffing

5.7.1 Effective Internet Outreach Staff

Not everyone has the skills that are necessary to provide outreach on the Internet. Agencies should be selective in choosing staff that will perform Internet outreach. Potential staff should be: Internet savvy, demonstrate at least intermediate computer skills, possess proficient and accurate typing skills, have a working knowledge of quality Internet resources, and be familiar with emoticons, electronic shorthand, and other online languages.

In addition to having basic skills and experience in STD/HIV health education, staff should be sensitive and non-judgmental regarding community norms, values, traditions, and cultural beliefs of the target population. Staff should be as knowledgeable as possible about the populations being served. Some groups have found it easier to use a peer-to-peer approach as shared common experiences increase the level of trust and rapport with the online community, e.g., MSM staff conducting outreach to online, MSM communities. This also allows staff to act as role models for the clients they serve. Staff should not only be emotionally supportive of their clients (client-centered) but also should be an advocate for the population. This includes acting as a liaison between the online community and having the knowledge of local community resources and the ability to refer clients to real-world providers.

Tip from the field

To minimize staff burnout, limit online shifts to 2-3 hours.

Staff should have a clear understanding of boundaries and how and when to disengage clients who, for example, are being sexually aggressive or abusive, and when to end sessions that are no longer productive. Overall, staff should be comfortable in the outreach role and willing to conduct the activity, as well as understand the goals and objectives of the program.

5.7.2 Use of Volunteer Peer Educators

Agencies that provide Internet outreach may choose to use volunteer peer educators to conduct online activities. As defined by CDC's HERR,¹³ peer education refers to a role-model method of education in which trained, self-identified members of the client population provide STD/HIV education to their behavioral peers. Additionally, the use of volunteer peer educators can sustain intervention efforts in the community, often

influencing community norms, long after the professional service providers are gone.

The following protocols are recommended when using volunteers:

- All volunteers should be fully trained on Internet outreach protocols, specifically those related to safety, confidentiality and ethics.
- All website accounts should be maintained by the program director, including username and passwords. A volunteer should never use his/her own personal account to conduct outreach on behalf of the agency.
- All volunteers should focus on marketing-related, outreach topics such as promoting an agency's upcoming testing event or other health-related services, unless they have been through an agency-approved training program.
- Volunteers should complete a series of role-playing conversations with the agency supervisor to prepare the volunteer.
- Volunteers should complete a log after each outreach session, recording any incidents.
- Volunteers should be closely monitored by trained staff and should be provided with regular feedback.

While volunteer peer educators can be very powerful, they cannot replace professional health educators; they should only complement the trained staff.

5.7.3 Internet Etiquette

Internet outreach programs will encounter individuals that will want to casually chat with the outreach worker. Just like in any community outreach setting, small talk can help establish rapport and normalize an agency's presence there. Internet outreach workers should be reminded that maintaining appropriate boundaries between themselves and the client is extremely important. No outreach worker should become too casual, 'talkative', or familiar with the client. The worker should always use standard outreach education skills and keep the conversation focused on prevention and the promotion of sexual health.

In general, when conducting Internet outreach:

- Make no assumptions about clients.
- Ask open-ended questions as often as possible to gain more information.
- Don't give personal advice or tell clients what they should or shouldn't do
- Include risk and harm-reduction messages.
- Use third-person techniques (e.g., "Most people consider unprotected oral sex safe.").
- Answer questions with facts as often as possible (e.g., "We know that unprotected oral sex puts men at a higher risk for STDs like syphilis or gonorrhea.").
- Try to keep responses on an impersonal level and try not to make statements that are, or might seem to be, a personal opinion.

- Provide relevant and up-to-date referrals for services.

Internet outreach workers should practice good manners when conducting outreach. Because chat room/website norms and values change from room to room and website to website and/or vary at different times of the day, Internet outreach workers should always be aware of the culture of the chat room/website they are in at a given time. Here are some courtesy tips:

- Don't type in all caps; it is considered to be the equivalent of shouting in cyberspace.
- If staff have to step away from the computer or are actively chatting in more than one IM or private session, they should tell the other clients they will 'be right back' (brb)*.
- Staff should be courteous and respectful at all times.
- Staff should not ignore IMs unless they are from potentially abusive chatters.
- Staff should respond to all e-mail in a timely manner, even if the e-mail is brief, simply gives a referral, or states that a response with a more in-depth answer will be sent soon.

* For assistance with chat acronyms, abbreviations, and meanings see **Appendix L**.

Communication in chat rooms/websites or via e-mail and IM, although similar to person-to-person communication, can vastly differ. Without the use of voice inflection and tone, or body language and other gestures, written communication can come across as cold, angry, or aggressive. Great care should be used when composing an e-mail or chatting online.

5.8 Training

Initial and ongoing training is important to the success of staff conducting Internet outreach. Specific skills-based training for Internet outreach may include hands-on training, a review of Internet shorthand, emoticons, and other online languages, and can also include their understanding of computer equipment, software, and referral resources. Other suggested areas in which Internet outreach staff should receive training are listed below. Many of these are adapted from the CDC's HERR.¹³

5.8.1 Suggested Training Topics

- Surfing the web/acclimating to online environment
- Information on HIV, STDs, and sexual health
- Information on substance use/abuse
- Orientation to human sexuality, including diverse lifestyles and sex practices
- Orientation to safer sex and safer drug-using guidelines
- Understanding of harm reduction, risk-reduction, and prevention counseling
- Thorough knowledge of confidentiality, privacy, and ethics
- Review of policies on security

- Sensitivity to issues for persons living with HIV/AIDS and STDs
- Cultural diversity and cultural competence
- Orientation to the agency, community, and available community resources
- Orientation to useful health-related websites and other Internet resources
- Skills in group facilitation for activities in chat rooms/websites
- Dynamics of community and agency collaboration
- Introduction to behavior-change theories
- Understanding of motivational interviewing techniques
- Build communication skills (e.g., active and reflective listening, clear written communication, and client-centered interaction)
- Basic knowledge of family planning and contraception
- Knowledge of treatment and therapy for people living with HIV/AIDS and STDs
- Orientation to crisis intervention

5.9 Online Screen Names and Profiles

The screen name and profile of each Internet outreach worker are very important elements for an Internet outreach program. Screen names should relate or refer to the program or agency and should never be sexually suggestive. Profiles should be developed with program objectives in mind and serve as a promotional outlet for the program. Profiles should not contain sexually explicit information. When creating a profile, the official agency/organization logo should be used as the account picture and other identifying information should be filled out respective to ISP/website protocol for health departments and community-based organizations. Some websites may require certain information be contained within your profile. For example, Manhunt recently created a standard logo for all profiles conducting IPS or outreach in order to provide a validation of legitimate health-related profiles.

Like a first impression, online clients can learn a lot about the program with a quick glance at the online profile. Below are some suggested elements to include in an online profile. To keep clients' interest, it may be necessary to change elements of a profile frequently. This can easily be done by revising a line or two of text, adding a recent fact or statistic about health, promoting a testing site or upcoming special event, or listing a link to a new or updated website of interest. See **Appendix C** for examples of program profiles and screen names.

5.9.1 Essential Elements

- Profiles should specifically identify the agency name, staff, and job title.
- Profiles should include an invitation to IM, chat, or e-mail the outreach worker.
- Profile pictures should contain logos for the agency when possible.
- Profiles should be viewed as marketing tools and should fit the venue in which they are posted.

Tip from the field

Include a timeframe that a person may expect a response, e.g.,
'We check our profile every business day and will try to
respond to your e-mail within 48 hours.'

5.9.2 Inappropriate Elements

- Profiles should not contain sex statistics, such as penis size, sexual position of choice, sexual desires, etc.*
- Profiles should never contain personal e-mail addresses or websites/homepages/blogs.
- Profiles should never contain numbers to personal cell phones, home phones, pagers, etc.
- Profiles should never contain personal pictures or statements saying you can e-mail personal pictures.
- Profiles should never contain links to websites that sell products not related to sexual health.
- Profiles should never contain links to pornographic websites or sites that sell pornography.
- Profiles should never contain discriminatory or judgmental statements.
- Profiles should never contain the HIV status of the outreach worker.

* Some sites require information of this type be completed within a profile. In this case options that include safer sex should be selected.

Because some online clients may come across an Internet outreach profile after performing a profile keyword search, it is recommended that profiles contain a variety of keywords related to sexual health and STD/HIV prevention. The following keywords are examples: sex, barebacking, HIV, STD, syphilis, sexual addiction, safe sex, oral sex, crystal meth, raw, and drugs. These keywords should be used in a context that will convey to the client that you are available to discuss these topics as they relate to sexual health and STD/HIV prevention. For examples see **Appendix C**.

Tip from the field

When setting up your profile, there are often choices that can be checked (e.g., HIV+). By checking off all choices, your profile will show up in more searches.

5.10 Features in Online Venues

5.10.1 Chat Rooms

Chat rooms are online venues where Internet outreach can be conducted. Chat rooms in the virtual world are similar to bars, clubs, or community centers in the real world. The chat room members and the room's group norms, behaviors, and/or attitudes may vary from day to day, time to time, and room to room. Chat rooms may be very active with a steady flow of exchanges between chatters or they can be extremely quiet even when the room is full. Each chat room has its own personality and this personality generally reflects the personality of the community. Some users of chat rooms participate in what is called 'lurking'. A user is lurking when they are logged in to the chat room and are not active in the room. It is possible that they are engaging in private chats with others.

To be successful in the erratic online environment, outreach workers may need to use different techniques in different chat rooms to engage individuals in discussion. Clear and open-ended questions posted to the chat room at the initial entry into the room and in increments during the outreach period (not more than four times in an hour, depending on the level of activity within the room) may create opportunities for discussion or private chats. For an example of a chat session see **Appendix B**.

5.10.2 Instant Messaging

Instant messaging (IM) is a real-time interaction that sometimes requires software to be downloaded and/or a profile to be created. Unlike the group atmosphere of a public chat room, IM provides an environment where Internet outreach workers can have a one-on-one conversation with individuals. These conversations cannot be viewed by others in the public chat room.

IM has seen an increase in popularity. According to the Pew Internet & American Life Project, the growth rate in IM users between 2000 and 20004 was around 29%. In 2004, Pew reported that 53 million American adults, approximately 42% of Internet users, were using instant messaging.³³

AOL's 2005 instant messaging survey revealed that 70% of Internet users use IM and 38% of IM users send as many, if not more, IMs than e-mails. According to AOL, 90% of 13-21 year olds use IM followed by 80% of 22-34 year olds, 65% of 35-54 year olds, and 49% of those aged 55 and older.³⁴

IM interactions can be used to answer questions, discuss safer sex and harm/risk reduction techniques, help improve communication and negotiation skills, refer to online and real-world resources, and recruit into prevention or care services. When using IM, outreach workers should use specific skills and strategies, such as open-ended questioning and active listening.

In general, there are three types of IM. Programs such as Skype, AIM, MSN, Yahoo!, ICQ, and others, offer an IM program (also called a chat client) or piece of software that can be downloaded, installed, and used to contact buddies or other users of the same product (usually through a screen name or e-mail address).

The second type of IM is one that is available only within a specific website and is exclusively used by members of that website. This type of IM is usually linked to a member's active profile. Websites such as Gay.com, Manhunt, and MySpace use proprietary IM that is available only on their sites and linked to the user's profile.

The third type of IM is usually referred to as private chat and is usually available only through a public chat room. Users of a public chat room will use private chat as a means to hold a private conversation. In a chat room you may be asked to 'go private'. In most chat rooms this is done by simply double clicking on the screen name of the member making the request.

IM, although generally perceived as private, is still communication between networked computers through the Internet and therefore is not 100% secure or completely private. It is important to remember that conversations conducted through IM can, in most cases, be saved, printed, e-mailed, or distributed in other ways. Additionally, these can be viewed by the IT staff of the website and of the program organization. The highest level of professionalism should always be maintained.

Tip from the field

Some IM programs have a log feature that can automatically save chats and allow you to print them as needed. You can typically find this feature under the Preferences setting.

5.10.3 E-mail

E-mail can also be used to communicate with an individual as a one-on-one conversation; however, e-mail may have a delay in response that IM does not. Be aware that some people share an e-mail address and that e-mail might not be as private as an IM session. Outreach workers may want to ask clients that want to communicate via e-mail if their e-mails can be viewed by other people.

E-mail can also be an effective tool for follow-up with clients. All e-mail should be responded to in a timely manner, typically within 24-48 hours, even if the return e-mail is simply to inform the client that an e-mail was received and an answer is forthcoming.

Tip from the field

Check your inbox at least once a day.

E-mail groups or listserves can be used to communicate to larger groups of people in a short amount of time. This tool can be used to promote agency services and events and to disseminate up-to-date information, articles, or statistics on STDs/HIV. However, use of e-mail groups or listserves should be done only if the e-mail user has given explicit consent to receive mass e-mails or has voluntarily joined the list.

Tip from the field

Designate a back up person to check e-mail when an outreach worker is out of the office.

Remember that e-mail is a written form of communication and e-mails should be drafted with care and spell checked before sending.

An e-mail, once sent, passes through many servers throughout the Internet. E-mail is not a secure means of communication and can be manipulated, copied, printed, and forwarded.

5.10.4 Bulletin/Message Boards and Forums

Electronic bulletin/message boards and forums allow users to post and read messages that have been posted on a website. A variety of websites offer bulletin boards; therefore, agencies may have to research and assess what bulletin boards are most effective at reaching the intended target population. (See Section 4.1, Community Assessment). These information-sharing bulletin boards can also be used to promote agency services and events and disseminate up-to-date information, articles, or statistics on STDs/HIV. Posted messages are public information and available to anyone who visits the bulletin board. Like messages posted on a physical bulletin board, these messages remain on the board until the message is removed. Bulletin boards (e.g., www.craigslist.org) may be useful for posting health-related messages, promote events, recruit participants in surveys, and advertise programs or agencies.

5.10.5 Social and Sexual Networking Sites

Social networking sites (SNS), like MySpace, Friendster, or Facebook, and sexual networking sites, like Manhunt, Adam4Adam, and M4MWorld, are additional venues that can be used to conduct Internet outreach.

Fifty-five percent of online teens use social networks and have created online profiles. 20% of online adults report having a social networking profile.³⁵

SNS are used for a variety of reasons including to enhance existing relationships, to form new relationships, sexual and otherwise, to express oneself, as a communication tool. How a SNS is used will vary by demographics, geographic location, behaviors, interests, etc. For example, the SNS Facebook was created by a college student as a way to stay in contact with other college students; hence, the site's membership base at the time was generally those that are of college age. The website Manhunt is a website created for the MSM community and is adult in nature. The average age for a Manhunt member is generally older than the average for a member of a site such as MySpace. As sites grow their population tends to diversify. When it was created, MySpace was a site that was intended for musicians and users under 30 but, as the site grows in popularity, it has become more diverse in its membership.

Strictly speaking, there has traditionally been a distinction between social networking, dating, and 'hook-up' sites. All SNS are created to connect people with similar interests, but it is important to be aware of the differences between traditional SNS such as Facebook, Friendster, or MySpace; dating sites such as Match, BlackPlanet, or eHarmony; and hook-up sites such as Manhunt, Adam4Adam, or M4MWorld.

There are some basic functions and features that most SNS have in common, such as a search feature, profiles, and a proprietary e-mail system, where member e-mail can only be accessed within the website.

It is recommended that agencies seek permission from these sites prior to conducting outreach on them, as many of them have traditionally not allowed public health providers to conduct outreach prevention services.

6. Limitations of Internet Outreach

Despite the versatility of the virtual setting and the variety of possible activities, Internet outreach has its limitations. Priority should be given to using methods for outreach that maximize time and energy. Internet outreach can reach a population of men and women that might be otherwise unreachable, but this comes at a cost.

The most significant portion of the cost involved with Internet outreach is related to staff salaries and time. To maximize the cost effectiveness of Internet outreach, the selection of staff is of the utmost importance. Selecting staff members that are capable of multitasking and are computer/Internet savvy is key to controlling the most significant costs for Internet outreach. It is important to note that, for agencies with limited resources, other forms of Internet work such as partner notification and health communication (as outlined in the other sections of these guidelines), might be considered more cost effective over Internet outreach.

When considering costs, organizations should remember the importance of choosing websites and times to perform outreach. To be as cost effective as possible, an agency may need to create options, such as flexible work schedules, to ensure that Internet outreach is being performed at the peak times that the high-risk target population is online.

7. Summary

When carefully planned out and implemented, online outreach can be a useful way of providing STD/HIV health information, prevention messages and referrals to online populations.

We hope this document will be a useful guide for all STD/HIV programs. This is the first iteration of many to come. We hope these guidelines will be living documents, that is, documents that are constantly changing and continuously being updated based on research and program experience, so that they remain relevant and useful.

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Glossary

AIM – America Online’s (AOL) instant messenger. The use of this messenger is not limited to AOL subscribers. One can maintain buddy lists on AIM. The AIM buddy list allows you to store information about your buddies and to know when they are logged in (online) and available for instant messaging.

Attachment - A file that is sent as part of an e-mail message but that is not part of the main message. Images, programs, or word processor files are usually sent as attachments, because most e-mail programs allow only plain text in the body of the message.

Atom – An evolving protocol for syndication and sharing of content. Atom is being developed as a successor to and improvement over RSS (see below). It is more complex than RSS while offering support for additional features such as digital signatures, geographic location of author, possibly security/encryption, licensing, etc. Like RSS, Atom is an XML-based specification.

Avatar - A graphical image of a user, such as used in graphical real-time chat applications, or a graphical personification of a computer or a computer process, intended to make the computing or network environment a friendlier place.

Bandwidth - How much data you can send through a connection. Bandwidth is usually measured in bits-per-second (*bps*). A full page of English text is about 16,000 bits. A fast modem (used in a dialup connection) can transfer about 57,000 bits in one second. A full-motion full-screen video would require roughly 10,000,000 bits-per-second, depending on compression.

Blog - A blog is basically a journal that is available on the Internet (or web). The activity of updating a blog is blogging and someone who keeps a blog is a blogger. Blogs are typically updated daily using software that allows people with little or no technical background to update and maintain the blog. Postings on a blog are almost always arranged in chronological order with the most recent additions featured most prominently. It is common for blogs to be available as RSS feeds.

Bookmark (or favorite) - Most Web browsers give you an option of adding a URL to a ‘HotList’ or by marking it with a ‘bookmark’. By doing this, you can store the linking information (the URL) to any Web pages you plan to revisit. That way, if you decide to go back to a website, its URL is already catalogued and at your fingertips for easy reference. (Spry Mosaic uses ‘hotlists’, Netscape Navigator uses ‘bookmarks’ and Microsoft Internet Explorer uses ‘favorites’). Other Web browsers may use those terms, or may call their URL-saving feature something else.

Bot - Synonymous with spider, which is the first part of a search engine. It automatically and frequently searches the Web to find pages and updates its database of information about old Web sites.

Broadband - Generally refers to connections to the Internet with much greater *bandwidth* than you can get with a *modem*. There is no specific definition of the speed of a broadband connection but in general any Internet connection using *DSL* or via cable-TV may be considered a broadband connection.

Browser - (see Web Browser)

Bulletin boards - Also known as a message board or BBS (Bulletin Board System) - Bulletin boards are a place for people to virtually meet online where they can post messages and respond to each other. These usually are set up to discuss a specific topic (e.g., children, computing, HTML).

Chat rooms - A chat room is a virtual room where people can communicate in real time while on the Internet. Users type their messages with a keyboard and the entered text will appear on the monitor, along with the text of the other chat room visitors.

Cookie - A small file that is used as a mechanism for transmitting information containing information and data between a website and a browser. This method is used by web designers to track visitors to a website so the visitors do not have to enter the same information every time they go to a new page or revisit a site. For example, web designers use cookies to keep track of purchases a visitor wants to make while shopping through a web catalog.

Favorite – (see Bookmark)

FTP - (File Transfer Protocol) - A very common method of moving files between two Internet sites. FTP is a way to login to another Internet site for the purposes of retrieving and/or sending files. There are many Internet sites that have established publicly accessible repositories of material that can be obtained using FTP, by logging in using the account name 'anonymous', thus these sites are called 'anonymous ftp servers'. FTP was invented and in wide use long before the advent of the World Wide Web and originally was always used from a text-only interface.

E-mail – Messages sent through an electronic network to specified groups or individuals. Though e-mail is general text, users can attach files that include graphics, sounds, and video. E-mail is not 'real time' – relying on the recipient to open the e-mail to read it.

Emoticon - A symbol that uses the characters on a computer keyboard to convey emotion or tone in an electronic message, such as the sideways smiley face. :-)

Home Page (or Homepage) - Several meanings. Originally, the web page that your browser is set to use when it starts up. The more common meaning refers to the main web page for a business, organization, or person or simply the main page out of a collection of web pages, e.g., 'Check out so-and-so's new Home Page.'

HTML - Hypertext Markup Language is the authoring software language used on the Internet's World Wide Web. HTML is used for creating World Wide Web pages.

Instant messaging - Like a chat room, IM is used to send messages back and forth through the Internet to a specific user. It is like a chat room in the way that you can communicate, but unlike a chat room, unless in a private chat, the information that is being typed is sent directly to the user and is not viewed by anyone else.

Internet (Upper case I) - The vast collection of inter-connected networks that are connected using the TCP/IP protocols and that evolved from the ARPANET of the late 60's and early 70's. The Internet connects tens of thousands of independent networks into a vast global Internet and is probably the largest Wide Area Network in the world.

Intranet - A private network inside a company or organization that uses the same kinds of software that you would find on the public Internet, but that is only for internal use. Compare with extranet.

ISP (Internet Service Provider) - An institution that provides access to the Internet in some form, usually for money.

IT (Information Technology) - A very general term referring to the entire field of Information Technology - anything from computer hardware to programming to network management. Most medium and large-size companies have IT departments.

Listserv - Mailing list program for communicating with other people who have subscribed to the same list. Using e-mail, you can participate in listservs pertaining to your topics of interest. When you submit a message to the server, your message is relayed to all those on the listserv. You receive messages from other participants via e-mail. It is similar to computer conferencing, but a listserv is asynchronous. Examples of a modern Listserv would be Yahoo! Groups.

Logic model – Tool used to visually describe the linkages between program goals, activities, and expected outcomes.

Login - Noun: The account name used to gain access to a computer system. Verb: The act of connecting to a computer system by giving your credentials (usually your 'username' and 'password').

JavaScript - JavaScript is a programming language that is mostly used in web pages, usually to add features that make the web page more interactive.

Maillist (or Mailing List) - Usually an automated system that allows people to send e-mail to one address, whereupon their message is copied and sent to all of the other subscribers to the mail list.

Modem (MODulator, DEModulator) - A device that connects a computer to a phone line.

Newsgroup - The name for discussion groups on *USENET*.

Password - A code used to gain access (login) to a locked system.

Podcasting or pod-casting - A form of audio broadcasting using the Internet, podcasting takes its name from a combination of 'iPod' and broadcasting.

RSS (Rich Site Summary or RDF Site Summary or Real Simple Syndication) - A commonly used protocol for syndication and sharing of content originally developed to facilitate the syndication of news articles, now widely used to share the contents of *blogs*. There are RSS 'feeds' that are sources of RSS information about web sites, and RSS 'readers' that read RSS feeds and display their content to users. RSS is being overtaken by a newer, more complex protocol called *Atom*.

Server - A computer, or a software package, that provides a specific kind of service to client software running on other computers.

Screen names - A screen name is the name a member of a website would use to represent himself online. Screen names may relay some general information about the user.

Spyware - A somewhat vague term generally referring to software that is secretly installed on a user's computer and that monitors use of the computer in some way without the user's knowledge or consent.

Hook up sites - These are websites that specialize in facilitating the connection of likeminded people. Sites that are referred to as hookup sites are sites that are created to help people find others with the same sexual desires and intentions. Hook up sites can provide services to a generalized population, such as the MSM community, or to a segment of the population, such as a bare backing site, or a site that caters to a particular fetish.

Social Networking Sites (SNS) - A social networking site is a website that connects individuals using various tools and features that assist in the connecting of individuals who share similar interests. Social networking sites provide features and tools that help to indicate the ways in which members of the site are connected, through various social familiarities ranging from casual acquaintance to close familial bonds.

Upload - Transferring data (usually a file) from the computer you are using to another computer. It is the opposite of *download*.

URL (Uniform Resource Locator) - An acronym for 'Uniform Resource Locator,' this is the address of a resource on the Internet. World Wide Web URLs begin with *http://*

USENET - A world-wide system of discussion groups, with comments passed among hundreds of thousands of machines. Not all USENET machines are on the Internet. USENET is completely decentralized, with over 10,000 discussion areas, called newsgroups.

Web page - A document designed for viewing in a web browser and typically written in HTML. A website is made of one or more web pages.

Web browser - A software application (either text-based or graphical) that lets you browse the World Wide Web (WWW). Examples are: Firefox, Netscape Navigator, and Microsoft Internet Explorer.

Website - The entire collection of web pages and other information (such as images, sound, and video files, etc.) that are made available through what appears to users as a single web server. Typically all of the pages in a website share the same basic URL.

Wi-Fi (Wireless Fidelity) - A popular term for a form of wireless data communication; basically Wi-Fi is 'Wireless Ethernet'.

XML (eXtensible Markup Language) - A widely used system for defining data formats. XML provides a very rich system to define complex documents and data structures such as invoices, molecular data, news feeds, glossaries, inventory descriptions, real estate properties, etc. As long as a programmer has the XML definition for a collection of data (often called a 'schema'), they can create a program to reliably process any data formatted according to those rules.

Appendix A

Confidentiality Agreement Example #1 – Howard Brown Health Center

PLEDGE OF CONFIDENTIALITY

It is the goal of Howard Brown Health Center (HBHC) to provide our clients (anyone seeking care or services with or through HBHC) with professional, competent and quality care and education in a respectful, affirming atmosphere. As an employee, consultant, auditor or volunteer of HBHC, you have a responsibility to maintain a sense of concern and professionalism while performing your duties. In the execution of this duty, you must be sensitive to the comfort, sensitivities and confidentiality of the client.

The comfort and confidentiality of our clients is of primary concern to HBHC. The professionalism of our staff is necessary to maintain the comfort and trust we have built through the years. Courts and health care professionals maintain that upholding patient confidentiality is an absolute necessity. Federal Courts guarantee absolute privacy regarding all STD medical records. Furthermore, sexual health histories may not be subpoenaed by any court. Breaches of confidentiality regarding the aforementioned data may be punished by dismissal. As an employee, consultant, auditor or volunteer of the HBHC, it is imperative that you follow all Federal, state and local confidentiality laws.

In addition to the legal confidentiality laws, as an employee, consultant, auditor or volunteer of HBHC, you must also abide by the following:

- Some of us, in the context of our duties, advise, within the clinical setting, appropriate and inappropriate behavior as it pertains to physical and/or mental wellness. In the context of this document, clinical setting includes all areas and/or physical space in which you perform your assigned duties.
- We do not, and cannot be, ‘moral custodians’, nor do we have policing rights.
- Do not discuss clients or client data with unauthorized persons.
- Discuss clients or client data only to conduct legitimate business, and such discussions should take place only in a manner(s) and location(s) that affords absolute privacy.
- Do not discuss clients or patients outside of HBHC for any reason.
- Make no reference to a client visit to HBHC should you meet a client elsewhere.
- Preserve the confidentiality of friends who are HBHC clients as you would any HBHC client.
- Never acknowledge the presence or absence of clients to any caller.
- Respect for clients is mandatory as a representative of HBHC.
- Client confidentiality is respected and maintained by all staff and other members of the Howard Brown Health Center’s workforce after concluding their working relationship with Howard Brown Health Center.

**BREACH(ES) OF CONFIDENTIALITY WILL NOT BE TOLERATED AND IS
GROUNDS FOR IMMEDIATE DISMISSAL.**

We guarantee our clients absolute confidentiality of their records. Any client requesting a copy of their records must follow the HBHC Policy of Chart Access. No person shall be permitted to view client medical, mental health, or case management records, unless written documentation of permission by the client involved is provided.

Your signature below confirms that you have read, understand and accept to follow the Howard Brown Health Center's Pledge of Confidentiality.

Signature: _____

Name: _____

Date: _____

Confidentiality Agreement Example #2 – San Francisco Department of Health

CONFIDENTIALITY AGREEMENT

USE OF DPH RECORDS AND INFORMATION SYSTEMS

Individuals with access to the records and information systems (Internet, e-mail, telephone, pager, fax machines, etc.) of the San Francisco Department of Public Health have a legal and an ethical responsibility to protect the confidentiality of medical, financial, and personnel information, and to use that information and those systems only in the performance of their jobs. The following rules apply to information that you receive or send from any source, including computer, paper, telephone, facsimile.

Confidential information may not be accessed, discussed, or divulged in any form except as required in the performance of your duties. Sharing confidential medical information is allowed within DPH among medical professionals in order to provide medical care to a patient.

You may not use any DPH information system for any type of personal use. Use the following test: ‘Is my use of this information system enabling me to provide better service, or to perform my duties more effectively or less expensively?’ If the answer is no, then your use of the information or system is unnecessary and/or inappropriate.

Be aware that most DPH information systems maintain records of what is viewed and/or sent by whom. You may be asked to justify why you viewed or released specific information.

You may be given a user ID and a password to enable you to view computerized information. Under no circumstances may you disclose your User ID or password other than to your supervisor or to IS staff. If you suspect someone else has knowledge of your password, you must immediately notify your supervisor and the divisional IS Manager.

The hardware, software, and data used in the DPH information systems are the property of DPH. All software installed on a DPH computer must be authorized in writing by IS and must be licensed to allow installation on a DPH computer. DPH has the right to review and remove personal or unlicensed software and data on any DPH computer.

If you, inadvertently or intentionally, misuse or improperly disclose your user ID or password, misuse or improperly disclose confidential information, use DPH information systems for personal reasons, or install personal or unlicensed software or data on a DPH computer, you may lose access to the computer system, be subject to disciplinary action up to and including termination, be reported to the appropriate licensing board, and/or be subject to civil or criminal liability.

I understand that I have no privacy right in the information in my DPH computer or the information that I access or send via my computer or other DPH equipment. I acknowledge that my use of DPH information systems and equipment may be monitored.

PRINT NAME

DIVISION

SIGNATURE

SSN

Appendix B

Sample Chat

Sample AOL Chat Room Transcript. *Courtesy of Legacy Community Health Services*

OnlineHost: *** You are in 'Town Square - houstonm4m'. ***

OnlineHost: See the ultimate form of self-expression. Check out AOL members' fantastic tattoos in the Photo Gallery of Body Art.

ProjectCORE1: Hello, I am a Project CORE Cyber Health Educator and am online and available to answer your questions about sexual health. Check out my profile and please IM/E-mail me if you have any questions. Thanks guys have safe and healthy fun!

Chatter #1: if anyone has a membership to a hot porn site and would like to trade username/password for another...so that we may double our viewing pleasures...

Chatter #1: i'm a member of seancody.com and falconvideo.com

Chatter #2: hey guys

Chatter #2: Anybody know where the post-ops hang out in town? Or the (passable) transvestites? THANKS

Chatter #2: No, seriously.

Chatter #3: 23.M.HOUSTON

Chatter #3: 5'6..120LBS..28WAIST...BRN/BRN

Chatter #3: Anyone want to hookup??? IM me

Chatter #1: 24 m brownsville pic...anyone care to chat or trade IM me

Chatter #3: 23.M.MONTROSE...5'6..120LBS..BRN/BRN....HISP BOI

Chatter #4: 23 hispanic mdtwn pvt ok w/pic

ProjectCORE1: Men who use Crystal are more likely to have condoms break during anal sex. If you'd like more information please IM/E-mail me for more information.

Chatter #5: why is that?

ProjectCORE1: Because Crystal dries up the natural fluids in the rectum...

Chatter #5: lots of lube boys

ProjectCORE1: Yep, yep!!! Just when you think that y ou are overdoing, that's almost enough!! :)

Chatter #6: what is you oing

Chatter #6: what is you up to night

Chatter #1: hey guys

Chatter #1: n. houston here

Chatter #1: spring

Chatter #7: hey spring here

Chatter #6: is it hot

Chatter #1: just read the advice on lube----

Chatter #1: quite interesting

Chatter #1: i like to slip and slide with wet

Chatter #1: not really...but...if i had a room made of plastic

Chatter #1: who knows

Chatter #6: I am getting off know.

Chatter #7: y'all in for fun and not for play??

Chatter #6: what do that mind

Chatter #6: so you are not for play?????

Chatter #6: what happen to the fun

Chatter #6: ByBy By ?????

Chatter #7: is everyone gone??

Chatter #8: BORED..in montrose alone...lookin for now...open to whatever

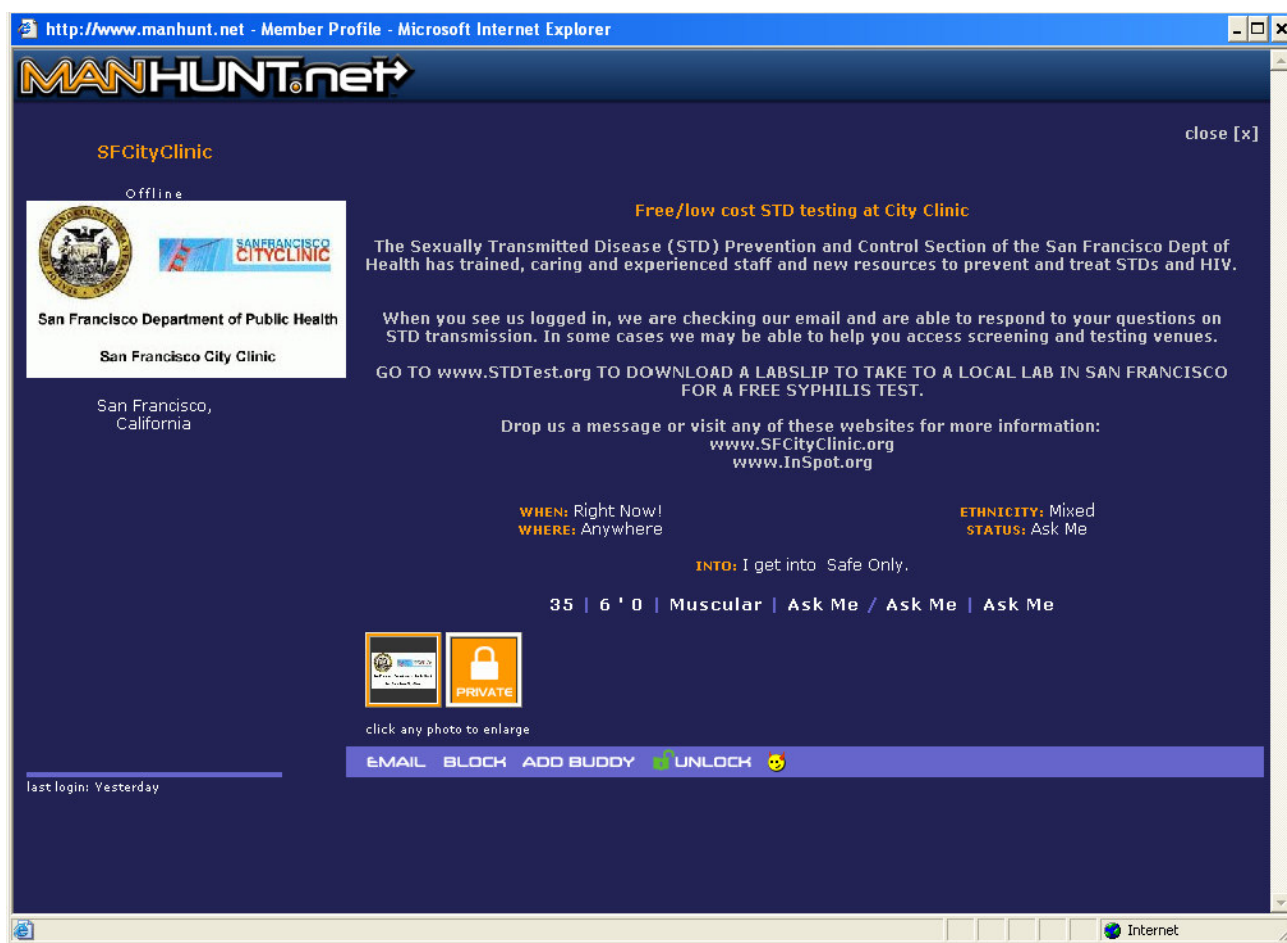
Appendix C

Examples of Screen Names and Profiles

<u>Organization</u>	<u>Screen/Profile Name</u>
San Francisco City Clinic	SFcityclinic
Massachusetts Department of Health, STD Division	DIVofSTDMA
Legacy Community Health, Houston, TX	ProjectCore1

Example of Online Profiles

Profile Example #1 - San Francisco City Clinic



Profile Example #2 - Legacy Community Health Services, Houston, TX



Project CORE Sample AOL Profile

Name	Jack from Legacy Community Health's Project CORE
Location	Houston, Texas
Gender	Male
Marital Status	I am a Cyber Health Educator
Hobbies & Interests	I am here to chat with anyone who has questions about sexual health, HIV, Syphilis, STD's and more! Did you know that Syphilis is easier to transmit than most people think? IM me to discuss the signs and symptoms of Syphilis.
Favorite Gadgets	In addition on how to protect yourself and your partners. Favorite gadgets are condoms and lube (without Nonoxynol-9).
Occupation	Project CORE is a program to promote health and wellness to gay, bisexual and other men who have sex with men.
Personal Quote	I can discuss: barebacking, sexual addiction, drugs, PnP, safe sex, down low, relationships, and more. Just IM or E-mail me.
Links	http://hometown.aol.com/projectcore1/ http://www.legacycommunityhealth.org/projectcore/about.htm

Appendix D

Check list for creating guidelines for Internet-based outreach

- ☐ Determine who will need to be involved with the creation of the guidelines
 - ___ Health Department Medical Director/Administrator
 - ___ Health Department Security Coordinator
 - ___ Health Department Information Technology (IT) Director
 - ___ Legal Department
 - ___ Management Information Systems (MIS) Director
 - ___ STD Epidemiologist
 - ___ STD Area Managers
 - ___ STD Program Managers
 - ___ STD DIS representative

- ☐ Determine who will be covered by the guidelines
 - ___ A specific department
 - ___ A city or county health department
 - ___ The entire state department of health

- ☐ Determine technological and staffing needs
 - ___ Do you need to hire someone new or are there existing staff members who can work on Internet/online projects such as online outreach?
 - ___ How much of this staff member's time will be dedicated to online projects (5–100%)?
 - ___ Does this staff member come to the position with the necessary knowledge or can they be trained on the job?
 - ___ Is there someone who has the time to supervise this staff member?
 - ___ Is there at least one computer that can be dedicated to this purpose?
 - ___ Creation of a dedicated e-mail account
 - ___ Approval will be needed to obtain unrestricted access to the Internet
 - ___ There should be at least one IT contact working with staff member

- ☐ Sections of guidelines
 - ___ Introduction/Purpose
 - ___ Involved personnel
 - ___ Description of responsibilities of all involved personnel
 - ___ Competencies required of personnel conducting Internet outreach
 - ___ Training
 - ___ Confidentiality & Ethics
 - ___ Standard Operating Procedures of conducting Internet outreach including templates and examples
 - ___ Adverse Events or Emergencies
 - ___ Documents and Documentation
 - ___ Evaluation

Details within each Guideline section

- ☐ Introduction/Purpose
 - ___ Statement of purpose, i.e., who, what, when, where, why
 - ___ Description of chat rooms, instant messaging, list serves, websites, etc. as well as passive vs. active outreach
- ☐ Personnel intimately involved with the Internet outreach
 - ___ Number of employees that will conduct Internet outreach
 - ___ Supervisor
 - ___ IT employee for guidance and technical support
- ☐ Description of responsibilities of all involved personnel
- ☐ Competencies required of personnel conducting Internet outreach
 - ___ Demonstration of good judgment and performance of responsibilities
- ☐ Training (some examples/suggestions)
 - ___ Introduction to STD Intervention (ISTDI)
 - ___ Information Security Training
 - ___ Ethics Training
 - ___ Internet Partner Notification and Referral Services Training
 - ___ Motivational Interviewing Training
- ☐ Confidentiality
 - ___ Description of how confidentiality will be handled and maintained
 - ___ Confidentiality agreement signed by all involved parties including IT and front-desk staff
- ☐ Standard Operating Procedures for conducting Internet outreach including templates and examples
 - ___ Creation of step-by-step procedures on how to conduct Internet outreach including what websites to visit
 - ___ creating online profiles
 - ___ active vs. passive outreach
 - ___ client follow-up
 - ___ chat room vs. instant messaging vs. e-mail
 - ___ Creation of documentation forms and logs
 - ___ Creation of online handles/names
 - ___ Creation of referral resources
 - ___ FAQ
 - ___ Templates of forms, logs, etc.
- ☐ Adverse Events or Emergencies
 - ___ Description of how adverse events or emergencies will be handled
 - ___ Who will handle adverse events or emergencies?

☐ Documents and Documentation

- ___ List of all documents to be used including copies
- ___ Where documents will be stored
- ___ When and who will review documents
- ___ Documents should include, at minimum, the following:
 - ___ websites visited
 - ___ handle names used
 - ___ copies of online messages and conversations
 - ___ dates & times that Internet outreach was conducted
 - ___ record of referrals made (to where, for what)

☐ Evaluation

- ___ **Process Evaluation** (ongoing evaluation while program is being developed and implemented)
 - ___ During development and implementation, meet on a regular basis with the team involved and ask the following questions:
 - ⌚ What is working?
 - ⌚ What should be improved?
 - ⌚ How should it be changed?
- ___ **Outcome Evaluation** (assessing the degree to which the program has met the objectives, or the degree to which the program has been of use to the target population)
 - ___ Outcome evaluation should be conducted at least yearly to gauge the impact of the program. Ask the following questions:
 - ⌚ What has happened?
 - ⌚ Who was affected?
 - ⌚ What was the most effective aspect of the program?
 - ⌚ Was it cost-effective?

Appendix E

Suggested Rules or Code of Conduct for Online Outreach Workers

Protocol for the use of a stand-alone computer with DSL line

Reasons for a specifically dedicated computer:

Research has shown that people are not only using the Internet for seeking sex partners but that these online behaviors are often antecedents to very risky offline sex behaviors including increases in anal sex and a decrease in condom use. Activities such as online outreach, partner notification, and health communications are additional public health tools for STD/HIV prevention and education.

Approved activities:

-  Access to sexually explicit websites and content on the Internet
-  Access to chat rooms
-  Access to social networking sites
-  Use of instant messaging programs
-  Use of web-based e-mail programs

Unacceptable activities:

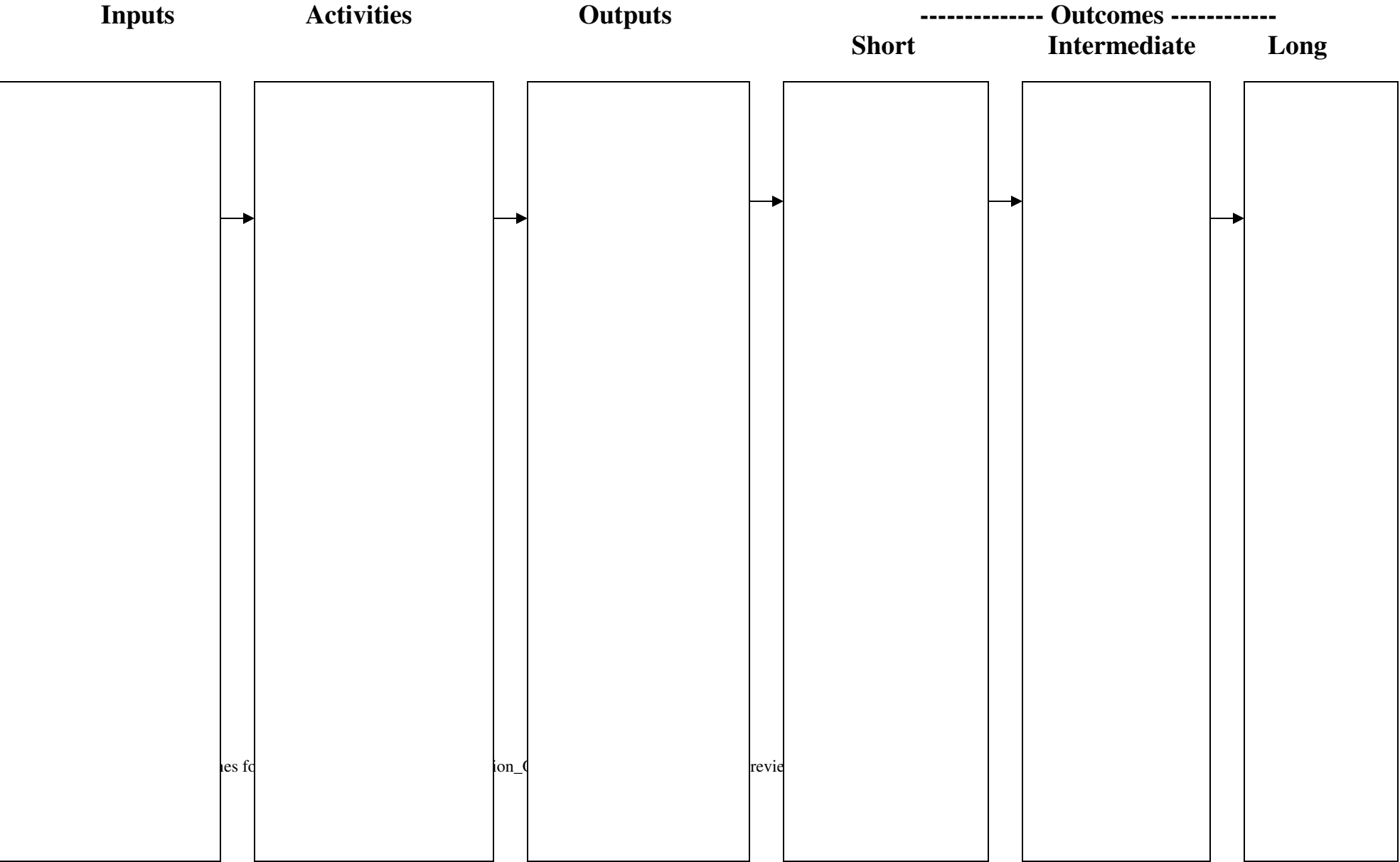
-  Gambling
-  Dating
-  Downloading non-work-related music or videos
-  Illegal activities

Computer access:

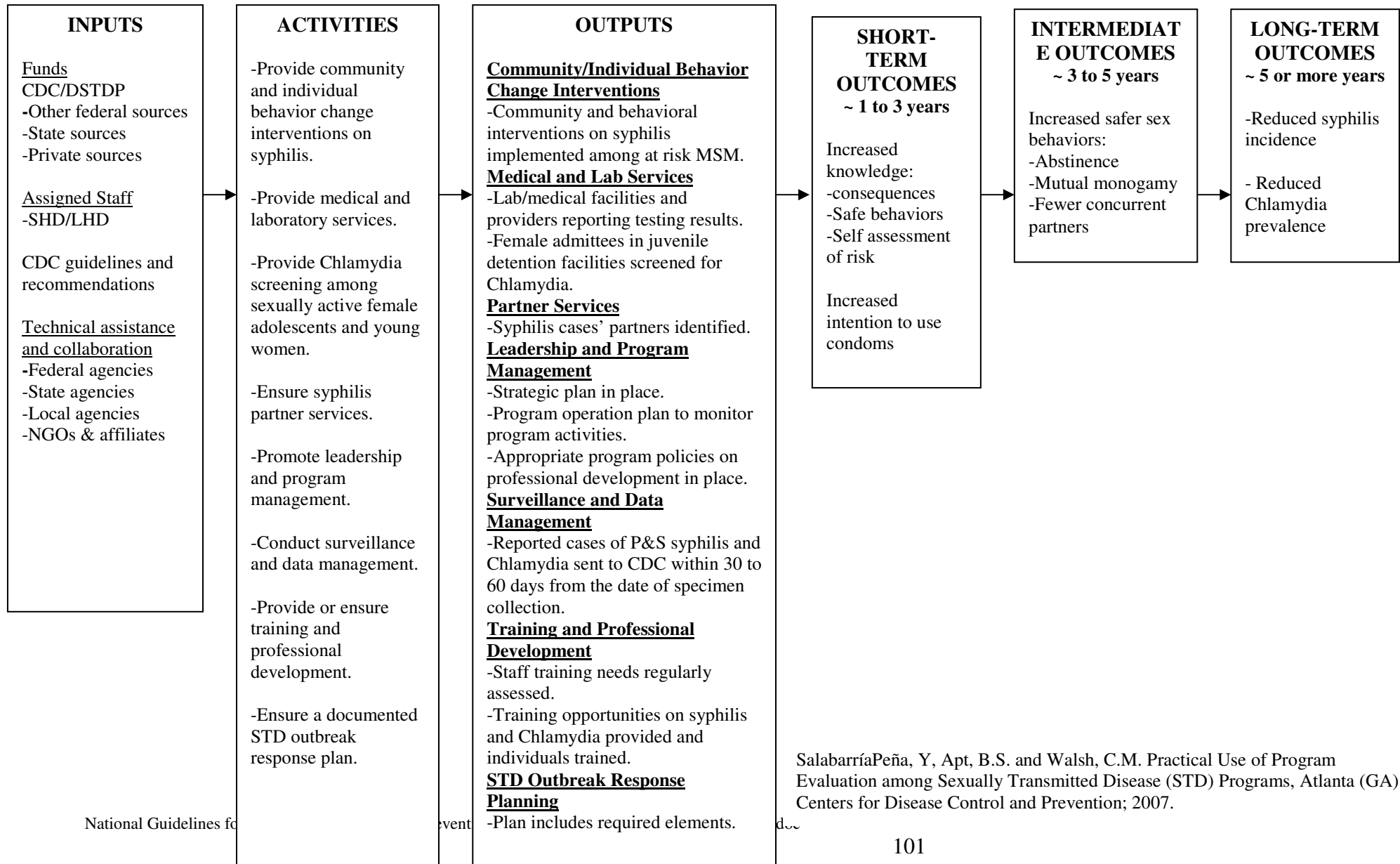
-  Researchers whose work specifically relates to the Internet (or other technologies) and STD/HIV prevention may use the dedicated computer
-  The computer will be password protected
-  All researchers with access to the computer will have to sign a form agreeing to use the computer only for the approved activities
-  The computer will be maintained on a unique server that has no connection to the main server
-  The computer will have virus protection that will be regularly updated

Appendix F
Logic Models
Logic Model for _____

Goal/Situation:



Logic Model for State X Comprehensive STD Prevention Systems (CSPS) Program



Appendix G

Sample Chat Room Activity Report Form
Courtesy of Legacy Community Health Services



Chat Room Activity Report Form

Date:	
Project CORE Staff:	
Chat Room Visited:	
Number of Bulletins Posted:	
Screen names that commented:	
Sexual Orientation of Room:	
Time Spent in Room:	
Referrals Given (Please List links)	
Chat Room Transcript?	
Recruit for Testing?	
Additional Information:	

Chat Room Transcript:

Appendix H

Sample Instant Message Activity Report Form
Courtesy of Legacy Community Health Services



IM Activity Report Form

Date:	
Project CORE Staff:	
Website Visited:	
Sexual Orientation:	
Ethnicity:	
Gender:	
Age:	
Risks Stated:	
Information Given:	
Referrals Given (Please List links)	
Was client added to Buddy List?	
Is IM transcript attached to this form?	
Additional Information:	
Recruit for Testing?	
CDC #:	
Testing Result:	

IM Transcript:

Appendix I

Sample Instant Message Log
Courtesy of Legacy Community Health Services

A14.7 CORE IM Log



Instant Messaging Log

Month: _____

			Client		Sex	Sex	Sex	Sex			
	Core		Screen	Website	Orient	Orient	Orient	Orient	Ethnic	Ethnic	Ethnic
	Mem	Date	Name	Visited	G	B	T	S	W	H	B
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21											
22											
23											
24					0	0	0	0	0	0	0

Appendix J

Sample E-mail Activity Report Form
Courtesy of Legacy Community Health Services



E-mail Activity Report Form

<u>From:</u>
<u>To:</u>
<u>Date:</u>
<u>Original E-mail:</u>
<u>E-mail Response:</u>

NOTES

Appendix K

Example of FAQ document

Courtesy of Legacy Community Health Services and adapted from Stop AIDS Project's Back to Basics Campaign Factoid:

HIV/AIDS/STD Basics

Question: What is AIDS?

Answer: AIDS is a condition that results from your body's weakened immune system as a result of infection with the Human Immunodeficiency Virus (HIV). AIDS is medically defined by three criteria: 1) HIV antibodies have been detected in the person's body, 2) T-cell (CD4) count less than 200, and 3) one or more opportunistic infections, including thrush, *Pneumocystis carinii* pneumonia, Kaposi's sarcoma, toxoplasmosis, and others.

Question: How do you get HIV?

Answer: HIV can be found in the blood, cum/pre-cum, vaginal fluid, or breast milk of an infected person. An uninfected person can get HIV if blood, cum/pre-cum, vaginal fluid, or breast milk from an infected person enters his body and gets into his bloodstream. HIV can enter the body through a vein (by IV drug use), the anus/vagina/penis/mouth (by unprotected sex), other mucous membranes (like the eyes or inside of the nose), or any open cuts/sores.

The two major ways you can get infected with HIV are through:

- **UNPROTECTED SEX** — That's having unprotected (without a condom/barrier) anal, vaginal, and (to a lesser extent) oral sex with an HIV-infected person, and/or
- **SHARING NEEDLES** — That's sharing intravenous (IV) drug needles, syringes, and/or equipment/rigs with an HIV-infected person.

On top of that, HIV is not the only infection that you can get from sexual contact. You can also get other sexually transmitted diseases (STDs) — such as Chlamydia, genital warts, gonorrhea, hepatitis B/C, herpes, intestinal parasites, non-gonococcal urethritis, and syphilis — through unprotected anal, vaginal, and oral sex as well as other sexual practices like rimming. If you have any of these STDs and do anything sexually that can transmit HIV, you're also at much greater risk of actually getting HIV.

Question: Can I get HIV from casual contact (shaking hands, hugging, using a toilet, drinking from the same glass, or the sneezing and coughing of an infected person)?

Answer: No. You can only get HIV from intimate contact with specific body fluids from an infected person (like blood, cum/pre-cum), vaginal fluid, or breast

milk). You can't get HIV from day-to-day contact in the workplace, schools, or social settings, and you can't get HIV from shaking hands, hugging, or a casual kiss. You also can't get infected from a toilet seat, a drinking fountain, a doorknob, dishes, drinking glasses, food, or pets. HIV is not an airborne or food-borne virus and does not live long outside the body.

A few cases have been reported where a person became infected with HIV from contact with blood or other body secretions from an HIV-infected person in a household. Although it's true that there's a slight possibility of getting HIV this way, instances of this kind of HIV transmission are rare. Still, people infected with HIV and people who provide home care for HIV-infected people should all be fully educated and trained about appropriate infection-control methods.

Question: What are the most common ways that HIV is transmitted from one person to another?

Answer: The three most common ways that HIV is transmitted are:

- By having sex, particularly unprotected sex (anal, vaginal, or oral) with an HIV-infected person,
- By sharing needles, syringes, or injection equipment with an IV drug user who is infected with HIV, and
- From HIV-infected women to babies before or during birth, or through breast-feeding after birth.

HIV can also be transmitted through transfusions of infected blood or blood clotting factors. However, since 1985, all donated blood in the United States has been tested for HIV. Therefore, the risk of infection through transfusion of blood or blood products is extremely low. The U.S. blood supply is considered to be among the safest in the world. Some health-care workers have become infected after being stuck with needles containing HIV-infected blood or, less frequently, after infected blood came into contact with a worker's open cut, or through splashes into a worker's eyes, or inside his/her nose, but this is not a common occurrence. There has only been one instance of any patients being infected by an HIV-infected health-care worker. This involved HIV transmission from an infected dentist to six patients (the dentist's instruments weren't properly sterilized).

HIV Testing

Question: Why should I get tested for HIV?

Answer: Because you should consider at what risk you put your partner(s) if you don't know your own HIV status, or if you are HIV positive. The only way to tell if you have been infected with HIV is by taking an HIV antibody test.

The advantages to knowing your HIV status are:

- You can prevent infection to others if you find out you are HIV positive,
- You can seek medical therapies earlier.

Question: How can I tell if I'm infected with HIV?

Answer: You can't unless you get tested for HIV. The early symptoms of HIV infection are often flu-like, but not everyone exhibits these early symptoms, so you may not even know or think you're infected. The only way to know for certain whether or not you have the virus is to be tested.

Question: How long after a possible exposure should I wait to get tested for HIV?

Answer: If your exposure was within 72 hours, contact your physician or a local STD/HIV organization. If your risk of contracting HIV from the exposure is high, a physician may prescribe you a course of anti-HIV medications that may decrease the odds of infection by 81%. The treatment is often known as **P.E.P.S.E., or Post-Exposure Prophylaxis for Sexual Exposure.**

Otherwise, since the tests commonly used to detect HIV infection are actually looking for the antibodies produced by your body to fight HIV, rather than HIV itself, it's suggested that you wait at least 2-3 weeks after a possible exposure to take the test. This will allow your body to develop more HIV antibodies if you have been exposed and can make for a more accurate test result. Most people will develop detectable antibodies within 3 months of the initial exposure, with the average being about 25 days. In rare cases, it can take up to 6 months for detectable antibodies to develop. For this reason, the CDC currently recommends testing 6 months after the last possible exposure (from unprotected vaginal, anal, or oral sex, and/or sharing needles). It's extremely rare for it to take longer than 6 months to develop detectable antibodies. It's also very important during the 6 months between a possible exposure and taking the HIV test that you protect yourself and others from further possible exposures to HIV (from unprotected sex or sharing needles).

Question: What's the difference between anonymous and confidential HIV testing?

Answer: There are two different ways to test for HIV — anonymously and confidentially.

Anonymous HIV testing means that absolutely no one besides you will have access to your test results since your name is never given or recorded at the testing site. Instead, you are given a unique identifier code, and you (the person being tested) are the only one who is ever made aware of the test results. This protects you from any risk of discrimination or adverse impact, especially in applications for insurance. Anonymous testing is available in many states.

At-home ‘collection kits’ are also anonymous. Each comes with a unique identification number. You do not give your name. Kits can be purchased over the counter or by mail. Home tests are generally quite accurate. However, you don't get the benefit of in-person counseling with at-home kits.

Confidential HIV testing does record your name and contact information. Confidentiality laws and regulations protect this information, but medical personnel and health department personnel will have access to your test records and results. However, other than what is reportable by law, no one else will have access to your testing results unless you sign a release of information to release results to one or more parties that you agree to. Health-care workers, insurers, or employers may see it once it becomes part of your medical record. Your status may become known if you make a claim for health insurance benefits, or apply for life insurance or disability insurance. Confidential testing is available in all states.

Question: Are there different kinds of HIV tests?

Answer: There are currently three kinds of HIV test available, though all three may not be available at every testing site.

- **Blood Antibody HIV Tests.** Blood antibody tests are used to detect HIV antibodies in the bloodstream. The most common screening tests used today are the EIA (enzyme immunoassay) and the ELISA (enzyme-linked immunosorbent assay). A second test, referred to as the western blot test, is run to confirm a positive result. When the EIA or ELISA is used in conjunction with the western blot confirmation test, the results are more than 99.9% accurate. Results from EIA/ELISA HIV tests are usually available several days to several weeks later.
- **Oral Antibody HIV Tests.** Oral HIV antibody EIA and oral HIV antibody western blot tests are alternatives to blood tests. Oral testing is done with samples of mucous from inside the cheeks and gums rather than with blood. Oral tests have been approved by the FDA and are as accurate as blood tests. This test is done to detect the presence of HIV antibodies, not the virus itself. No cases of HIV transmission have been attributed to saliva. Results from Oral Antibody HIV tests are usually available in several days, although rapid oral tests are now available that give results in 20 minutes.
- **Home HIV Testing Kits.** Consumer-controlled test kits (popularly known as ‘home HIV test kits’) were first licensed in 1997. Although various home HIV test kits are sometimes advertised via the Internet, currently only the *Home Access* test kit has been approved by the FDA (the accuracy of home test kits other than Home Access cannot be verified). Home HIV test kits contain HIV/AIDS literature and materials that enable you to take your own blood sample. The testing procedure involves pricking your finger with a special device, placing

drops of blood on a specially treated card, then mailing the card in to be tested at a licensed laboratory where your HIV status will be determined. The test results are accessed by using an anonymous identification number, which customers are given in the kit. They use this number when phoning for their test results several weeks later. Home testing kits are sold in drugstores throughout the country and are available by mail. The Home Access test kit can be found at most local drug stores. Callers may speak to a counselor before taking the test, while waiting for their test results, and when getting their results.

Question: What are rapid HIV tests?

Answer: A rapid test for detecting antibodies to HIV is a screening test that produces very quick results, usually in 5 to 30 minutes. By comparison, results from the commonly used HIV antibody screening test, the EIA (enzyme immunoassay), are not available for 1-2 weeks. Only one rapid HIV test is currently licensed by the Food and Drug Administration for use in the United States. The availability of rapid HIV tests may differ from one place to another. The rapid HIV test is considered to be just as accurate as the EIA. Both the rapid test and the EIA look for the presence of antibodies to HIV. As is true for all screening tests (including the EIA), a reactive rapid HIV test result must be confirmed before a diagnosis of infection can be given.

Question: Are there other HIV tests available?

Answer: The EIA (enzyme immunoassay) is the standard screening test used to detect the presence of antibodies to HIV. The EIA should be used with a confirmatory test such as the western blot. Tests that detect other signs of HIV are available for special purposes, such as for additional testing of the blood supply and conducting research. Because some tests are expensive or require sophisticated equipment and specialized training, their use is limited. In addition to the EIA, other tests now available include:

- **Radioimmunoprecipitation assay (CONDOMA):** A confirmatory blood test that may be used when antibody levels are very low or difficult to detect or when western blot test results are uncertain. An expensive test, the CONDOMA requires time and expertise to perform.
- **Rapid latex agglutination assay:** A simplified, inexpensive blood test that may prove useful in medically disadvantaged areas where there is a high prevalence of HIV infection.
- **Dot-blot immunobinding assay:** A rapid-screening blood test that is cost-effective and that may become an alternative to conventional EIA and western blot testing.
- **p24 antigen capture assay:** Also known as the HIV-1 antigen capture assay. This blood test was added as an interim measure by the Food and Drug Administration (FDA) in 1996 to HIV-antibody testing to protect the blood supply further until other tests become available to

detect early HIV infection before antibodies are fully developed. Because some activity of p24 antigen is unpredictable, this test is not useful for helping people find out if they have HIV.

- **Polymerase chain reaction (PCR):** A specialized blood test that looks for HIV genetic information. Although expensive and labor-intensive, the test can detect the virus even in someone only recently infected. To further protect the blood supply, the FDA has indicated that the development and implementation of tests for HIV genetic material such as PCR is warranted.

Question: Where can I get tested for HIV infection?

Answer: Many places provide testing for HIV infection. Common testing locations include local health departments, hospitals, private doctors, family planning and/or sexually transmitted disease mobile sites, drug treatment facilities, and sites specifically set up to provide HIV testing. It is important to seek testing at a place that also provides counseling about HIV and AIDS. Counselors can answer any questions you might have about risky behavior and ways you can protect yourself and others in the future. In addition, they can help you understand the meaning of the test results and describe what HIV/AIDS-related resources are available in your local area.

Question: If I test HIV negative, does that mean that my partner is HIV negative also?

Answer: No. Your HIV test result reveals only your HIV status. Your negative test result does not tell you whether your partner has HIV. HIV is not necessarily transmitted every time there is an exposure. Therefore, your taking an HIV test should not be seen as a method to find out if your partner is infected. Testing should never take the place of protecting yourself from HIV infection. If your behaviors are putting you at risk for exposure to HIV, it is important to reduce your risks.

Question: What if I test positive for HIV?

Answer: If you test positive for HIV, the sooner you take steps to protect your health, the better. Early medical treatment and a healthy lifestyle can help you stay well. Prompt medical care may delay the onset of AIDS and prevent some life-threatening conditions. If you do not have health insurance, there may be health care providers in your area that provide reduced-cost or free care to uninsured persons. There are a number of important steps you can take immediately to protect your health.

- See a doctor, even if you do not feel sick. Try to find a doctor who has experience treating HIV. There are now many drugs to treat HIV infection and help you maintain your health. It is never too early to start thinking about treatment possibilities.
- Have a TB (tuberculosis) test done. You may be infected with TB and not know it. Undetected TB can cause serious illness, but it can be

successfully treated if caught early. Also, test for hepatitis B and C and syphilis.

- Smoking cigarettes, drinking too much alcohol, or using illegal drugs (such as speed, ecstasy, cocaine, or heroin) can weaken your immune system. There are programs available that can help you to reduce or stop using these substances.

There is much you can do to stay healthy. Learn all that you can about maintaining good health. Check out Project Inform (www.projectinform.org) or The Body (www.thebody.com) for good info on HIV/AIDS and being positive. Call the CDC National AIDS Hotline to get additional information, order publications, and obtain referrals to local, state, and national resources that may be useful to you. The Hotline numbers are 1-800-342-2437 (English), 1-800-344-7432 (Spanish), and 1-800-243-7889 (TTY). You also can order publications and get referrals from the CDC National Prevention Information Network (operators of the National AIDS Clearinghouse) by calling 1-800-458-5231.

Being HIV-Positive

Question: I'm HIV positive. Where can I get information about treatments?

Answer: The CDC recommends that you be in the care of a doctor or medical service, ideally one with experience treating people living with HIV. Your doctor can provide you with relevant information and guidance. You can also contact Project Inform for more information. Detailed information on specific treatments is also available from the HIV/AIDS Treatment Information Service (ATIS) at 1-800-448-0440. You can obtain information on enrolling in trials from the AIDS Trials Information Service (ACTIS) at 1-800-874-2572 (English and Spanish) and 1-800-243-7012 (TTY). The CDC National AIDS Hotline can offer practical information on maintaining health and general information about a wide variety of treatments, including antiretroviral and prophylaxis (preventive therapy) for opportunistic infections. The Hotline can also provide referrals to national treatment hotlines, local AIDS organizations, and HIV/AIDS-knowledgeable health care providers. The Hotline numbers are 1-800-342-2437 (English), 1-800-344-7432 (Spanish), and 1-800-243-7889 (TTY).

Question: Can HIV-positive guys become re-infected?

Answer: The short, simple answer is yes they can because there are different strains of the virus, so it's possible for someone who's HIV positive to become infected with multiple and more virulent strains of HIV.

Question: Can I tell if someone is HIV positive just from looking at them?

Answer: No, you can't. Many of the typical outward symptoms of HIV — like rashes — are not necessarily clear indicators that someone is HIV positive. The only sure way to find out is to ask the guy if he knows his HIV status and hope that

he answers honestly. And if he doesn't know his status, it's probably a good idea to assume he's HIV positive and play safely.

HIV/STD Risk Reduction

The following practices can help reduce your risk of becoming infected with HIV/STDs.

- Keep cum and blood (including blood from piercing, shaving, or menstruation) out of the mouth, anus, or vagina and away from other mucous membranes (like the eyes or nose) and any cuts/breaks in the skin.
- Use latex or plastic (polyurethane) condoms for anal and vaginal sex, and pull out of your partner before ejaculation for added safety.
- Use only water- or silicone-based lubricants with latex condoms. Oil-based lubes like Crisco, Vaseline, baby oil, hand creams, etc., can cause latex to break. If you must use oil-based lubricants, use polyurethane condoms since these are safe to use with oil.
- If you are barebacking (unprotected anal sex), the insertive partner (top) should pull out before ejaculating. Avoid douching (enema) beforehand as this actually puts you at a higher risk for becoming infected with HIV. Douching may wash away helpful or 'good' bacteria in the mucous membrane lining your rectum as well as reducing your natural lubrication. This increases the friction during anal penetration, which can cause tears in the rectum and anus. It's also not good to douche after anal penetration since this could spread the virus around even more. Also, use lots of lube, to make sure that your anus and rectum are as thoroughly lubricated as possible, which also helps to avoid cuts and tears which make it easier for HIV to get into your body's blood stream.
- Use a condom during oral sex even if your partner does not ejaculate in your mouth. HIV from cum or pre-cum could enter the blood stream through cuts or sores in your mouth. If you don't like the taste of plain latex, try flavored condoms—they can turn oral sex into a whole new experience for both you and your partner.
- Use dental dams, latex squares, cut-open condoms, or saran wrap for mouth to anus contact (rimming) or performing oral sex on a woman.
- Use latex gloves or finger cots for fingering, especially if you have any cuts or sores on your hands.
- Don't brush or floss your teeth for at least an hour before kissing or performing oral sex. You can use a mouthwash, breath mint, or gum instead. This will keep the number of tears and cuts in your mouth to a minimum. Try not to eat abrasive foods (tortilla chips, French bread, pretzels, etc.) for the same reasons. You should also try to be aware of whether or not you have any cuts or sores in your mouth. In general,

it's a good idea to maintain excellent oral hygiene to prevent the possibility of having any easy tears/cuts in your mouth.

- Avoid getting semen in your mouth; semen contains HIV. If you do get semen in your mouth, as the saying goes: 'Swallow or spit, just don't let it sit.' The longer semen stays in your mouth, the more potential for HIV to find an entry point into your body. Also, avoid deep throating since this can cause abrasions in your throat. Pre-cum/semen can come into contact with these abrasions, creating an effective entry point for HIV infection.
- Don't share sex toys. Use condoms on dildos or vibrators, and/or clean them with soap and water or in hydrogen peroxide after use.
- Alcohol and other drugs can impair your judgment and put you at risk for HIV infection or, if you already have HIV, for transmitting it to others. Many people have trouble keeping to their commitments to safe/healthy sexual behaviors after getting high.
- Massage, hugging, masturbation (solo or with others), and other activities that don't let blood or cum into your bloodstream are always safe.

Oral Sex

Question: Can I get HIV from performing oral sex?

Answer: Yes, it is possible for you to become infected with HIV through performing oral sex, but it is considered low to medium risk. There have been a few cases of HIV transmission from performing oral sex on a person infected with HIV. While no one knows exactly what the degree of risk is, evidence suggests that the risk is less than that of unprotected anal or vaginal sex. Blood, semen, pre-cum, and vaginal fluid all may contain the virus. Cells in the mucous lining of the mouth may carry HIV into the lymph nodes or the bloodstream.

The risk increases:

- If you have cuts or sores around or in your mouth or throat,
- If your partner ejaculates in your mouth, or
- If your partner has another sexually transmitted disease (STD).

If you choose to have oral sex, and your partner is male:

- Use a latex condom on the penis; or
- If you or your partner is allergic to latex, use a plastic (polyurethane) condom.

If you aren't going to use a condom, the following are ways to reduce the risk of HIV transmission.

- Don't brush or floss your teeth for at least an hour before giving head. You can use a mouthwash, breath mint, or gum instead. This will keep the number of tears and cuts in your mouth to a minimum.
- Try not to eat abrasive foods (like tortilla chips, French bread, pretzels, etc.) for the same reasons.
- In general, it's also a good idea to maintain excellent oral hygiene to prevent the possibility of easy tears/cuts in the mouth.
- Avoid getting semen in your mouth; semen contains active HIV. If you do get semen in your mouth, as the saying goes: 'Swallow or spit, just don't let it sit.' The longer semen is in your mouth, the more potential for HIV to find an entry point into your body.
- Avoid deep throating since this can cause abrasions in the throat. Pre-cum/semen can come into contact with these abrasions, creating an effective entry point for HIV infection.

If you choose to have oral sex, and your partner is female:

- Use a latex barrier (such as a dental dam or a cut-open condom that makes a square) between your mouth and the vagina. Plastic food wrap also can be used as a barrier. Using a barrier will reduce the risk of blood or vaginal fluids entering your mouth.

Research has shown the effectiveness of latex condoms used on the penis to prevent the transmission of HIV. Condoms are not risk-free, but they greatly reduce your risk of becoming HIV-infected if your partner has the virus.

Question: Can I get HIV from someone performing oral sex on me?

Answer: Yes, it is possible for you to become infected with HIV through receiving oral sex, but it is considered low risk, though no one knows exactly what the degree of risk is. Evidence suggests that the risk is less than that of unprotected anal or vaginal sex. If your partner has HIV, blood from his or her mouth may enter the urethra (the piss-slit, or opening at the tip of the penis), the vagina, the anus, or directly into the body through small cuts or open sores.

If you choose to have oral sex, and your partner is male:

- Use a latex condom on the penis; or
- If you or your partner is allergic to latex, use a plastic (polyurethane) condom.

If you aren't going to use a condom, you can reduce your risk of HIV infection by avoiding deep throating, which makes it easier for the piss-slit of your penis to come into contact with the mucous membranes at the back of your partner's throat, providing a good entry point for HIV to get into the body's blood stream.

If you choose to have oral sex, and your partner is female:

- Use a latex barrier (such as a dental dam or a cut-open condom that makes a square) between your mouth and the vagina. Plastic food wrap also can be used as a barrier. Using a barrier will reduce the risk of blood or vaginal fluids entering your mouth.

Research has shown the effectiveness of latex condoms used on the penis for preventing the transmission of HIV. Condoms are not risk-free, but they greatly reduce your risk of becoming HIV-infected if your partner has the virus.

Question: If someone is HIV positive, but has an undetectable viral load, is it still ‘safe’ to suck their penis without a condom?

Answer: An undetectable viral load is only a measure of the HIV levels in a blood sample, but there is still no sure way to know or average how much HIV virus there is in semen or pre-cum since it varies from man to man.

Question: How much HIV is there in pre-cum?

Answer: Pre-cum is generally considered to have low levels of HIV, but there is no sure way to know or average how much HIV virus there is in pre-cum since it varies from man to man, and is dependent on a bunch of factors, including the potential presence of some semen in any pre-cum.

Kissing

Question: Can I get HIV from kissing on the cheek or open-mouth or deep kissing (‘swapping saliva’)?

Answer: HIV is not casually transmitted, so kissing on the cheek is very safe. Even if the other person has the virus, your unbroken skin is a good barrier. No one has become infected from such ordinary social contact as dry kisses, hugs, and handshakes. Open-mouth kissing is considered a very low-risk activity for the transmission of HIV because the amount of HIV in saliva is very small and relatively inactive. However, prolonged open-mouth kissing could damage the mouth or lips and allow HIV to pass from an infected person to a partner and then enter the body through cuts or sores in the mouth. Because of this possible risk, the CDC recommends against open-mouth kissing with an infected partner.

Rimming (Oral-Anal Intercourse)

Question: What's the risk of getting HIV from rimming?

Answer: There's a very, very low risk of getting HIV from rimming, but there are others STDs that are much easier to get from rimming — like hepatitis A/B, *Shigella*, and herpes.

Fingering

Question: How safe is fingering?

Answer: Fingering is generally considered a low-risk activity for the transmission of HIV, particularly if there are no open cuts or abrasions on the fingers/hand or the body orifice (anus, vagina) being fingered. To be sure, it's a good idea to use latex gloves or finger cots for fingering.

Urine

Question: How safe is urine/piss?

Answer: If you're talking about the risk of getting hepatitis A/B, or other STDs, urine is not safe! But the risk of getting HIV is relatively low since there's normally probably not a lot of HIV in urine. But there is a chance that there may be some semen or blood in the urine, which could contain active HIV, and enough of it to cause infection.

Anal Sex

Question: Can I get HIV from anal sex?

Answer: Yes, it is possible for either sex partner to become infected with HIV during anal sex. HIV can be found in the blood, semen, pre-cum, or vaginal fluid of a person infected with the virus. In general, the person being penetrated or receiving the semen is at greater risk of getting HIV because the lining of the rectum is thin and may allow the virus to enter the body during anal sex. However, the person doing the penetrating (or inserting his penis into an infected partner) is also at risk because HIV can enter through the urethra (the piss-slit or opening at the tip of the penis) or through small cuts, abrasions, or open sores on the penis.

Having unprotected (without a condom) anal sex is considered to be very risky behavior. If you're going to have anal sex, you can reduce the risk of HIV transmission significantly by using a latex or plastic (polyurethane) condom. Most of the time, condoms work well. However, condoms are more likely to break during anal sex than during vaginal sex. So, even with a condom, anal sex can be risky. You should also be sure to use a water-based lubricant (rather than an oil-based lube) in addition to the condom to reduce the chances of the condom breaking.

If you are barebacking, have the insertive partner (top) pull out before ejaculating. Avoid douching (enema) beforehand as this actually puts you at a higher risk for becoming infected with HIV. Douching may wash away helpful or 'good' bacteria in the mucous membrane lining your ass as well as reducing your natural lubrication. This increases the friction of being penetrated, which can cause tears in the rectum and anus. It's also not good to

douche after being penetrated since this could spread the virus around even more. Also, use lots of lube, to make sure that your anus and rectum are as thoroughly lubricated as possible, which also helps to avoid cuts and tears which would make it easier for HIV to get into your body's blood stream.

Vaginal Sex

Question: Can I get HIV from having vaginal sex?

Answer: Yes, it is possible to become infected with HIV through vaginal intercourse. In fact, it is the most common way the virus is transmitted in much of the world. HIV can be found in the blood, semen, pre-cum, or vaginal fluid of a person infected with the virus. The lining of the vagina can tear and possibly allow HIV to enter the body more easily. Direct absorption of HIV through the mucous membranes that line the vagina also is a possibility.

Men may be at less risk for HIV transmission than women are through vaginal intercourse. However, HIV can enter the body of the male through his urethra (the piss-slit or opening at the tip of the penis), or through small cuts or open sores on the penis. The risk for HIV infection also increases if you or a partner has a sexually transmitted disease (STD).

If you choose to have vaginal intercourse, use a latex condom to help protect both you and your partner from the risk of HIV and other STDs. Studies have shown that latex condoms are very effective, though not perfect, in preventing HIV transmission when used correctly and consistently. If either partner is allergic to latex, plastic (polyurethane) condoms for either the male or female can be used.

Condoms

Question: How effective are latex condoms in preventing HIV?

Answer: Studies have shown that latex condoms are highly effective in preventing HIV transmission when used consistently and correctly. These studies looked at uninfected people considered to be at very high risk of infection because they were involved in sexual relationships with HIV-infected people. The studies found that even with repeated sexual contact, 98-100% of those people who used latex condoms correctly and consistently did not become infected with HIV.

Question: I'm allergic to latex (and/or my partner is). What brands of plastic (polyurethane) condoms are available as an alternative?

Answer: There are currently three readily available brands of plastic (polyurethane) condom that can be used as alternatives to latex condoms.

Reality 'Female' Condom: The first condom designed to be worn by women for vaginal sex: it's also easily used by men for anal sex. Made of

soft polyurethane, this product actually offers more protection against pregnancy and disease because it covers more area and is compatible with water-, silicon-, and oil-based lubricants.

Avanti Duron Condom: Avanti was the first polyurethane condom. It's strong, nonporous, and non-permeable to all viruses and protects against STDs including HIV. It's hypoallergenic and thinner than latex, so it can transmit more sensation and warm to the body's temperature unlike latex. It's safe to use with water-, silicon-, and oil-based lubricants. Because polyurethane isn't quite as elastic as latex, the Avanti is slightly larger than the average latex condom. For the record, Consumer Reports and the FDA have both reported that the Avanti breaks more readily than a latex condom, and are recommending them exclusively for those with latex allergies.

Trojan Supra Condom: The Supra is made from a medical-grade, advanced material called Microsheer, it's ultra-thin, strong, and clear (almost invisible), and has no latex allergens. It's compatible with water-, silicon-, and oil-based lubricants, has no taste or smell, and can transmit body heat, unlike latex. Supras are also quite a bit larger than the average condom.

DO NOT use lambskin condoms; they do not prevent transmission of HIV.

Question: Is it safe/safer to use two condoms (instead of one) at the same time?

Answer: While controversy continues over this question, it is generally believed that it is better to use a single condom at a time. When a single condom is used properly, the resulting safety factor for prevention of HIV transmission increases dramatically. When two condoms are used, there is a much bigger chance of friction between the two latex barriers. Friction (heat) is a condom's worst/biggest enemy. Heat contact with latex will increase the chance of breakage. (Hot temperatures, humidity, and even ultraviolet light can contribute to the deterioration of latex condoms.) Although, if you were to use a small bit of latex-safe (water- or silicone-based) lubricant between the two condoms, the chances of the condoms breaking is reduced significantly.

Lubricants/Spermicides

Question: Does the spermicide nonoxyl-9 (N-9) help prevent HIV infection?

Answer: No. Recent scientific studies have conclusively proven nonoxyl-9 ineffective in preventing HIV transmission. In fact, it actually appears to increase your chances of becoming infected with HIV. Given the risks and the lack of any preventive benefits, **the use of nonoxyl-9 is no longer recommended** as a preventive measure against HIV transmission/infection.

Question: What kinds of lubricants should I use?

Answer: It is always safe to use **water-based** lubricants and **silicone-based** lubricants with latex condoms. The lubrication heightens the sexual experience and, if you put a few drops of lube inside the tip of the condom, you'll have better stimulation along with added safety.

It is NEVER safe to use oil-based lubricants (skin lotions, baby oil, Vaseline, Crisco, cold cream, or even whipped cream) with latex condoms because oil dramatically weakens latex and definitely increases the chances of condom failure/breakage. For example, mineral oil is a common ingredient in many lotions. According to the CDC, within as little as 60 seconds of exposure, a 90% decrease in latex strength will occur in a condom when using an oil-based lubricant. [To demonstrate, blow up a latex condom, place a dab of oil or lotion on it, and watch it explode! The moral of the story? Don't use oil on latex.]

Only polyurethane condoms can safely be used with oil-based lubricants, so if you must use an oil-based lubricant, please use only polyurethane condoms. Polyurethane condoms also work well with water- and silicone-based lubricants.

HIV & Other STDs

Question: Is there a connection between HIV and other sexually transmitted diseases (STDs)?

Answer: Yes. Having an STD can increase a person's risk of becoming infected with HIV, whether the STD causes open sores or breaks in the skin (e.g., syphilis, herpes, chancroid), or does not cause breaks in the skin (e.g., Chlamydia, gonorrhea).

If the STD infection causes irritation of the skin, breaks or sores may make it easier for HIV to enter the body during sexual contact. Even when the STD causes no breaks or open sores, the infection can stimulate an immune response in the genital area that can make HIV transmission more likely. In addition, if an HIV-infected person is also infected with another STD, that person is three to five times more likely than other HIV-infected persons (who don't have an STD) to transmit HIV through sexual contact.

For those who are sexually active, the following HIV prevention activities are highly effective:

- Engaging in sex that does not involve vaginal, anal, or oral sex;
- Having intercourse with only one uninfected partner; or
- Using latex or plastic (polyurethane) condoms every time you have sex.

Common STD Symptoms

Sore Subjects (the most common symptoms associated with STDs)

What to look out for:

First of all, remember that some sexually transmitted diseases (STDs) cause no symptoms, and when symptoms do occur, they often go unrecognized. **Most people with STDs have no symptoms—none!** So you can be infected and even infect someone else without knowing it.

However, there are some common signs to watch for. The symptoms listed below are tricky, as they can show up anywhere from two days to a couple of months after initial exposure to the disease. Sometimes symptoms can show up as much as several years after the initial STD infection.

If you have any of these symptoms or think you have been exposed to an STD, contact a healthcare provider immediately.

Take note of any:

- * sores, bumps, or blisters near the mouth or genitals
- * burning or pain during urination or a bowel movement
- * flu-like symptoms including fever, chills, and aches
- * swelling in the groin area

For women only:

- * unusual odor or discharge from the vagina
- * pelvic pain
- * burning or itching around the vagina
- * unusual bleeding
- * pain during intercourse
- * increased severity of menstrual cramps or abnormal period

Just for men:

- * discharge from the penis
- * pain in the testicles

Alcohol/Drugs

Question: Who or what is Crissy? Tina?

Answer: Crissy and Tina are nicknames for speed a.k.a. crystal or crystal methamphetamine. Crystal is a popular club and sex drug, which can impair judgment and decision-making and so potentially increase the risk of getting HIV.

Question: Why is injecting drugs a risk for HIV?

Answer: At the start of every intravenous injection, blood is introduced into needles and syringes. HIV can be found in the blood of a person infected with the virus. The reuse of a blood-contaminated needle or syringe by another drug injector (sometimes called ‘direct syringe sharing’) carries a high risk of HIV transmission because infected blood can be injected directly into the bloodstream.

In addition, sharing drug equipment (or ‘works’) can be a risk for spreading HIV. Infected blood can be introduced into drug solutions by:

- Using blood-contaminated syringes to prepare drugs;
- Reusing water;
- Reusing bottle caps, spoons, or other containers (‘spoons’ and ‘cookers’) used to dissolve drugs in water and to heat drug solutions; or
- Reusing small pieces of cotton or cigarette filters (‘cottons’) used to filter out particles that could block the needle.

‘Street sellers’ of syringes may repackage used syringes and sell them as sterile syringes. For this reason, people who continue to inject drugs should obtain syringes from reliable sources of sterile syringes, such as pharmacies. It is important to know that sharing a needle or syringe for any use, including skin-popping and injecting steroids, can put one at risk for HIV and other blood-borne infections.

Question: How can people who use injection drugs reduce their risk for HIV infection?

Answer: The CDC recommends that people who inject drugs should be regularly counseled to:

- Stop using and injecting drugs;
- Enter and complete substance abuse treatment, including relapse prevention.

For injection drug users who cannot or will not stop injecting drugs, the following steps may be taken to reduce personal and public health risks:

- Never reuse or ‘share’ syringes, water, or drug preparation equipment;
- Only use syringes obtained from a reliable source (such as pharmacies or needle exchange programs);
- Use a new, sterile syringe to prepare and inject drugs;
- If possible, use sterile water to prepare drugs; otherwise, use clean water from a reliable source (such as fresh tap water);
- Use a new or disinfected container (‘cooker’) and a new filter (‘cotton’) to prepare drugs;
- Clean the injection site prior to injection with a new alcohol swab;
- Safely dispose of syringes after one use.

If new, sterile syringes and other drug preparation and injection equipment are not available, then previously used equipment should be boiled in water or disinfected with bleach before reuse. Injection drug users and their sex partners also should take precautions, such as using condoms consistently and correctly, to reduce risks of sexual transmission of HIV. Persons who continue to inject drugs should periodically be tested for HIV.

Tattoos/Body Piercing

Question: Can I get HIV from getting a tattoo or through body piercing?

Answer: A risk of HIV transmission does exist if instruments contaminated with blood are either not sterilized or disinfected or are used inappropriately between clients. CDC recommends that instruments that are intended to penetrate the skin be used once, then disposed of or thoroughly cleaned and sterilized.

Personal service workers who do tattooing or body piercing should be educated about how HIV is transmitted and take precautions to prevent transmission of HIV and other blood-borne infections in their settings. If you are considering getting a tattoo or having your body pierced, ask staff at the establishment what procedures they use to prevent the spread of HIV and other blood-borne infections, such as hepatitis B virus. You also may call the local health department to find out what sterilization procedures are in place in the local area for these types of establishments.

Question: I just got an oral or genital piercing. How long should I wait before having sex?

Answer: A fresh piercing should be treated just like an open wound to the body, so it's best not to expose it to potentially infectious body fluids until it has fully healed (at 8-10 weeks depending on the piercing). Condoms and dental dams should provide you with proper protection from infection when used correctly. Your piercer should be knowledgeable enough to let you know when it's safe to play with a pierced area again.

Appendix L

Chat Acronyms/Abbreviations and Meanings

ADN	Any day now
AFAIK	As far as I know
AFK	Away from keyboard
ARE	Acronym-rich environment
A/S/L	Age/sex/location?
B4N	Bye for now
BAK	Back at the keyboard
BBIAB	Be back in a bit
BBL	Be back later
BEG	Big evil grin
BFN	Bye for now
BG	Big grin
BL	Belly laughing
BOTEC	Back-of-the-envelope calculation
BRB	Be right back
BTA	But then again...
BTW	By the way
CU	See you
CUL	See you later
CYO	See you online
DBA	Doing business as
DL	Dead link
DIKU	Do I know you?
DQMOT	Don't quote me on this
EG	Evil grin
EMFBI	Excuse me for butting in
EOM	End of message
EOT	End of thread (meaning: end of discussion)
F2F	Face to face
FAQ	Frequently asked question(s)
FISH	First in, still here
FLA	Four-letter acronym
FOCL	Falling off chair laughing
FUBAR	Fouled up beyond all repair or recognition
FUD	Fear, uncertainty, and doubt
FWIW	For what it's worth
FYI	For your information
G	Grin
GA	Go ahead
GAL	Get a life
GD&R	Grinning, ducking, and running
GMTA	Great minds think alike

GOL	Giggling out loud
GTRM	Going to read mail
HTH	Hope this helps
IAC	In any case
IANAL	I am not a lawyer (but)
IC	I see
IHA	I hate acronyms
IIRC	If I recall/remember/recollect correctly
ILU	I love you
ILY	I love you
IM	Immediate message
IMHO	In my humble opinion
IMing	Chatting with someone online in a private message box
IMNSHO	In my not so humble opinion
IMO	In my opinion
IOW	In other words
IRL	In real life (that is, when not chatting)
JBOD	Just a bunch of disks (like redundant array of independent disks, etc.)
JIC	Just in case
JK	Just kidding
KOTC	Kiss on the cheek
KWIM?	Know what I mean?
L8R	Later
LD	Later, dude
LDR	Long-distance relationship
LLTA	Lots and lots of thunderous applause
LOL	Laughing out loud
LTM	Laugh to myself
LTR	Long-term relationship
LULAB	Love you like a brother
LULAS	Love you like a sister
MorF	Male or female
MOSS	Member of the same sex
MOTOS	Member of the opposite sex
MUSM	Miss you so much
NP	No problem
NRN	No response necessary
OIC	Oh, I see
OLL	Online love
OTF	Off the floor
OTOH	On the other hand
PANS	Pretty awesome new stuff (as opposed to ‘POTS’)
PDA	Public display of affection
PEBCAK	Problem exists between chair and keyboard
PIBKAC	Problem is between keyboard and chair
PMFJIB	Pardon me for jumping in but...

::POOF::	Goodbye (leaving the room)
POTS	Plain old telephone service
PU	That stinks!
RL	Real life (that is, when not chatting)
ROR	Raffing out roud (Engrish for 'laughing out loud')
ROTFL	Rolling on the floor laughing
RPG	Role-playing games
RSN	Real soon now
RYO	Roll your own (write your own program)
S4L	Spam for life
SHCOON	Shoot hot coffee out of nose
SF	Surfer-friendly (low-graphics Web site)
SNAFU	Situation normal, all fouled up
SO	Significant other
SOMY	Sick of me yet?
STW	Search the Web
TAFN	That's all for now
TGIF	Thank God it's Friday
THX	Thanks
TIA	Thanks in advance
TLA	Three-letter acronym
TL8R	Talk later
TMI	Too much information
TOPCA	Till our paths cross again (early Celtic chat term)
TPTB	The powers that be
TTFN	Ta-Ta for now
TTT	Thought that, too (when someone types in what you were about to type)
TTYL	Talk to you later
TU	Thank you
UW	You're welcome
VBG	Very big grin
WFM	Works for me
WIBNI	Wouldn't it be nice if
WT?	What/who the...?
WTG	Way to go!
WTGP?	Want to go private?
WU?	What's up?
WUF?	Where are you from?
WYSIWYG	What you see is what you get
YMMV	Your mileage may vary