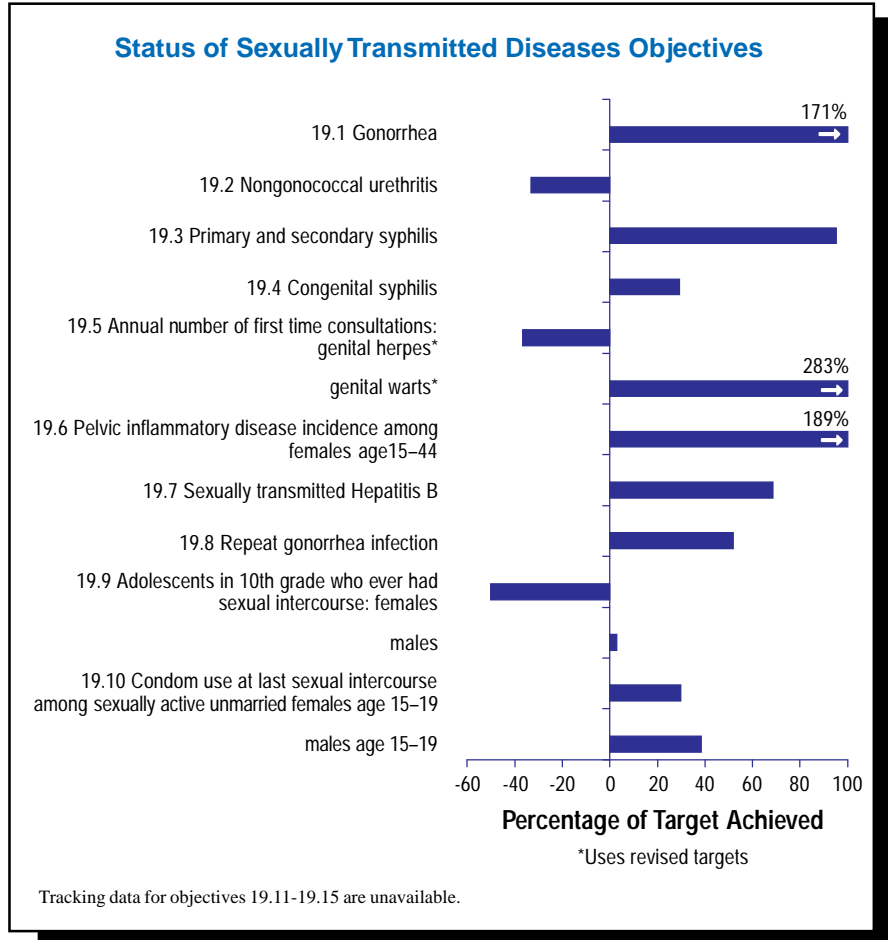


# 19

# Sexually Transmitted Diseases



**Lead Agency:** *Centers for Disease Control and Prevention*

### SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases (STDs) disproportionately affect the young, the poor, and minorities. STDs have serious health effects and can lead to impaired fertility, ectopic pregnancies, and other adverse pregnancy outcomes such as low birthweight and prematurity. Chronic pain, cervical cancer, and chronic liver disease also are the potential consequences of sexually transmitted infections. STDs and HIV infection are linked not only by common underlying risk behaviors but also by biological mechanisms. The presence of STDs has been documented as increasing the transmission and acquisition of HIV infection.

The burden and suffering from STDs make prevention of the estimated 12 million cases that occur each year in the United States imperative. Two-thirds of the STD cases occur among young people under the age of 25 years, and STD infection rates are higher in the southern States (see State map). Both statistics show the opportunity and challenge of shaping effective STD prevention strategies. Different approaches in different communities are needed, and in all instances must be shaped by the people at risk and those who are infected.

Population-based, community-wide efforts of State and local health departments are the first line of defense against STDs. Public sector programs often are the preferred provider of STD services because they can offer confidentiality. However, the public sector cannot possibly combat STD infections alone. STD prevention must be integrated into the health care practice of private sector primary care providers. This service can be facilitated through sharing information from the public sector's surveillance and laboratory systems. Developing a community's capacity for rapid response to STD outbreaks and effective partner notification programs will help prevent STDs.

Public education about the risk and the spread of disease is important. Rather than stigmatize people with fear, effective prevention messages stress positive and esteem-enhancing imagery such as "take care of yourself, you are worth it." School health programs are educating adolescents about healthy behaviors and adopting a lifestyle at an early age to minimize risk of STD infections. STD and HIV prevention services are being combined, as are STD services and reproductive health care in family planning clinics to strengthen behavioral interventions in the most at-risk communities. STD program linkages with substance abuse prevention programs enable street and community outreach workers to get important information and services to people who do not seek care in traditional health care settings.

Health department and university collaborations are being supported through the National Institutes of Health (NIH)-funded STD Cooperative Research Centers and the Centers for Disease Control and Prevention (CDC) STD Accelerated Prevention Campaign grant program. Through the NIH, CDC, World Health Organization, and U.S. Agency for International Development, work is underway to develop new and

inexpensive rapid STD diagnostic tests. Together biomedical and behavioral research can provide a strong science base to support effective STD prevention.

## Review of Progress

At an October 1994 HEALTHY PEOPLE 2000 progress review with the Assistant Secretary for Health there was both good and bad news. Nearly all STD rates are on the decline, including gonorrhea, repeat gonorrhea infection, primary and secondary syphilis, and congenital syphilis. Pelvic inflammatory disease (PID) and sexually transmitted Hepatitis B also show progress toward the year 2000 targets. Among special population groups the rates of decline are not as great. The challenge over the remaining 5 years of the decade will be narrowing the gap between the total population and reducing rates of STD infections among adolescents and certain racial and ethnic minority groups.

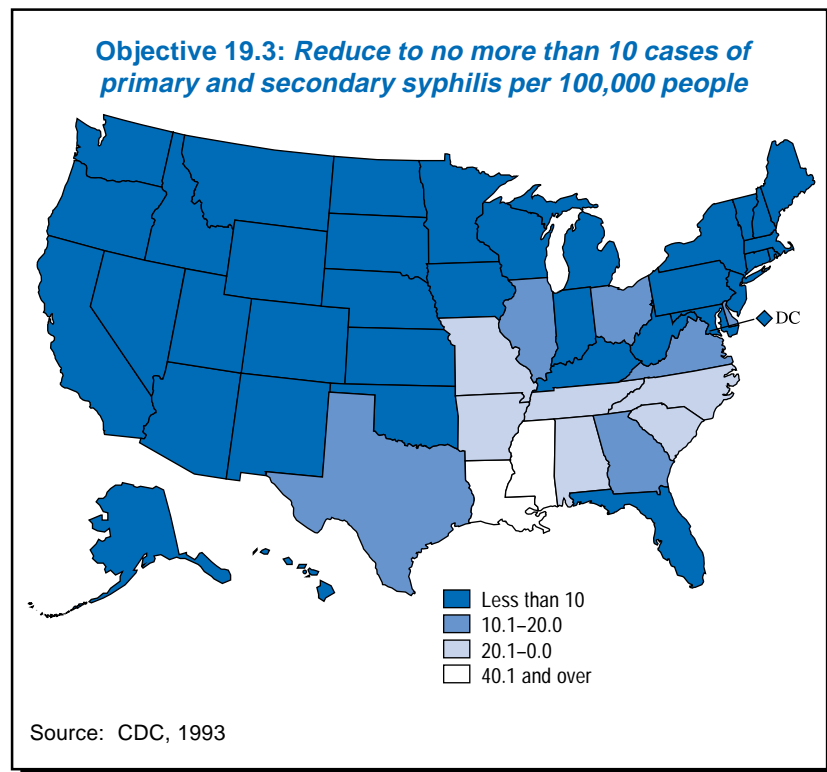
One objective moving away from the year 2000 target is the number of adolescents engaging in sexual intercourse. Among 15- and 17-year-old males and females, sexual activity has increased. At the same time, the percent of sexually active teens who report using a condom at last sexual intercourse has risen.

Baseline data for objective 19.14 show that clinicians do not routinely inquire about sexual practices of adolescents and adults. They provide counseling on STD and HIV prevention more routinely. Nurse practitioners reported that they routinely inquired about sexual practices of 52 percent of their patients and routinely counseled 50 percent about HIV and STD infections. For the other services and protection objectives, 19.11, 19.12, 19.13, and 19.15, there are no tracking data beyond the baseline.

## 1995 Revisions

Because of the success in preventing STDs, many of the year 2000 targets have been met at the midpoint of the decade. The targets have been made more challenging for reducing gonorrhea, primary and secondary syphilis, congenital syphilis, and pelvic inflammatory disease.

In 1988 chlamydia infection was difficult to document because of the



limited use and expense of diagnostic methods (culture). At that time, a nonspecific surrogate marker, nongonococcal urethritis, was used to monitor trends in *Chlamydia trachomatis*. Dramatic changes in diagnostic technology in the past few years have resulted in wide-scale screening for chlamydia infection in medical practice throughout the country. For this reason objective 19.2 has been revised to be a direct measurement of chlamydia infection. As screening for chlamydia becomes more and more common, especially among women, most of the infections detected will be among asymptomatic women and will represent predominantly prevalent disease. Monitoring this condition is problematic if only the number of infections detected is counted because as screening increases, so will the number of cases detected. Screening demonstration projects have suggested that a more meaningful measurement of the reduction in chlamydia infection is the proportion of women who screen positive over time.

In 1992 data became available for the first time to monitor repeat gonorrhea infection by race/ethnicity. These data were collected in 26 sentinel STD clinics throughout the United States as part of the Gonococcal Isolate Surveillance Project. Abstractors reviewed the medical charts of male patients with confirmed gonorrhea infection to determine whether any other episodes of gonorrhea were recorded for the patient within the previous 12 months. These data show that blacks have had a higher rate of repeat gonorrhea infection and support the establishment of a special population target for blacks for objective 19.8.

The baseline and target for objective 19.4 have been revised to reflect the 1988 change in definition for congenital syphilis. Many infants who would not have been counted in previous years now are included. Because the adoption and implementation of the new case definition by all States took 4 years, the 1990 data are regarded as most complete and now have become the baseline. In 1992 data became available to determine congenital syphilis incidence by race/ethnicity, allowing identification of population groups with disparate STD burdens. Based on these data, special population targets were established for blacks and Hispanics.

The baseline and target for objective 19.5 also have been revised. These adjustments are based on a new analysis and new weighting of the 1988 data. The original baselines were 167,000 (herpes) and 451,000 (warts); the new baselines are 163,000 (herpes) and 290,000 (warts) for 1988.

PID hospitalizations per 100,000 women aged 15–44 in 1991 surpassed the year 2000 target. To some extent this decrease may be the result of changes in medical practice as well as a decline in disease incidence. A more challenging target for reducing PID hospitalizations has been established for the year 2000.

Data from the 1988 National Hospital Discharge Survey suggest substantive differences in the rates of hospitalizations for PID between white and black women. Adolescents also were found to have some of the highest rates of acute gonorrhea and chlamydia and have higher rates of hospitalization for PID than the general

population. Special population targets have been established in objective 19.6 for blacks and adolescents (ages 15–19).

STD epidemiologic trends suggest that chlamydia is likely to be the cause of an increasing proportion of PID in U.S. women. Because the severity of chlamydia PID appears to be less on average than that from gonorrhea, a significant number of women with PID in the 1990s are likely to be treated as outpatients. Objective 19.6 has been expanded to track and reduce outpatient visits for PID.

