

## Sexual Risk Assessment and Intervention in the Outpatient Setting



## Sexual Health and Responsibility Program (SHARP)



Navy Environmental Health Center  
Bureau of Medicine and Surgery



## Foreword

This document is a student handout used in conjunction with the SHARP lecture “Sexual Risk Assessment in the Outpatient Setting”. 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:

Navy Environmental Health Center  
Directorate of Health Promotion and Population Health  
Sexual Health and Responsibility Program (SHARP)  
620 John Paul Jones Circle, Suite 1100  
Portsmouth VA 23708-2197  
Internet: [www-nehc.med.navy.mil/hp/sharp](http://www-nehc.med.navy.mil/hp/sharp)  
voice: (757) 953-0974 [DSN 377]

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

## Table of Contents

Foreword.....	1
Learning Objectives.....	3
Continuing Education Credit.....	4
The Impact of Sexually Transmitted Diseases and Unplanned Pregnancy.....	5
Sexual Health and Responsibility Program.....	12
Risk Assessment and Risk Reduction Counseling – Guidance and Training for Health Care Providers.....	14
Attachments:	
Lecture Evaluation Form.....	20
HIV-STD Prevention Counseling Desktop Assistant.....	21
PowerPoint Slides.....	23

## 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

Physicians may claim **1.5** credit hours in Category II of the Physician's Recognition Award.

### Nurse Corps

Educational Activity I credit of **1.8** contact hours has been approved by the Naval School of Health Sciences, Bethesda, which is accredited as an approver of continuing education by the American Nurses Credentialing Center Commission on Accreditation. The accreditation approval number is **010814I** (expires Aug 2003).

### Navy Independent Duty Corpsmen

The accreditation approval number is 53/02-9013.

### Certified Environmental Health Technicians / Registered Sanitarians

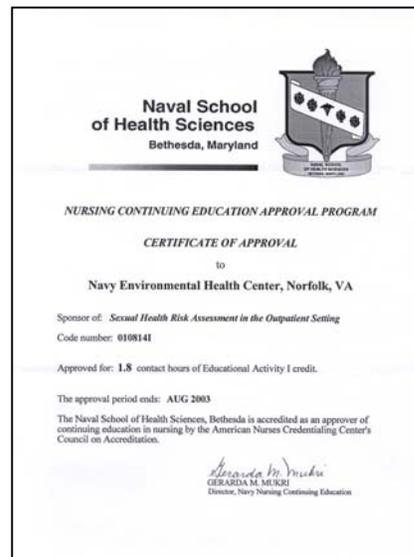
This course has been approved by the National Environmental Health Association (NEHA Letter 8 Feb 2002) for 14 contact hours of continuing education credit.

### Other Professions

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

**To apply for Nursing Continuing Education Credit, course facilitators** should send the following information to Commanding Officer, Naval School of Health Care Sciences- Bethesda Code OP2, 8901 Wisconsin Ave. Bethesda, MD 20889-5611 (copy to NEHC-SHARP):

1. Student roster.
2. A report including these data:
  - Sponsoring Command.
  - Title of CE Activity: "Sexual Risk Assessment and Intervention in the Outpatient Setting".
  - Inclusive Dates.
  - Number of Nurse Corps Officers.
  - Number of Civilian RNs.
  - Total Number of participants.
  - Number of participants completing the evaluation.
  - Strengths and weaknesses of the CE activity as identified by the participants and by the faculty.List planned changes for subsequent offerings or programs based on the evaluations.
  - Was the overall goal of this activity achieved? \_\_\_ Yes \_\_\_ No
  - Name, date, and signature of report author.



## 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).

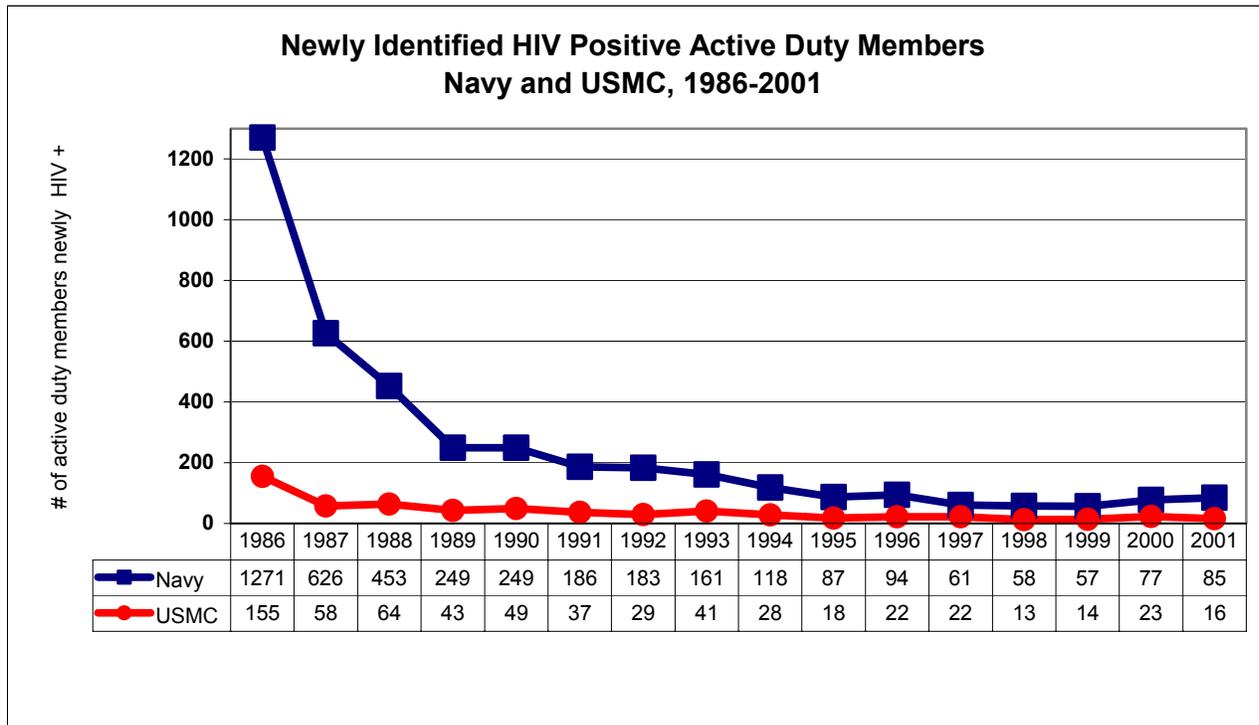
Evidence indicates that infection with some STDs other than HIV increases the likelihood of both transmitting and acquiring HIV infection. The Centers for Disease Control and Prevention (CDC) estimates that 1 in 300 Americans are infected with HIV, and suggests the incidence of AIDS to be increasing 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 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.

From 1985, when HIV testing in the Department of Defense began, through 31 December 2001, there have been 4,786 documented cases of HIV infection among U.S. Navy and Marine Corps active duty personnel. Among active duty members of the Navy and Marine Corps, HIV infections have occurred in members of all racial groups, all age groups, officer and enlisted, males and females (NNMC Bethesda, 2002).

Newly identified cases of HIV infection among active duty Sailors and Marines from 1986-2000 are shown below. Note that this graph plots newly *identified* infections, not necessarily newly *acquired* infections. The distinction is important, particularly in the early two or three years,

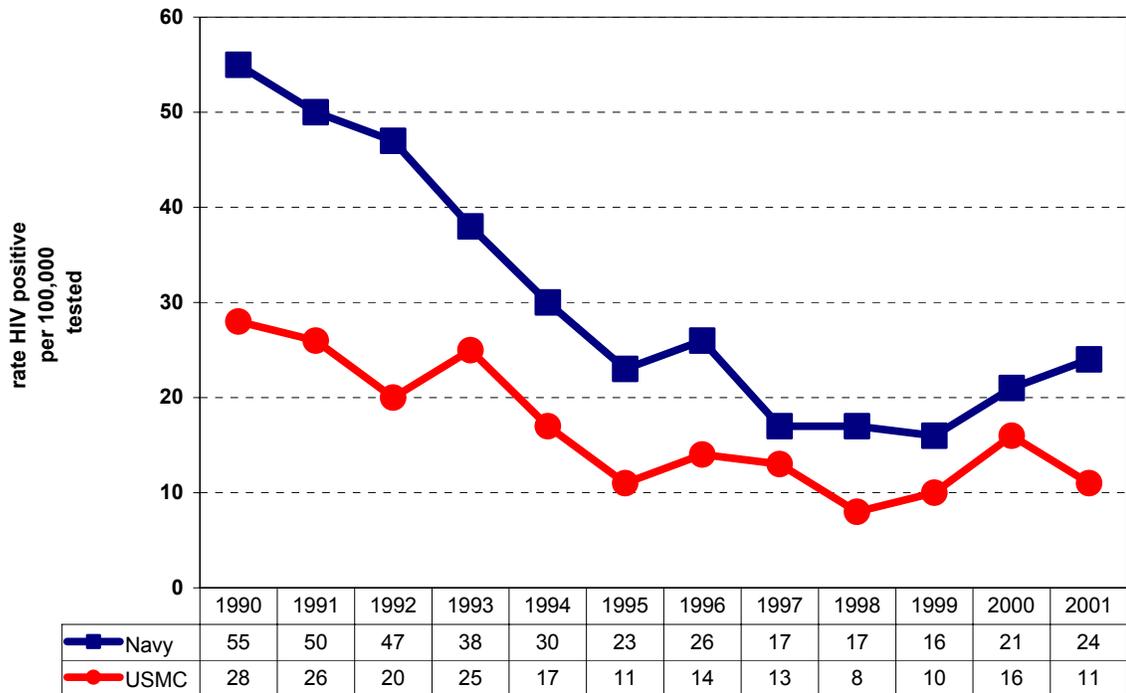
where the number of positive members is more an indication of pre-existing plus newly acquired HIV infection (prevalence). Predictably, the first few years of testing identified higher numbers of HIV positive members. Since all new accessions into the Navy and Marine Corps are screened for HIV infection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



HIV screening policies are given in DoD Directive 6485.1 (for all of the military services) and in Secretary of the Navy Instruction (SECNAVINST) 5300.30C (for Navy and Marine Corps members). SHARP’s self-study course “Navy and Marine Corps HIV Policy” provides a more detailed discussion of DoN HIV policies.

HIV seroconversion rates (newly identified HIV positive people per 100,000 tested) among active duty members of the Navy and Marine Corps from 1990-2001 are shown below. Over the period of a dozen years, these rates ranged from a high of 55 (Navy, 1990) to a low of 8 (Marine Corps, 1998). In 2001, HIV seroconversion rates among Marines fell from 16 to 11, while rates among Sailors rose from 21 to 24.

**HIV Seroconversion Rates per 100,000 Tested  
Navy and USMC, 1990-2001**



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 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).

In the Navy and Marine Corps, unplanned pregnancy rates parallel civilian rates for age cohorts. A 1996 study (Navy Personnel R&D Center, 1998) found that 65% of pregnancies among enlisted women were unplanned. In 1999, a similar survey of Navy enlisted women saw some improvement, with 60% of pregnancies 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 20<sup>th</sup> week of gestation, Navy studies have found that many (but less than half) 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).

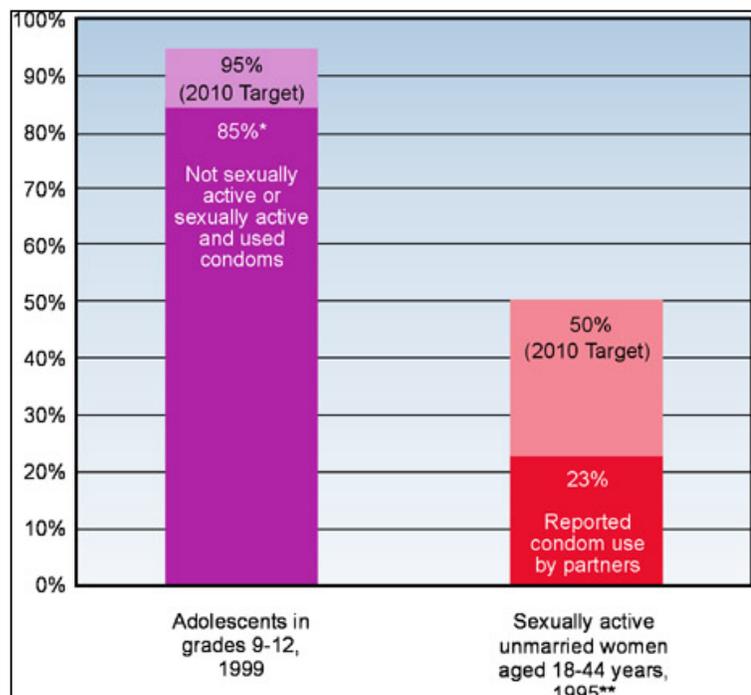
### Prevention.

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.

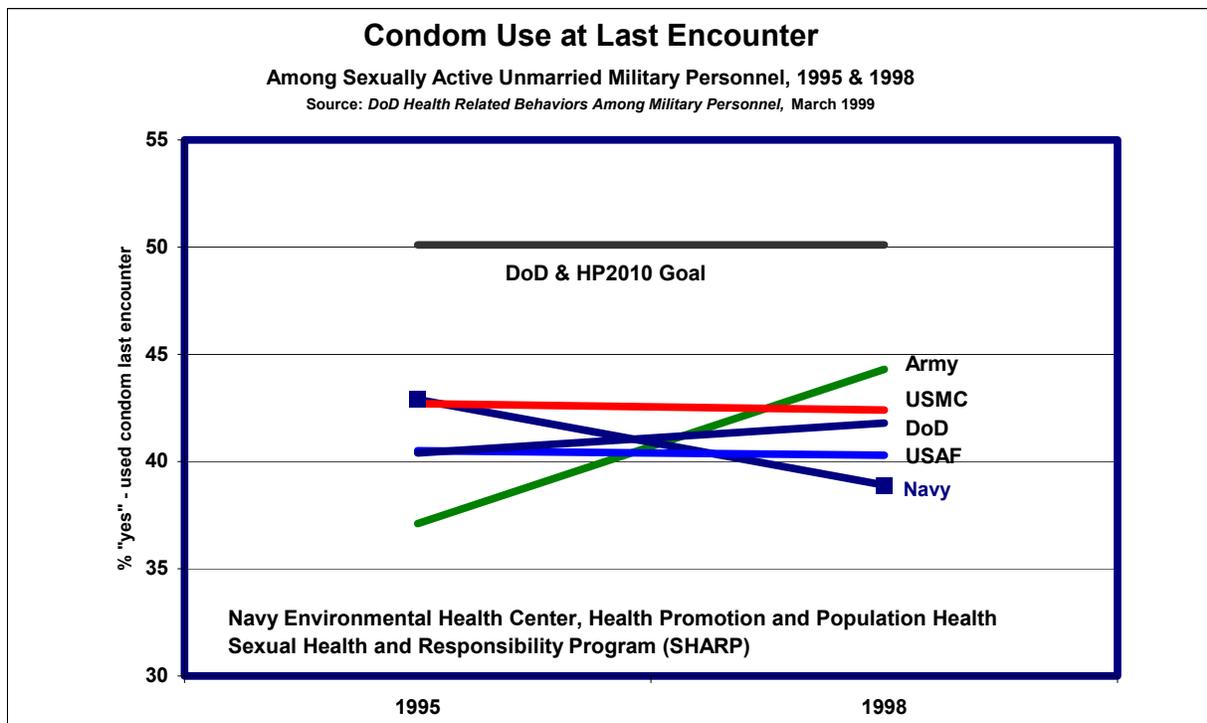
Considering these three components, prevention strategies for all STDs would include the first two components since the prevention of HIV transmission is closely related to the prevention of other STDs. ***For those individuals who choose to engage in sexual activity, increasing condom usage appears 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 can be expected to provide different levels of risk reduction for different STDs. There is no one definitive study about condom effectiveness for all STDs. Several studies have demonstrated that condoms can protect against the transmission of 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. In addition, definitive data are lacking regarding the degree of risk reduction that latex condoms provide in preventing transmission of chancroid and genital HPV. It is important to note that the lack of data about the level of condom effectiveness indicates that more research is needed – not that latex condoms don’t work” (STD Advisor, 2001).



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). In 1998, among unmarried, active duty Sailors and Marines, condoms were reportedly used during the last sexual encounter by only 38.9% and 42.4%, respectively. Further, more than half of all military personnel who had one or more casual partner used condoms inconsistently if they used them at all (Bray, 1998). The national target for condom use at last sexual encounter is 50% (USDHHS, 2000).

American Social Health Association (1999). *STDs in America – How Many and at What Cost*, Research Triangle Park, NC.

Bray, R.M., Sanchez, R.P., Ornstein, M.L., Lentine, D., Vincus, A.A., Baird, T.U., Walker, J.A., Whelless, S.C., Guess, L.L., Kroutil, L.A., & Iannacchione, V.G. (1999). *1998 Department of Defense survey of health related behaviors among military personnel* (RTI/7034/006-FR). Research Triangle Park, NC: Research Triangle Institute, NC.

Center for Health Policy Studies (2000). *Final Report. Tri-Service study of HIV education and prevention needs in the U.S. military*, January 28, 2000. Center for Health Policy Studies, Columbia, MD.

Centers for Disease Control and Prevention (2002). *Sexually Transmitted Disease Treatment Guidelines-2002*. *MMWR* 51:RR-6, Author, Atlanta, GA.

Centers for Disease Control and Prevention (2000). *Sexually Transmitted Disease Surveillance, 1999*. Author, Atlanta, GA.

Cohen, M.S., Dallagetta, G., Laga, M., Holmes, K.L. (1994). A new deal in HIV prevention: lessons from the global approach. *The New England Journal of Medicine* 333(15), 1072-1078.

Garland, F.C., Gorham, E.D., Miller, M.R., Hickey, T.M., & Balaza, L.L. (1990). Cross-sectional demographic characteristics of human immunodeficiency virus seropositive Navy and Marine Corps active-duty personnel (Report No. 90-3). Naval Health Research Center, San Diego, CA.

Kaiser Family Foundation (2001). *The AIDS Epidemic At 20 Years, The View From America*. Henry J. Kaiser Family Foundation, Menlo Park, CA, 52-57.

National Navy Medical Center, Bethesda 2002. Incidence Rate of HIV Seroconverters, 1990-2001 (unpublished data provided to NEHC 14 Feb 2002), Wash. D.C.

Navy Environmental Health Center. (1999). Reported communicable diseases in active Navy and Marine Corps personnel: 10 year report, 1988-1997. *Naval Medical Surveillance Report* (pp. 13-18). Author, Norfolk, VA.

Navy Personnel Research and Development Center (1998). *Pregnancy and Single Parenthood in the Navy: Results of a 1997 Survey* (TR-98-6), San Diego, CA

Public Health Service (1998). *Clinicians Handbook of Preventive Services*, Department of Health and Human Services, Atlanta, GA

STD Advisor (2001). CDC issues condom guidance for HIV, HPV, and other STDs. 4:6;66-67

Tou, Irwin, and Kassler (2000). Missed Opportunities to Assess Sexually Transmitted Diseases in U.S. Adults During Routine Medical Checkups, *Am J of Prev Med* 2000;18(2):109-114

U.S. Department of Health and Human Services (2000). *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

US Preventive Service Task Force (1996). *Guide to Clinical Preventive Services*, 2nd ed., Baltimore: Williams & Wilkins

## 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

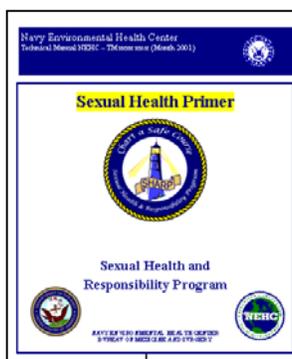
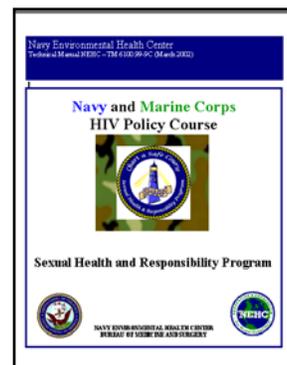
A DoN cultural norm in which sexual responsibility and safety is encouraged, supported, and expected, and a population in which all pregnancies are planned, syphilis is eliminated, and other STDs, including HIV are prevented.

### 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.

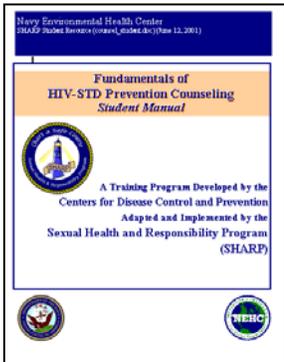
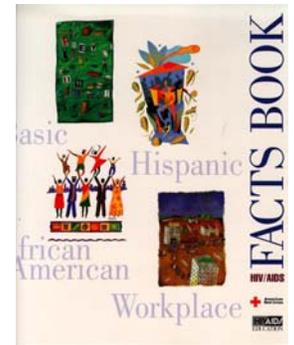
## SHARP Instructor Training Sources

**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.



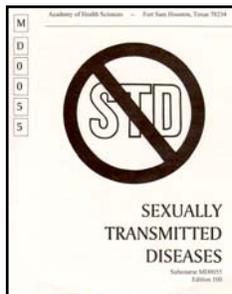
**SHARP's Sexual Health Primer** includes the impact of STDs and unplanned pregnancy, risk assessment and risk reduction counseling guidance for health care providers, “SHARP Facts” Fact Sheets on STDs; HIV testing; options for risk reduction; male and female condoms; talking to teens about sexual responsibility; 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.



Navy people can also enroll in the **US Army “Sexually Transmitted Disease”** correspondence course. This one-volume self-study course is available at no cost. SHARPNews Vol 2 No 10 contains a fax-ready enrollment form and more information. You’ll find a link to it on the SHARP website at <http://www-nehc.med.navy.mil/hp/sharp/shrpnws.htm>.

**American Red Cross HIV Instructor Course** –This training is American Red Cross Chapters. Students learn the facts about AIDS and learn how to conduct educational sessions for groups. availability vary somewhat by location. Contact your local Red 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>.



conducted by HIV and Cost and Cross

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

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. 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.

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 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.

blank page

## Sexual Health Risk Assessment Lecture Evaluation

(Note: completion of this form and the attached “CME Activity Evaluation” is required for students applying for **AMA** continuing education credit, such as physicians)

Please provide feedback on this course by mail, fax, or e-mail

**e-mail:** [macdonaldb@nehc.med.navy.mil](mailto:macdonaldb@nehc.med.navy.mil)

**voice:** (757) 953-0974; DSN 377

**fax:** (757) 953-0688; DSN 377

Navy Environmental Health Center, ATTN: HP/SHARP  
620 John Paul Jones Circle, Suite 1100, Portsmouth VA 23708

Date: \_\_\_\_\_ Lecture Location: \_\_\_\_\_

### Optional:

Name (optional) \_\_\_\_\_

Duty Phone: \_\_\_\_\_ Professional Affiliation \_\_\_\_\_ (i.e. RN, M.D., etc)

E-mail address: \_\_\_\_\_

**Suggestions for improving this course** (continue on reverse):

How helpful was the material in helping you to achieve the overall learning objective:

**“The student will be able to discuss sexual risk behavior with adolescent and adult patients.”**

**not helpful**

**helpful**

**very helpful**

(Completion of this standard form is required for students applying for **AMA** continuing education credit, such as physicians and physician assistants)

**CME ACTIVITY EVALUATION**

SHARP Sexual Risk Assessment \_\_\_\_\_

(Name of Activity)

(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
<b>1. The student will be able to discuss sexual risk behavior with adolescent and adult patients</b>		

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 Health and Responsibility Program (SHARP)



Navy Environmental Health Center  
Directorate of Health Promotion and Population Health  
www-nehc.med.navy.mil/hp/sharp  
(757) 953-0974 [DSN 377]

## Sexual Risk Assessment and Intervention in the Outpatient Setting

(11 June 2002)



## Put Prevention Into Practice

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

## Sexual Health

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

## 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

## STD Trends

- U.S. has the highest STD rate in the industrialized world
- Earlier age of sexual initiation

*If you don't know where you're heading,  
you'll probably never get to where you want  
to go...*

## 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

## 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
  - 4680 Sailors and Marines (thru 200)

## Barriers to Effective Counseling

- Lack of Training in Sexual Risk Behavior Counseling
- Lack of Time

## Recommendations

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



## 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
• <b>STDs</b>	<b>27.9</b>
	single: 33.9
	married: 24.1
	aged 18-24: 38.4

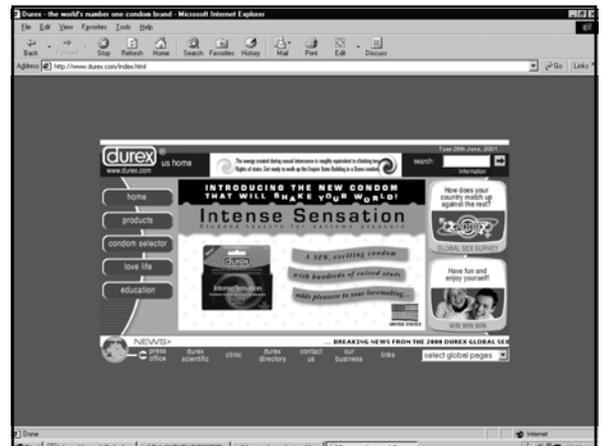
## Sexual History

- Number of partners/frequency
- Type of practices
  - vaginal, oral, anal (receptive/insertive)
- Use of latex barriers
  - consistency/correctness
- Drug or alcohol use and sexual activity
- STD history/current status of 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...**



## 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 Client 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 have taken care of your chief complaint, let’s talk about your risk of acquiring HIV or other STDs and way you might be able to reduce that risk”*

#### **2. Identify Client 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 client can take to achieve the goal behavior(s).

*Example of steps: carry condoms whenever going out, don't get drunk, learn to communicate techniques for 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 counselor do to support William?

### Barriers

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

-What could William do?

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

## Barriers

Alcohol sometimes takes over – loses control.

- What could William do?
- What could the counselor 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 counselor 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**

**Sexual health and Responsibility Program (SHARP)  
Navy Environmental Health Center  
Directorate of Health Promotion and Population Health  
[www-nehc.med.navy.mil/hp/sharp](http://www-nehc.med.navy.mil/hp/sharp)  
(757) 953-0974 [DSN 377]**