

Sexual Risk Assessment and Intervention in the Primary Care Setting



Sexual Health and Responsibility Program (SHARP)



Navy Environmental Health Center
Bureau of Medicine and Surgery M-11

Foreword

This document is a student handout used in conjunction with the SHARP PowerPoint lecture “Sexual Risk Assessment in the Primary Care Setting” which may be accessed at <http://www-nehc.med.navy.mil/downloads/hp/PPIP-3.ppt>. This lecture is designed to provide Department of the Navy (DoN) health care providers with information about HIV, other STDs and unplanned pregnancy among DoN health care beneficiaries and provide an overview of a client-centered model of prevention counseling they may use to assess and intervene in sexual risk taking behavior.

Comments on this course or additional training needs are encouraged and can be forwarded to the SHARP Program Manager at:

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Views and opinions expressed are not necessarily those of the Department of the Navy

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Learning Objectives

Overall Objective: The student will be able to discuss sexual risk behavior with adolescent and adult patients.

Cognitive Learning Objectives

Enabling Objectives: Upon completion, the student will be able to **identify** and **discuss** basic facts concerning:

- ✓ the impact of sexually transmitted diseases and unplanned pregnancy in the U.S. and in the Navy and USMC
- ✓ Sexual Health and Responsibility Program (SHARP) mission, vision, goals, products, and services
- ✓ purpose and content of sexual risk assessment and risk reduction counseling by health care providers
- ✓ recommendations from the Task Force on Clinical Preventive Services
- ✓ six steps in the client-center Project Respect HIV-STD prevention counseling model
- ✓ options to reduce the risk of acquiring of transmitting STDs including HIV
- ✓ availability of other trained HIV-STD prevention counselors patient referral

Affective Learning Objectives

Upon completion, the student will:

- ✓ be motivated to bring up the issue of sexual health with routine outpatients
- ✓ believe that sexual risk behavior can be identified in a brief encounter
- ✓ believe that effective, client-centered messages for safer sexual behavior can be offered to patients during brief outpatient encounters
- ✓ be motivated to refer patients to other trained HIV-STD prevention counselors, when appropriate

Continuing Education Credit

Medical Corps

The Navy Medical Education and Training Command, Bethesda, Maryland, is accredited by the Accrediting Council for Continuing Medical Education to provide continuing medical education for physicians and designates this educational activity for a maximum of **1.5** hours of Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity. Bethesda CME Category 1 Approval number 2001-124 (through 23 October 2004).

Nurse Corps

Educational Activity I credit of **1.8** contact hours has been approved by the Navy Medical Education and Training Command, Bethesda, which is accredited as an approver of continuing education by the American Nurses Credentialing Center Commission on Accreditation. The accreditation approval number is 031024 (through 30 Nov 2005).

Navy Independent Duty Corpsmen. This course is approved for **1.5 credit hours**. The BUMED control number is 53/02-9013.

Certified Environmental Health Technicians / Registered Sanitarians

This course has been approved by the National Environmental Health Association (NEHA Letter 8 Feb 2002) for 1.5 contact hours of continuing education credit.

Certified Health Education Specialist: This course is approved by the National Center for Health Education Credentialing for **1.5** hours of credit.

Other Professions: Students are responsible for contacting their own respective professional organizations to determine appropriate category and documentation requirements.

The Impact of Sexually Transmitted Diseases and Unplanned Pregnancy

Sexually transmitted diseases (STDs) refer to the more than 25 infectious organisms transmitted primarily through sexual activity (USDHHS, 2000). According to the American Social Health Association, the United States has the highest STD rates of any country in the industrialized world – an estimated 15.3 million new infections each year (ASHA, 1999). Of the top ten infections in the U.S., five are STDs.

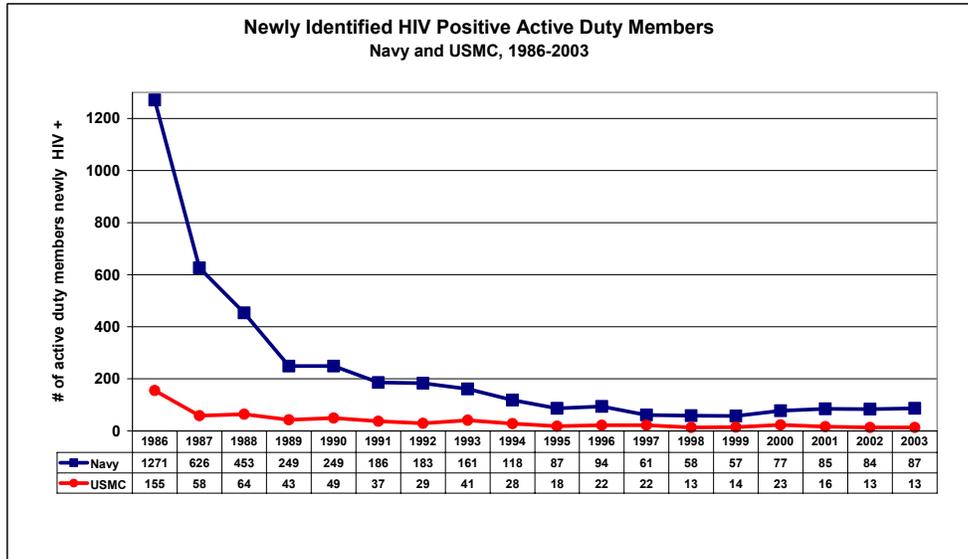
The total cost of the most common STDs and their complications is conservatively estimated at \$17 billion annually (USDHHS, 2000). Women generally suffer more serious STD complications than men, including pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain, and cervical cancer from the Human Papillomavirus (USDHHS, 2000).

Evidence indicates that infection with some STDs other than HIV increases the likelihood of both transmitting and acquiring HIV infection. The Centers for Disease Control and Prevention (CDC) estimates that 1 in 300 Americans are infected with HIV, and suggests the incidence of AIDS to be increasing 5% per year overall, with an increase of 15% each year for heterosexual transmission (CDC, 2000). Over 700,000 cases of AIDS have been reported in the United States since the HIV/AIDS epidemic began in the 1980s. CDC estimates that 800,000 to 900,000 Americans are currently infected with HIV. The lifetime cost of health care associated with HIV infection has been estimated at \$155,000 (1996 dollars) or more per person. About one-half of all new HIV infections in the United States are among people under age 25 years, and the majority are infected through sexual behavior. HIV infection remains the leading cause of death for African American men aged 25 to 44 years (USDHHS, 2000).

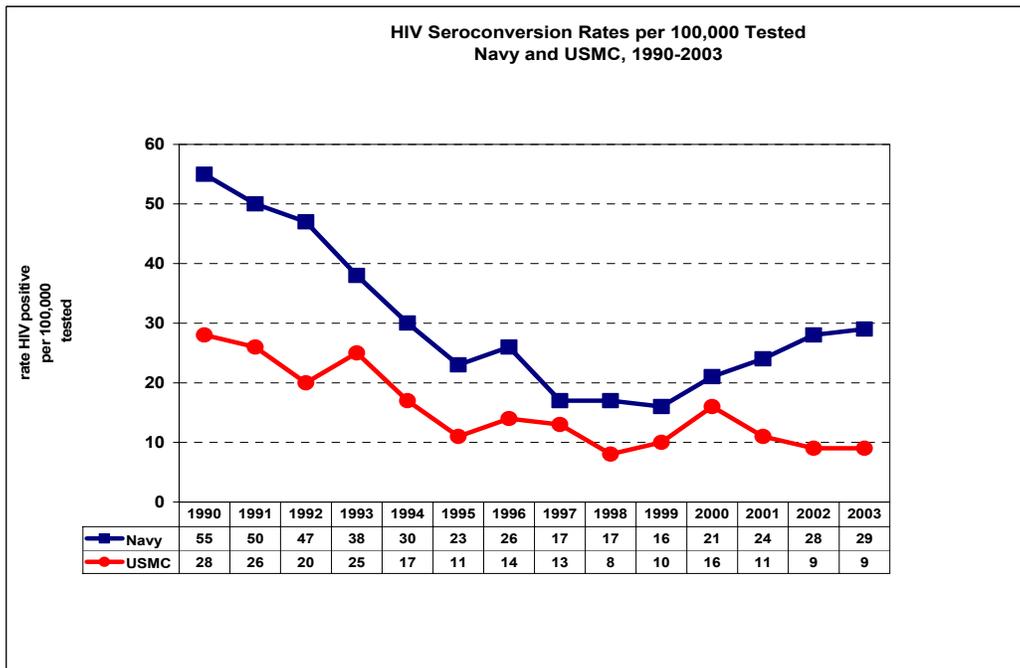
In a ten year report on reportable communicable diseases (not all STDs are reportable) for active duty Navy and Marine Corps personnel (Navy Environmental Health Center, 1999) syphilis, chlamydia and gonorrhea are in the top ten categories for the most commonly reported communicable diseases by both frequency and incidence. These diseases rank second, sixth, and tenth, respectively, for the Navy and second, third and tenth, respectively, for the Marine Corps. It is interesting to note that chlamydia, the most common STD in the U.S., was only reportable from 1997, the last year accounted for in the ten year summary. In just one year of data, its frequency and incidence propelled it to sixth and third overall for the decade.

HIV testing of all active duty Sailors and Marines was begun in late 1985. The total force screening program goal was to test all active duty members at least once within the first 2 years, and again during the next 2 years. Data on newly identified cases of HIV infection among active duty Sailors and Marines from 1986-2003 are shown in Figure 1. Since 1985, there have been over 5000 documented cases of HIV infection among active duty Sailors and Marines (NNMC, Bethesda 2004). Figure 1 does not plot the HIV positive members identified in late 1985 when testing first began (126 Navy, 13 USMC). Note that Figure 1 plots newly identified infections, not necessarily newly acquired infections. The distinction is important, particularly in the earlier years, where the number of positive members is more an indication of pre-existing plus newly

acquired HIV infection (prevalence). Predictably, the first few years of testing identified higher numbers of HIV positive members. Since all new accessions into the Navy and USMC have been screened for HIV infection (and people who are positive are excluded), the number of HIV infections identified in later years is more an indication of newly acquired infections (annual incidence).



During calendar year 2003, 87 Sailors and 13 Marines were newly identified as HIV positive. HIV seroconversion rates (cases per 100,000 members tested) among active duty Sailors and Marines from 1990-2003 are shown in Figure 2. Among active duty Sailors, the rate has risen each year since 1999, from 18 to 29. Among Marines, the rate has fallen each year since 2000 from, 16 to 9. These data demonstrate that the **HIV epidemic continues to affect the active duty force**.



Americans generally underestimate their risk of becoming infected with an STD. While an estimated one in four Americans will get an STD in their lifetime, the majority of men (74%) and women (69%) believe the rate is one in ten Americans or fewer. Only 14 percent of all men and 8 percent of all women say they think they are at risk for STDs — and single men and women are not much more likely to feel they are at risk. The story is similar among teens 15-17 years: the majority of teen girls (73%) and boys (77%) think the STD rate is one in ten Americans or fewer in a lifetime. Only one in five teens say they think they are at risk of getting an STD (ASHA, 1999).

Half of all **pregnancies** in the United States are unintended; that is, at the time of conception the pregnancy was not planned or not wanted. Nearly half of all unintended pregnancies end in abortion. The rates remain highest among teenagers, women aged 40 years or older, and low-income African American women. Approximately 1 million teenage girls each year in the United States have unintended pregnancies. Although unplanned pregnancy rates have dropped since 1997, the rate is much higher than those seen in any other developed nation.

Unplanned pregnancy in the US is serious and costly. The cost to U.S. taxpayers for adolescent pregnancy is estimated at between \$7 billion and \$15 billion a year. The pregnancy care cost for one woman who does not intend to be pregnant, yet is sexually active and uses no contraception is estimated at about \$3,200 annually in a managed care setting. The costs can also be measured in many social aspects such as reduced educational attainment and employment opportunity for the mother. With unintended pregnancy, there is increased likelihood of child abuse and neglect. There is also increased likelihood of infant and maternal illness and an increased likelihood of abortion. For teenagers, these problems are compounded. They are less likely than their non-pregnant peers to get or stay married, less likely to complete high school or college, and more likely to live in poverty. The national target is to increase the proportion of pregnancies that are intended to 70% (USDHHS, 2000).

Among active duty enlisted female Sailors, unplanned pregnancy rates have been historically high. A 2003 Navy survey (NPRST unpublished 2004) found that 70% of pregnancies among enlisted women were unplanned. Half of the women who had an unplanned pregnancy had not used any form of birth control to prevent it. The study also found that the pill was the most failure prone form of birth control (as is true in the general population).

Unplanned pregnancy impacts Sailors and Marines and their commands in many ways. The financial and contingency child-care challenges of single parenthood for men and women, can be significant. Pregnant Sailors aboard ships can be difficult to manage because of the need to protect the health and careers of service women without degrading the mission of the command. Though Navy policy permits pregnant members to remain on board until the 20th week of gestation, Navy studies have found that many are transferred early, leaving the command shorthanded until a replacement arrives.

The secrecy and shame surrounding STDs interfere with communication between parents and children, sexual partners, teachers and students, and even patients and health care providers. According to the CDC,

“STDs are hidden epidemics of enormous health and economic consequence in the United States. They are hidden because many Americans are reluctant to address sexual health issues in an open way and because of the biologic and social characteristics of these diseases. All Americans have an interest in STD prevention because all communities are impacted by STDs and all individuals directly or indirectly pay for the costs of these diseases. STDs are public health problems that lack easy solutions because they are rooted in human behavior and fundamental societal problems. Indeed, there are many obstacles to effective prevention efforts. The first hurdle will be to confront the reluctance of American society to openly confront issues surrounding sexuality and STDs”. (CDC, 2000)

Further complicating STD control is the asymptomatic nature of STDs. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they often are disregarded, resulting in a low index of suspicion by infected people who should, but often do not, seek medical care. For example, as many as 85 percent of women and up to 50 percent of men with chlamydia have no symptoms. A person infected with HIV may be asymptomatic and may transmit the disease to another person. That person may be infected for years but remain unaware until symptoms manifest themselves (CDC, 2000).

Another factor which complicates control is the lag time between infection and complications. Often, a long interval—sometimes years—occurs between infection and the appearance of a noticeable health problem. Examples are cervical cancer caused by HPV, liver cancer caused by Hepatitis B virus infection, and infertility and ectopic pregnancy resulting from chlamydia or gonorrhea. Because the original infection is asymptomatic, people often fail to perceive a connection between the infection and the resulting health problem (CDC, 2000).

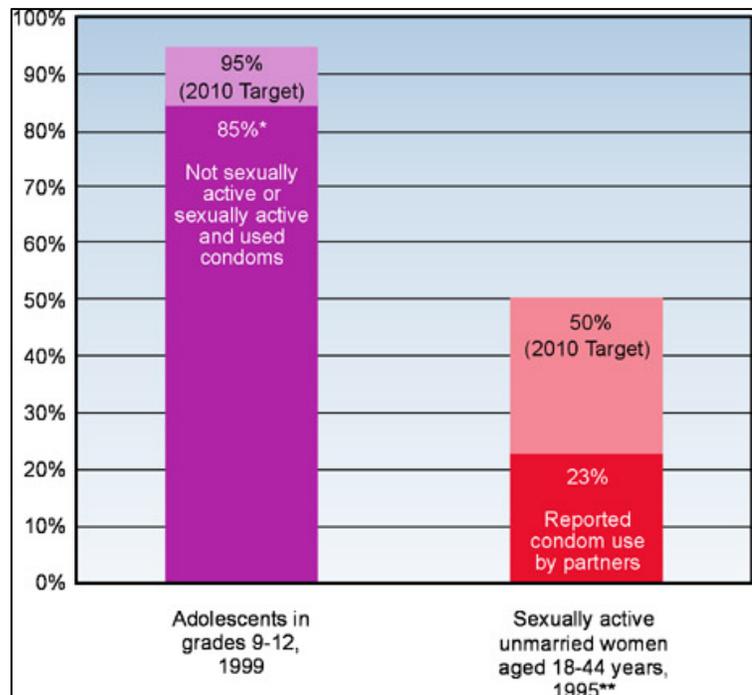
Prevention.

Refraining from having sexual intercourse with an infected partner is the best way to prevent transmission of HIV and other STDs. For people who choose to have sex outside a mutually monogamous relationship, three components have been identified as strategies for the prevention of sexual transmission of HIV (Cohen, Dallagetta, Laga & Holmes, 1997). They include

- (1) increasing the use of condoms
- (2) decreasing the frequency of unsafe sexual behavior (decreasing number of partners and/or number of sexual encounters), and,
- (3) controlling STDs which facilitate the transmission of HIV.

Considering these three components, prevention strategies for all STDs would include the first two components since the prevention of HIV transmission is closely related to the prevention of other STDs. ***For those individuals who choose to engage in sexual activity, increasing condom usage appears to be the best prevention strategy.***

The correct and consistent use of latex condoms during sexual intercourse—vaginal, anal, or oral—can ***greatly reduce*** a person’s risk of acquiring or transmitting most STDs, including HIV infection, gonorrhea, chlamydia, trichomoniasis, human papilloma virus (HPV), and Hepatitis B



CDHHS HP2010: Condom Use National Targets and Baselines

Condoms reduce risk. According to the CDC (2003):

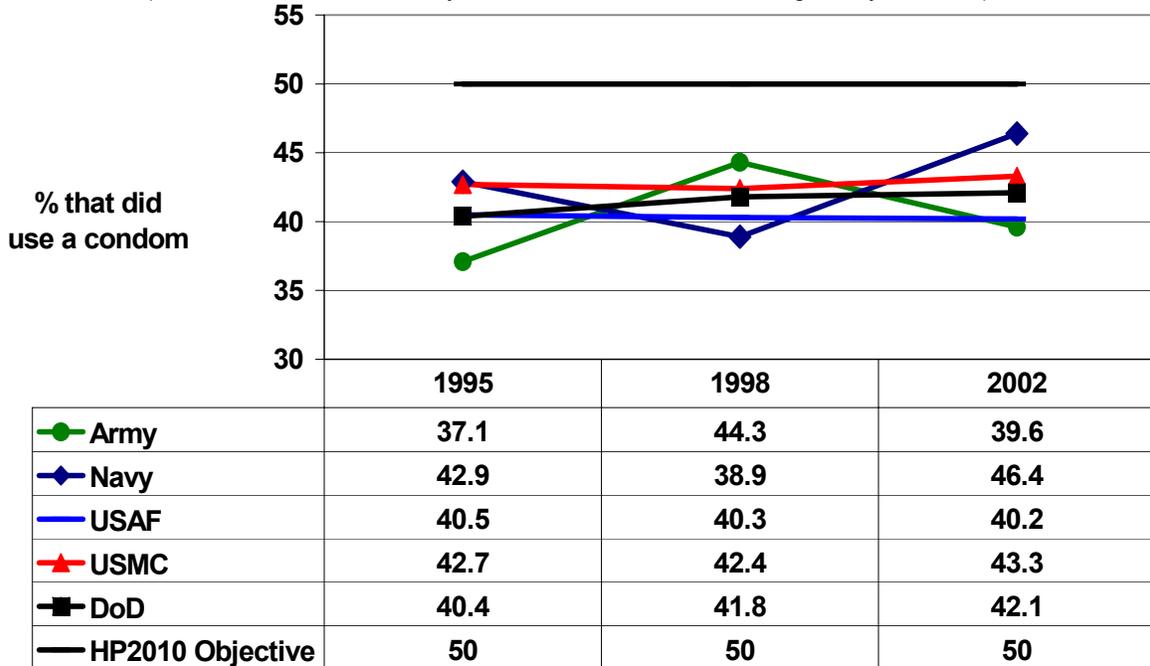
“Latex condoms when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases. While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.”

Condoms can be expected to provide varying levels of protection from different STDs. There is no one definitive study about condom effectiveness for all STDs. Several studies have demonstrated that condoms can reduce the risk for chlamydia, gonorrhea, and trichomoniasis, and may protect against herpes and syphilis. However, because not all studies have demonstrated protective effects, the body of evidence is considered inconclusive. Data are lacking regarding the degree of risk reduction for chancroid and genital Humanpapilloma Virus. The lack of data about condom effectiveness indicates that more research is needed – not that latex condoms don’t work.

Condom Use at Last Sexual Encounter

Among Unmarried Active Duty Members

(source: DoD Worldwide Survey of Health Related Behaviors Among Military Personnel)



In the U.S., condom use is inconsistent. The CDC reports that only 23 percent of unmarried females aged 18 to 44 years reported condoms used by partners in 1995 (USDHHS, 2000).

Most unmarried, active duty Sailors and Marines say they did not use a condom the last time they had sex. In 2002, the Worldwide Survey of Health Related Behaviors of Military Personnel (Bray, 2003) found that condoms were reportedly used during the last sexual encounter by 46.4% of Sailors and 43.3% of Marines. The national target for condom use at last sexual encounter is 50% (USDHHS, 2000).

While condom use among active duty Sailors and Marines has improved since 1998, when condom use for Sailors and Marines was 39.9% and 42.4%, respectively, more effort is needed to further boost the frequency of condom use by those members who choose to have sex outside of a monogamous relationship, and to boost correct condom use. Some studies indicate that young Americans put the condom on *after* some penetration has occurred. Health educators and health care providers should include a description of *correct and consistent* condom use in their discussions with groups and patients. The *SHARPFact* factsheet “Condoms and Their Use in Preventing HIV and STDs” (on line at <http://www-nehc.med.navy.mil/downloads/hp/CONDOMS.pdf>) is a free and useful excellent resource.

Risk Assessment and Risk Reduction Counseling - Guidance and Training for Health Care Providers

Most clinicians don't ask...

A Gallop Organization poll commissioned by ASHA in 1995, found that over half of adults and over one-third of teens said their health care providers spend “no time at all” discussing STDs with them. Kaiser Family Foundation/*Glamour* survey conducted in 1997 found that STDs are rarely discussed during OB/GYN visits, and that providers may not be asking adequate risk-assessment questions. In a national survey of 2683 adults in 2000 by the Kaiser Family Foundation, when asked "Have you ever talked to your doctor about HIV or AIDS?", 70% of respondents said "no". And of the 30% who answered "yes", only slightly more than half said their doctor discussed risk and prevention. Thus, only about 17% of patients in this nationwide sample said they discussed HIV risk behavior and prevention with their doctor (Kaiser Family Foundation, 2001). This data is closely mirrored in other studies. For example, a study reported in the American Journal of Preventive Medicine (2000:Vol 18, No 12) revealed that only 28% of adults who had a routine check-up in the past year reported being asked about STDs during that visit. The survey measured topics which were asked by providers during routine check-ups.

<u>Topic</u>	<u>% of patients asked</u>
Smoking	58.7
Physical Exercise	52.3
Alcohol	49.3
Diet	43.8
Contraceptives (aged 18-50)	36.1
Illegal drugs	31.3
STDs	27.9

Another national survey of internal medicine specialists found that 40% reported routinely asking patients about STDs. Still another survey among primary care physicians showed that, overall, only 49% asked. These data demonstrate that most providers don't ask patients about their sexual health, as recommended by the Institute of Medicine and US Preventive Services Task Force, and thus are missing opportunities to identify, diagnose and treat STDs and to identify and intervene in risky sexual behavior.

If this is typical of Navy primary care encounters, it is alarming, especially considering that sexually transmitted diseases and unplanned pregnancies may have a dramatic and acute impact on the health, readiness, and availability of active duty Sailors and Marines. In the case of other consequences, such as HIV infection, congenital syphilis, pelvic inflammatory disease, and unplanned pregnancy, sexual behavior may also have dramatic long-term health, personal, and financial consequences. Health care providers can and should speak with all their sexually active patients about their sexual health. OPNAVINST 6120.3 (Preventive Health Assessment, 5

December 2001) requires an annual health assessment of active duty men and women that includes appropriate family planning, contraceptive and STD counseling. Also required is chlamydia screening for all sexually active women aged 25 and younger, as well as older women at risk for chlamydia, as part of their regular health care visits.

Why don't physicians initiate discussions about sexual health? A study of physicians in Houston, TX (Merrill, J., Laux, L., Hornby, J., 1990) found the most commonly reported reasons physicians did not assess sexual risk behavior were non-relevance of the sex history to the chief complaint (25%), embarrassment on the part of the physician (22%), inadequacy of the physician's training (20%), and fear of offending the patient (14%).

Regarding this last perceived barrier, a 2000 study among outpatients in a primary care setting found that most patients would be comfortable talking with their healthcare provider about sex and AIDS (Kosko, 2000). In a study by the Kaiser Family Foundation (2001), over half of the people who reported discussing HIV with a doctor say they (the patient) raised the topic. In a 1990 telephone survey of American adults, researchers found that although 94% of the respondents had seen a physician, only 15% of these had discussed AIDS and 72% of these patients initiated the discussion (Gerbert, B., Coates, T., 1990).

A study of adolescent HIV risk behavior published in 2001 revealed that 70% of teens who wanted more information would ask their family physician – more than would ask their parents, friends, school nurse, teachers or siblings (A. Facente, J of School Nursing 17;4 Aug 2001). Another study of 221 patients aged 12-15 found that while 89% valued their physician's opinion about sex, only half would feel comfortable disclosing a sexual problem – however – this percentage increased significantly when physicians discussed sexual issues in the general health examination (Boekeloo B., et al 1996). A 1990 study (Gerbert, MacGuire, Coates 1990) found in a telephone survey that among patients who were not asked about AIDS during their last doctor's visit, only 7% said they would be unwilling to answer a doctor's questions about their sexual behavior; 59% said they would be glad for the opportunity to talk with their doctor about sex; 67% said they would be comfortable talking with their physician about AIDS.

In a comparison of the relative value of clinical preventive services recommended by the US Preventive Services Taskforce, Coffield, et al (2001) examined cost effectiveness and quality-adjusted life years lost. Each clinical preventive service was then scored from 2 (lowest priority) to 10 (highest priority). Assessing STD risk and provide counseling to reduce risk was rated as a "6", ranking 15th of 30 recommendations. Although physicians offered this service to less than half of their patients, it is interesting to note that assessing STD risk ranked equal or higher than some commonly offered preventive services such as screening for breast cancer, assessing diet, screening for rubella among women of childbearing age, and Tetanus-diphtheria (Td) boosters.

According to the Guide to Clinical Preventive Services, ...prevention at all levels – primary (preventive disease), secondary (early diagnosis), and tertiary (preventing or slowing deterioration) – requires active participation by the patient with guidance from the clinician. The patient must take responsibility for carrying out the day-to-day preventive behaviors, accurately reporting progress to the clinician, and discussing health-related problems. Effective

patient participation requires education, motivation, and counseling. While busy clinicians cannot fill all the education needs, they can be pivotal in starting and guiding the process”

Some **general recommendations for patient behavior counseling** are given in the *Guide to Clinical Preventive Services*. Here is an excerpt (emphasis added):

Recommendations for Patient Education and Counseling

(from the *Guide To Clinical Preventive Services; An Assessment of the Effectiveness of 169 Interventions*, Report of the U.S. Preventive Services Task Force; Williams & Wilkins, 1989) (on-line 17 Apr 2001 at <http://wonder.cdc.gov/wonder/prevguid/p0000109/p0000109.asp#head005000000000000>)

“Empirical research and clinical experience yield certain principles that clinicians can use to induce behavior change among patients...”

1. Develop a therapeutic alliance. See yourself as an expert consultant available to help patients who remain in control of their own health choices. This perspective facilitates development of a therapeutic alliance in which health is maintained or achieved through a provider-patient partnership. Help **motivate** patients who smoke, abuse alcohol and other drugs, or do not exercise to change these behaviors. Assist them in acquiring the necessary **attitudes and skills** to succeed in their attempts.
2. **Counsel all patients.** Most patients are eager for health information and guidance and generally want more than physicians provide. Whites tend to receive more information than blacks and Hispanics and middle class patients tend to receive more than working class patients. Physicians tend to talk more with patients who pose more questions, but those who are quieter are often in greater need of education. Make a concerted effort **to respond to the educational needs** of all your patients in ways **appropriate** to their age, race, sex, socioeconomic status, and interpersonal skills.
3. Ensure that patients understand the relationship between behavior and health. **Inquire about what your patients already know or believe** about the relationship between risk factors and health status. Do not assume that patients understand the health effects of smoking, lack of exercise, poor nutrition, and other lifestyle factors. Explain in simple terms the idea that certain factors can increase the risk of disease and that combinations of factors can sometimes work together to increase risk beyond the sum of their individual contributions. Respond to patients' questions, reinforce key points, and encourage patients to write down questions about risk factors for discussion at the next visit. Bear in mind that **knowledge** is a necessary, but **not a sufficient, stimulus for behavior change**.
4. Work with patients to **assess barriers** to behavior change. Anticipating obstacles to behavior change is fundamental to effective patient education since patients often do not follow physicians' advice concerning medication use or lifestyle changes. According to one well-studied model, three areas of beliefs influence the adoption and maintenance of behavior change: (1) susceptibility to continuing problems if the advice is not followed; (2) severity of problems associated with not following the advice; and (3) the benefits of adopting the advice weighed against the potential risks, costs, side effects, and barriers. Assess those areas and address those beliefs that are not conducive to healthful behaviors. In addition, try to determine other obstacles to change, including **lack of skills, motivation, resources, and social support**, and help patients determine ways to overcome them.
5. **Gain commitment from patients** to change. This is a critical step in patient education and counseling because patients typically come into the physician's office expecting to be treated for a condition. If patients do not agree that their behaviors are significantly related to health outcomes, attempts at patient education may be irrelevant.

6. Involve patients in selecting risk factors to change. Do not overwhelm patients by asking them to try to change all their unhealthful behaviors at the same time. Let patient need, patient preference, and your own assessment of relative importance to health dictate your recommendation of which risk factor to tackle first. Patients who achieve success in one effort may attempt other changes, since many behavior patterns tend to be linked. For example, quitting smoking may lead to renewed energy to begin exercising, which in turn may lead to better eating habits. There are situations, however, where it is advisable to address risk factors simultaneously, such as chemical dependence involving several substances.

7. Use a combination of strategies. Educational efforts that integrate individual counseling, group classes, audiovisual aids, written materials, and community resources are far more effective than those employing only one single technique. Be flexible about tailoring programs to individual needs; for example, some patients will not attend group classes, and others may have inflexible work schedules. Ensure that printed materials are accurate, consistent with your views, and at a reading level appropriate to the patient population. Use written materials to strengthen the message, personalizing them by jotting pertinent comments in the margins; this will help to remind patients later of your suggestions. Be wary of excessive use of print materials as a substitute for verbal communication with patients. Multiple studies have demonstrated that clinicians' individual attention and feedback are more useful than media or other communication channels in changing patient knowledge and behavior.

8. Design a **behavior modification plan**. Patient education should be oriented toward what patients should do, not merely what patients should know. Ask patients if they have ever tried to change the specific behavior before and discuss the methods used, the barriers encountered, and the degree of success. If patients have tried and failed, ask them to identify what they have learned from the attempt. Agree on a specific, time-limited goal to be achieved and record the goal in the medical record. Discuss the behaviors that need to be modified to achieve the goal, paying special attention to patient cultural **beliefs and attitudes that might facilitate or impede success**. Assist patients in writing action plans, review relevant instructional materials, and stress your willingness to be of continued assistance. Remember, at best patients often recall only about 50% of what they are told by their physicians, and lifestyle recommendations are remembered less than are medication regimens. Close your visit by **summarizing your mutual expectations** and expressing your confidence that the patient will make a good effort to modify his or her risk factors.

9. Monitor progress through follow-up contact. Once a strategy for behavior change has been developed, schedule a follow-up appointment or telephone call within the next few weeks to evaluate progress in achieving the goal. Reinforce successes through positive verbal feedback. If patients have not followed the plan, work with them to identify and overcome obstacles. Modify the plan if necessary to facilitate successful risk factor reduction. Strategies include **referring patients to community agencies** or self-help groups and eliciting support for the patient's prescribed regimen from family members or significant individuals in their social networks. Progressively transfer responsibility for self-care to patients by scheduling follow-up contacts with increasingly longer time intervals. Evaluate your office's capacity to monitor patient progress through computerized records or other tracking systems, and make necessary improvements.

10. Involve office staff. Use the team approach to patient education. Share responsibility for patients with nurses, health educators, dietitians, and other allied health professionals, as appropriate. Ask your receptionist to encourage patients to read materials that you have reviewed, approved, and placed in your reception area. Ensure that team members and the office environment communicate consistent positive health messages. Well-meaning comments such as "Well, you know the doctor is a fanatic about exercise," or "I can't lose weight either" can unintentionally sabotage patient education strategies. If possible, form a patient education committee to generate program ideas and promote staff commitment."

Recommendations for STD counseling by health care providers are given in a number of documents. An essential document is the *Sexually Transmitted Diseases Treatment Guidelines – 2002* (CDC, 2002) which offers disease-specific prevention and partner management information, in addition to the current treatment protocols. Others include the *Clinicians Handbook of Preventive Services* (PHS, 1998) and the *Guide to Clinical Preventive Services*.

These documents recommend that all adolescent and adult patients should be advised about risk factors for STDs and HIV infection and be counseled appropriately about reducing their risk. The assessment of risk should be based on a client-centered evaluation of sexual behavior and circumstances.

These documents include examples of questions a provider might ask to assess risk. Some examples of questions which can quickly reveal specific and general risk behaviors and can reveal important circumstances are given below. Notice that these questions (except the first) are open-ended.

Suggested Questions for Assessing Sexual Risk Behavior

Are you currently, or recently, in a sexual relationship?

How many people have you had sex within the last few weeks/months?

Were these partners new, casual, regular?

Have you ever traded sex for money or drugs?

What do you think is the riskiest thing you're doing that places you at risk of getting HIV?

What are your experiences with drugs / alcohol?

How has your use of alcohol influenced your sexual behavior?

What have you done to protect yourself from infection in the past?

What do you think you could do to protect yourself in the future?

What do you see as the advantages of doing [each safer goal behavior]?

What do you see as the disadvantages of doing [each safer goal behavior]?

Healthcare providers can help patients understand their options and can guide patients toward the adoption of safer behaviors. Here is one list of behaviors patient may be willing to try:

SAFER GOAL BEHAVIORS

Abstain from sex or delay sex

Refraining from having sexual intercourse with an infected partner is the best way to prevent transmission of HIV and other STDs. People can choose to not have sex. People can also decide to wait, or delay sex, until a later time in their life. They may choose to have personal relationships that do not involve sex.

Outercourse vs. Intercourse

Outer-course is non-penetrative contact, such as massaging, hugging, and kissing. Non-penetrative contact vs. intercourse can eliminate transmission risk for HIV and many (though not all) STDs.

Monogamy

Monogamy is sex between two people, who only have sex with each other, as part of a long-term relationship. If neither partner is infected, there is no risk of disease transmission. People who get to know their partner and his/her sexual history before deciding to have sex can also reduce the chance of exposure to disease. A series of short-term relationships is not as safe because of the increased risk that one of those partners will be infected.

Use Condoms and other barriers

When used correctly and consistently, condoms can significantly reduce the risk of getting a sexually transmitted disease. A variety of male condoms are available. Female condoms and oral barriers are also available. Condoms can reduce both the risk of pregnancy and the risk of disease transmission. A new condom/barrier should be used for each act of vaginal, oral, or anal sex.

Reduce # of partners

Many people who are infected with an STD don't know it, and you can't tell if a person is infected just by looking at them. The more people a person has sex with, the more likely one (or more) will be infected with an STD. Though not as safe as monogamy, reducing the number of people a person has sex with can reduce risk by reducing the number of potential exposures to an STD.

Do not have sex with "high-risk" people

You can't tell if potential partners are "high risk" just by looking at them. People who may be at higher risk of having a sexually transmitted infection including those who trade sex for money or sex for drugs, because they may have sex with many other people. Other people who may be at higher risk are people who share needles, because this activity can result in HIV, Hepatitis B and C infections, which can then be spread sexually. Non-monogamous men who have sex with men are also at higher risk of being infected with HIV and Hepatitis B because the risk of transmitting these viruses is greater with anal intercourse than with vaginal or oral intercourse and because these men may have many sex partners. Though not as safe as monogamy, avoiding sex with people you know engage in these risk behaviors can reduce your risk of exposure to an STD.

Here is an example of a brief but effective **Sexual Health Encounter**

Provider: Now that we've taken care of your (chief complaint), let's talk about your general health. Let me first ask about your sexual health. Are you having any problems?

Patient: Nope.

About how many people have you had sex with in the past 6 months or so?

Well, 4 or 5, I guess.

What do you do to protect yourself from sexually transmitted diseases, like HIV, and from an unplanned pregnancy?

I usually use condoms.

I'm glad to know that you use condoms. What prevents you from using a condom every time?

Well, I guess I don't think about having them when I end up needing them.

I'm concerned that you are putting yourself at considerable risk for a sexually transmitted infection, such as HIV, and for unplanned pregnancy as well, because you use condoms inconsistently. Abstaining from sex, or having sex with one uninfected person who only has sex with you, in other words monogamy, are completely safe options to avoid getting a sexually transmitted disease. For people who choose to have sex outside a monogamous relationship, latex condoms, when used correctly and every time you have sex, significantly reduces your risk of getting a sexually transmitted disease and for an unplanned pregnancy as well. In addition to using a condom every time you have sex, you can further reduce your risk by having sex with fewer people. What would you like to do to reduce your risk?

Well Doc, I'm really not ready to have just one sex partner...I guess I need to think about using a condom more often.

How would you feel, how would you be affected, if you got HIV or got (got someone) pregnant?

Well, I really hadn't thought about it – but a baby is definitely something I don't want to deal with at this point in my life, and HIV – I sure don't want HIV.

What would be difficult about using a condom every time you have sex?

Well, I guess having them when I need them. I better start carrying them with me when I go out.

Do you have any at home now?

No – I don't. I guess I need to go and buy some or see if the pharmacy will give me some.

Condoms are also available at (Preventive Medicine / pharmacy / etc) and are sold in every Navy Exchange and local convenience store. Do you have any other concerns about your sexual health?

Nope.

I'm glad you've decided to get condoms now so you have them to carry with you the next time, and every time, you "go out". And I'm glad you've decided to use a condom every time you have sex to protect yourself, since inconsistent use places you at considerable risk. Do you feel you're able to do this now?

Yes Doc. I do. And I'll pick some up today.

Good. If you have any other questions or problems concerning condoms or your sexual health, do make an appointment to see me, or you may want to speak with our Preventive Medicine people. They're very helpful and can talk with you about condoms and other sexual health issues.

You're all set. Good luck.

Sexual Health and Responsibility Program (SHARP)

The **Sexual Health and Responsibility Program (SHARP)** is one of the teams within the Directorate of Health Promotion and Population Health of the Navy Environmental Health Center.

SHARP Mission

Provide Department of Navy (DoN) members and family members with health information, education, and behavior change programs for the prevention of sexually transmitted diseases (STDs), including HIV, and unplanned pregnancy.

SHARP Vision

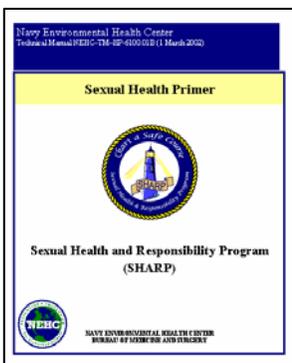
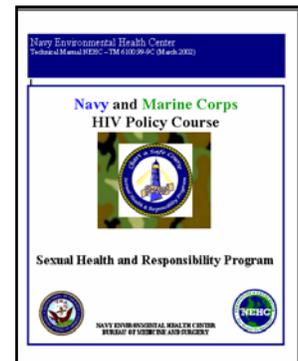
A DoN cultural norm in which sexual responsibility and safety is encouraged, supported, and expected, and a population in which all pregnancies are planned, syphilis is eliminated, and other STDs, including HIV are prevented.

SHARP Goal

Reduce the occurrence of STDs, including HIV, and unplanned pregnancy among DoN members and beneficiaries to levels specified in select Healthy People 2010 Objectives.

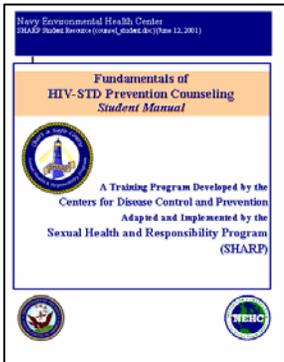
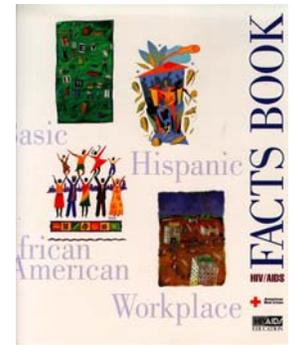
SHARP Instructor Training Sources

Navy and Marine Corps HIV Policy (previously known as “Navy HIV Instructor Course”) explains DoD and DoN policy regarding HIV. This course and the examination are available on the SHARP web site at <http://www-nehc.med.navy.mil/hp/sharp/education&training.htm>. SHARP issues a certificate of training to each person who completes the 38-question exam. Continuing education credit is awarded.



SHARP's Sexual Health Primer includes the impact of STDs and unplanned pregnancy, risk assessment and risk reduction counseling guidance for health care providers, “SHARP Facts” Fact Sheets on STDs; HIV testing; options for risk reduction; male and female condoms; talking to teens about sexual responsibility; and family planning. The manual may be downloaded from the SHARP website. SHARP issues a certificate of training to each person who completes the 50-question exam. Continuing education credit is awarded.

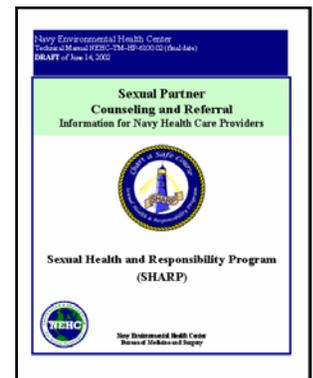
SHARP’s “HIV-AIDS Facts Quiz” is a resource and self-study course for health care professionals, including Nurses, Physicians, Preventive Medicine Technicians, Independent Duty Corpsmen, and Environmental Health Officers. These registered SHARP instructors receive a copy of the American Red Cross **Facts Book** to help them answer, in a culturally sensitive, non-judgmental way, the HIV-AIDS questions people in their community are likely to ask. SHARP issues a certificate of training to each person who completes the 50-question quiz.



Fundamentals of HIV-STD Prevention Counseling is a 2 day course for physicians, nurse practitioners, physician assistants, clinical and DoDDS school nurses, Preventive Medicine Officers and Technicians, Environmental Health Officers, Independent Duty Corpsmen, health promoters, and family service counselors – people tasked to counsel individual Sailors and Marines regarding sexual behavioral risk reduction. Based on Project RESPECT, a study which meets CDC’s HIV/AIDS Prevention Research Synthesis project criteria for relevance and methodological rigor and also has positive and significant behavioral/health findings. Intervention are based on the Theory of Reasoned Action and Social Cognitive Theory. Sessions are interactive

and designed to change factors that could facilitate condom use, such as self-efficacy, attitudes, and perceived norms. The intervention goal is to reduce high-risk behavior and to prevent new STDs. Project RESPECT Participants reported significantly higher condom use compared with participants in the comparison condition (didactic session). Of the counseling participants, 30% fewer had new STDs compared with participants in the didactic message condition. Continuing education credit is awarded.

Sexual Partner Counseling and Referral – Information for Navy Health care Providers is a reference manual and self-study course that covers the CDC’s 11-step model for bringing the sexual partners of infected patients to treatment. The manual may be downloaded from the SHARP website. SHARP issues a certificate of training to each person who completes the 33-question exam. Continuing education credit is approval is pending.



American Red Cross HIV Instructor Course –This training is conducted by American Red Cross Chapters. Students learn the facts about HIV and AIDS and learn how to conduct educational sessions for groups. Cost and availability vary somewhat by location. Contact your local Red Cross Chapter HIV/AIDS Training Coordinator for training opportunities in your area. A complete list of Red Cross Chapters is available on line at <http://www.redcross.org/hss/swan.html>.



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CME ACTIVITY EVALUATION

SHARP Sexual Risk Assessment (Bethesda CME Category 1 Approval #2001-124)

(Date) _____ (Location) _____

I. Please evaluate this educational activity as a whole by checking the appropriate box:

OVERALL EVALUATION						
	Excellent	Very Good	Good	Fair	Poor	N/A
Usefulness						
Quality						
Facilities/Management						
Registration						
Environment						
Audiovisuals						
Food & Beverage						

II. Course Objectives: Were the following course objectives met?

Course Objective	Yes	No
1. The student will be able to discuss sexual risk behavior with adolescent and adult patients		

III. General Comments

A. Do you feel the program was fair, balanced, and free from commercial bias?

YES NO

If NO, please state reasons: _____

B. Suggested topics and/or speakers you would like for future programs:

C. Did the presenters provide verbal disclosure? YES NO

D. Did presenters provide information regarding unapproved/off-label use of products?

YES NO

E. This Educational activity has contributed to my professional effectiveness and improved my ability to:

	Strongly agree			Strongly disagree	
• Treat/manage patients	1	2	3	4	5
• Communicate with patients	1	2	3	4	5
• Manage my medical practice	1	2	3	4	5
• Other:	1	2	3	4	5

HIV-STD Prevention Counseling Desktop Assistant

HIV-STD Prevention Counseling

Client-centered exchange designed to support people in making behavior changes that will reduce their risk of acquiring or transmitting HIV/STD

6 Steps of HIV-STD Prevention Counseling and some suggested open-ended questions

1. Introduce and Orient

- names
- duration of session
- purpose:
“We are here to talk about your risk of acquiring HIV or other STDs and ways you might be able to reduce that risk”

Risk Behavior

sex or drug-use behaviors that in of themselves can result in the transmission of HIV or other STD

2. Identify Risk Behaviors

“What are you doing in your life that might put you at risk of getting HIV and other STDs?”

“Tell me more about that”

“What were the circumstances?”

“Do you give/receive oral, anal, vaginal sex?”

“What are your experiences with drugs / alcohol?”

“How has your use of drugs / alcohol influenced your sexual behavior and your use of condoms and other safer behaviors?”

3. Identify Safer Goal Behaviors

How do you feel about getting this infection / getting an infection in the future?

How do you think this infection might affect your life / career / plans?

What have you done to protect yourself from infection in the past?

What do you think you could do to protect yourself in the future?

- ⇒ Support positive statements
- ⇒ Clear-up misconceptions
- ⇒ Offer other options / safer behaviors

Safer Goal Behaviors

Abstain from sex or delay sex
Outer-course vs. Intercourse
Monogamy

Condoms and other barriers

Reduced # of partners

Do not have sex with “high-risk” people
Do not share needles or “works”

Note: Use of drugs or alcohol can affect sexual behavior because of reduced inhibitions and clouded judgment.

4. Action Plan

What do you see as the advantages of doing [each safer goal behavior]?

⇒ Support positive statements

What do you see as the disadvantages of doing [each safer goal behavior]?

⇒ Offer ways to make this a positive

How will you do [the safer goal behavior]?

How will things be better?

⇒ Support positive statements

What about [the safer goal behavior] will be difficult for you?

5. Make Effective Referrals

“Would you like me to help you see someone about [the referral issue]?”

“How would you feel about coming back in a month to discuss your progress?”

6. Summary and Close

“Will you do [the safer goal behavior]?”

“Do you feel better able now to [do the safer goal behavior]?”

3 Selected Counseling Concepts

Focus on Feelings

In successful helping interactions, the focus must first be placed on how the client feels.

Until the counselor attends the client's feelings, the client will not hear much of what the counselor says.

Be willing to bring up, listen to, and respond to the client's feeling-level reactions, beliefs, and issues.

Manage Your Own Discomfort

Examine and know your own values and seek to understand how others feel.

Recognize your discomfort and manage it – don't let it become a barrier to communication with the client.

Set Boundaries

Both the counselor and the client must be in charge of their own lives.

Don't allow the client to make the counselor's behavior the focus of the session.

Counselor's should not assume responsibility for the client's behavior or expect to solve the client's problems – only the client can do these things.

4 Selected Counseling Skills

Open Ended Questions

Open-ended questions can't be answered with a simple "yes" or "no".

Be careful about using "why" questions – they may be received as threatening.

Use polite imperatives like "Tell me more about..."

Attending

Show the client you are listening through positive verbal and non-verbal cues.

Offer Options, Not Directives

Giving directives sets up a power struggle between the counselor and client.

Offer a "buffet" of all relevant options.

Avoid "You need to.." statements.

Give information Simply

Offer the client information that is relevant to their life circumstances and their risk behaviors.

Use terms and language the client can understand.

It's Okay to say "I don't know".

Selected Factors that Influence Behavioral Change

Knowledge – The client's understanding of how transmission happens and how it can be prevented.

Perceived Risk - Does the client feel at risk for HIV-STD?

Perceived consequences - What the client thinks will happen if he/she tries the safer behavior?

Access - Can the client get to the product/service needed for the safer behavior?

Skills - Can the client perform the safer behavior?

Self-efficacy - Does the client believe he/she can do the safer behavior?

Actual consequences - What has happened in the past when the client tried the safer behavior?

Attitudes - What is the client's general feeling about the new behavior?

Intentions - What does the client intend to do now?

Perceived social norms - What do the people in the client's life think about the safer behavior?

Policy - What laws encourage or inhibit the safer behavior?

Sexual Risk Assessment and Intervention

(July 2004)



Navy Environmental Health Center
Directorate of Population Health
Sexual Health and Responsibility Program (SHARP)

Navy Environmental Health Center



Ensure Navy and Marine Corps readiness through leadership in prevention of disease and promotion of health.

Navy Health Promotion Focus Areas

- Tobacco Use Prevention & Cessation
- Stress Management and Suicide Prevention
- Nutrition Education
- Weight Management
- Clinical Preventive Services/Clinical Epidemiology
- Sexual Health and Responsibility

SHARP Overview

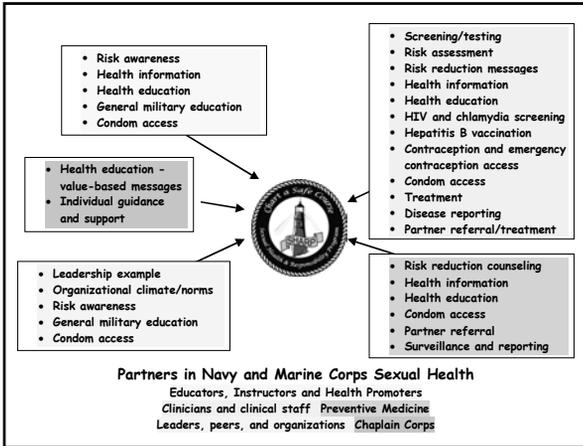


STD/HIV Directives

- SECNAVINST 5300.30 C
 - Establishes DON policy on identification, surveillance and administration of HIV
- SECNAVNOTE 5300
 - Defines Navy policy on HIV/AIDS training
 - Requires annual, 1-hr, all hands HIV education
- BUMED 6222.10A
 - STD Prevention and Control

Sexual Health

Intimate personal relationships free from coercion, violence, or risk of negative outcomes such as sexually transmitted disease or unplanned pregnancy.

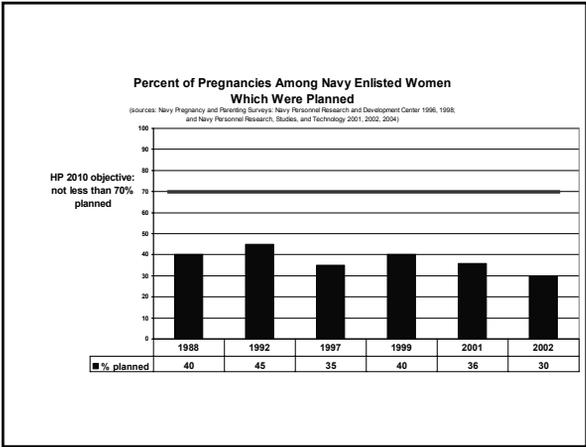


*HIV, STDs, and
 Unplanned Pregnancy
 in the Navy and Marine Corps*

some data...

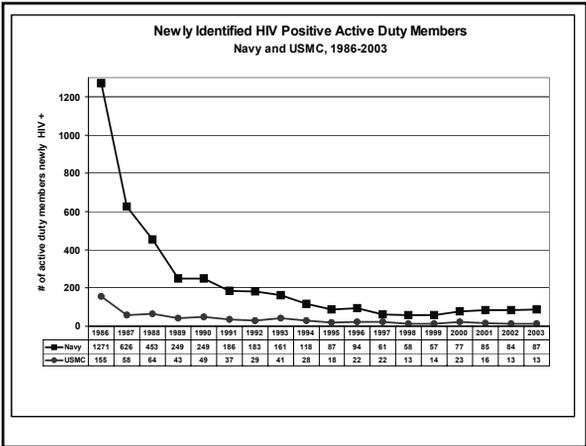
Unplanned Pregnancy in the Navy
 (2002 Navy Pregnancy and Parenting Survey, NPRST, unpublished as of 12 Apr 2004)

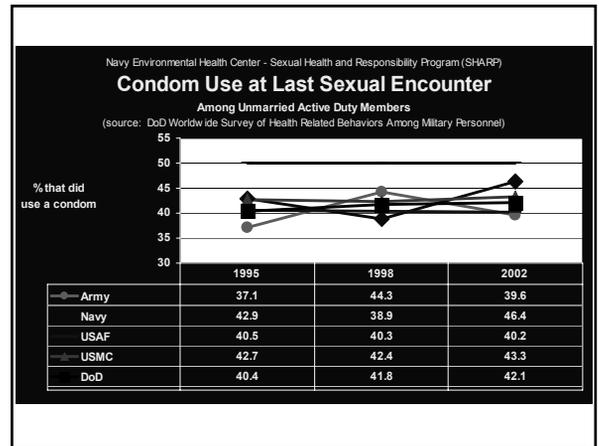
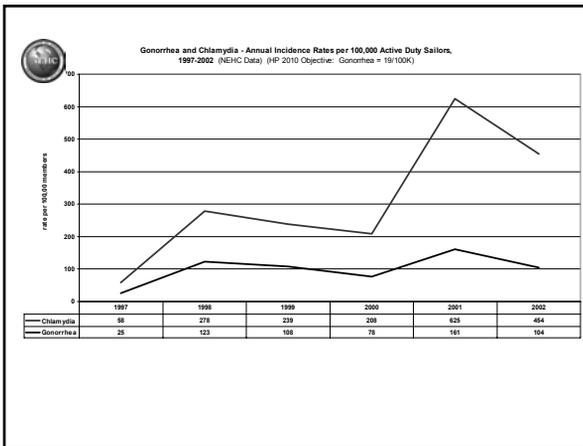
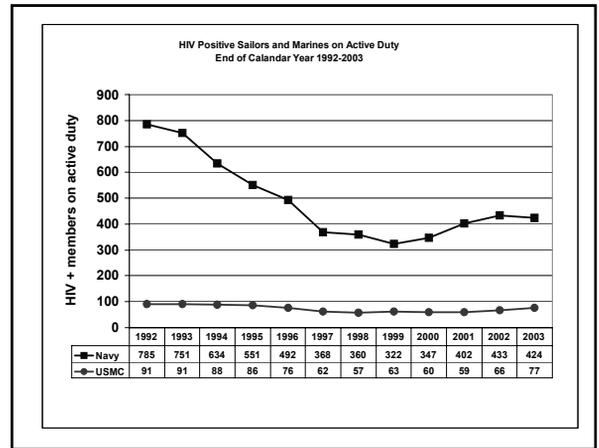
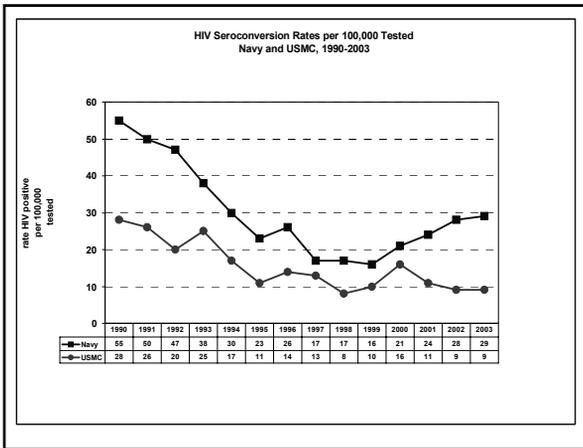
- In 2002, **55%** of all pregnancies among all active duty Navy women were unplanned
- Among enlisted active duty Sailors: **64%** in 2001



Unplanned Pregnancy in the Navy
 (TR-98-6, Sep 98, Navy Personnel Research and Development Center, San Diego)

- Why** Navy Women Who Had Unplanned Pregnancies in 1997 Did Not Use Birth Control
- “Rhythm method or withdrawal work well enough” **29%**
- “I am not sexually active” **24%**
- “I (or my partner) have been sterilized” **5%**
- “I (or my partner) am not fertile” **2%**
- Religious beliefs **2%**
- Other reason **38%**





Other Risk Behavior – Paying for Sex

- Trading money or drugs for sex is high risk
 - What % of Sailors and Marines said they paid for sex during a 6-month deployment
 - Enlisted?
 - Officer?
- (study period 1989-1991)

Risk Behavior Summary

- Sailors and Marines do
 - not usually wear a condom
 - not always use condoms correctly
 - sometimes pay for sex
 - become infected with HIV and other STDs
 - experience unplanned pregnancies
- Your patients can benefit from a risk assessment and discussion

STD Trends

- U.S. has the highest STD rate in the industrialized world
- In 2000, 32% of new HIV infections in the US were women.
- The number one cause of death for Black American males age 25 to 44 is AIDS.

“Curable” STDs

- Chlamydia: 3 Million
- Gonorrhea: 650K
- Syphilis: 70K
- Trichomonas: 5 Million

Chronic STDs

- **Herpes Simplex-2**
 - 1 million new cases/yr.
 - 45 million infected
- **Hepatitis B**
 - 77 K new cases/yr.
 - 750 K chronic (sexual transmission)
- **HPV**
 - 5.5 million new cases/yr.
 - 20 million actively shedding virus
- **HIV**
 - 40 K new cases/yr.
 - 650 K AIDS
 - 4786 Sailors and Marines (thru 2001)

STDs: What are the costs?

- 15.3 million new STDs annually
- Direct medical costs of \$8.4 Billion
- Indirect costs
 - Pain and suffering
 - Physical and emotional trauma

Impact of STDs on US Population

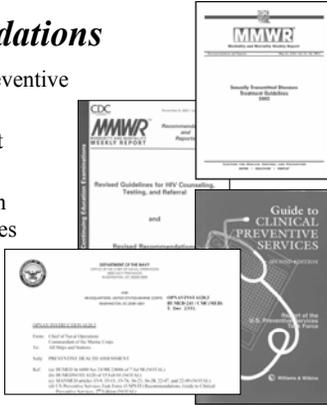
- **Infants**
 - premature, low birth weight, conjunctivitis, pneumonia, congenital defects
- **Women**
 - infertility, tubal pregnancy, cervical cancer
- **Teens and Young Adults**
 - higher STD rate
 - young females: immature cervix

Clinical Preventive Services (CPS)

- **Key Areas for Sexual Health within CPS:**
 - Screening for STDs and HIV
 - Counseling to Prevent STDs and Unplanned Pregnancies
 - Immunization Against Viral Hepatitis

Recommendations

- Guide to Clinical Preventive Services
- CDC STD Treatment Guidelines
- CDC HIV Prevention Counseling Guidelines
- OPNAV 6120.3



Realities...

1. True or False - Most adult patients are not asked about their sexual health during routine visits with their health care provider.
2. According to a 2000 survey reported in the AmJ of PrevMed (Vol 18, No 12), what percentage of adults who had a routine check-up in the past year reported being asked about STDs during that visit?

Topics asked during routine check-ups

within the past year, U.S. adults, aged 18-64
1994 National Health Interview Survey - Am J Prev Med 2000;18(2):109-114)

Topic	% patients asked
• Smoking	58.7
• Physical exercise	52.3
• Alcohol	49.3
• Diet	43.8
• Contraceptives (aged 18-50)	36.1
• Illegal drugs	31.3
• STDs	27.9
	single: 33.9
	married: 24.1
	aged 18-24: 38.4

Barriers to Effective Counseling

- Lack of training in sexual risk behavior counseling
- Lack of time
- Perception of non-relevance
- Physician embarrassment
- Fear of offending the patient

Your patient wants to talk...

- Clinician Barrier: fear of offending the patient
- Patient Barrier: waiting for clinician to ask...

What to talk about – Taking a sexual history

- How many partners?
- What kind of sex?
 - vaginal, oral, anal (receptive/insertive)
- Use of latex barriers?
 - Consistent? / Correct?
- How do drugs / etoh influence sexual activity?
- STDs in the past?
- Current / chronic STDs / HIV?

Risk-Reduction Recommendations

- **Abstinence**
- **Monogamy**
- **Non-penetration (Outercourse)**
- **Condoms and other barriers**
- Reduce number of partners
- Evaluate/reject high risk partners (STD/HIV/drug use)

Why people say they didn't use condoms...



**Correct
and
Consistent**

Risk-Reduction Recommendations

- Abstinence
- Monogamy
- Non-penetration (Outercourse)
- Condoms and other barriers
- **Reduce number of partners**
- **Evaluate/reject high risk partners (STD/HIV/drug use)**

Clinical Preventive Services in action (or "Putting Prevention Into Practice")

- A Brief Clinical Intervention



Project Respect

- Theoretically Based
 - Theory of Reasoned Action
 - Social Cognitive Theory
- Reduce Re-infection rate by 30%
- Significantly increased condom use

Counseling Concepts

1. Focus on Feelings
2. Manage your own Discomfort
3. Set Boundaries

Counseling Skills

1. Open Ended Questions
2. Attending
3. Offer Options, Not Directives
4. Give Information Simply

Six Steps of Prevention Counseling

1. Introduction and Orientation
2. Identify patient Risk Behaviors and Circumstances
3. Identify Safer Goal Behavior
4. Develop a Personal Action Plan
5. Make Effective Referrals
6. Summarize and Close

1. Introduction and Orientation

Describe the purpose and duration of the session and respective roles.

“Now that we’ve taken care of your (chief complaint), we have a couple minutes we can spend talking about keeping you healthy. Let me ask about your sexual health. – about how many people have you had sex with over the past 6 months?”

2. Identify Patient Risk Behavior and Circumstances

With the patient, identify specific behaviors, situations, and partner encounters that place him or her at risk.

3. Identify Safer Goal Behavior(s)

Identify specific actions that directly prevent or greatly reduce STD transmission which the patient is willing and able to try to adopt.

Example of Safer Goal: use condoms each and every time he/she has sex (if not in a monogamous relationship)

4. Develop a Personal Action Plan

Identify concrete, incremental steps the patient can take to achieve the goal behavior(s).

Example of steps: carry condoms whenever going out, don't get drunk, learn to negotiate condom use with partner

Scenario: William

Background: Single, 30 year-old Marine. Concerned about symptoms and "special" woman. Buddies concerned he's "out of control".

Risk Behavior: Unprotected vaginal and oral sex with multiple partners.

Circumstances: Sex with anonymous partners while TAD, drinking. Sometimes pays for sex. Sex with "special" woman at home.

Previous Successes: Has used condoms in past with when partner "just put it on".

Safer Goal Behavior: Wants monogamy with "special" woman or condom use if this intention fails.

Barriers

Doesn't like condoms (lowers sensitivity / ruins the mood).

- What could William do?
- What could the provider do to support William?

Barriers

Wouldn't know how to bring up condom use – little experience.

- What could William do?
- What could the provider do to support William?

Barriers

Wouldn't want to lose sex partners because they don't like them.

- What could William do?
- What could the provider do to support William?

Barriers

Doesn't want to give up sex while deployed – too long to wait.

- What could William do?
- What could the provider do to support William?

Barriers

Alcohol sometimes takes over – loses control.

- What could William do?
- What could the provider do to support William?

Benefits

- Would not have to worry about infecting his special woman or about losing her by getting caught.
- Would not have to “pay” for sex anymore
- Would avoid getting HIV and affecting his career.

What could William do?
What could the provider do to support him?

5. Make Effective Referrals

Providers need to be familiar with other services and sources of help to assist patients with other needs or to provide more extensive assistance.

6. Summarize and Close

A supportive, concise statement that briefly describes what has been discussed and restates the commitment for risk reduction, referrals, and next steps.

Demonstration

Conclusion

1. Sexual risk assessment of every adult and adolescent patient is recommended by CDC, USPSTF, DoD, and DoN
2. Sailors and Marines
 - engage in risk-taking behavior
 - need to hear your risk assessment
 - want to talk to you about sex and AIDS
 - can adopt safer behaviors with your patient-centered help
3. You have trained referral help (PMTs, some IDCs)



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Sexual Health and Responsibility Program (SHARP)
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e-mail: sharp@nehc.med.navy.mil
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SHARP Vision:

**A DoN cultural norm in which
sexual responsibility and safety
is encouraged, supported, and expected,
and a population in which
all pregnancies are planned,
Syphilis is eliminated,
and other STDs, including HIV are prevented.**