

# Emerging Issues in Sexually Transmitted Diseases



## Focus on the Treatment of STDs in Military Populations

March 27, 2013



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**Centers for Disease Control and  
Prevention**



# Learning Objectives

- **Discuss clinical significance of the sexual health/clinical issue.**
- **Describe epidemiological trends related to the sexual health/clinical issue.**
- **Identify key screening and treatment recommendations for management of the sexual health/clinical issue, in accordance with CDC 2010 STD Treatment Guidelines.**
- **Promote health improvement, wellness, and disease prevention in cooperation with patients, communities, at-risk populations, and other members of an interprofessional team of health care providers.**

# Presenters



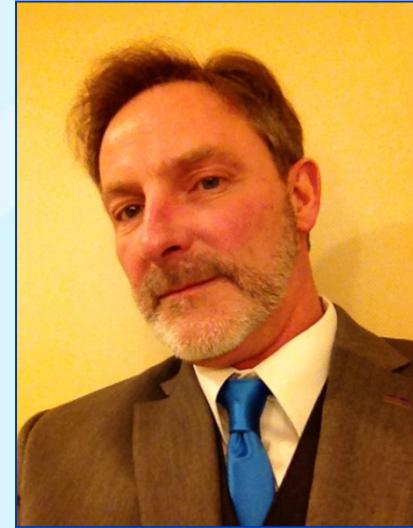
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Navy and Marine Corps  
Public Health Center

# Webinar Overview

- **Epidemiology of STDs in U.S. military populations**
- **Diagnostic and management challenges for specific STDs among U.S. military populations**
- **2010 STD Treatment Guidelines relevant to U.S. military populations**
- **Additional resources relevant to clinicians working with U.S. military populations**
- **Question and answer session**

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MAJ, MC, USA**

Deputy Director,  
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# Disclosures

- Views expressed are my own and do not necessarily reflect the views of the U.S. Department of Defense, The Department of the Army, or the US Army Public Health Command.
- All data reported was collected as part of routine public health surveillance and does not represent human subjects research.

# Outline: Epidemiology of Sexually Transmitted Infections in the U.S. Military

1. Military STI ecology: Why so much disease?
2. Review of basic demographics of our Active Duty (AD) population
3. Describe health risk behavior in the active duty military
4. Describe the distribution of chlamydia and gonorrhea across the military
5. Primary and secondary syphilis in the military
6. Review the current status of HIV in the military
7. Issues of military deployment

# Ecology of Military STIs

- Population is made up of higher risk demographics
- Military service generates a complex ecology for STI transmission
  - Accession into the military with STIs
  - “Culture of Machismo”
  - Worldwide deployment
  - Leave/holiday travel (bridging)
  - Coupling between multiple interrelated communities
  - Diverse care seeking behaviors
- Despite similar demographic risk factors to the general population, key difference is that the US military population has easy access to free care and a well resourced public health community



# Sexual Health Behavior in the Military

- Condom use:
  - 36% of sexually active, unmarried service women reported condom use at last intercourse (2005)\*
  - 2008 Army survey: 70% did not use condoms regularly\*\*
- Multiple sex partners:
  - 27% >1 partner in last 90 days in female army recruits †
  - 2011 veterans study: 42% reported partners with concurrent sexual partners while active duty ††
- Binge Drinking
  - 33% of service women reported binge drinking in last 30 days
  - 24% of veterans reported unintended sex after drinking alcohol

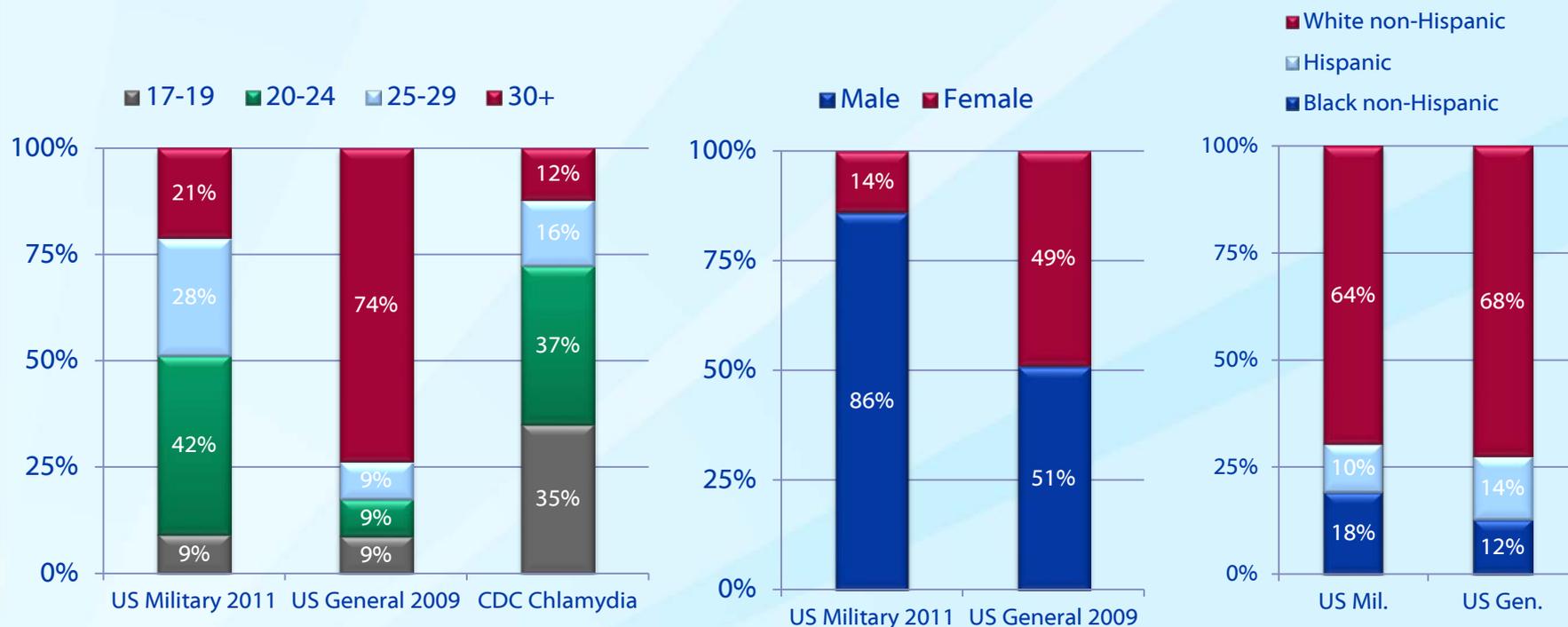
\* DoD Survey of Health related Behaviors. 2006 [www.ha.osd.mil/special\\_reports/2005\\_Health\\_Behaviors\\_Survey\\_1-07.pdf](http://www.ha.osd.mil/special_reports/2005_Health_Behaviors_Survey_1-07.pdf)

\*\* von Sadvoszky et. al., Women's Health Issues 2008;18:174-180

† Gaydos et al., N Engl J Med 1998;339:739-744

†† Sadler et al., J WomensHealth 2011;20:1693-1701

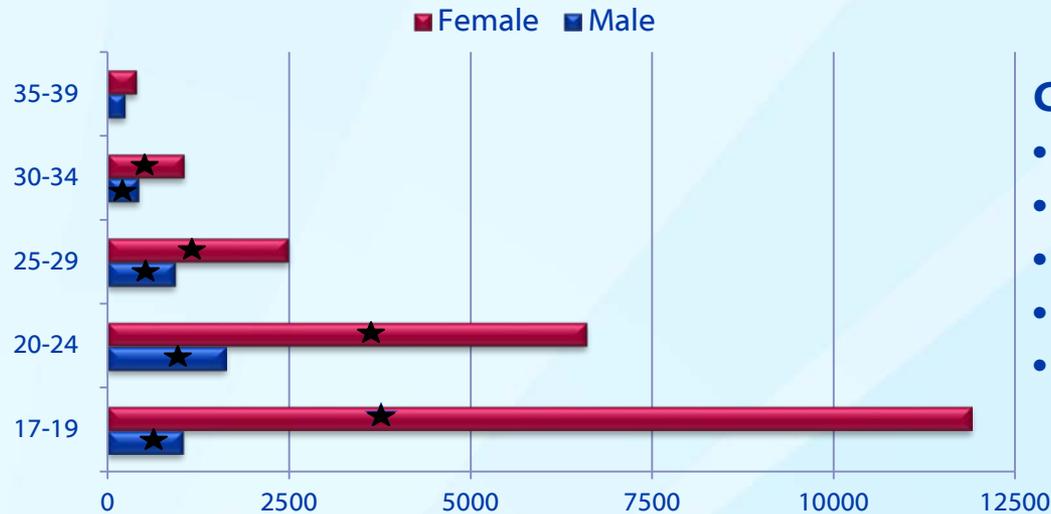
# US Military Baseline Demographics



1. US military is a young population organization
2. US military is predominantly male
3. Ethnicities similar to general U.S. population

What does this mean for STI risk?

# Genital CT and GC Incidence (2011): Gender / Age



## Chlamydia

- Greatest burden in females
- Highest risk different by gender
- IRR (high vs. low risk) F= 29 M=6.7
- Screening bias present age/gender
- Rates for all age groups greater than civilian rates from same demographic



## Gonorrhea

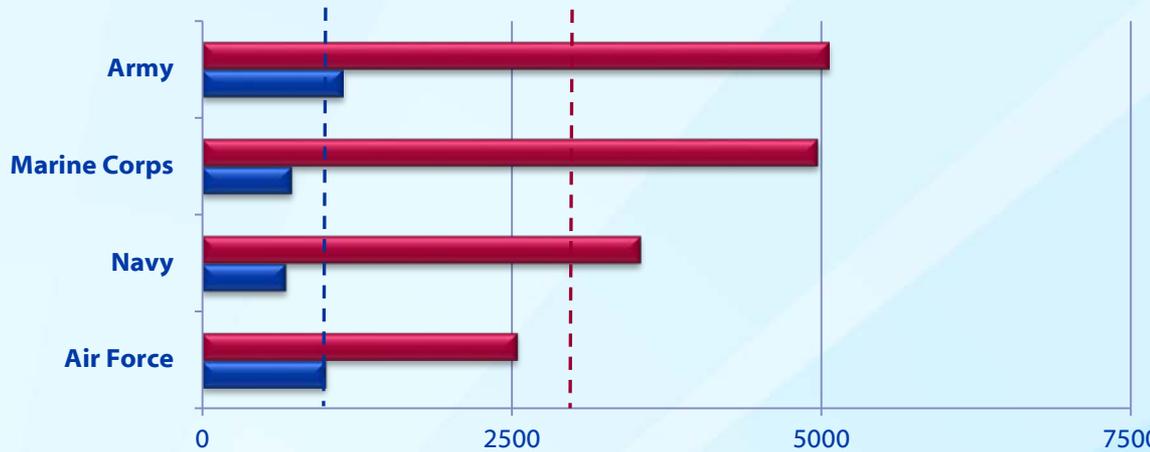
- Greatest burden for younger females
- IRR (high vs. low risk) F=15 M=4.2
- Rates in military females higher than civilians
- Rates in military males lower than civilians

\* U.S. rates for 2009 population from CDC, WONDER database

Stars (★): strata specific US population rates

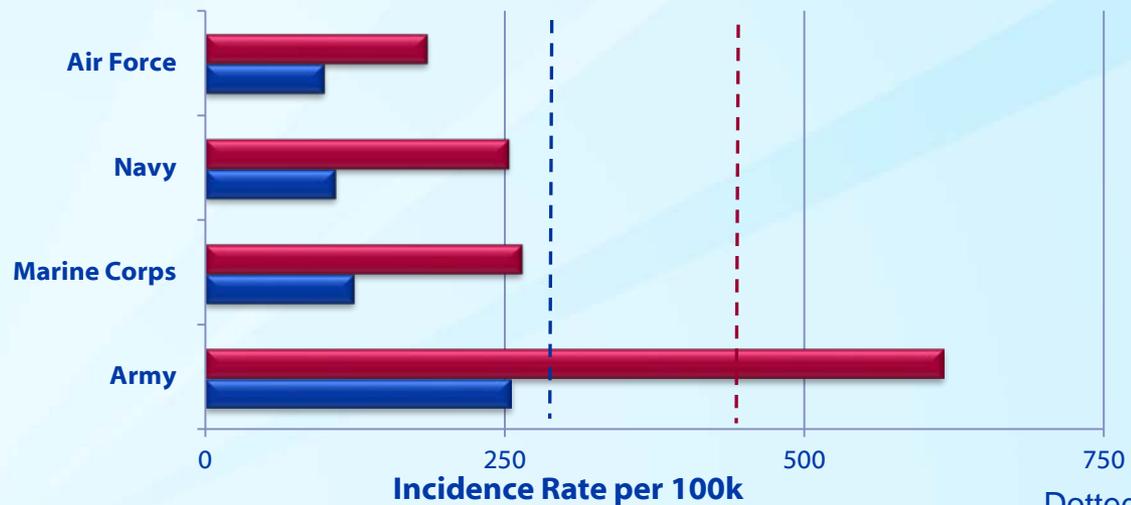
# Genital CT and GC Incidence (2011): Military Branch of Service

■ Females ■ Males



## Chlamydia

- U.S. Army with highest rates
- Marines with comparable rates
- Men in all services with similar rates of genital chlamydia
- Female Army/Navy/Marines > US rates

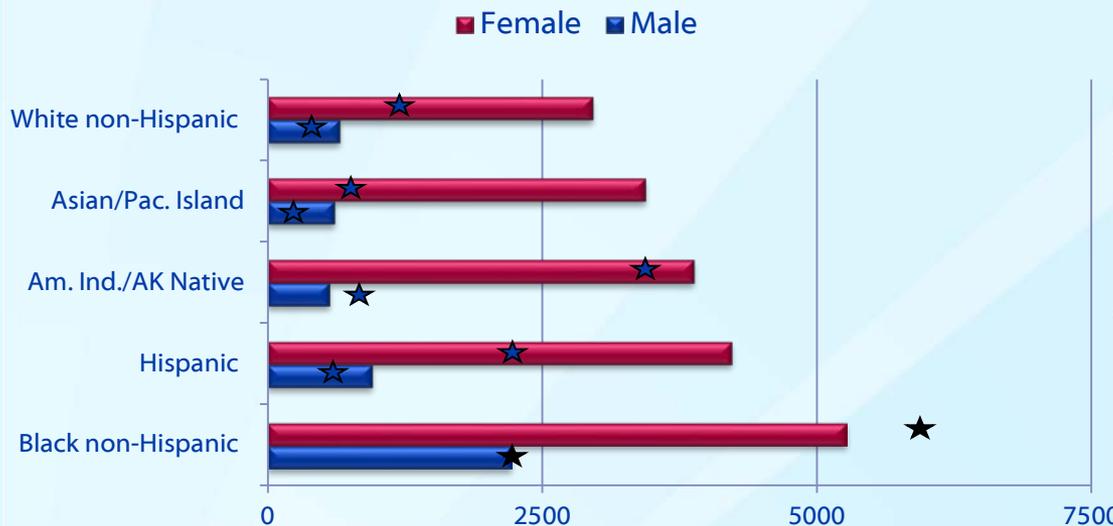


## Gonorrhea

- Clear differential with U.S. Army
- Striking differences for both genders in the Army
- Burden of disease in males is less than seen in US

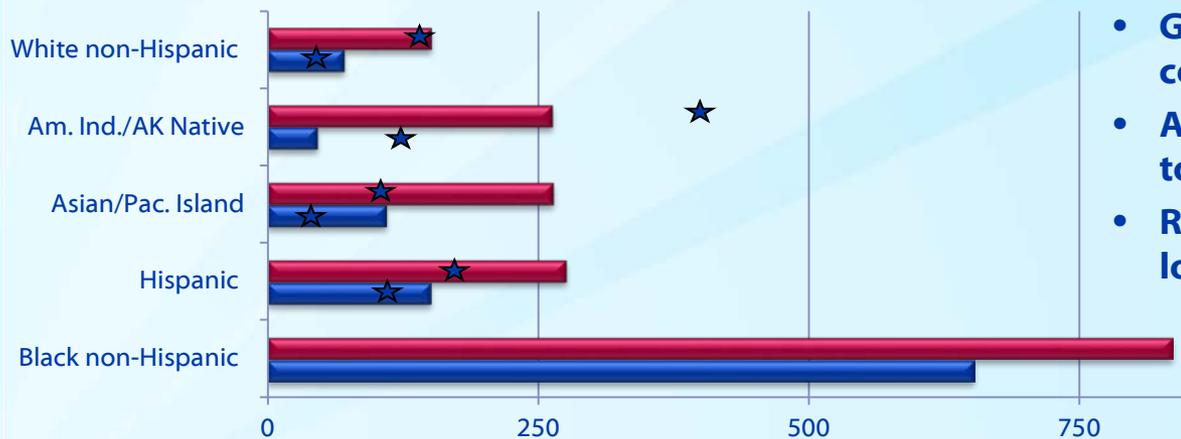
Dotted lines = gender specific US rates (15-30)

# Genital CT and GC Incidence (2011): Race/ Ethnicity



## Chlamydia

- **Black non-Hispanic**
  - Highest burden M and F
  - Highest rates in males
- **Asian**
  - Surprising rates in the military compared to general pop.



## Gonorrhea

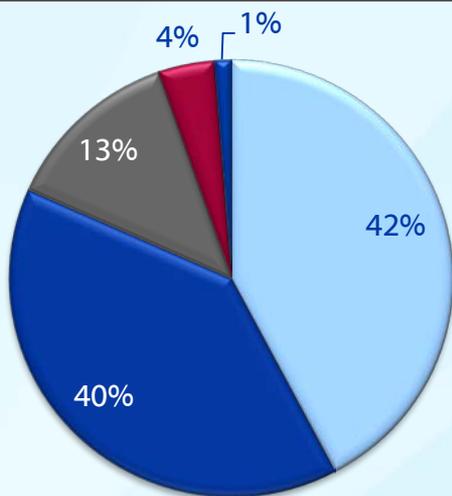
- **Greatest burden in the black community**
- **Alarming rate in black males relative to both other ethnicities and females**
- **Rates in American Indians/AK natives lower than general pop.**

Incidence Rate per 100k

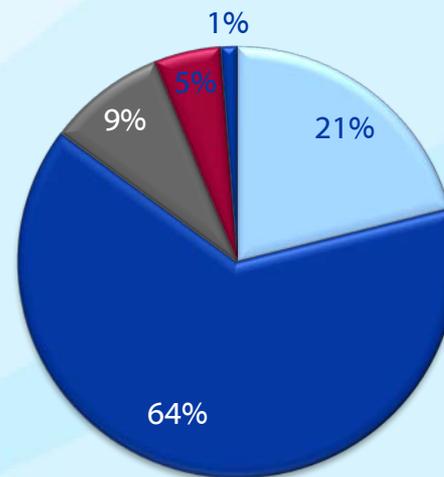
Stars (★): strata specific US rates (15-30)

# Ethnicity of Recurrent CT/GC Infections 2000-2011

>1 case of CT/GC



≥3 case of CT/GC



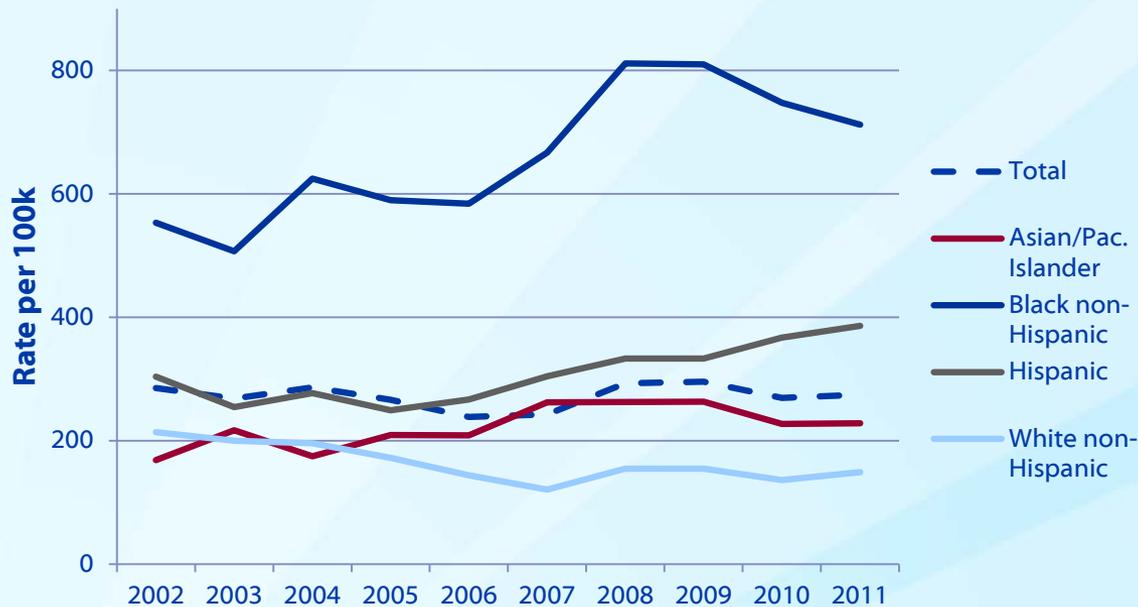
■ White  
■ Black  
■ Hispanic  
■ AsianPI  
■ Am Ind  
Alaska

- Percent of individuals with at least one case of GC/CT: Black/White > Hispanic > Asian
- Multiple infections demonstrates further burden in Black Non-Hispanic population

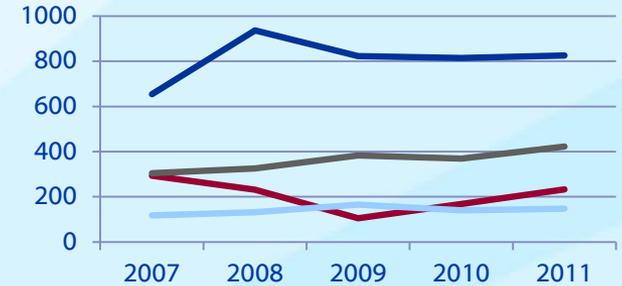
# Extragenital CT/GC Infections and Other STIs

- Rectal and pharyngeal gonorrhea and chlamydia
  - Reporting is rare
  - Pharyngeal infections reported in all 4 services and both genders
  - No recent increase noted by gender, ethnicity
  - Rectal infection reported in 2 services and both genders
  - Increased screening may be relevant to the military as literature continues to demonstrate increased disease prevalence in high risk communities
- Chancroid: 4 cases per 100k per yr
- Lymphogranuloma venereum: 2 cases reported in 10 years
- Granuloma inguinale: no cases reported 2002-2011

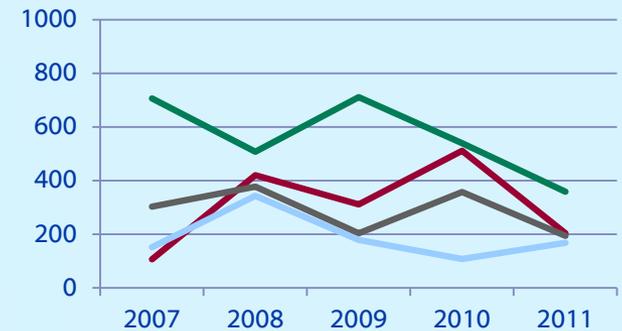
# 1° and 2° Syphilis Incidence: Ethnicity / Gender



**Military Males**



**Military Females**



- Relatively stable over time ethnicities
- Increasing rates in black non-Hispanic
- By gender, females rates have trended down over time, but burden of disease in black males becomes evident

# Military HIV

- HIV is a disqualifying condition for accession
- Not a disqualifying condition for military services
- Limitations on deployment, change of station (residence), and mandated infectious disease care
- Pre and post deployment testing (90 days) plus routine testing by service

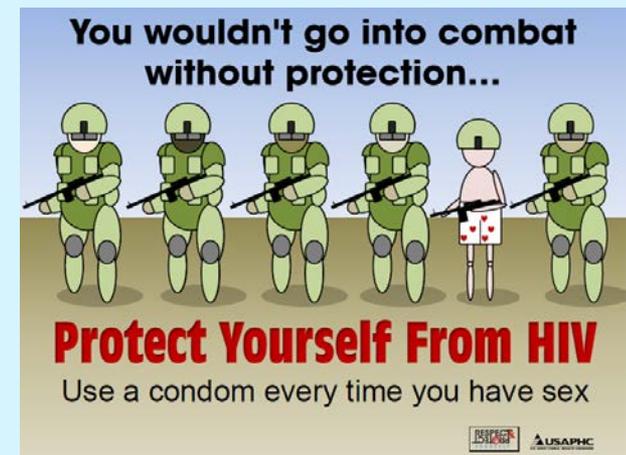


\*Through June 2012; "Data from the Defense Medical Surveillance Center, The Armed Forces Health Surveillance Center, U.S. Department of Defense, Silver Spring, Maryland [1986-2012; <http://www.afhsc.mil/msmrToc>]"

† Incidence rate (per 100 tested of newly diagnosed HIV-1 by service, Active component 2002-2012, Armed Forces Health Surveillance Center, MAR2013

# STIs During Deployment

- Complex ecology in theater
  - Multiple social communities
  - High risk environment increases risk behavior
- Policies in place to reduce sexual interactions
- GC/ CT rates in the deployed force 2004-2009 (US Army/Iraq)\*\*
  - No routine screening in theater (either gender)
  - Males 6146 tests: 51+ (GC) 425+ (CT)
  - Females 6236: 22+ (GC) 256+ (CT)
  - 26 CENTCOM evacuations for PID
- One case of HIV by sexual contact \*



\*Scott, PT et al., AIDS Res Hum Retroviruses. 28OCT2012 1308-12

\*\*Aldous, WK et al., Mil Med vol176, JUN2011 705-10

# U.S. Military STI Surveillance Data

- Defense Medical Surveillance System (DMSS): ICD-9 code data base of all care in the military health system plus care purchased by *TriCare*\*
- Data capture from Reportable Medical Events (RME)
- Surveillance bias
  - Under diagnosis in males
  - Screening protocols differ between the services
  - Not a complete capture of cases due to access to non-military public health care

# Summary

- Complex and unique dynamics of military sexual networks
- Military is composed of higher risk age, ethnicity, and home locations
- Rates of chlamydia and gonorrhea are high
- Prevention programs should address disparities in racial/ethnic groups
- Although primary and secondary syphilis rates are stable, there is a significant burden of disease in black men
- Efforts should be made in education and prevention, even in the deployed environment

# Acknowledgements

- 2LT Erin Tompkins, MS4, Uniformed Services University
- Leslie Clark PhD, Armed Forces Health Surveillance Center
- Joel Gaydos, MD, MPH Armed Forces Health Surveillance Center.
- Jose (Toti) Sanchez, MD, MPH, Armed Forces Health Surveillance Center
- Paul Scott, MD, MPH, Military HIV Research Program (MHRP)

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SCHOOL OF MEDICINE

**W** DEPARTMENT OF GLOBAL HEALTH  
UNIVERSITY *of* WASHINGTON



SCHOOL OF PUBLIC HEALTH  
UNIVERSITY *of* WASHINGTON



# Mil Med 2005;170 (Suppl 4):S61-5

## History of U.S. Military Contributions to the Study of Sexually Transmitted Diseases

**Guarantor:** Maj Mark S. Rasnake, USAF MC

**Contributors:** Maj Mark S. Rasnake, USAF MC\*; Maj Nicholas G. Conger, USAF MC\*; COL C. Kenneth McAllister, MC USA†; King K. Holmes, MC PhD‡; COL Edmund C. Tramont, MC USA (Ret.)

Sexually transmitted diseases have posed a threat to military service members throughout history. Among these diseases, syphilis, gonorrhea, and human immunodeficiency virus infections have accounted for the most significant morbidity and mortality rates in the U.S. military. In response, military researchers have made significant contributions to the treatment and prevention of these diseases. We review the impact of these diseases throughout the history of the U.S. Armed Forces and review selected sexually transmitted disease-oriented publications of U.S. military researchers.

# Studies of Venereal Disease

## Probenecid-Procaïne Penicillin G Combination and Tetracycline Hydrochloride in the Treatment of “Penicillin-Resistant” Gonorrhea in Men

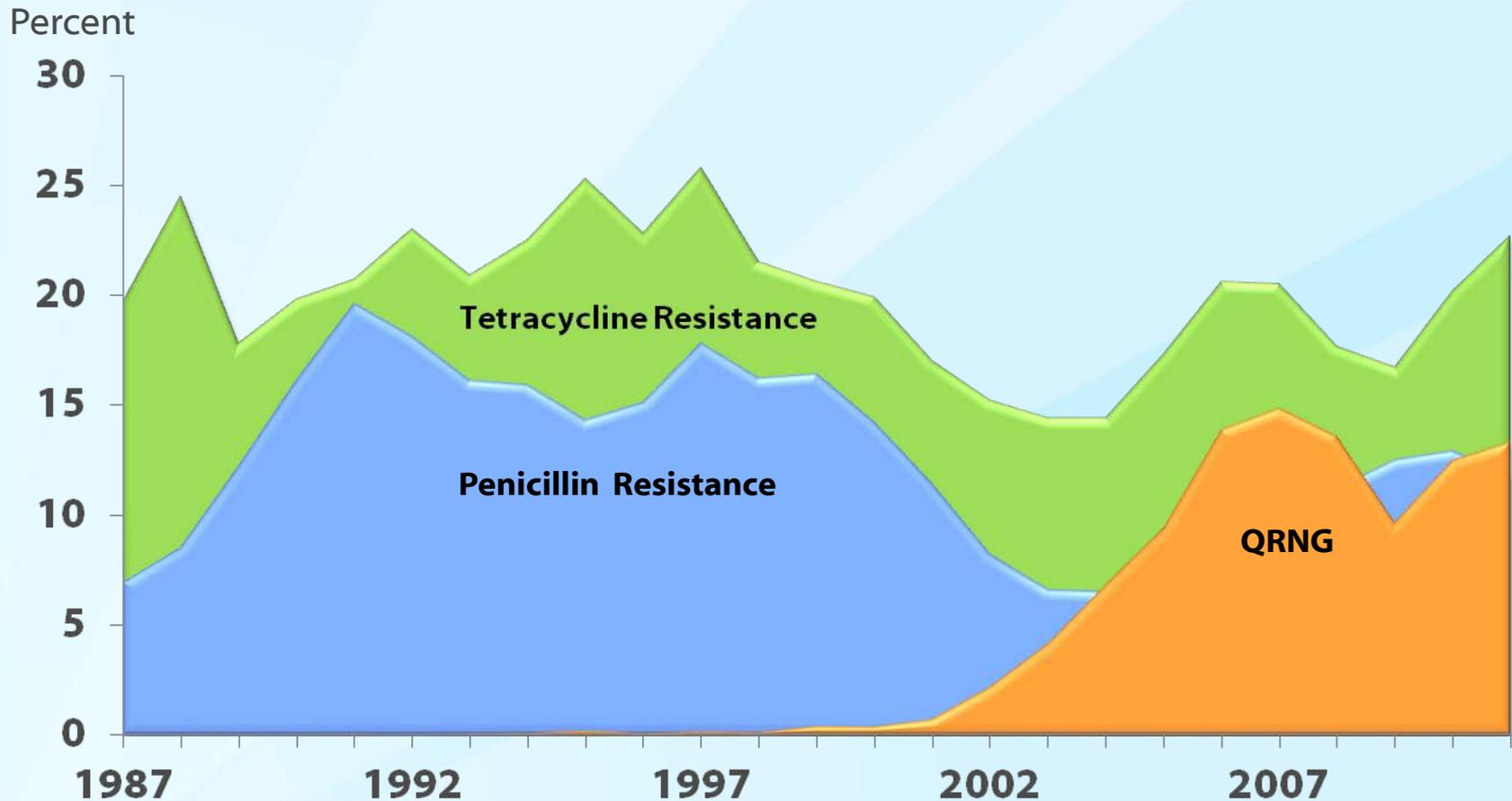
*LT King K. Holmes, MC, USNR;  
LCDR David W. Johnson, MC, USN;  
and CAPT Thomas M. Floyd, MSC, USN*



Treatment of gonorrhea in men with a single intramuscular dose of 2,400,000 units of procaine penicillin G, recommended by the US Public Health Service and the armed forces in 1965, continues to result in 20% to 30% treatment failures among military personnel in the Far East. In studies of confined populations aboard aircraft carriers, 63 men with gonorrhea received 2,400,000 units of procaine penicillin G with 18 (29%) treatment failures; 58 men received 2,400,000 units procaine penicillin G plus probenecid orally, with only one failure. Resistance to 0.05 units of penicillin per milliliter of medium was noted in 26 of 41 (63%) and 57 of 74 (77%) *Neisseria gonorrhoeae* isolates from the respective groups.

JAMA 1967;202:461-6.

# Prevalence of *N. gonorrhoeae* Penicillin, Tetracycline and Fluoroquinolone Resistance, 1987–2011

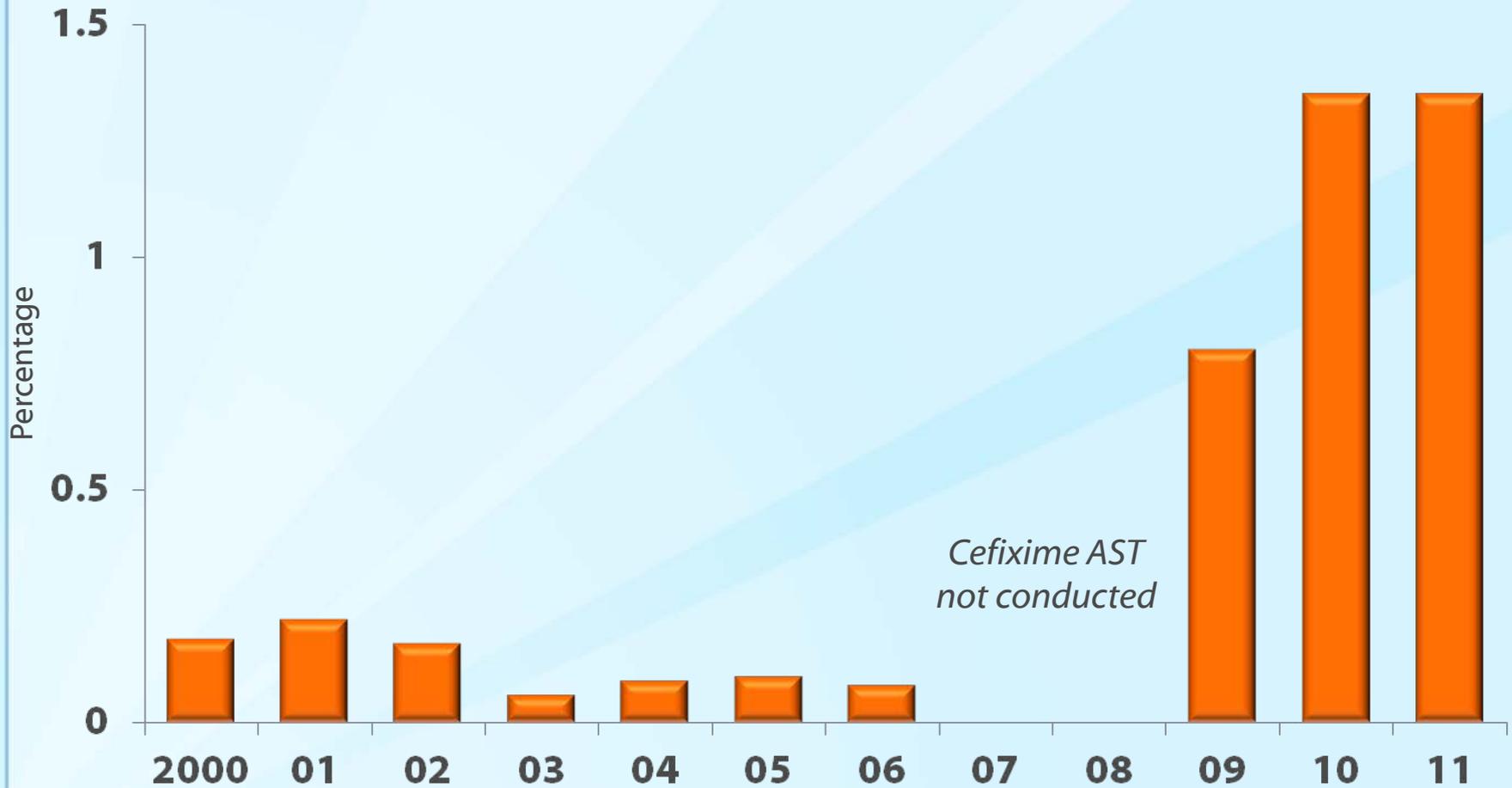


Source: Gonococcal Isolate Surveillance Project

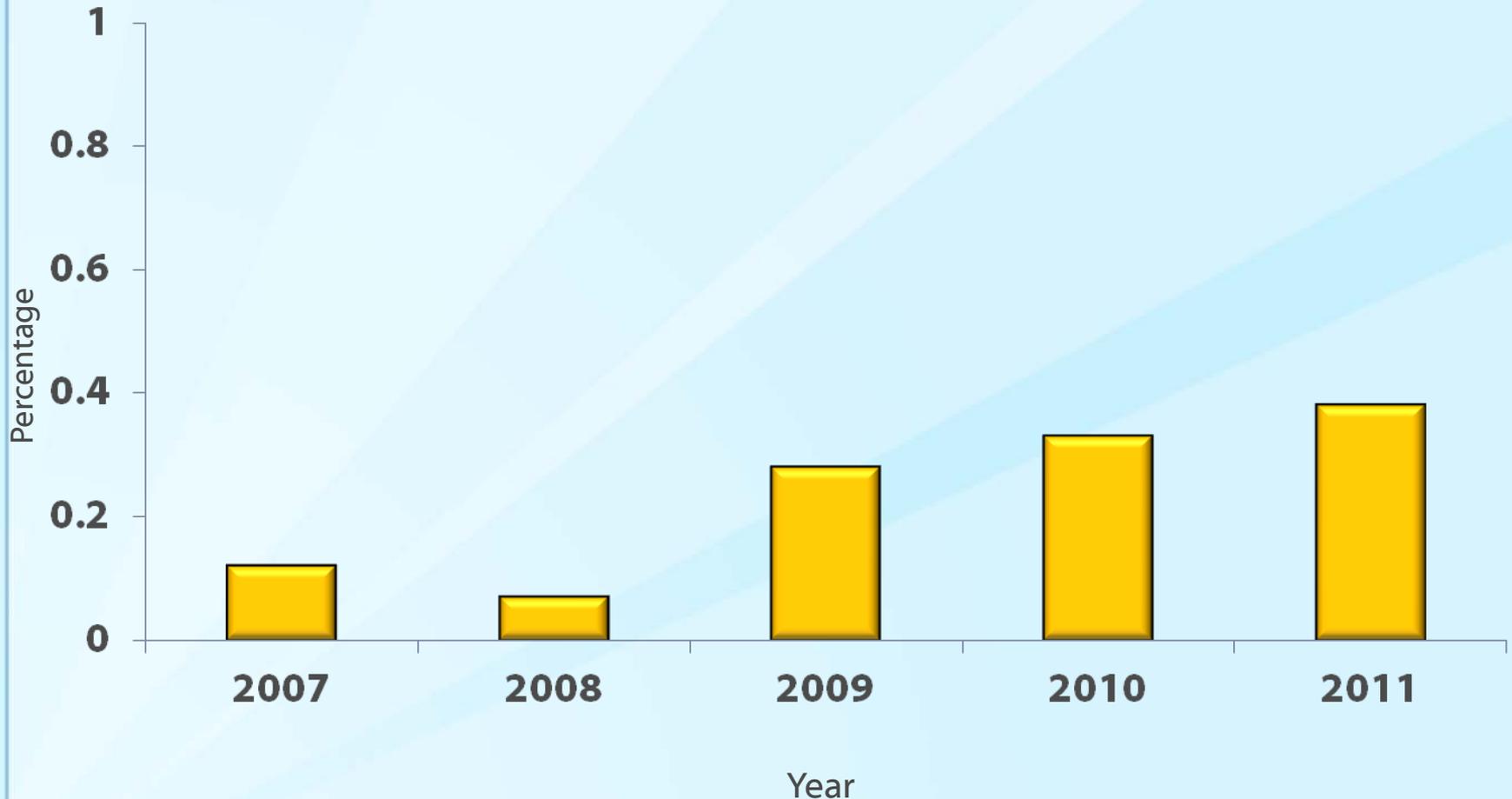
# **Emerging Threat of Cephalosporin-Resistant *N. gonorrhoeae***

- ❑ **Cefixime treatment failures in Asia and Europe**
- ❑ **Identification of cefixime and ceftriaxone-resistant isolates in Japan (2009), France (2011), Spain (2011), and Canada (2011)**
- ❑ **Increasing MICs in Asia, Australia, Europe and US**

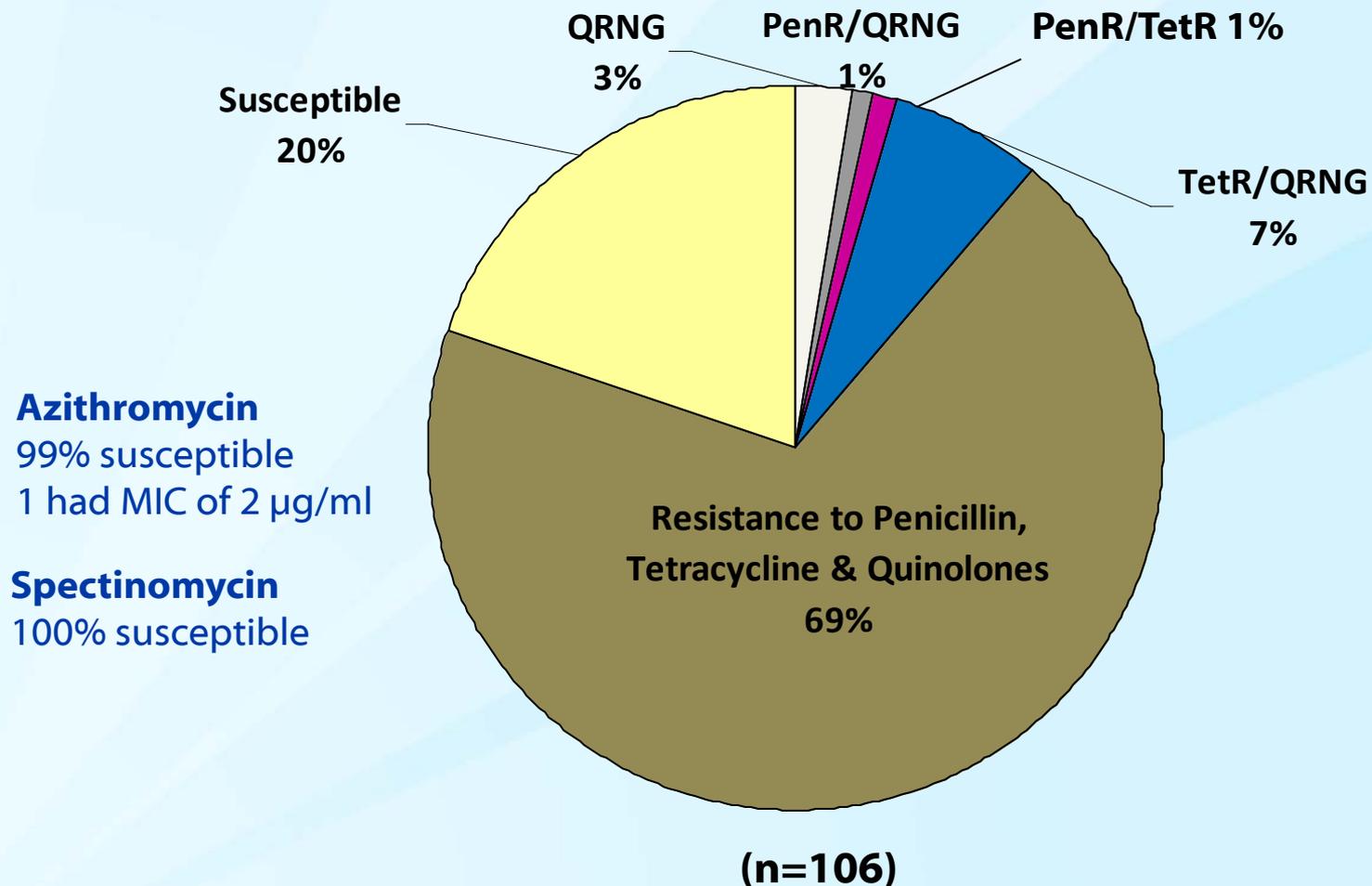
# Percentage of *N. gonorrhoeae* isolates with elevated cefixime MICs ( $\geq 0.25 \mu\text{g/ml}$ ), 2000–2011



# Percentage of *N. gonorrhoeae* isolates with elevated ceftriaxone MICs ( $\geq 0.125$ $\mu\text{g/ml}$ ), 2007–2011



# Antimicrobial Susceptibility Among Urethral *N. gonorrhoeae* Isolates with Elevated Cefixime MICs ( $\geq 0.25$ ), 2010–2011



# Uncomplicated Gonococcal Infections of Cervix, Urethra & Rectum

**Update Recommended August 2012**

---

Dual therapy

**Ceftriaxone 250 mg as a single intramuscular dose**

**PLUS**

**Azithromycin 1 g orally  
or Doxycycline 100 mg twice daily for 7 days**

**Centers for Disease Control and Prevention. Update to CDC's *Sexually Transmitted Diseases Treatment Guidelines, 2010*: Oral Cephalosporins No Longer a Recommended Treatment for Gonococcal Infections. *MMWR* August 10, 2012 / 61(31);590-594**

[www.cdc.gov/mmwr/preview/mmwrhtml/mm6131a3.htm?s\\_cid=mm6131a3\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6131a3.htm?s_cid=mm6131a3_w)

# Uncomplicated Gonococcal Infections of Cervix, Urethra & Rectum

**Alternative #1** *(if ceftriaxone is not available)*

---

Dual therapy

**Cefixime 400 mg as a single oral dose**

**PLUS**

**Azithromycin 1 g orally  
or Doxycycline 100 mg twice daily for 7 days**

**PLUS**

**Test of Cure at infected site in 1 week,  
preferably with culture**

Centers for Disease Control and Prevention. Update to CDC's *Sexually Transmitted Diseases Treatment Guidelines, 2010*: Oral Cephalosporins No Longer a Recommended Treatment for Gonococcal Infections. *MMWR* August 10, 2012 / 61(31);590-594

[www.cdc.gov/mmwr/preview/mmwrhtml/mm6131a3.htm?s\\_cid=mm6131a3\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6131a3.htm?s_cid=mm6131a3_w)

## Activities to Enhance Ceph-R NG Surveillance

- ❑ **Strengthen local culture and AST capacity**
- ❑ **Routinely review local AST results (if available)**
- ❑ **Monitor and investigate patients with multiple gonorrhea diagnoses within 30-60 days**
  - Duplicates vs. re-infections vs. treatment failures
- ❑ **Establish local GISP-like surveillance system**
- ❑ **Implement routine test of cure for certain populations**

## Unpublished Data – Dr. Lindley Barbee

- Yield of the CDC-recommended NAAT screening of MSM for pharyngeal and rectal GC and CT?
- Proportion of GC, CT, and non GC or CT urethritis in MSM attributable to oral sex?
- Progress in access to NAAT testing for pharyngeal and rectal CT and GC in MSM (e.g., using the Aptima Combo2 assay)

# NAATs

- NAATs perform better than culture for extragenital sites (rectum, pharynx)
- Commercial laboratories validated NAATs
- Most infections asymptomatic
- Self-collected vaginal swabs preferred specimen in females
- Urine preferred specimen in men

# NAAT Laboratory Ordering and Billing Codes

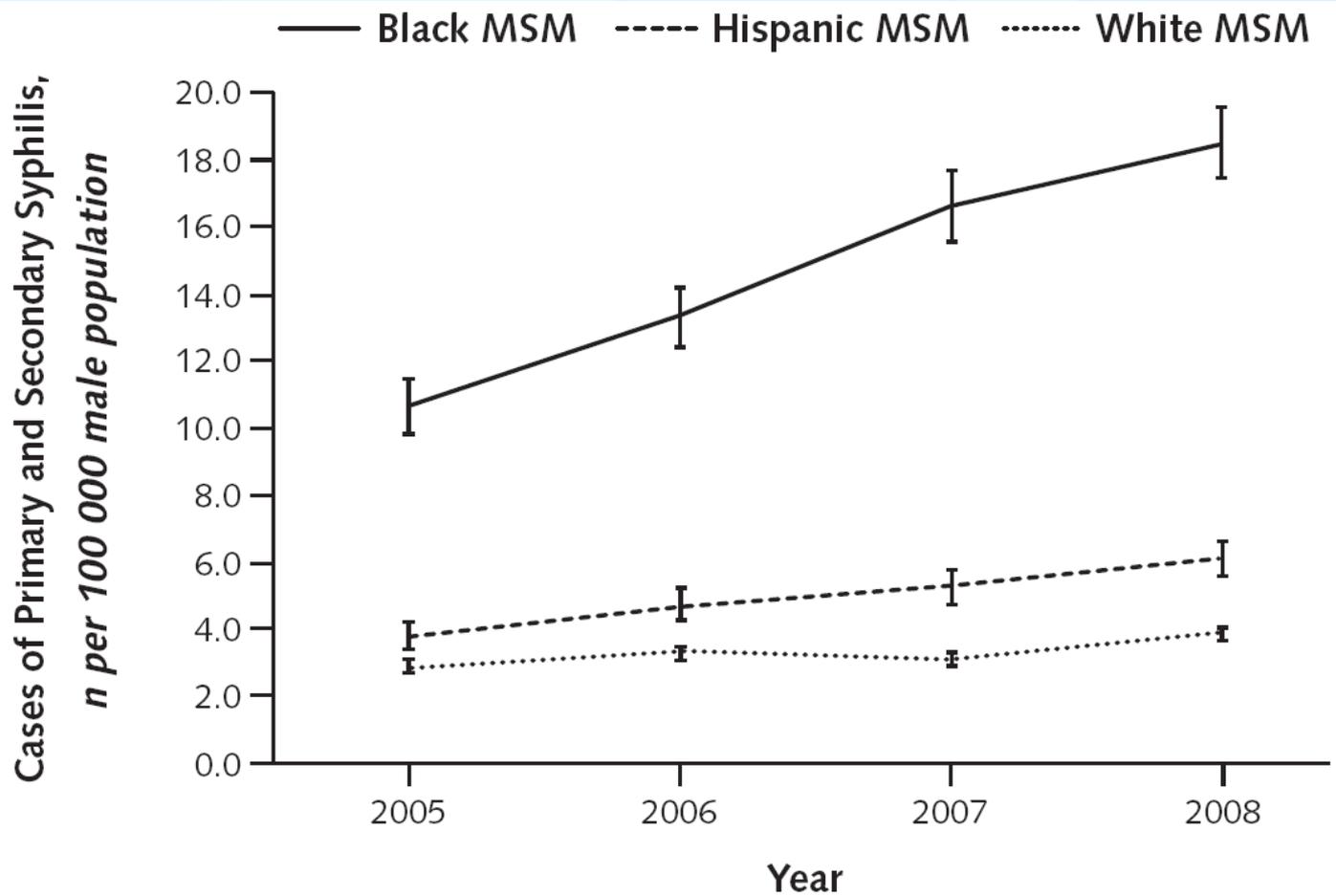
	Company-Specific Ordering Codes for Combined GC/CT Nucleic Acid Amplified Tests (NAATs)		Company-Specific Ordering Codes for CT test only
	LabCorp*	Quest*	LabCorp
Rectal	188672	16506	188706
Pharyngeal	188698	70051	188714
NAATs are offered at (or from) any location in the country with these two codes.			

For information on specimen collection and transportation, clinicians should contact the local reference laboratory representative.

CPT Billing Codes	
CT detection by NAAT	87491
GC detection by NAAT	87591

\* CDC does not endorse these laboratories, however, they represent the largest laboratories nationally. There may be other private laboratories that have verified rectal and pharyngeal testing with NAATs. Many PHLs have also verified rectal and pharyngeal testing.

# Rates of primary and secondary syphilis among MSM, by race or ethnicity, in 27 US states in 2005 to 2008



Su JR, et al. "Primary and secondary syphilis among black and Hispanic men who have sex with men: case report data from 27 states." *Ann Intern Med* 2011;155(3):145-151

# VENEREAL DISEASES

**AMBROSE KING**

T.D., M.B., B.S.(Lond.), F.R.C.S.(Eng.)

**CLAUDE NICOL**

T.D., M.D., F.R.C.P.



## 1964

Chapters feature:

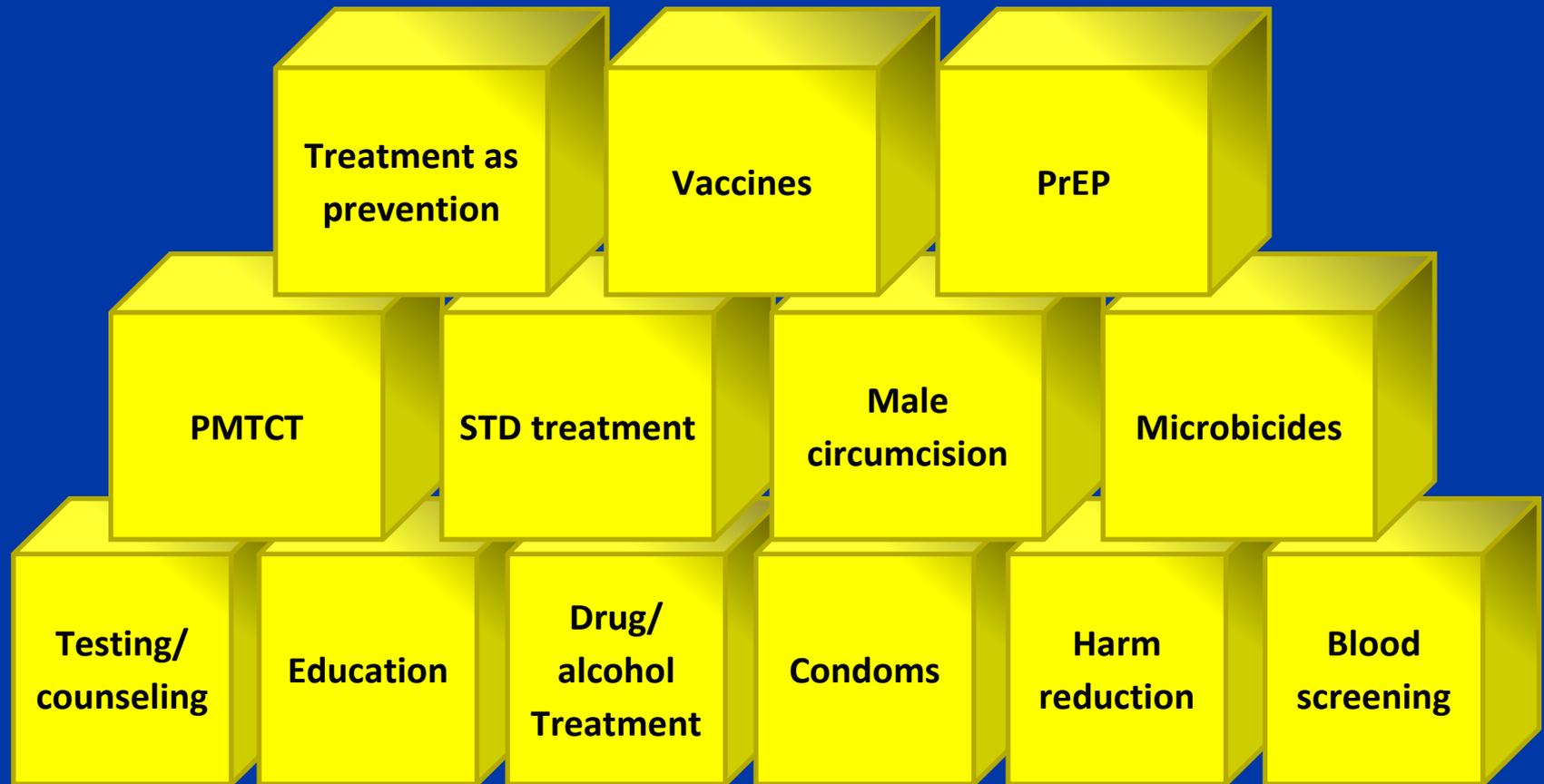
- syphilis
- gonorrhoea
- “tropical” venereal diseases
- trichomoniasis
- NGU

- Today, there are 35 known sexually transmitted pathogens including HIV 1 and 2.
- Microbiome studies are defining many more.

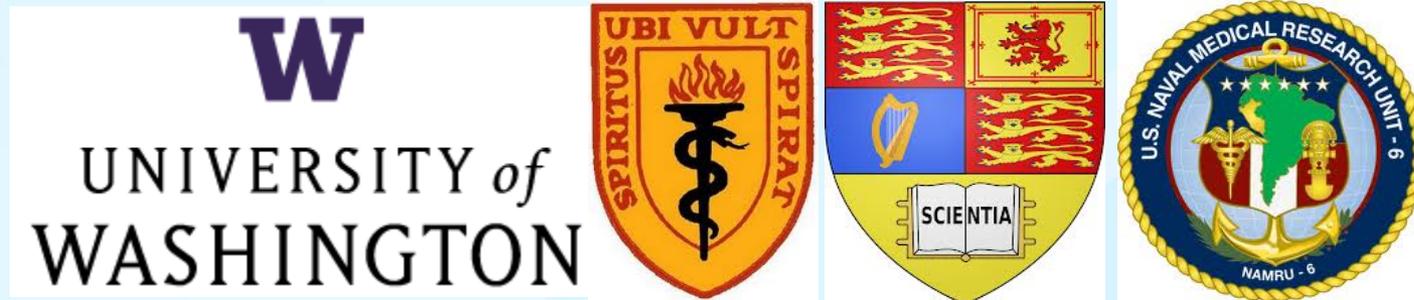


- We are not going to control STI with screening/diagnosis and treatment alone!

# Combination ~~HIV~~ Prevention STD



*A collaboration including the US Naval Medical Research Unit–6 in Lima, Peru*



**THE LANCET**

 **Prevention of sexually transmitted infections in urban communities (Peru PREVEN): a multicomponent community-randomised controlled trial**

*Patricia J García, King K Holmes, César P Cárcamo, Geoff P Garnett, James P Hughes, Pablo E Campos, William L H Whittington, Peru PREVEN Study Team\**

*Lancet* 2012; 379: 1120–28

Early Online Publication, 15 February 2012

doi:10.1016/S0140-6736(11)61846-1

Bravazo (very cool)  
Condom with ribs

100 points  
Condom with studs



Aphrodisiac

Chocolate-flavored condom

Condom social marketing proved so popular in Peru that unprotected sex became 20% less common in intervention cities than in control cities ( $p=0.02$ )

# Actions for Clinicians

- The five “P”s
- Promote condoms as normative protective behavior in the military; casual sex without condoms is abnormal
- Identify and screen those at risk for STI; be aware of race/ethnic, gender, age, sex-orientation disparity
- Take a look at CDC STD Guidelines, key recommendations
- Ensure confidentiality of risk behaviors, STI/HIV reports

# 2010 STD Guidelines: 110 Pages; What Else is New?

- ① Spread of antibiotic-resistant GC
2. Azithro or Amoxicillin for CT in pregnancy
- ③ *M. genitalium* and TV in urethritis, cervicitis  
NGU: Azithro 1gm po or  
Doxycycline 100mg po bid x 7d  
Persistent NGU: Moxifloxacin 400mg bid x 7d for *M. gen.* ?  
Metronidazole or Tinidazole 2gm po x 1 for TV ?
- ④ LGV proctocolitis in MSM: Don't miss this diagnosis! Test for CT; give 3wks doxy Rx
- ⑤ Azithro-resistant *T. pallidum*
6. Diagnostic evaluation after rape
- ⑦ Screening high risk persons
- ⑧ STD prevention
- ⑨ Patient-delivered partner therapy (PDPT)

# HIV/STI Screening and Rescreening for MSM

Question for all men: “Have you had sex with men, women, or both?”

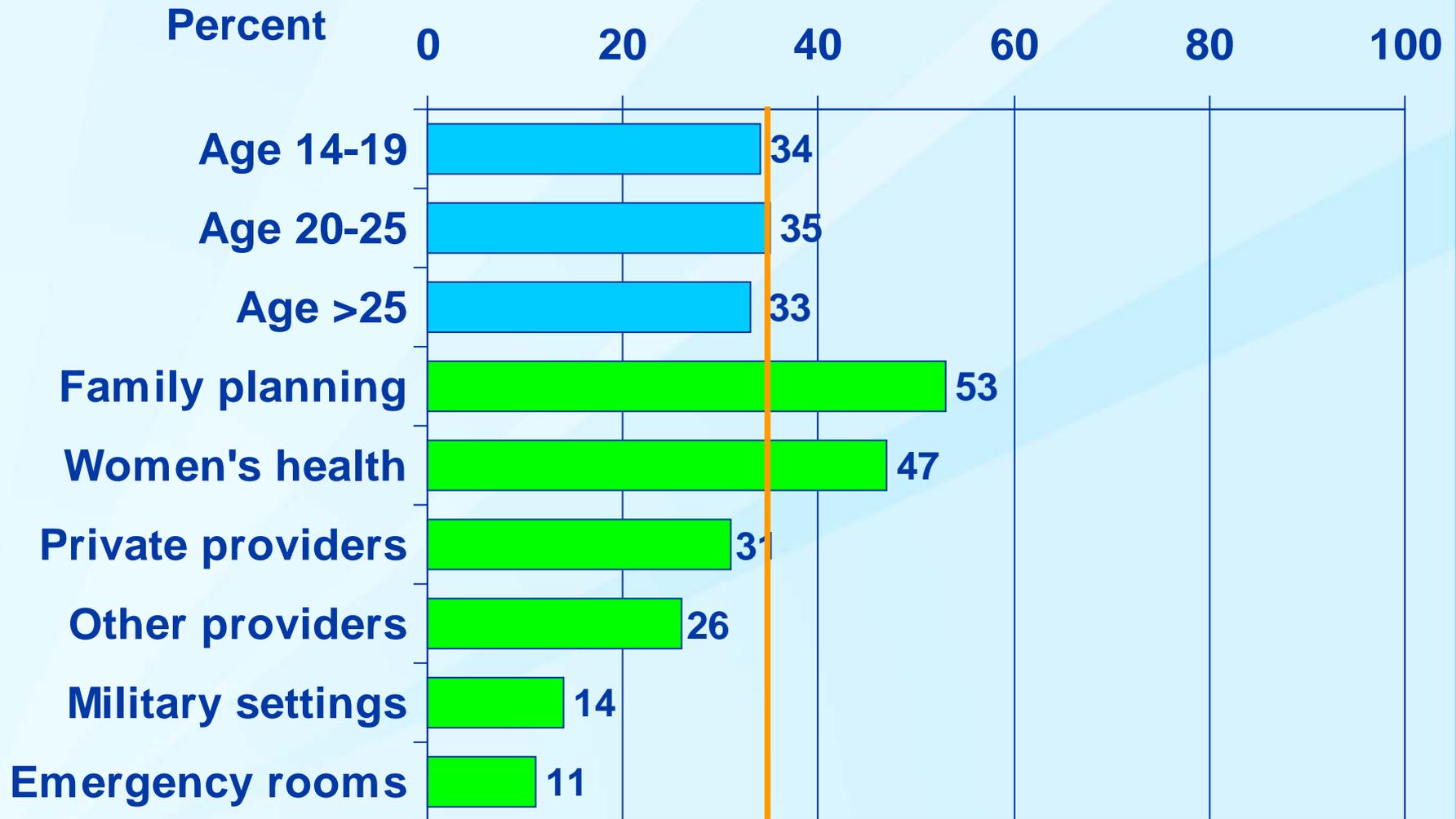
Annual screening for all MSM (except for those in  $\geq 1$  yr mutually monogamous, HIV concordant relationship)

1. HIV (unless already known to be HIV+)
2. Syphilis serology
3. Rectal NAAT for GC/CT for those reporting receptive anal sex
4. Pharyngeal NAAT for GC

Every 3–6 months screening for those reporting during past year:

- Bacterial STI; *or*
- Methamphetamine or popper use; *or*
- Unprotected anal sex with HIV serodiscordant or serostatus unknown partner; *or*
- $\geq 10$  sex partners (anal or oral)

# Percentage of Patients Receiving PDPT from Provider



R. Kerani, unpublished data, Washington State

**34% overall received PDPT**

# Michael R. (Bob) MacDonald, MS, CHES

Manager, Sexual Health and Responsibility  
Program (SHARP),  
Navy and Marine Corps Public Health Center



**Sexual Health Promotion  
in the Navy and Marine Corps  
and  
Clinician Resources**

# Disclaimer

- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, nor the U.S. Government

# Overview

- SHARP Overview
- SHARP Objectives
- Priorities and the Clinician's Role
- Clinical Policies and Practices
- Resources for Clinicians

# Sexual Health and Responsibility Program (SHARP)



## **SHARP Program Description and Background**

MacDonald MR (2013). Sexual Health and Responsibility Program: Preventing HIV, STIs and Unplanned Pregnancy in the Navy and Marine Corps. Public Health Reports, 2013 Sup 1; Vol 128; Mar/Apr 2013. Assoc of Schools of Public Health

# Sexual Health Objectives

- HIV Incidence
- Condom Use by Unmarried Members
- Unplanned Pregnancies
- Family Plans / Contraception Use
- Chlamydia Incidence
- Gonorrhea Incidence
- Syphilis Incidence
- Annual Chlamydia Screening for Females <25 years old

# Sexual Health Promotion Priorities

- Unintended pregnancy among female enlisted aged 17-24, married and single

**Clinician role:** Offer LARC as first line option for most women

- HIV among MSM; especially black men aged 20-29 and white men aged 30-39

**Clinician role:** Ask about sexual health; identify risk; offer risk-based counseling and screening



# Sexual Health Clinical Policies and Practices

- STI Treatment IAW CDC Guideline
- Initial HBV and HAV screening / vaccination
  - HBV and HAV vaccination (family members PRN)
- HPV vaccination access
- Initial and Annual Ct Screening for Woman <25 years old
- Initial, Periodic and Pre-deployment Well-Woman's Exam
  - Cervical Cancer Screening (clinician-determined frequency)
  - Family Planning Counseling
- Initial Syphilis screening
- Initial and Biennial HIV Screening
  - (family members PRN)
- Annual Preventive Health Assessment (includes HRA)
- For STI Patients:
  - Referral for prevention counseling (RESPECT model) and sexual partner notification
  - HIV, STS screening; HBV, HAV, HPV immunization PRN
- For HIV positives:
  - Three Navy HIV care centers
  - Initial and semi-annual eval; STI screen; prevention counseling; partner notification

# Sexual Health Promotion Resources for Clinicians

- Intensive Prevention Counseling Guideline
- Sexual Partner Referral Services Guideline
- Web page – Gay Men's Health
- Clinician's Sexual Risk Assessment Guide



DEPARTMENT OF THE NAVY  
JULY 1917 MEE C NE ARD B, RFD 37  
7520 E STREET, NW  
WASHINGTON DC 20354-2100

11 878748P/EN/10

6000  
Ser M307UM433215  
20 Nov 07

Dear Healthcare Provider,

A recent review of the most current public health statistics for our active duty (AD) Sailors and Marines indicate an alarming trend in unintended consequences from sexual risk taking. These include two out of three pregnancies that were not planned and an HIV infection seroconversion rate among AD Sailors at about twice the rate observed within the other three services. The data indicated lack of contraceptive use was a major factor in these results.

These results are concerning and as an organization we would like to have a positive impact on the sexual health of our AD Sailors and Marines. To facilitate this effort, we consulted the U.S. Preventive Service Task Force and several other professional medical associations for their recommended evidence-based health care practices.

My strongest recommendation is for every healthcare provider practicing in primary care settings to speak with their adult and adolescent patients about their sexual health. I recommended the provider take this opportunity as appropriate to the circumstances. Because this can be a sensitive issue for both the healthcare provider and the patient to broach, a user-friendly sexual risk assessment guide is provided in Enclosure 1. This guide is also available at the following web sites:

[http://www-nenc.med.navy.mil/downloads/hp/PMA\\_sexual\\_risk\\_assessment.pdf](http://www-nenc.med.navy.mil/downloads/hp/PMA_sexual_risk_assessment.pdf),  
<http://www-nche.med.navy.mil/hp/harp/index.htm>.

Our goal is a safe and healthy force. To help meet this goal, please include sexual risk behavior assessments in your discussions as appropriate. Thank you for helping our AD Sailors and Marines "chart a safe course."

A handwritten signature in black ink, appearing to read "T. R. Cullison".

T. R. CULLISON  
Rear Admiral, Medical Corps  
Deputy Surgeon General

Enclosures: 1, Brief Counseling Guide for Sexual Risk Assessment and Intervention

# Clinician's Sexual Risk Assessment Guide

## Brief Guide for Sexual Risk Assessment and Intervention

-- For military service members during their annual Periodic Health Assessment (PHA) or any routine encounter --

### Part I – Assess Risk

#### 1. OPENING STATEMENT

"I want to ask some direct questions about your sexual health so I can help you stay healthy. I ask these questions of all of my patients, regardless of age or marital status."

#### 2. PREVENTION OF PREGNANCY (MEN AND WOMEN). Determine family planning intentions and use of contraception.

"Are you or your partner trying to get pregnant?" If no - What are you doing to prevent a pregnancy?"

#### 3. PARTNERS. Make no assumptions of partner gender in the initial history taking.

"In the past six months, about how many people have you had sex with?"

"Tell me more about these people. Are they people you know well or people you just met?"

#### 4. PRACTICES. If the patient has **risk** (see inset), explore sexual behavior and circumstances.

"With your recent sex partner(s), did you engage in vaginal, oral or anal sex?"

"Regarding pregnancy and STDs, what is the riskiest thing you've done in the past 3 months?"

"How does your use of alcohol or other drugs influence your sexual decisions?"

#### 5. PROTECTION FROM STDs. If the patient has **risk** (see inset), explore types of risk reduction the patient has used in the recent past, such as condom use.

"What do you do to protect yourself from STD and HIV?"

"What have you done in the past to protect yourself?"

#### 6. PAST HISTORY OF STDs. A history of STDs increases the risk of repeated infection. Affirmative answers should be followed up with questions about the type of infection and dates of treatment. Consider hepatitis B immunization.

"Have you ever had an STD?"

"Have any of your partners had an STD?"

"Do you have any symptoms/problems now?"

"Risk" of an unplanned pregnancy or STD/HIV exists:

- All sexually active adolescents
- Adult with STI (current or in the past year)
- Adult with more than 1 "current" sexual partner

ALSO Consider...

- Not wanting pregnancy but no current contraception.
- More than 1 recent sex partner (past 3 months).
- New partner in past 3 months.
- Sex partner who may have an STD.
- Exchange of sex for money or drugs.

## Sexual Risk Assessment and Interventions

-- For military service members during their annual Periodic Health Assessment (PHA) --

### Part II – Intervene

#### 7. DESCRIBE RISK AND EXPLORE THE PATIENT'S PERCEPTION OF RISK AND CONSEQUENCES. If the patient has **risk**, ask:

"I'm concerned that you are placing yourself at risk of an unplanned pregnancy and/or sexually transmitted disease because you [ describe the risky behavior(s) and relevant circumstances ]."

"How do you see your risk?"

"How would an unplanned pregnancy or HIV infection affect you?"

#### 8. EXPLORE RISK REDUCTION. What does the patient know about risk reduction? What does the patient want to try?

"What are some ways a person could avoid a pregnancy or getting HIV or another STD?"

"Here are ways you could reduce your risk:"  
(see inset – **risk reduction**)

"What would you like to do to reduce your risk?"

- ENCOURAGE THE PATIENT TO CHOOSE A RISK REDUCTION OPTION.

#### Risk Reduction Options:

1. Abstain from sex or delay sex until a later time in life - or have relationships that do not involve sex.
2. Monogamy - sex between two people, who only have sex with each other, in a long-term relationship.
3. Use Condoms correctly and every time
4. Have sex with fewer people.
5. Do not trade money or drugs for sex.

Note - Stay sober to stay in control.

#### 9. EXPLORE BENEFITS AND BARRIERS TO SAFER BEHAVIOR

"What would be the hardest thing about [DOING THE SAFER BEHAVIOR CHOSEN BY THE PATIENT ] ?"

"What would be the best thing about [DOING THE SAFER BEHAVIOR CHOSEN BY THE PATIENT ] ?"

#### 10. DEVELOP AND ACTION PLAN. What concrete incremental steps can the patient take succeed?

"How will you [DO THE SAFER BEHAVIOR CHOSEN BY THE PATIENT ] ?"

i.e.

How will you say "no" to sex?

How will you insist on faithfulness from your partner?

When – Where - How will you get condoms / contraception?

Where and when will you have condoms?

#### 11. MAKE REFERRALS. Consider referrals that may help the patient reduce sexual risk

"Would you like to speak with [CHAPLAIN / OB-GYN / PREV MED / FLEET-FAMILY SERVICES / SOCIAL WORKER / BEHAVIORAL HEALTH]?" Note: all females aged 25 and under AND older females with risk should be referred for annual Chlamydia screening.

# Additional Resources for Clinicians

- **CDC 2010 STD Treatment Guidelines**

- [www.cdc.gov/std/treatment/2010](http://www.cdc.gov/std/treatment/2010)
- [www.cdc.gov/std/2010-ebook.htm](http://www.cdc.gov/std/2010-ebook.htm)



- **The Growing Threat of Multidrug-Resistant Gonorrhea**

- [www.youtube.com/watch?v=rE2th3A0Oxs](http://www.youtube.com/watch?v=rE2th3A0Oxs)
- [www.cdc.gov/about/grand-rounds/archives/2012/download/15-May/GR\\_05-15-2012.wmv](http://www.cdc.gov/about/grand-rounds/archives/2012/download/15-May/GR_05-15-2012.wmv)

# Additional Resources for Clinicians

- **A Spotlight on LGBT Health: Transgender Health Issues – a Healthy People 2020 webinar**
  - [www.healthypeople.gov/2020/connect/webinarsArchive.aspx](http://www.healthypeople.gov/2020/connect/webinarsArchive.aspx)
- **National Network of STD/HIV Prevention Training Centers**
  - [www.nnptc.org](http://www.nnptc.org)
- **CDC Division of STD Prevention**
  - [www.cdc.gov/std/training](http://www.cdc.gov/std/training)



# Questions and Answers



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- To receive CE credit, an evaluation must be completed at CDC's Training and Continuing Education Online site: [www2a.cdc.gov/TCEOnline](http://www2a.cdc.gov/TCEOnline).
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- For those viewing the webinar on or after April 27, 2013, enter **WD1956** into the *Keyword Search* box and then click on *View*.

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The logo features the letters 'STI' in a large, bold, black serif font. A green caduceus symbol is superimposed over the 'I'. Below this, the words 'Treatment Guidelines' are written in a smaller, black, sans-serif font. At the bottom, the year '2010' is displayed in a large, bold, green sans-serif font.

**STI**  
Treatment Guidelines  
**2010**

**For more information please contact Centers for Disease Control and Prevention**

1600 Clifton Road NE, Atlanta, GA 30333

Telephone, 1-800-CDC-INFO (232-4636) / TTY: 1-888-232-6348

E-mail: [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov) Web: [www.cdc.gov](http://www.cdc.gov)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.