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Controlling Sexually Transmitted Diseases: An IHS Perspective

Introduction

Sexually transmitted diseases (STDs) remain a “hidden” epidemic of tremendous health and economic consequence in the United States. Rates of curable STDs in the US are the highest in the developed world. Public health efforts at prevention are hampered frequently because many Americans are reluctant to address sexual health issues in an open manner. The scope, impact, and consequences of STDs are underrecognized by the general public and many health care professionals.¹ Another more ominous feature of STDs is the increasing awareness of the association between other STDs and HIV/AIDS. Recent research has shown that the risk of HIV seroconversion is three to five times higher among women infected with chlamydia than among uninfected women.² Prevention of STDs may be one of the most effective means to prevent HIV/AIDS.³

Available information for American Indian and Alaska Native populations reveals STD rates in many communities that exceed the national average. For example, in 1995, gonorrhea rates for American Indians and Alaska Natives were almost three times that of the White, Non-Hispanic population. In addition, data collected from 1995 screening programs reveal chlamydia rates among American Indian and Alaska Native women that are nearly two times higher than the 1994 national chlamydia rate for women (265.3 per 100,000 population).^{4,5} More recent data, collected as part of the “IHS Stop Chlamydia - Use Azithromycin Program,” reveal that some IHS Areas have the highest documented rates of chlamydia in the US (see the accompanying articles *STD Prevention and Control in the IHS* on page 4 and *IHS Chlamydia Rates* on pages 5-6).

To address the health, social, and financial implications of STDs, the Institute of Medicine (IOM) has issued a report that profiles STDs in our nation and provides recommendations to confront and control these diseases (see *IOM Releases Report on STDs* on pages 10-11).

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In This Issue...

- 1 Controlling Sexually Transmitted Diseases: An IHS Perspective
- 2 Taking a Sexual History: Communicating Prevention
- 4 STD Prevention and Control in the IHS: An Emphasis on Chlamydia
- 5 Chlamydia Rates in the IHS
- 7 Screening and Treatment of Chlamydial Infections: Recommendations by the Centers for Disease Control and Prevention
- 9 Erratum
- 9 AAAHC Draws Interest
- 10 Institute of Medicine Releases Report on Sexually Transmitted Diseases
- 11 Meetings of Interest
- 14 NCME Videotapes Available
- 15 Native American Medical Literature

Taking a Sexual History: Communicating Prevention

Alarming high rates of sexually transmitted diseases (STDs) and the human immunodeficiency virus (HIV) present complicated and severe, widespread public health problems. Several social, psychological, biological, and cultural factors contribute to risk-taking behaviors leading to STD/HIV infection. These factors must be seriously considered, openly discussed with patients during a clinical visit, and made part of a standard health assessment. Because traditional training in medical history taking mainly focuses on the task of diagnosing illness, psychological and social factors demonstrated to be important in patient care are often overlooked.¹

Facilitating communication between providers and patients about sexual health provides patients with more information about prevention and risk reduction measures to discourage certain behavioral patterns. One way to determine risk for STDs/HIV is to conduct a sexual history as part of a general health assessment. Obtaining a complete sexual history is critical in identifying high risk behaviors on which to base appropriate risk reduction messages and the use of subsequent diagnostic and therapeutic interventions. Unfortunately, sexual histories and counseling are not routinely performed by most primary care providers. A 1994 nationwide survey of 450 physicians and 514 other primary care providers showed that 60 percent of physicians and 51 percent of other primary care providers do not routinely evaluate all or most new adult patients for STDs/HIV. In addition, only 30 percent of physicians and 34 percent of primary care providers reported collecting information regarding their patient's sexual activity.²

Many issues are to blame for this important omission of the health assessment. Most of these issues originate in providers feeling discomfort and embarrassment when discussing intimate sexual practices and concerns, making assumptions that patients will disclose risky behaviors or symptom history without being asked, and lastly, thinking they simply do not have the time to counsel patients thoroughly about STDs, HIV, and sexual health concerns, given other pressing needs within the clinic. As a result of these and other issues, sexual histories and risk reduction counseling may not occur during clinic visits even for high risk patients.

Despite such difficulties, identifying risk factors remains an essential part of STD/HIV prevention and management. A well conducted sexual history can elicit the possibility of STD/HIV infection and assist the provider in making decisions regarding screening a patient, developing risk reduction messages, and making additional referrals. Performing a sexual history need not be intimidating or difficult. Awareness of important communication factors can diminish anxiety raised by this crucial part of a clinic visit. A more comprehensive patient assessment can improve patient care, increase patient compliance, prevent new infections and reinfections, and play a major role in slowing the epidemic of STDs/HIV. The following recommendations will enable providers to feel more comfortable asking the critical questions necessary for obtaining complete sexual history information from patients:

- Communicate these health questions in a friendly, relaxed, and professional manner.
- Stress confidentiality. Remind patients that this information is necessary to make well informed medical decisions.
- Create an environment conducive to communication.
- Emphasize that these questions are asked in order to provide the most comprehensive medical care.
- Move from questions that are least threatening to the more sensitive ones. Once rapport has been established and the general medical history has been gathered, you can move to the sexual history itself.
- Ask all patients the same questions. Perceptions and attitudes influence communication styles.
- Don't make assumptions regarding the lifestyle of any patient based on first impressions or other biases. Making assumptions puts the provider at a disadvantage for obtaining a thorough history and may result in poor decisions on the direction of their health care based on inaccurate information. When conducting a sexual risk assessment, remember not to assume:
 - All patients are currently sexually active.
 - All single patients have multiple partners.
 - Older patients or the disabled aren't sexually active.

- Patients who practice safer sex with one partner do so with all partners.
- You can tell who is lesbian or gay by how they look or act.
- Sexually active people know all the information necessary to make informed choices about birth control, STD prevention, etc.
- All married persons only have sex with their spouse.
- Use words with which patients are familiar. Determine the appropriate language level of the patient. Don't talk over their heads, but don't talk down to them either. Use genderless terms such as "partners" rather than "husband," "boyfriend," or "spouse" until the partner(s) status is assessed.
- Ask questions in a nonjudgmental manner. Talking in a matter-of-fact manner will tell the patient that these questions cause no embarrassment or awkwardness.
- Establish a standard set of questions as a guide. A sample follows these recommendations (see Figure 1). Monitoring the sexual health of patients is an important part of their total health care. A standardized set of questions provides a way to document behavioral factors that put patients at risk for potential health problems.

Providers often have unique relationships with patients, and they provide care in the context of the patient's family and social network; therefore, they have several opportunities to

educate their patients about prevention. STD/HIV prevention and detection efforts can be routinely integrated into daily patient encounters. For patients at low risk, prevention should include education about risk reduction activities and positive feedback on steps the patient has already taken to protect themselves. For high risk patients found to be uninfected with STDs or HIV, prevention efforts should focus on risk reduction strategies, including additional testing if risk taking behaviors are not discontinued. For the person who is found to be infected, the importance of treatment, disease management, and partner notification must be stressed, as well as strategies for reducing the risk of transmission to others and avoiding reinfection.³

In conclusion, providers who ask questions about sexual activity and associated risk factors when conducting a medical interview are better prepared to address their patients' health. By openly discussing STDs/HIV during routine visits, providers open communication about all aspects of sexual health, increase awareness, and promote preventative behaviors. □

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Figure 1. Sample Sexual Risk Assessment.

1. Is your sexual partner(s): Male _____ Female _____ Both _____ I have no sexual partner _____.		
2. How many sexual partners have you had in the last three months? _____. In the last year?_____.		
3. Do you/have you engaged in oral sex?_____ Vaginal sex? _____ Anal sex? _____		
4. Have you had a new sexual partner in the last three months?	Yes	No
5. Date you last had sex ___/___/____. Did you use protection?	Yes	No
6. Do you know if your partner(s) has engaged in sex with others?	Yes	No
7. Do you use condoms? Yes___ No___ With each act of intercourse?	Yes	No
8. Have you ever had a partner refuse to wear a condom?	Yes	No
9. Have you ever been diagnosed with an STD? If so, which one(s)? _____	Yes	No
10. Have you ever used drugs intravenously?	Yes	No
11. Has your partner(s) used drugs intravenously?	Yes	No
12. What questions/concerns do you have about STDs/HIV? _____		

STD Prevention and Control in the IHS: An Emphasis on Chlamydia

In an effort to address the need for better sexually transmitted disease (STD) surveillance, treatment, and prevention efforts among the American Indian and Alaska Native populations, the Epidemiology Branch at the Indian Health Service, Headquarters West (IHS-HQW), with support from the Centers for Disease Control and Prevention (CDC), has implemented a program of chlamydia surveillance and control. The "Stop Chlamydia - Use Azithromycin Program" was specifically designed with the intent of decreasing the incidence of chlamydia, and simultaneously developing an effective surveillance system for chlamydia and other STDs.

During the past two decades, genital *Chlamydia trachomatis* infections have surpassed gonorrhea as the most common sexually transmitted bacterial infection in the United States. Although the precise rates of chlamydial infections are not known, it is estimated that more than 4 million infections occur each year, with direct and indirect costs exceeding \$2.4 billion annually.¹ Chlamydial infections in most women are asymptomatic, occurring for months before causing serious and costly complications such as pelvic inflammatory disease (PID), ectopic pregnancy, infertility, and chronic pelvic pain. In pregnancy, untreated chlamydia can result in conjunctivitis and pneumonia in newborns.²

Controlling and preventing chlamydial infections is relatively simple, relying on screening and treatment programs, including treatment of sex partners, and education aimed at primary prevention of all STDs.³ The incidence of chlamydia and other STDs among American Indians and Alaska Natives is often greater than in similar, non-Indian communities. To assist with screening, prevention, and surveillance of chlamydia, the IHS Chlamydia Prevention Program makes available azithromycin, a relatively new and expensive, but effective treatment for chlamydia, to IHS medical facilities at no cost to the local facility.

Azithromycin is a single dose therapy that can be administered on site at the time of diagnosis. Its use may substantially improve cure rates for many people who may be noncompliant with other, multidose therapies, such as doxycycline. Because azithromycin retails at four times the cost of other approved therapies for chlamydia, most clinics are unable to implement widespread use of the drug. Through the Stop Chlamydia - Use Azithromycin Program, each participating clinic receives this expensive medication at no cost. In exchange, participating clinics agree to offer screening to eligible women and to provide basic surveillance data on each positive chlamydia case. Through surveillance, local communities may gain information on disease incidence and risk factor prevalence to assist them in better controlling STDs in their community. Surveillance data are analyzed at HQW and results are reported back to participating sites informing them of the chlamydial infection profile in their Area, as well as providing comparisons with other IHS regions. This information will prove beneficial in creating prevention and control strategies unique to each particular Area.

Currently there are 84 IHS and tribal facilities enrolled in the program. If your clinic is interested in participating in the Azithromycin Program or if you would like additional information on the program, please contact Laura Shelby, IHS STD Program Coordinator, at (505) 248-4226. □

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Chlamydia Rates in the IHS

All facilities participating in the Indian Health Service's (IHS) "Stop Chlamydia - Use Azithromycin" Program submit a surveillance report for each positive chlamydia case diagnosed at their facility. The Epidemiology Program at the IHS Headquarters West (HQW) analyzes and interprets the data, providing quarterly reports to each facility summarizing the information. The following surveillance data were collected from participating clinics in the Alaska, Aberdeen, Albuquerque, Phoenix, Oklahoma, Portland, Tucson, and Nashville IHS Areas during the period October 1996 to March 1997. This summary provides insight into the magnitude of chlamydia, and indirectly, other sexually transmitted diseases (STDs).

Positivity rates can be a useful indicator when prevalence

data are not available. The Centers for Disease Control and Prevention (CDC) reports that comparisons of positivity rates (which may include more than one test for some patients) with prevalence rates (which are based on a single test per patient) indicate that positivity rates frequently underestimate prevalence, but generally by less than 10% (e.g., a positivity rate of 10% may correspond to a prevalence rate of 11%).¹ IHS Areas report positivity rates from 2.3 to 5.6% (See Figure 1). These rates are similar to state positivity rates reported by family planning clinics in the United States (See Figure 2). Although prevalence rates may be true indicators of disease, they are also affected by screening policies. Changes in screening policies may drastically affect positivity rates.

Figure 1. Percentage of chlamydia test positivity among men and women of all ages tested by IHS Areas—July to December 1996.

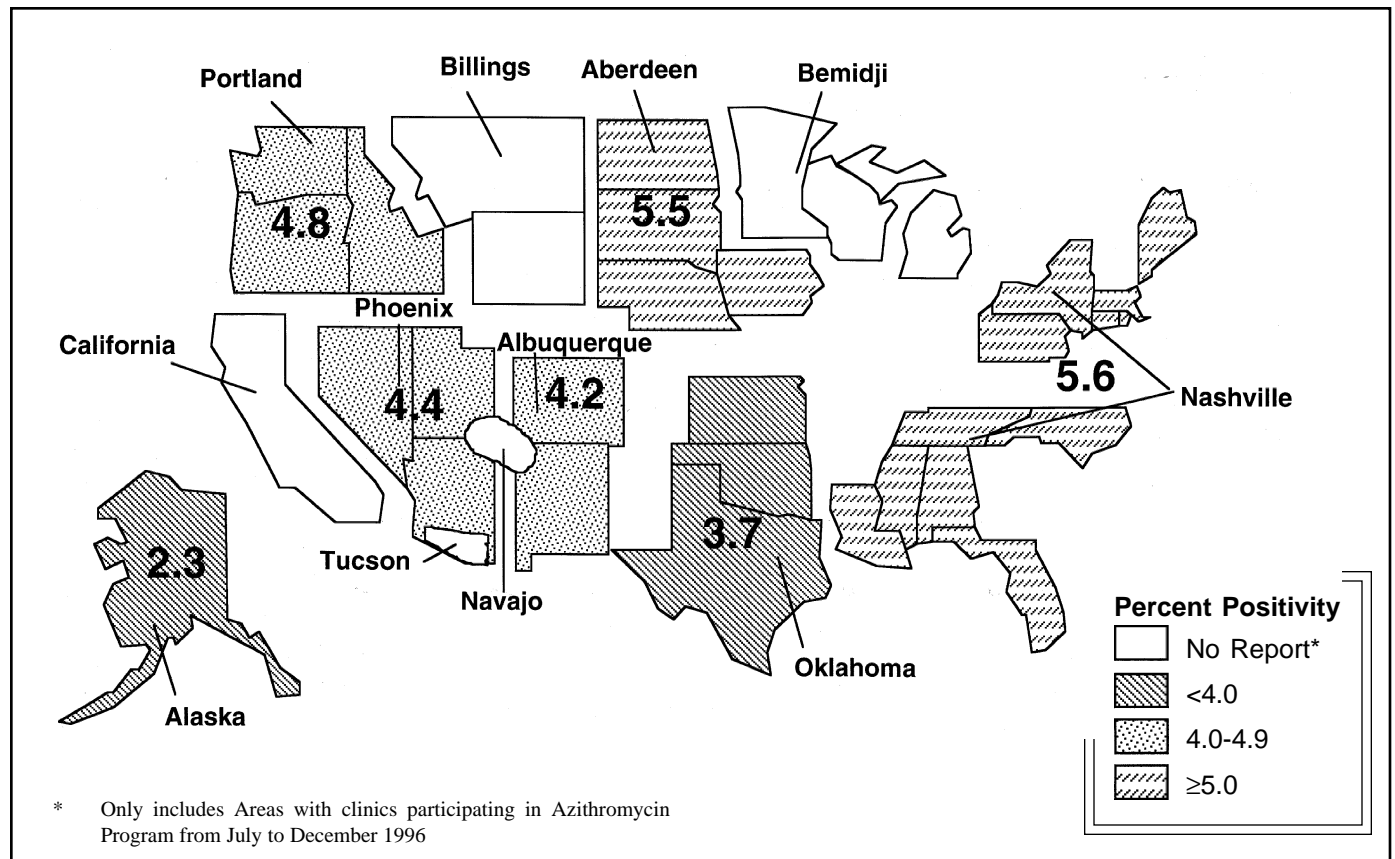
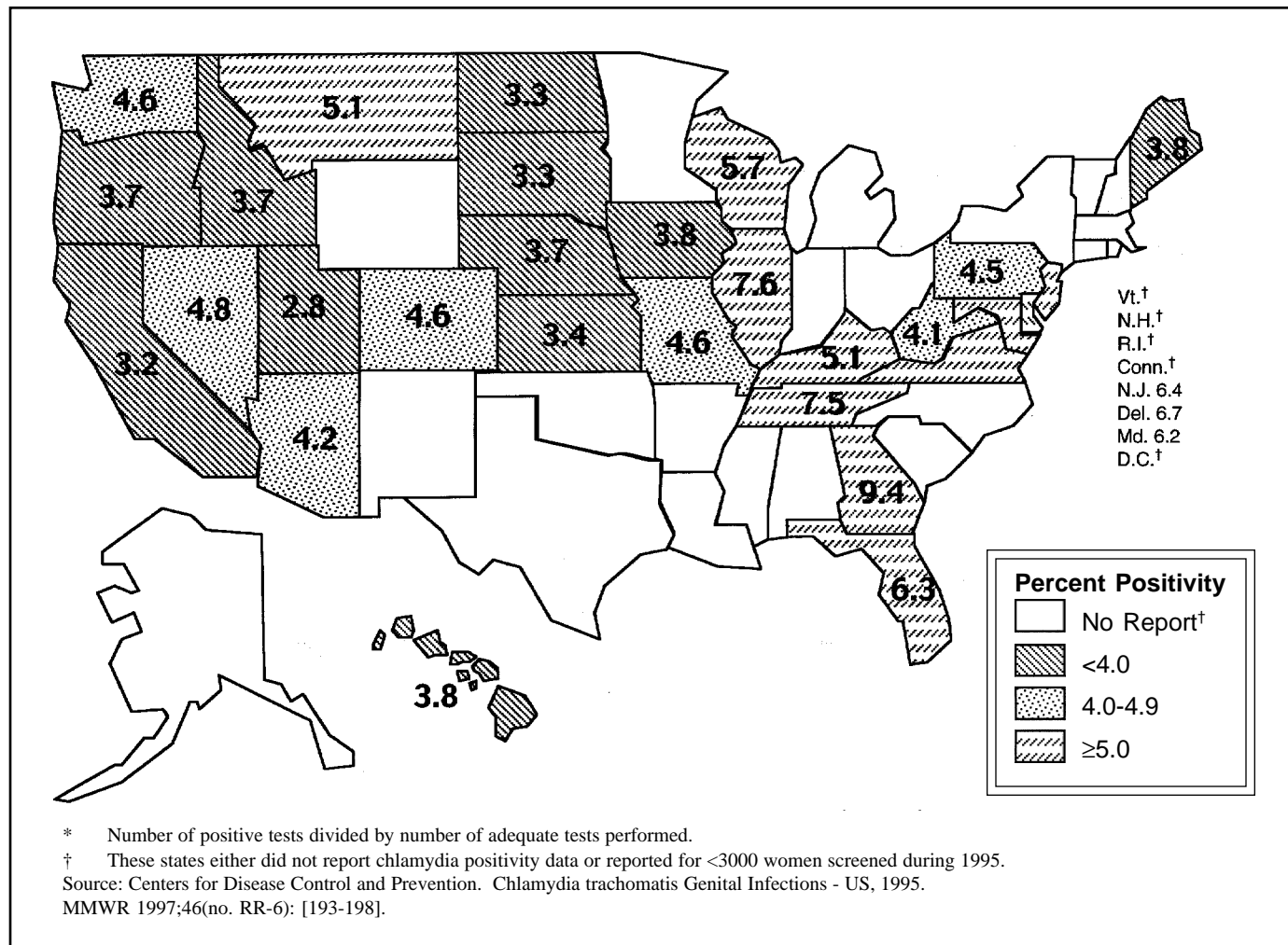


Figure 2. Percentage of chlamydia test positivity* among men and women aged 15-24 years who were tested in selected family planning clinics, by state – US, 1995.



Because not all clinics within service units are participating in the Azithromycin Program, chlamydia rates by IHS Area are greatly underestimated. Data, however, suggest that chlamydia rates in some Areas may be 10-15 times higher than the 182.2 cases per 100,000 population reported for the US general population¹. State reported rates for chlamydia and other STDs may also be underestimated due to racial misclassification of American Indians and Alaska Natives.

The majority of female patients in IHS facilities (62%) with chlamydia were screened during routine Papanicolaou (pap) smears and prenatal visits. Fifty-nine percent of infected females had no symptoms, indicating that targeted screening programs for women ages 15-24 are essential to detect the majority of chlamydia cases. A previous history of chlamydia

is a major risk factor for infection. Seventy percent of patients reporting a prior STD were infected with chlamydia.

Men are often asymptomatic and seldom screened for chlamydia, therefore few are diagnosed. Eighty-nine percent of the 649 reported positive chlamydia cases were female and only 11% male. Of concern are male partners of infected patients who are often not notified, tested, or treated. Until screening men and notifying male partners become more routine, stopping chlamydia transmission will be difficult, if not impossible. □

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1. Centers for Disease Control and Prevention. Chlamydia trachomatis Genital Infections - United States, 1995. *Morbidity and Mortality Weekly Report*. 1997;46(9)193-198.

Screening and Treatment of Chlamydial Infections: Recommendations by the Centers for Disease Control and Prevention^{1,2}

Healthcare providers need to be aware of the high prevalence of chlamydia and recognize chlamydial illness, screen asymptomatic patients, arrange for the treatment of sex partners, and counsel all sexually active patients about the risks of STD infections. Providers should be trained to recognize and manage the following conditions that may be caused by chlamydia: mucopurulent cervicitis (MPC), pelvic inflammatory disease (PID), urethral syndrome (women), and urethritis and epididymitis (men). To effectively prevent, screen, and control chlamydia, the Centers for Disease Control and Prevention (CDC) recommends the following guidelines for health care providers.

Screening

The screening of women for chlamydial infection is a critical component in a chlamydia prevention program since many women are asymptomatic, and the infection may persist for extended periods of time.

Providers such as family physicians, internists, obstetricians-gynecologists, and pediatricians who provide care for sexually active young women should implement chlamydia screening programs. Testing sexually active adolescent women for chlamydial infection should be routine during gynecologic examination, even if symptoms are not present. Screening is also suggested for young adult women age 20-24. The following criteria can help identify women who should be tested for chlamydia:

- Women with MPC
- All sexually active women <20 years of age
- Women 20-24 years of age who meet either of the following criteria: inconsistent use of barrier contraception, or new or multiple sex partners during the last 3 months
- Women age 25 or older who meet both of the following criteria: inconsistent use of barrier contraception, or a new or multiple sex partners during the last 3 months

Recommendations for the frequency of testing for chlamydia are listed below:

- Women <20 years of age should be tested when un-

dergoing a pelvic examination, unless sexual activity since the last test for chlamydia has been limited to a single, mutually monogamous partner

- All other women who meet the suggested screening criteria (listed above) should be tested for chlamydia annually

As an alternative to using risk-based criteria such as these, some public health programs can obtain comparable sensitivity and test a similar proportion of female clinic patients by screening all sexually active women age <30 years.³ Screening criteria need to be evaluated periodically and tailored to fit the needs and characteristics of the population.

Although young men infrequently seek routine health care, medical providers should use such opportunities to evaluate them for asymptomatic chlamydial infection.

Preventing Chlamydial Infection During Pregnancy.

To prevent maternal postnatal complications and chlamydial infection among infants, pregnant women should be screened for chlamydia during the third trimester so the treatment, if needed, will be completed before delivery. The screening criteria already discussed can identify those at higher risk for infection. Screening during the first trimester prevents transmission of the infection and adverse effects of chlamydia during the pregnancy. However, the evidence of adverse effects during pregnancy is minimal. If screening is performed only during the first trimester, a longer period exists for infection before delivery.

Infants with chlamydial infections respond readily to treatment; morbidity can be limited by the early diagnosis and systematic treatment of infants who have conjunctivitis and pneumonia caused by chlamydial infection. Further, the mothers of infants diagnosed with chlamydial infection and the sex partner(s) of those mothers should be evaluated and treated.

Treatment of Chlamydial Infections

The following recommended treatment regimens and alternatives relieve symptoms and cure infection. Treatment of cervical infection is believed to reduce the likelihood of se-

quela, although few studies have demonstrated that antimicrobial therapy reduces the risk of subsequent ascending infections or decreases the incidence of long term complications of tubal infertility and ectopic pregnancy.

Treatment of infected patients prevents transmission to sex partners, and treatment of infected pregnant women may prevent transmission of *C. trachomatis* to infants during birth. Treatment of sex partners will help to prevent reinfection of the index patient and infection of other partners.

Because of the high prevalence of coinfection with *C. trachomatis* among patients with gonococcal infection, patients being treated for gonorrhea should be treated for presumptive chlamydia infection, particularly if no diagnostic test for *C. trachomatis* infection will be performed.

Recommended Regimens

- **Azithromycin** 1 g orally in a single dose
OR
- **Doxycycline** 100 mg orally 2 times a day for 7 days

Alternative Regimens

- **Ofloxacin** 300 mg orally 2 times a day for 7 days
OR
- **Erythromycin base** 500 mg orally 4 times a day for 7 days
OR
- **Erythromycin ethylsuccinate** 800 mg orally 4 times a day for 7 days
OR
- **Sulfisoxazole** 500 mg orally 4 times a day for 10 days (inferior efficacy to other regimens).

Doxycycline and azithromycin appear similar in efficacy and toxicity; however, the safety and efficacy of azithromycin for persons ≤ 15 years of age have not been established. Doxycycline has a longer history of extensive use, safety, and efficacy and the advantage of low cost, however, azithromycin has the advantage of single-dose administration. Ofloxacin is similar in efficacy to doxycycline and azithromycin, but is more expensive than doxycycline, cannot be used with persons ≤ 17 years of age, and offers no advantage in dosing. Ofloxacin is the only quinolone with proven efficacy against chlamydial infection. Sulfisoxazole is the least desirable treatment because of inferior efficacy.

Patient compliance with multiple-dose regimens is a major consideration in the treatment of sexually transmitted diseases. Therefore, the use of single-dose treatment with azithromycin becomes an attractive alternative.¹ In addition, with the avail-

ability of azithromycin through the Stop Chlamydia - Use Azithromycin Program, IHS HQW supports the use of this drug for treating chlamydia.

For pregnant women, doxycycline and ofloxacin are contraindicated. Sulfisoxazole is also contraindicated for women during pregnancy near term and for women who are nursing. The safety and efficacy of azithromycin among pregnant and lactating women have not been established. Repeat testing, preferably by culture, for pregnant women after treatment is recommended because there are few data regarding the effectiveness of these regimens, and the frequent gastrointestinal side effects of erythromycin may discourage a patient from complying with the prescribed treatment.

Recommended Regimen for Pregnant Women

- **Erythromycin base** 500 mg orally 4 times a day for 7 days

Alternative Regimens for Pregnant Women

- **Erythromycin base** 250 mg orally 4 times a day for 14 days
OR
- **Erythromycin ethylsuccinate** 800 mg orally 4 times a day for 7 days
OR
- **Erythromycin ethylsuccinate** 400 mg orally 4 times a day for 14 days
OR

If erythromycin cannot be tolerated:

- **Amoxicillin** 500 mg orally 3 times a day for 7-10 days

NOTE: Erythromycin estolate is contraindicated during pregnancy because of drug-related hepatotoxicity. Few data exist concerning the efficacy of amoxicillin.

Treatment of Sex Partners

Treatment of sex partners of infected persons is an important strategy for reaching large numbers of men and women with asymptomatic chlamydial infection. Also, if partners are not treated, reinfection may occur. Patients should be instructed to refer their sex partners for evaluation and treatment. Because exposure intervals have received limited evaluation, the following recommendations are somewhat arbitrary. Sex partners of symptomatic patients with chlamydia should be evaluated and treated for chlamydia if their last sexual contact with the index patient was within 30 days of onset of the index patient's symptoms. If the index patient is asymptomatic, sex partners whose last sexual contact with the index patient was within 60 days of diagnosis should be evaluated

and treated. Health-care providers should treat the last sex partner even if the last sexual intercourse took place before the foregoing time intervals.

Patients should be instructed to avoid sex until they and their partners are cured. In the absence of microbiologic test-of-cure, "cured" means until therapy is completed and patient and partner(s) are without symptoms.

If chlamydia screening is widely implemented, the number of infected women identified may exceed the capacity of some public health systems to notify, evaluate, and treat partners. Therefore, health department personnel should assist health care providers in developing cooperative approaches to refer partners for treatment. IHS facilities may find training public health nurses and/or community health representatives (CHRs) to assist with partner notification to be very beneficial. Where possible, health care providers who treat female patients for chlamydia should offer examination and treatment services for the patient's male sex partner(s), or should arrange the appropriate referral of such partners.

Risk Reduction Counseling

In addition to screening, treatment, and referral of sex partners of persons with chlamydial infection, health care providers should:

- Educate sexually active patients regarding HIV and other STDs
- Assess the patient's risk factors for infection
- Offer at-risk patients advice about behavior changes to reduce the risk of infection
- Encourage the use of condoms □

References:

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Erratum

Regrettably, there were errors discovered in Table 4 in the article "The Role of Firearms in American Indian Deaths" (*The IHS Provider*, Volume 22, Number 7, July 1997, page 111). The corrected table is reproduced below.

Table 4. Firearm-related death rates, by type, for American Indians and Alaska Natives residing in the IHS service area, calendar years 1991-1993 (3-year total population = 3,811,930); U.S. All Races rates, 1992; and ratio of AI/AN to U.S. All Races.

	Total AI/AN Rate*	U.S. All Races Rate	Ratio AI/AN to U.S. All Races
Unintentional	1.9	0.5	3.5
Suicide	8.13	7.1	1.1
Homicide	5.2	6.9	0.7
Undetermined	0.2	1.6	0.1
Total	16.9	14.9	1.1

* Rate per 100,000 population

AAAHC Draws Interest

There have been a number of inquiries about how to reach the Accreditation Association for Ambulatory Health Care following the publication of our article "The Accreditation Association for Ambulatory Health Care: An Option for Ambulatory Health Centers," (*The IHS Provider*, Volume 22 Number 9, September 1997, pages 137-139). The address and phone numbers for that organization are as follows:

Accreditation Association for Ambulatory
Health Care, Inc.
9933 Lawler Avenue
Skokie, Illinois 60077-3708
Phone: 847-676-9610
Facsimile: 847-676-9628

Institute of Medicine Releases Report on Sexually Transmitted Diseases

A bold national initiative is needed to confront a “hidden epidemic” of sexually transmitted diseases that is causing tremendous personal, social, and financial hardship.

Approximately 12 million new cases of sexually transmitted diseases (STDs) occur in the United States each year — 3 million of them among teenagers. The rate of curable STDs in the United States is the highest of any developed country. These diseases cause thousands of deaths and serious long-term health problems, and cost taxpayers about \$10 billion a year, not including costs associated with sexually transmitted HIV infection, notes an Institute of Medicine committee in its report *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. A reluctance to discuss healthy sexual behaviors has obscured the scope and impact of the epidemic in the United States and has constrained effective interventions to prevent STDs.

The committee calls for a comprehensive approach to STD prevention that would enlist government agencies, the private health care sector, educators, the media, and entire communities in a united effort to promote healthy sexual behaviors, protect adolescents, ensure access to high-quality clinical services, and foster strong leadership in the fight against STDs.

A Rampant Problem

The term “sexually transmitted diseases” encompasses more than 25 infectious organisms that are transmitted through sexual intercourse — including eight organisms identified just since 1980 — along with the numerous clinical syndromes that these infections cause. Certain sexually transmitted pathogens cause cervical, liver, and other cancers. Other serious health complications include ectopic pregnancy, infertility, and liver disease. Infections in pregnant women can result in spontaneous abortion, stillbirth, pre-term delivery, and serious illness among infants.

Despite the huge toll imposed by STDs, especially on women and infants, their full effects are hidden from public view. Some health consequences, such as cancer or infertility, occur years after infection, so that many people are unaware of any link to an STD. Many STDs are asymptomatic and can go undetected, although an infected person can continue to spread the disease to others.

An Effective Response

Many STDs are curable; all are preventable. But the lack of an effective national system to combat STDs has allowed these diseases to pose a growing threat to the public health. Because many STDs increase the risk of acquiring and transmitting HIV infection, preventing STDs should be an essential strategy in the fight against sexually transmitted HIV infection.

Building a national system to confront STDs requires coordination of related programs, sharing of responsibilities, and adequate resources and support in several critical areas.

- **Promoting healthy sexual behaviors.** All interventions to prevent STDs are partly dependent on healthy behaviors. In order for social norms regarding sexual behavior to change, information on STDs must be easily available and openly discussed. The committee therefore recommends establishment of an independent, long-term national campaign to serve as a catalyst for social change toward healthy sexual behavior in the United States.

As part of this campaign, public opinion leaders — including elected officials — should provide highly visible leadership to promote healthy sexual behaviors and the implementation of a national system for STD prevention. In addition, the mass media should be enlisted to disseminate information on STDs and safer behaviors. Television, radio, print, music, and other media should accept advertisements and sponsor public service messages that promote healthy behaviors, especially among adolescents. These include delaying sexual intercourse, using condoms, and taking other precautions against STDs.

- **Reaching adolescents and underserved populations.** All school districts should ensure that schools provide essential, age-appropriate services, including health education, access to condoms, and clinical services, the committee says. While adolescents should be strongly encouraged to delay sexual intercourse, the reality is that nearly 70 percent of high

school seniors have had intercourse. There is no scientific evidence that school-based education programs or condom availability programs promote sexual activity.

Programs to prevent STDs among disenfranchised groups — including illicit-drug users, alcohol abusers, sex workers, the homeless, prisoners, and migrant workers — also need to be expanded because these groups pose a risk of infection for the entire community. Innovative interventions need to be developed for these people since they are difficult to reach through traditional clinical settings.

- **Ensuring access.** Each community should ensure universal access to comprehensive STD-related services, with the organization of services tailored to local needs and circumstances, the committee says. Some health departments may incorporate these services into primary health care. Others may rely on dedicated public STD clinics; many of these clinics, however, need to be improved.

Managed care organizations and other health plans should take more responsibility for STD prevention and participate in activities to prevent STDs in the entire community. They should provide comprehensive STD-related services to plan members and their sex partners regardless of the partners' insurance status, the committee says.

- **Leadership, investment, and surveillance.** The

public sector must continue to play a major role in preventing STDs, but there are limits on what it can do; consequently the private sector needs to take on more responsibility. The committee recommends that an independent, long term national roundtable be established as a neutral forum for public and private agencies to work together in developing a comprehensive system of STD-related services in the United States.

Leadership also is required to increase public and private investments in STD prevention and research. The public sector invests only \$1 to prevent and fight STDs for every \$43 spent on treatment and other costs. Additional investments will avert substantial human suffering and save billions of dollars.

Finally, surveillance and other information systems need to be improved to monitor the incidence of STDs and the effectiveness of prevention programs.

The study was funded by the Centers for Disease Control and Prevention; Glaxo Wellcome Inc.; the Henry J. Kaiser Family foundation; the National Institute of Allergy and Infectious Diseases and the Office of Research on Women's Health, both of the National Institutes of Health; Ortho-McNeil Pharmaceutical; and SmithKline Beecham Pharmaceuticals.

The Hidden Epidemic: Confronting Sexually Transmitted Diseases. Institute of Medicine, 1996 © National Academy of Sciences

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MEETINGS OF INTEREST □

Fetal Alcohol Syndrome

Four identical sessions: February 25-27, 1998, March 25-27, 1998, May 27-29, 1998, and June 10-12, 1998
Seattle, Washington.

This conference is cosponsored by the University of Washington Fetal Alcohol and Drug Unit, the University of Washington FAS Diagnostic and Prevention Network, and the Indian Health Service. Native Americans or those working with Native Americans are eligible, including professionals (physicians, psychiatrists, psychologists, social workers, nurses, teachers, CHNs, chemical dependency counselors, lawyers, judges,

etc.) as well as advocates and parent activists. Six trainees will be selected for each session by the IHS Alcohol and Substance Abuse Program, HQW. Costs for lodging and most meals will be paid for by the UW Fetal Alcohol and Drug Unit. Costs for travel to and from Seattle, airport transfers, and some meals are the responsibility of the attendees or their organizations.

The curriculum includes 1) preventing and overcoming secondary disabilities in people with FAS and FAE across the lifespan (1 day); 2) preventing FAS with the Birth to Three Advocacy Model for working with very high-risk mothers and their families (1 day); and 3) demonstration of a multidisciplinary

the Indian Health Service; the Colleges of Medicine and Public Health, University of Oklahoma Health Sciences Center; the National Institute of Diabetes and Digestive and Kidney Diseases; the Centers for Disease Control and Prevention Diabetes Translation Division; and several American Indian tribes. The accredited sponsor of the conference for continuing education is the IHS Clinical Support Center.

Abstract submissions should be postmarked no later than February 1, 1998. The abstract should be approximately 175

words, single-spaced on a single, plain white, 8½ by 11 inch sheet of paper. Include the title and the name(s) of the author(s) at the top, exclude the affiliations of the author(s), and underline the presenter's name. In a separate cover letter, provide the address and phone and fax numbers of the contact to whom we should send all correspondence. Please send abstracts to the University of Oklahoma Health Sciences Center, College of Public Health, Office of the Dean, P.O. Box 26901, Oklahoma City, OK 73190.

NCME VIDEOTAPES AVAILABLE □

Health care professionals employed by Indian health programs may borrow videotapes produced by the Network for Continuing Medical Education (NCME) by contacting the IHS Clinical Support Center, 1616 East Indian School Road, Suite 375, Phoenix, Arizona 85016.

These tapes offer Category 1 or Category 2 credit towards the AMA Physician's Recognition Award. These CME credits can be earned by viewing the tape(s) and submitting the appropriate documentation directly to the NCME.

To increase awareness of this service, new tapes are listed in The IHS Provider on a regular basis.

NCME #718

Risk Management in Clinical Practice: General Strategies for Preventing Liability (60 minutes) Even if you have never been named in a malpractice suit, the possibility of such an action can produce considerable anxiety. In the first segment of a two-part series on risk management and medical liability issues, the risk manager of one of the nation's largest medical centers reviews the most common causes of malpractice suits in today's rapidly changing healthcare environment. A case-scenario format is used to illustrate specific measures you can take to reduce your personal liability exposure.

NCME #719

Significant Advances in the Treatment of Obesity (60 minutes) An estimated 105 million Americans--one out of three adults--are obese. Obesity is second only to smoking as a leading cause of preventable deaths. Obese patients suffer from a number of serious co-morbid conditions, including insulin resistance, hypertension, dyslipidemia, cardiovascular disease, and non-insulin-dependent diabetes mellitus. Traditional weight reduction programs incorporating diet, exercise, and behavioral modification do not always work at keeping the weight off. A distinguished faculty reviews the epidemiol-

ogy and treatment of obesity with an emphasis on newly approved pharmacotherapies that help these patients achieve long-term weight loss and improved health.

NCME #720

Optimizing Control of Chronic Obstructive Pulmonary Disease (60 minutes) Although many people assume that airway obstruction due to chronic bronchitis or emphysema is totally irreversible, there is growing evidence that effective use of inhaled bronchodilators, including ipratropium bromide and albuterol, can significantly improve lung function in patients with chronic obstructive pulmonary disease (COPD). In this program, a distinguished faculty uses a case-based format to review the latest approaches to the treatment of COPD, including tips on how to educate patients and enhance compliance so they can achieve the full benefits of therapy.

NCME #721

The Medical/Legal Aspects of Pain Management (60 minutes) How can physicians provide patients with adequate pain relief with minimal concern about medical/legal issues? What forms of documentation and clinical management techniques will let physicians focus on patient management and not on fear of legal action? How can we improve communication and understanding among physicians, pharmacists, patients, state medical boards, and regulatory officials? Using real-life case studies, a distinguished, interdisciplinary faculty will illustrate the medical/legal issues that arise during the treatment of patients with chronic pain. Physicians will receive practical advice and sound recommendations about prescribing opioids appropriately and with confidence.

NCME #722

Risk Management in Clinical Practice: Specific Strategies for Effective Communication (30 minutes) Most malprac-

tice suits are brought because patients become angry--which means that many liability actions could probably be prevented by improved physician/patient communication. No matter how expert your critical care, patients place great importance on the way you interact with them. In the second segment of a two-part series on risk management and medical liability issues, the risk manager of one of the nation's largest medical centers uses a case-scenario format to dramatize effective communication skills that can help reduce the chances that you are sued.

NCME #723

Advances in the Treatment of Heart Failure (60 minutes) Diuretics continue to be a cornerstone of management for patients with lung congestion and edema secondary to heart failure. In this program, two experts on heart failure, Drs. Ellison and Nicklas, review the pathophysiology and etiolo-

gies of the disease, and outline the basic steps in patient evaluation. The overall goals of treatment are examined, with a comparative analysis of the roles of each major drug class. The presenters discuss specific criteria for selecting individual agents within the class of diuretics, and their recommendations are illustrated with case studies.

NCME #724

Contemporary Issues in HIV Disease (60 minutes) New information on HIV pathogenesis, viral load monitoring, and antiretroviral therapies continues to grow at a rapid rate. Knowledge of these developments is critical, particularly when selecting effective therapeutic regimens for patients with HIV disease. In this program, Dr. Polsky brings viewers up to date on the latest studies, guidelines, and recommendations as they relate to the clinical management of these patients.

NATIVE AMERICAN MEDICAL LITERATURE □

The following is an updated MEDLINE search on Native American medical literature. This computer search is published regularly as a service to our readers, so that you can be aware of what is being published about the health and health care of American Indians and Alaska Natives.

The Clinical Support Center cannot furnish the articles listed in this section of The Provider. For those of you who may wish to obtain a copy of a specific article, this can be facilitated by giving the librarian nearest you the unique identifying number (UI number), found at the end of each cited article.

If your facility lacks a library or librarian, try calling your nearest university library, the nearest state medical association, or the National Library of Medicine (1-800-272-4787) to obtain information on how to access journal literature within your region. Bear in mind that most local library networks function on the basis of reciprocity and, if you do not have a library at your facility, you may be charged for services provided.

Welty TK, Darling K, Dye S, et al. Guidelines for prevention and control of hepatitis A in American Indian and Alaska Native communities. *S D J Med.* 1996 Sep;49(9):317-22. 97007535

Havas S, Sherwin R. Putting it all together: summary of the

NHLBI Workshop on the Epidemiology of Hypertension in Hispanic American, Native American, and Asian/Pacific Islander American Populations. *Public Health Rep.* 1996;111 Suppl 2:77-9. 97054487

Rhoades ER. American Indians and Alaska Natives—overview of the population. REVIEW ARTICLE: 9 REFS. *Public Health Rep.* 1996;111 Suppl 2:49-50. 97054477

Howard BV. Blood pressure in 13 American Indian communities: the Strong Heart Study. *Public Health Rep.* 1996;111 Suppl 2:47-8. 97054476

Gilbert TJ, Percy CA, White LL, Romero FC. Blood pressure and body measurements among Navajo adolescents. *Public Health Rep.* 1996;111 Suppl 2:44-6. 97054475

de Courten MP, Pettitt DJ, Knowler WC. Hypertension in Pima Indians: prevalence and predictors. *Public Health Rep.* 1996;111 Suppl 2:40-3. 97054474

Casper M, Rith-Najarian S, Groft J, Giles W, Donehoo R. Blood pressure, diabetes, and body mass index among Chippewa and Menominee Indians: the Inter-Tribal Heart Project Preliminary Data. *Public Health Rep.* 1996;111 Suppl 2:37-9. 97054473

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Wesley J. Picciotti, MPA Director, CSC

John F. Saari, MD Editor

Thomas J. Ambrose, RPh
E. Y. Hooper, MD, MPH Contributing Editors

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Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via the IHS Banyan electronic mail system.

Authors should submit one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or through our fax retrieval service. Call 602-640-2140, ask for the fax retrieval service, and request document #3005. After business hours, press 8, and follow the instructions.

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