

# STD EXAMINER

Shirley Fannin, MD  
Director, Disease Control Programs

Gary A. Richwald, MD, MPH  
Director, STD Program

November 1998

Volume 3, Number 5

## Remarks from Dr. Richwald

A draft of new national sexually transmitted disease objectives for the year 2010 was recently released by the U.S. DHHS Healthy People 2010 initiative. The Draft 2010 objectives differ in a number of significant ways from this decade's Healthy People 2000 objectives for STDs, reflecting an increased understanding of the spectrum of STDs and their sequelae as well as the need for broader, non-traditional approaches to prevention.

Among the diseases receiving increased emphasis in the 2010 document is human papillomavirus (HPV), which is given its own public health objective for the first time. Reflecting a newfound understanding of cervical cancer as a sexually transmitted infection (STI) with a long latency period, the objective targets a decrease in the prevalence of HPV subtypes associated with cervical cancer. Herpes simplex virus type 2 (HSV-2) also receives increased attention, with a new objective targeting a decrease in prevalence among persons 20 to 29 years of age. This new national emphasis on viral STIs, and the more serious fashion in which the HPV and HSV-2 epidemics are being tracked and dealt with, are long overdue considering the number of Americans already infected.

Pelvic inflammatory disease (PID) and infertility are also given increased attention in the 2010 draft document, which proposes the first national objective calling for a reduction in the number of women experiencing STD-related fertility problems. A new objective is also proposed to track newborn STD complications in addition to congenital syphilis, including chlamydial pneumonia, eye infections resulting from chlamydia and gonorrhea, laryngeal papillomatosis (from HPV), and neonatal herpes.

The document also emphasizes new and broadened approaches to STD prevention and

Please see DIRECTOR, page 2



## Talking to Patients about Sex: Improving Our Skills

How comfortable are most health care providers with taking a sexual health history and counseling patients about sexual risk behaviors? Not comfortable enough, many experts say, as providers' reluctance to broach sensitive topics often results in critical missed opportunities for STD prevention.

"Since we all come from the same culture in which we're not supposed to speak openly about sex," says Joshua S. Golden, MD, clinical professor of psychiatry and former director of the UCLA Human Sexuality Program, "providers as well as patients tend to feel awkward and uncomfortable" when discussing sexual practices. Golden and his wife, Peggy, a former lecturer and supervisor at the UCLA program, have been training health care providers to be more comfortable and effective in discussing sexual issues for over 25 years. The Goldenes will be conducting a special two-part L.A. County STD Program inservice on the topic on November 20 and December 18, 1998 (see insert).



Recent research indicates that many providers are so uneasy talking about sexual practices that they often avoid the subject, even when their patients may be at high risk for STDs. In 1997, the Kaiser Family Foundation and *Glamour* magazine surveyed 482 women between the ages of 18 and 44 who had been to a new doctor in the past year for gynecological or obstetrical care. Only 12% of women surveyed reported that the provider raised the subject of STDs at their first visit, and many reported that STD risk factors were never assessed. For example, 31% of women were not asked whether they were currently sexually active; 55% were not asked if they were in a monogamous relationship; 62% were not asked if they used condoms regularly; 71% were not asked about the number of sex partners they had had in the last year; and 92% were not asked about oral or anal sex. When providers did not broach these topics, women were unlikely to bring them up on their own; just 3% of the

### Inside . . .

Clinical Corner . . . . . Page 2

STD DataWatch . . . . . Page 3

Satellite Video

Conference Tapes . . Page 4

Inservice Info . . . . . Insert

Please see SEX, page 4



## Clinical Corner

# Hepatitis A and B Immunization in STD Clinics: L.A. Gay and Lesbian Center Conducts Pilot Study

By Ellen Rudy, MPH, Health Data Analyst, Los Angeles Gay and Lesbian Center

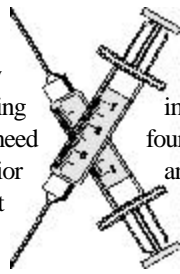
The hepatitis A and B viruses (HAV and HBV) remain major causes of illness in the United States adult population. Of particular concern are the five percent of adults infected with HBV who never resolve the disease. These individuals may transmit the virus indefinitely, and are at greater risk of developing serious liver complications. HAV and HBV are unique among STDs in that effective vaccines are now available for preventing infection. In 1998, the CDC published guidelines recommending that all STD clinic patients be immunized against HBV. HAV vaccination in STD clinics was recommended for all men who have sex with men (MSM) and illegal drug users.

The CDC treatment guidelines also briefly discuss the role of prevaccination serologic screening for HBV (but not HAV) to determine which patients need the vaccine and which are already immune due to prior infection or immunization. One study suggests that screening patients first, as opposed to simply immunizing all patients, is cost-effective when over 30% of the target population is already immune (and thus does not need vaccination). A disadvantage to prevaccination screening, however, is that many high risk patients may never return to the clinic to receive even the first dose of vaccine. While HAV and HBV vaccines are administered in a series of two and three doses, respectively, even a single injection can provide protection for many patients. Protective levels of HBV antibody are present in 50% of young adults after one dose of the HBV vaccine and in 85% after 2 of the 3 doses. One dose of HAV vaccine produces nearly 100% protective immune response one month after vaccination; a booster dose confers long-term immunity.

The L.A. Gay & Lesbian Center (LAGLC) operates an STD clinic primarily serving MSM, but also provides care

to sexually active heterosexual men and women. Clients are seen Monday through Friday evenings and receive care regardless of their ability to pay. To gather information for developing a cost-effective HAV/HBV vaccination program, LAGLC conducted a seroprevalence survey in collaboration with the L.A. County STD Program and the Public Health Laboratory.

From May to August 1998, 377 specimens were collected to estimate clinic clients' susceptibility to HAV and HBV infection. Detectable antibodies against HAV (HAVAb) indicate immunity to HAV due to prior infection or immunization; detectable antibodies against HBV core antigen (HBcAb) indicate immunity to HBV due to prior infection. The survey found HAVAb and HBcAb seroprevalences to be 36% and 32%, respectively. These results indicate that there is a large reservoir of high-risk, susceptible clients (over two-thirds of clients) already seeking care at the clinic who could potentially benefit from HAV and HBV immunization.



The LAGLC is currently working with the L.A. County Immunization Program and the L.A. County STD Program, with funding from SmithKline Beecham Pharmaceuticals, to develop an HAV/HBV vaccination study to be implemented at the LAGLC STD clinic. The objectives of the study will be to determine the feasibility of implementing CDC recommendations in an STD clinic setting; to identify factors associated with completion of the vaccination series; and to determine cost-effective strategies that increase vaccine completion rates in a high risk population. The study is expected to begin early next year. A similar study addressing hepatitis vaccination in County STD clinics is also being planned.

## Director

Continued from page 1

control. Proposed objectives include increasing the number of junior high and high schools which have school-based clinics providing reproductive health care; increasing the number of youth detention facilities and adult jails which conduct screening for common bacterial STDs within 24 hours of admission; and increasing the number of television networks that include positive messages related to responsible sexual behavior in their programming.

Among the most controversial changes proposed for 2010 is the removal of race- and ethnic group-specific objectives for both gonorrhea and syphilis -- diseases for which significant racial disparities in incidence still persist across the U.S., as well as in L.A. County. Proponents of the

YEAR 2010											
1	2	3	4	5	6	7	8	9	10	11	12
15	16	17	18	19	20	21	22	23	24	25	26
27	28	29	30	31	32	33	34	35	36	37	38

change argue that because such disparities are unacceptable, the Year 2010 goal should be the same for all groups. Opponents (including this author) are concerned, however, that the change may result in a reduced awareness of this issue and in resources being directed away from those communities with the greatest need. In either case, L.A. County will require significant additional resources and commitment to meet the proposed 2010 goals for chlamydia (3% prevalence among persons 15-24 years old), gonorrhea (19 cases per 100,000 population) and primary and secondary syphilis (0.25 cases per 100,000).

Local input on the draft Healthy People 2010 objectives is being solicited in a series of regional meetings being held across the country from October through December 1998. Copies of the draft objectives and information on the Sacramento meeting to be held on December 9-10 may be obtained via the Internet, at <http://web.health.gov/healthypeople>, or by calling (800) 367-4725.

# STD DataWatch

Reported STDs in Los Angeles County, Second Quarter 1998\*. Provisional data; rates per 100,000 population\*\*.

HEALTH DISTRICT	CHLAMYDIA			GONORRHEA			EARLY SYPHILIS <sup>1</sup>			CONGENITAL SYPHILIS		
	Cases	Rates <sup>1</sup>	% Change <sup>H</sup>	Cases	Rates <sup>1</sup>	% Change <sup>H</sup>	Cases	Rates	% Change <sup>H</sup>	Cases	Rates <sup>‡</sup>	% Change <sup>H</sup>
Alhambra	101	129.0	+3	15	18.7	+91	1	1.0	-1	0	0.0	---
Bellflower	154	213.2	+1	43	58.2	+57	0	0.0	---	0	0.0	---
Central	269	449.9	+14	72	117.8	+6	19	25.4	+88	1	57.2	-14
Compton	294	527.8	-2	114	200.2	+28	10	14.4	+98	1	57.5	-2
East L.A.	110	245.7	-22	15	32.8	+119	1	1.8	-67	0	0.0	---
East Valley	268	316.7	+27	41	47.4	+55	3	2.8	-1	0	0.0	---
El Monte	223	233.6	+16	13	13.3	-5	3	2.5	-1	0	0.0	---
Foothill	117	185.9	+20	19	29.5	+14	7	8.9	+38	0	0.0	---
Glendale	70	101.3	-20	19	26.9	+115	2	2.3	-67	1	92.4	---
Harbor	85	210.6	-26	15	36.4	-27	2	4.0	+98	0	0.0	---
Hollywood-Wilshire	314	319.0	+6	149	148.1	+20	10	8.1	-34	2	96.4	+85
Inglewood	437	530.6	+14	183	217.3	+21	20	19.4	-38	0	0.0	---
Northeast	198	290.7	-13	27	38.8	+20	5	5.9	+65	1	56.9	---
Pomona	213	193.5	+43	28	24.9	-21	3	2.2	-41	0	0.0	---
San Antonio	248	290.8	-10	29	33.3	+34	8	7.5	+13	0	0.0	---
San Fernando <sup>^</sup>	249	184.4	+1	55	39.9	-6	2	1.2	-67	0	0.0	---
South	272	813.1	+5	101	295.3	-12	21	50.2	-13	2	167.9	-53
Southeast	199	670.3	+26	51	168.0	+41	8	21.5	-28	0	0.0	---
Southwest	525	724.9	+15	168	226.9	-6	29	32.0	-1	4	232.6	+27
Torrance	143	156.6	-1	37	39.6	+89	2	1.8	-1	0	0.0	---
West	189	151.2	+3	42	32.9	-11	3	1.9	+197	0	0.0	---
West Valley	294	196.3	-12	41	26.8	+55	2	1.1	-60	2	64.7	---
Whittier	109	166.1	-14	27	40.3	+53	7	8.5	+592	0	0.0	---
<b>DISTRICT SUM</b>	5,081			1,304			168			14		
District Unknown	1,272			291			0			0		
<b>COUNTY TOTAL</b>	6,353	<b>280.8</b>	<b>+4</b>	1,595	<b>70.5</b>	<b>+15</b>	168	<b>7.4</b>	<b>-8</b>	14	<b>35.4</b>	<b>-21</b>

\* Based on the disease week calendar (3/29/98 to 6/27/98).

<sup>1</sup> Rates adjusted for cases with Health District Unknown.

\*\*Rate calculations are based on 1997 population estimates due to the current unavailability of 1998 estimates.

<sup>†</sup> Percent change in rate from second quarter 1997 to second quarter 1998.

<sup>‡</sup> Rates expressed per 100,000 live births.

§ Early Syphilis=Primary, Secondary, and Early Latent Syphilis.

<sup>^</sup> Includes cases reported from Antelope Valley.

# Videotapes of Recent Satellite Video Conferences Available

Videotapes of three recent satellite video conferences are now available to borrow, free of charge, from the STD Program. The programs, which aired this September and October, are:

- *Clinical Guidelines for Chlamydia Screening and Treatment* (2 hours), presented by the Region IX Infertility Prevention Project and the Center for Health Training;
- *Caring for Women: Management and Prevention of Cervicitis and Pelvic Inflammatory Disease* (2½ hours), presented by the National Network of STD/HIV Prevention Training Centers; and
- *Practical Evaluation of Public Health Programs* (in two parts: 2 hours and 3 hours), presented by the Public Health Training Network.

Please contact Philip Phan, STD Program Health Education Unit, at (213) 744-5952 to borrow any of these videotapes or for more information.

# Sex: Talking to Patients

Continued from page 1

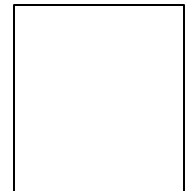
women said that they volunteered information about their sex lives or asked about STDs themselves. Most women indicated that they would have welcomed the opportunity to discuss these issues, however.

The American Social Health Association (ASHA) has developed a model sexual health history form to assist providers in gathering important risk information from patients, and offers several tips for providers on discussing sexual issues. The ASHA suggestions include stressing confidentiality; counseling patients while they are fully dressed, rather than during the exam; avoiding interruptions; and interacting in a friendly, relaxed and caring manner. Women in the Kaiser Family Foundation/*Glamour* survey indicated that an assurance of confidentiality and a non-judgmental attitude on the part of the health professional were the most important factors which might affect their level of comfort in talking about STDs.

According to Dr. Golden, practice is the key for health care providers to feel more at ease and become more effective at sexual health history taking and counseling. "Nobody is born with the ability" to talk with patients about sexual issues, he says. Even staff at STD and family planning clinics, who may be more accustomed than other providers to conversations about sexual risk, can improve their skills and comfort level through additional training and practice. The Golden's' workshops in November and December are opportunities for providers at all levels to learn and practice such skills in a safe and supportive environment.

---

**STD Examiner**  
**Los Angeles County STD Program**  
**2615 S. Grand Avenue, Room 500**  
**Los Angeles, CA 90007**



*STD Examiner* is published quarterly by the Los Angeles County Sexually Transmitted Disease (STD) Program. We welcome your comments and suggestions.

Editor-in-Chief  
*Gary A. Richwald, MD, MPH*

Managing Editors  
*Robyn K. Davis, MPH*  
*Karen Bernstein, MPH*

Contributing Staff  
*Irene Dyer, MS, MPH*  
*Rose T. Wang, MPH*

STDEXAMINER  
Los Angeles County STD Program  
2615 S. Grand Avenue, Room 500  
Phone: (213) 744-3070  
FAX: (213) 749-9606