Transcript of "S3 E12: Four Decades of Sexual Health: History of the CAPTC"

Tammy Kremer: The California Prevention Training Center was founded in 1989. Today's episode is guest hosted by our current director, Dana Cropper, interviewing our two former directors about how the sexual health field has evolved in the last four decades and how that's reflected in the work of our institution. Welcome to Coming Together for Sexual Health, where we talk about enhancing sexual healthcare.

Speaker 2: For most of us, having sex is easier than talking about it. This is not related necessarily to the people who have the infection. It's related to the healthcare system in which they exist.

Speaker 3: What can I do? What can I learn that impacts change for the people that are in my sphere of influence?

Speaker 4: This is so, so, so preventable.

Tammy Kremer: These conversations are brought to you by the California Prevention Training Center at the University of California, San Francisco. It's time. Let's come together for sexual health. All views expressed are those of the persons speaking and not of the CAPTC or their employer. I'm Tammy Kramer and here's Dana Cropper.

Dana Cropper: Well, let's just get it started, because we're all old friends here. Hello, I'm Dana Cropper. I'm the current director of the California Prevention Training Center and today I will be speaking with two of our former directors and we're going to be talking about the history of the California Prevention Training Center, or as everyone knows over the last 30 years, the CAPTC. And we're going to be doing that with Dr. Gail Bolan and Alice Gandelman.

Welcome, Dr. Bolan.

Welcome, Alice.

Alice Gandelman: Hello.

Dr. Gail Bolan: Thank you, Dana.

Dana Cropper: Since I know both of you, I'm going to go ahead and just use your first names during our talk today. So, let's start with Dr. Gail Bolan.

Dr. Bolan is a recognized leader in the field of STD prevention and directed the California Prevention Training Center for 23 years. After she left the CAPTC, she was the director of the division of STD prevention at CDC from 2011 to 2020.

Previously, Gail served as the chief of the STD control branch at the California Department of Public Health and the director of the San Francisco City and County STD Prevention and Control branch and the medical director of San Francisco City Clinic. Well, Gail, what a lineage there. And also, we have Alice Gandelman. Alice was the director of the CAPTC from 1994 through 2021. She just retired.

She oversaw growth and development of the CAPTC in numerous training and capacity building programs including STD, HIV, and sexual and reproductive health along with the initiation of COVID. So, we had two legends in the field of public health, and I am just honored to continue in their footsteps. And as I mentioned, I am Dana Cropper, the director of CAPTC. Since April 1st, 2021, I previously served as a director of education at Health HIV and as a director of training and education at the National Coalition of STD Directors.

All right. So, Gail, I think I'm going to go ahead and start with you as our pioneer, our trailblazer. Give us a little bit about what your tenure was, what were some of the major events that happened around the time in the formation of the PTC?

Dr. Gail Bolan: So, thank you Dana for that wonderful introduction and it's a great opportunity to sort of think back to really the wonderful professionally satisfying years I had with the training center. So, as you said, I came into San Francisco after my clinical training and infectious disease fellowship and work at CDC, SEIS in 1987. And CDC had a funding announcement that came out in 1988 for clinical training centers. I'd ended up applying because I felt like it was a really right thing for San Francisco to do. The training center expanded to not only clinical training, but to the behavioral DIS partner services training in 95. And I would like to say that Alice and I co-directed the comprehensive three-part training center and there were some really important things happening that actually informed how we developed the training center. So, the first big major event was, it was 1988.

This was the beginning of the AIDS epidemic. I was also an AIDS clinician at San Francisco General and on faculty there. And I saw what the significant impact the age was having on the health of gay men in San Francisco. At that time, most gay men did not have a medical home. There was not the field of gay men's sexual health. Not a lot of providers took care of gay men and a lot of gay men ended up at the STD clinic for their healthcare. I mean, it became their medical home. But I also learned at that time that this epidemic really exposed the role of stigma, discrimination, social determinants of health and healthcare access, the disparities we saw with HIV. But if you actually looked at it closely, it also applied to STDs.

Dana Cropper: Absolutely.

Dr. Gail Bolan: And this is an important lesson that I think a lot of people in the STD field were not paying attention to for a number of years.

And I think we now recognize that these disparities and these equity issues apply to STIs just as much. And also, we've learned apply to COVID today. So, that was one big major event. It's also important to recognize that that time city clinic was actually seeing 400 patients a day and there were only seven exam rooms. People coming to the clinic were predominantly gay, bisexual, or other men who had sex with men, who as I said, didn't have a regular source of healthcare. The good news of having this many patients with SEIS coming to the STD clinic was that they received timely diagnosis and recommended treatment. The disadvantage was that the focus of the clinic was very siloed in myopic in its goal was just to treat those STDs and recognizing the need to link to other needed services for co-occurring conditions like behavioral health was not as much of a focus.

I actually was able to hire a psychiatric social worker in the city and county of San Francisco who was initially told by the personnel office, You don't get to have someone like that in the STD clinic. That's those are people we hire for mental health division services. I said, "We have a lot of need in the STD clinic for someone like that." So, we have the luxury of actually having the opportunity to refer our patients to a psychiatric social worker to meet some of their behavioral health needs. Then, the other big major event that was occurring at this time that chlamydia, a bacteria that wasn't even recognized before the 1960s was when newly recognized caused of pelvic inflammatory disease and tubal factor infertility. And that chlamydia screening in females was becoming a recommended strategy to prevent these severe adverse health outcomes in female.

So, in San Francisco, we looked at our data, not that many people were screening for chlamydia in the late 80s, but we saw that most of the chlamydia infections were not coming from women seen at the STD clinic. And that programs needed to be established in places where women were being seen, such as family planning clinics. And this required STD programs to have to pivot to invest beyond the services being provided in the STD clinics and saying, we're only going to meet patients that come to us. And that we really needed to start establishing trusted partnerships with colleagues in family planning. I always say that people in the field of STD are used to working with little resources, lots of problems, and I have a can-do attitude about what we need to do. But to complicate the work of STD prevention, when I entered the field, most clinical providers were not adequately trained in medical or nursing schools to conduct sexual health assessments, discuss sexual health concerns.

Also, we're not up to date on how to manage STIs accordingly. So, most individuals were really not getting the care they deserved. It really pointed to this need to improve training and skills for these clinicians. If you really look back at the history of STDs, we haven't had a lot of investment in sort of innovation research, new medications, new diagnostics. So, I felt San Francisco was very lucky to establish a clinical training center of excellence in 1988. And I'm also always glad to see that something you start is sustained and that it's still in existence today. So, very proud of this training center.

Dana Cropper: What a great history and background for CAPTC.

Alice Gandelman: A couple of other things in the late 80s and even in the early 90s in the field of STIs and HIV, it was still very, very difficult to get work done just because of the stigma associated with both of those. We worked really hard to try to remove some of that stigma, but just the political and economic and social and environmental conditions that we were all working under, you knew that people that were working in the field were working there because it meant a lot to them, and they had had personal or professional experience. They reflected the communities who were affected. And that really, I think also helped to make a difference. And to this day, makes a difference to the quality of work that's being done.

Dr. Gail Bolan: One of my mentors, before I went to medical school, I was working on breast cancer research at NIH. He always assumed I'd be coming back to NIH to work on breast cancer work. And when he heard that I had decided to take my first job in the field of STD, he said to me, "You're going to be a clap doctor." So, that's kind of the rewards you get for entering this field as a clinician. So, what I really was proud of is that our training center clinical expertise was not viewed as, oh, those public health doctors, all they are is a bunch of bureaucrats. The big a bunch of rules that make our lives difficult, that they really saw us as respected, recognized experts in the field and that we had very diverse colleagues. I would say as the training center grew, it wasn't just in the area of biomedical, it was behavioral, it was partner services and that we were the go-to people to figure out what the answer is.

So, our respected expertise really allowed for these true two-way street collaborations, not the top down where academic just comes and wants something from public health or the private sector wants something. And it allowed us to really increase the reach of the PTC beyond the traditional public health programs.

Alice Gandelman: Yeah. And I think that one of the reasons that those relationships were so successful is because we are very accessible, we're accessible to the providers. We had all been doing the work in that respective field. So, we really kind of helped to bring the importance of practice informing research because we were on the ground. We had been practitioners.

Dr. Gail Bolan: And I think the other thing was that with those partnerships, we were able to show the clinical world the services that their patient weren't getting. And I think most providers care about what their patients need, and they were just not aware. So, I think a lot of times people don't look at the resource of humans. People for a long time, as Dana have talked about, well, we should integrate STD and HIV. Oh, STDs to stay separate, to maintain their expertise. And when I look around the country, some of the programs that have integrated, because they didn't have leadership at the top, STDs became a second-class citizen, and the STD program was not as robust as what I consider in California. We were always

a separate STD program, but because we embraced HIV and we were at the table with HIV, we even got HIV to fund an integration coordinator.

Remember that, Alice?

Alice Gandelman: Absolutely.

Dr. Gail Bolan: To coordinate integrated HIV/STD services at the local level. I made sure that there was good collaboration going on between program and the training centers and our academic partners. So, the PTC became, even though we weren't funded by CDC to do any of this, we became the go-to organizations for grand round speakers or for big medical conferences. They wanted to plenary talk on the treatment guidelines. We also established a warm line that we modeled after the HIV hotline that was developed because HIV was struggling with disseminating information quickly to complicated cases. So, we really didn't have the resources to market beyond California, but we had a lot of providers that again, got to know us, they could call up and get an answer to that complicated syphilis case that they didn't know how to manage.

Alice Gandelman: And I think to this day, even though the warm line is now instituted throughout all the clinical training centers, I think we probably take the vast majority of calls. One, because California is a big state in our region, but also because as you were saying, Gail, we started it so early and so we have kind of a track record and people know where to go to get those questions answered.

Dr. Gail Bolan: Yes, I felt that investing in people who will go out into their communities and be an STD leader was important. The field was fairly small, and so we actually established an STD fellowship through UCSF back in the nine early 90s to train physicians post residency. And I'm proud to say that of all the fellows that we've trained only one into academic medicine and the rest have found very important positions in public health STD programs that are still working today. And then lastly, I think this holistic approach. We never siloed HIV, viral Hepatitis, prevention partner services. We included all of that content in the work that we did, and we also talked about the importance of linkage to these other co-occurring conditions. Models weren't really established in STD programs as they had been done well in HIV programs. And this was 1990.

I mean, this was amazing to think back that we were doing all of this in 1990, and I think only recently the rest of the nation is catching up about the importance of integrated non-siloed services. And certainly, encourage everybody to read the new HHS STI HIV and viral Hepatitis National Action Plans, which when you read it lays out this more integrated approach. Also, the new initiative of ending the HIV epidemic is recognized finally, which was obvious to some of us for a number of years, that STD clinics have been serving populations that for whatever reasons are not receiving the HIV prevention services that are out there. And that STD clinics, prep services and initiation of HIV treatment should be routinely offered in STD clinics.

Alice Gandelman: Well, I think it just points to the importance of not only meeting people where they're at, but if you can integrate services, you're going to increase your chances that people are going to get the services that they need. When you're embedded in a program or practice setting like our training center was at the time, you can identify maybe small changes that will have a much bigger impact. We're working with people that were already practicing clinicians, but maybe not aware of some of the latest medical advances, for example.

Dr. Gail Bolan: Right.

Dana Cropper: Yeah. What I've been hearing in this conversation is it's really all about the relationships and the partnerships that have been developed over the years and how to make sure that we're leveraging them, whether they were created through necessity or not, because of low funding resources, what have you, but continuing those relationships and making sure that they're beneficial to all the parties involved.

Alice Gandelman: That's right.

Dr. Gail Bolan: Yeah. Sometimes I feel like money stifles innovation. If you got too much money, you get set in your way. So, I think you're required to be creative and to constantly be pivoting.

Alice Gandelman: In fact, a lot of times in training when we're trying to think about what we need to do and improve practice, I'm like, "Take money off the table." We know that money is number one. Yeah. When we ask, what do you need? We know it's going to be money, so forget it. Aside from money, what else do you need to improve practice? So.

Dana Cropper: I hear you.

Alice Gandelman: I first came to the training center in 94, and it was great because previous to that, I had worked in local health departments in San Joaquin County, in Stockton, and in Solano County in Vallejo. And I feel like those both gave me excellent public health experiences because sometimes when you're not in an innovative place like San Francisco, you really get a very good hands-on experience with what some of the real public health issues are in needs. And also, sometimes in smaller health departments, you're not funded to the extent that you are in large or health departments like San Francisco. And then what happened was in 1995, CDC broadened their funding beyond just the STD clinical training centers, and they opened up funding to behavioral interventions and disease intervention training. We decided we can do this, let's apply for these. And as fate had it, we were funded for all three components.

So, that was a new and exciting time, not only in STDs, but it was also a really interesting time with HIV, because HIV was front and center. There were no effective antiretroviral treatment therapies. It was pre-PrEP, pre-PEP. But at the

time, a lot of the HIV prevention activities that were funded nationally at the time were funded to community-based organizations. Health departments got funding, but at that time, there wasn't really a strong evidence-based established for how can we help reduce HIV infections? There weren't biomedical effective treatments. So at that time, we started working very closely and CDC develop many, many strong relationships with behavioral scientists. And so, many of us will remember that was the birth of the DEBIs, the Diffusion of Effective Behavioral Intervention programs. And so, the Behavioral Intervention Training Centers became responsible for delivering training and technical assistance in these evidence based behavioral approaches.

Because at the time, that was the best thing that was thought to be done to try to help people to increase their knowledge, change their attitudes and beliefs around condom use, for example, build their self-efficacy so that they could learn these skills. We really, I felt, became advocates to the extent that we could for how the practice could really inform the research and what might be more effective at the program level, knowing that you're not going to get people to attend a 10 session group session for two hours each if they can't even find a way to get to the clinic or whatever, or if that's not the priority in their life. And I think we learned that behavioral interventions weren't the whole answer. It was a part of it, the behavioral individual level. That's one aspect that there are many, many other issues like social, economic, political, environmental factors that really probably have much more to do with the health conditions we've been talking about.

But at the time, that's where we were, and I think we learned a lot from it, but we helped nationalize and standardize these trainings. And that was the basis for probably over a decade, even though it wasn't quote the magic bullet, I think it allowed HIV prevention programs to continue to be funded, because this helped to begin to establish an evidence base for HIV prevention at the behavioral level. So, that was exciting. It was frustrating. And what we realized was this is a small piece of these broader issues, and Gail has alluded to this, really looking at what are some of the social determinants of health that are impacting HIV/STDs. You can put any chronic health condition in and it would probably fit the bill.

In other words, what are some factors that are beyond individual control? It doesn't matter how knowledgeable you are about something or whether you know how to use a condom, but if you can't afford to get the care you need, or if you can't access healthcare, or if they're transportation or even bigger, if they're broader social discriminatory, structural racism issues, these are big, big issues that are really hard to deal with that a lot of times we don't want to look at, because I think one reason is they're so hard to deal with.

The answers aren't easy. It's like homelessness, huge issue, not an easy answer. And I think people want easy answers to these big, big problems. People who are personally affected by a lot of these conditions were working in the field. So, they added a lot of insight into what was happening. And so, our training center

continued to work in that area, really trying to help people understand how can you address these issues in a broader way? What structural approaches can be taken to end some of these other issues? Sometimes we look back and we go, ugh, that didn't work. It didn't work. But it allowed us to think of something else that might have addressed the issue that helped force us to look inside and say like, "What's going on in our own organizations?" It's very challenging, but once you do it and go through some of those discomfort, I think it helps make us all see things a little bit differently, and it allows us to support each other in the work much more effectively.

Dana Cropper: A little comment to reflect on this early on with the sort of traditional approaches that public health was taking, It was a very individual focus. We live in a world of personal responsibility, so that was a factor. But when I've been reflecting over my career, I think once we recognize, like you said, individual behavioral interventions help in a certain way, but really difficult to scale. And there were a lot of people that just wanted biomedical magic bullets, but it taught us that behavioral matters, not just behavior to prevent STIs. And I think all the things that we've learned about barriers and behavioral factors came to light with COVID and the people who were working on COVID were oblivious to the fact that you need to deal with these social determinants of health. You need to deal with community trust, and you really need to look at the community and look for system level changes, not look at the individuals within the community and try to influence that way.

So, I think the healthcare has recognized the role of where you live, work, and play matters to your health. The STD field was slow to pick up on the idea that the community you live in, it doesn't matter what you do. If you've got high prevalence of STIs and HIV, you are more likely to get infected. So, I think we've moved from individual to community level thinking. Anyway, for those of you out there who are thinking about joining the field of STIs, I will say you'll never be bored.

Alice Gandelman: But it's true, never a dull moment. The other thing I thought was really interesting was that I think the field of STD and the field of HIV, their histories were very different. And so, the staff who worked in those field were trained differently and had a different perspective. And this sometimes created some conflicts, especially when we are talking about interviewing people or trying to identify infection in the communities for some of the disease intervention work and some of the HIV work HIV grew out of, and all this has completely understandable and rightly so in some ways, but grew out of kind of an advocacy-based grassroots energy, because the federal government was not paying any attention to HIV or the people who were becoming infected or affected by it. And so, it had to be kind of this grassroots thing. In some ways, you could probably make the same argument about STIs, but they never really had that grassroots movement.

And so, their training tended to be very, very different in many ways. And the people who worked in the fields tended to be different. And I think what our

training center did, and I'm sure others did too, but I know we did this 20, 30 years ago, and we're still doing it today, is really trying to integrate and provide some perspective on some of the cultural riffs or cultural differences. And even though I would say that the fields are both very diverse racially and ethnically, I think that there were fewer gay, bisexual trans questioning folks, And this is probably true to this day that work in the disease intervention field. And so, sometimes having that personal perspective can affect how you do your job. So, our staff have done a lot of work to try to really provide understanding and cultural background and provide more client centered approaches.

Dr. Gail Bolan: I would just say in fairness, the culture clashes also existed between family planning and STD programs. They came from a different client centered approach. They didn't use the term patient, they used client, they used STI, not STD. So I think, again, this is, if you look at these culture classes as opportunities to learn together.

Alice Gandelman: Yes. Absolutely.

Dr. Gail Bolan: And move forward together. And I think great strides have been made between family planning and STD and between HIV and STD. But as all said, it's hard work.

Alice Gandelman: Yeah, definitely.

It's the relationship building that is so invaluable, especially if you don't agree with your partners, because it provides you with different perspectives. And I think when you get to a point, you recognize that even among competitors, because those of us that are in this field, we have to compete for our funds. You always learn when there's more people in the room, and if there's something that goes it about what's going on with another person, you're talking to pay attention to that. Cause that's probably happening for a reason, for a good reason. And we're all strengthened by somebody else's expertise. I think other things, really trying to diversify our staff to reflect the communities that are affected by a lot of these different health conditions. You know, HIV, STDs, when you look at all the different types of professionals that are within our training center, our training is very, very different.

We often see the world differently. And then this is, I think a big thing, but it may not feel very important and may not seem as relevant. But for others who are heading up any type of organization, I think we're funded by CDC state, some CBOs. But I think one of the things that I helped do was really build bridges between bureaucracies that don't know how to talk to each other, and they don't want to talk to each other and they don't care what the rules are over there. This is what our rules are here. I think that that was really helpful to really understand how you can work with inflexible systems to get the work done.

Dr. Gail Bolan: I just wanted to add another thing that I think Alice and I truly believed in that to be a good clinician, public health practitioner, you were better by also teaching. Because you learned from your students and vice versa.

Alice Gandelman: Totally.

Dr. Gail Bolan: To be a good teacher. It's also good to practice your trade.

Dana Cropper: That's right.

Dr. Gail Bolan: Because you'll learn a lot from your patients. And then part of their job was training and capacity building, which also gives you a different type of learning that you can bring back to help make you be a better practitioner.

Alice Gandelman: Completely agree. Gail. I think probably one of the things that I would've loved to have done more, but then kind of COVID happened and we were refocused on that, is I really would've liked to have amplified clear distinction of health inequities, structural racism as the key public health and STD and HIV priorities of our time. And then, I think just more internal work. I think it's always good to do more internal work on white privilege, implicit racism, and how we can become more effective advocates for each other.

Dana Cropper: I think all of that is really good stuff because I absolutely agree that working around health inequities and structural racism and pulling out that information and creating programs, education and training for people outside of public health that may not even be thinking of those things is really important.

Dr. Gail Bolan: I mentioned the HHS, STD, HIV, viral Hepatitis strategic plans. There's some very important work that the training centers could be doing to advance those plans and objectives. The other thing is there is an IOM report that was just published that even has sexual health in the title.

Alice Gandelman: Institute of Medicine reports. IOM is Institute of Medicine reports.

Dr. Gail Bolan: Yeah, reading it thoughtfully, figuring out in my work where I sit, what can I do to contribute to this plan? What can I do to move the needle?

Dana Cropper: So, the title of our podcast is Coming Together for Sexual Health. So, what do you both hope that we can accomplish by all of us Coming Together for Sexual Health? You see all the things we've been doing for the last 20 years. Right.

Dr. Gail Bolan: Well, I think first of all, it seems like the field has embraced the term sexual health. There are so many years of controversy of what that term meant. And I think people still define it in many different ways, which is fine. I think that everyone, it's part of human nature, wants to be in a healthy relationship. And how do you create that environment and those communication skills in our society when we still have so much stigma around sexual health. My fantasy is

that sexual health would be normalized so that people are discussing more openly with their families, their children, their partners needs and concerns, and that the training centers could be providing the skills and the competencies to be able to do that. These things need to start at an early age, I believe, to normalize.

Alice Gandelman: Yeah, I totally agree, Gail. And I think that what we hope we can create by Coming Together for Sexual Health is how do we envision sexual health as a normal important part of our total overall health and destigmatize it. And there are many, many organizations that are working to help do that. Ours, of course, is one of them. We partner with National Coalition for Sexual Health. It's not just a matter of discussing things differently or doing things differently. I think we have to recognize the political and social context that we're living in. It's really looking at this as something not to be ashamed of, not to be embarrassed about, not to be stigmatized, and what are the things that we can put in place to achieve that? There are a lot of strategies that we can try. And so, I am hopeful for the future.

Dr. Gail Bolan: And I also think is not real realistic. When we want to be free of STIs in our society, there's just too many asymptomatic infections to accomplish that. And our goal should be, let's really reduce the consequences of these infections, like neuro syphilis in men, in gay men, or ocular syphilis like congenital syphilis. And if we could accomplish reducing the bad sequela, and certainly include infertility for women as well, I think that would be a great accomplishment. And I think the younger generation, at least I get more calls from friends of friends and friends of my kids, and they're very open about questions about their sexuality and about these infections and what they should do before they start relationships and things that I think, at least of my generation, really, we weren't equipped to deal with. So, hopefully getting more younger people into the field. And I think we need to change the age demographic. Dana, that would be my other recommendation to help us move towards achieving sexual health.

Dana Cropper: Well, I appreciate that the three of us came together for sexual health, and you all gave us a wonderful background in history of the California Prevention Training Center. So, I want to thank you both for just taking the time that you spent with us today.

Dr. Gail Bolan: Thank you, Dana.

Alice Gandelman: Well, thank you for the invitation.

Tammy Kremer: Thanks for listening. And check out the show notes for the resources mentioned in this episode. You'll also find the link to the transcript of the show.

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