Complete Summary

GUIDELINE TITLE

Behavioral counseling to prevent sexually transmitted infections: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Behavioral counseling to prevent sexually transmitted infections: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2008 Oct 7;149(7):491-6, W95. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 62, Counseling to prevent HIV infection and other sexually transmitted diseases. p. 723-37. [111 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Sexually transmitted infections (STIs):

- *Chlamydia trachomatis*
- Hepatitis B
- Hepatitis C
- Herpes simplex
- Human immunodeficiency virus (HIV)

- Human papillomavirus
- *Neisseria gonorrhea*
- Syphilis
- *Trichomonas vaginalis*

GUIDELINE CATEGORY

Counseling
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations and supporting evidence on behavioral counseling to prevent sexually transmitted infections
- To update the 1996 USPSTF recommendations

TARGET POPULATION

All sexually active adolescents and adults

INTERVENTIONS AND PRACTICES CONSIDERED

High-intensity behavioral counseling

MAJOR OUTCOMES CONSIDERED

Key Question 1: Is there direct evidence that behavioral counseling interventions to reduce risky sexual behaviors and increase protective sexual behaviors reduce sexually transmitted infection (STI) incidence and/or related morbidity and mortality?

Key Question 2: Do behavioral counseling interventions to prevent STIs in primary care reduce risky sexual behaviors or increase protective sexual behaviors?

Key Question 3: Are there other positive outcomes besides sexual behavioral changes and reduced incidence of STI resulting from behavioral counseling interventions to prevent STIs in primary care?

Key Question 4: What are the adverse effects associated with behavioral counseling interventions to prevent STIs in primary care to reduce risky sexual behaviors and increase protective sexual behaviors?

Key Question 5: Do sexual behavioral changes, including reducing risky sexual behaviors and increasing protective sexual behaviors, lead to a reduced incidence of STIs and/or related morbidity and mortality?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Literature Search Strategy

EPC staff developed literature search strategies and terms for each key question (KQ) (see Appendix A, Table 1 in the Evidence Synthesis [see the "Availability of Companion Documents" field]) and conducted two separate literature searches (Search one was for KQ1, KQ2; and Search two was for KQ5). For behavioral counseling interventions that met the inclusion criteria for KQ1 and KQ2, EPC staff examined if there were other positive (KQ3) or potentially harmful (KQ4) behavioral or biological outcomes. Because the search for potential adverse effects was limited to behavioral or biological outcomes, which are the paradoxical effects of beneficial outcomes (i.e., increase in risky sexual behavior rather than a decrease in risky sexual behavior), the same study design criteria were used for beneficial (KQ1, 2, 3) and harmful (KQ4) outcomes. Therefore, EPC staff was able to use a single, broad search strategy for KQ1, 2, 3, and 4.

For KQs 1 and 2, EPC staff searched Medline (ML), Cochrane Central Registry of Controlled Trials (CCRCT), Cochrane Database of Systematic Reviews (CDSR), PsycINFO (PI), and the Centers for Disease Control and Prevention's (CDC) Prevention Synthesis Research (PRS) Project's database from 1988 to December 31, 2006. EPC staff explicitly chose to examine the literature since 1988 because

it marks the initial year for published studies on sexual behavioral counseling in the post-HIV era. This approach is consistent with both the CDC's Guide to Community Preventive Services and the Prevention Research Synthesis (PRS) Project. For KQ5, ML and CCRCT were searched from 1988 to August 2006. KQ5 focused on the effectiveness of female condoms, which were first manufactured in 1988. Literature searches were supplemented with outside source material from experts in the field and from examining the bibliographies of existing systematic reviews on this topic (see Appendix A Table 4 in the Evidence Synthesis [see the "Availability of Companion Documents" field]).

While EPC staff did not conduct systematic searches for contextual questions, they searched the National Health Service Economic Evaluation Database (NHSEED) through October 2006 for any articles related to cost-effectiveness.

Article Review and Data Abstraction

EPC staff reviewed all abstracts for potential inclusion for any of the KQs using the inclusion/exclusion criteria described in Appendix A, Table 2 in the Evidence Synthesis (see the "Availability of Companion Documents" field). To be included, a study had to evaluate a primary care feasible behavioral counseling intervention addressing sexual behavior change (e.g., sexual risk reduction or sexual risk avoidance) with the primary intention of preventing sexually-transmitted infection (STI) transmission. Consistent with the USPSTF's scope, behavioral counseling interventions needed to be conducted in primary care settings, or judged to be feasible for delivery in primary care based. In general, primary care feasible counseling interventions had to involve individual-level participant identification; a primary care practitioner or related clinical staff; and individual or small-group format, with a limited number of sessions, or at a minimum be viewed as connected to the health care system. Behavioral counseling interventions that included an active component of community outreach, use of community members (e.g., opinion leaders, peer facilitators), use of community programs (e.g., worksite programs, school programs), use of social marketing, or use of public policy changes were not considered primary care feasible. School- and university-based trials were excluded unless conducted in a school- or university-based health clinic. (see Appendix A Table 2 in the Evidence Synthesis [see the "Availability of Companion Documents" field] for criteria details).

EPC staff also required that studies evaluating primary care feasible behavioral counseling interventions be conducted in populations representative of primary care patients. Therefore, they excluded studies that exclusively enrolled participants from correctional facilities, substance-abuse-treatment facilities, HIV clinics, and inpatient hospital units.

For inclusion, studies had to report either biological (e.g., STI incidence) or behavioral outcomes at 3 months after the counseling intervention or later. EPC staff excluded studies only reporting outcomes centered around knowledge, attitudes, self-esteem, and ability changes (skills).

All included studies were limited to those reported in English language. For KQs 1, 2, 3, and 4, studies were also limited to those conducted in English-speaking countries with cultural similarity to the United States (e.g., Australia, Canada, New Zealand, and United Kingdom). For KQ5, studies were not limited to English-

speaking countries. The study design was limited to randomized controlled trials (RCTs) and controlled clinical trials (CCTs). For KQ5, however, comparative observational research designs were included in addition to RCTs and CCTs. Trials of comparative effectiveness (i.e., trials without a control arm) were excluded. Trials had to include a control arm with no intervention (e.g., wait-list control, usual care), minimal intervention (e.g., usual care limited to no more than 15 minutes of information), or matched control (e.g., similar format and intensity intervention on a different content area).

Two investigators independently screened all abstracts for potential inclusion.

NUMBER OF SOURCE DOCUMENTS

This review included 19 articles representing 13 unique trials for key questions (KQs) 1, 2, and 3, and three articles for KQ 4.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Abstraction

One primary reviewer abstracted relevant information into standardized evidence tables for each included article (see Appendix B of the evidence synthesis [see the "Availability of Companion Documents" field]). A second reviewer checked the abstraction process.

Literature Synthesis

EPC staff members were unable to conduct quantitative synthesis for any key question due to the heterogeneity of intervention methods, populations addressed, and settings. Instead, they qualitatively synthesized their results within categories focusing first on the population(s) addressed, and second on the setting in which the population was identified and the counseling intervention

delivered. The results text and corresponding summary tables reflect these qualitative summaries.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	**Magnitude of Net Benefit**			
	Substantial	**Moderate**	**Small**	**Zero/Negative**
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

**A*, *B*, *C*, *D*, and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)

3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist us in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that 1 of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty.

Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF, et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875 [5 references].

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service

is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center (EPC) and the Agency for Healthcare Research and Quality (AHRQ) send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations, and federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations regarding behavioral counseling to prevent sexually transmitted infections were considered from the following groups: the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the American Medical Association (AMA).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs. **This is a grade B recommendation**.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of behavioral counseling to prevent STIs in non–sexually-active adolescents and in adults not at increased risk for STIs. **This is an I statement**.

Clinical Considerations

Patient Population under Consideration

This recommendation applies to all sexually active adolescents and adults.

Assessment of Risk

All sexually active adolescents are at increased risk for STIs and should be offered counseling. Adults with current STIs or infections within the past year are at increased risk for future STIs. In addition, adults who have multiple current sexual partners should be considered at increased risk and offered counseling to prevent STIs. Married adolescents may be considered for counseling if they meet the criteria described for adults. Clinicians should also consider the communities they serve. If the practice's population has a high rate of STIs, all sexually active patients in nonmonogamous relationships may be considered to be at increased risk.

Effective Behavioral Counseling Interventions

Among the studies reviewed, successful high-intensity interventions were delivered through multiple sessions, most often in groups, with total durations from 3 to 9 hours. Little evidence suggests that single-session interventions or interventions lasting less than 30 minutes were effective in reducing STIs. Although 2 studies of moderate-intensity interventions did not demonstrate effect, a third study demonstrated that two 20-minute counseling sessions before and after human immunodeficiency virus (HIV) testing resulted in a clinically and statistically significant reduction in STIs. The USPSTF found no studies of abstinence-only counseling programs delivered in the clinical setting.

Suggestions for Practice Regarding the I Statement

Because of the lower incidence of STIs among adults who are not at increased risk, the potential net benefit of behavioral counseling is likely to be smaller for this population than for those at increased risk. Given the current lack of evidence of effectiveness; the substantial costs in time and money for clinicians, patients, and the health system; and the potential missed opportunity for the provision of higher-priority, evidence-based preventive services, primary care clinicians should consider not routinely offering behavioral counseling to prevent STIs to adults who are not at increased risk for infection. The USPSTF found limited evidence on the counseling of non–sexually-active adolescents, with no effect or harms from brief counseling in 1 small study. Although clinicians may not be able to identify all adolescents who are sexually active, intensive counseling for all adolescents to reach those who are not appropriately identified as at risk is not supported by current evidence and would require significant resources. The effectiveness of less intensive counseling has not been established and the benefits of intensive counseling for adolescents who are identified as at risk may not be generalizable to those who deny sexual activity.

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the	Offer or provide this service.

Grade	Grade Definitions	Suggestions for Practice
	service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice

Level of Certainty	Description
	• Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

CLINICAL ALGORITHM(S)

None available

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Counseling to Change Behavior

- There is convincing evidence that high-intensity behavioral counseling interventions targeted to sexually active adolescents and adults at increased risk for sexually transmitted infections (STIs) reduce the incidence of STIs. These results were found 6 and 12 months after counseling took place.
- The U.S. Preventive Services Task Force (USPSTF) has identified the absence of studies and evidence on behavioral counseling interventions directed towards adults not at increased risk for STIs and non–sexually-active adolescents as a critical gap in the literature.

POTENTIAL HARMS

Harms of Counseling

No evidence of significant behavioral or biological harms resulting from behavioral counseling about risk reduction has been found. The U.S. Preventive Services Task Force (USPSTF) concluded that the potential harms of counseling are no greater than small.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs.

Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

Implementation for Behavioral Counseling

High-intensity behavioral counseling may be delivered in primary care settings or in other sectors of the health system after referral from the primary care clinician or system. In addition, risk-reduction counseling may be offered by community organizations. Strong linkages between the primary care setting and the community may greatly improve the delivery of this service.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Behavioral counseling to prevent sexually transmitted infections: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2008 Oct 7;149(7):491-6, W95. PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2008 Oct)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

*Task Force Members**: Ned Calonge, MD, MPH, *Chair*, USPSTF (Colorado Department of Public Health and Environment, Denver, Colorado); Diana B. Petitti, MD, MPH, *Vice-chair*, USPSTF (Keck School of Medicine, University of Southern California, Sierra Madre, California); Thomas G. DeWitt, MD (Children's Hospital Medical Center, Cincinnati, Ohio); Allen J. Dietrich, MD (Dartmouth Medical School, Hanover, New Hampshire); Leon Gordis, MD, MPH, DrPH (Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland); Kimberly D. Gregory, MD, MPH (Cedars–Sinai Medical Center, Los Angeles, California); Russell Harris, MD, MPH (University of North Carolina School of Medicine, Chapel Hill, North Carolina); George Isham, MD, MS, (HealthPartners, Inc., Minneapolis, Minnesota); Rosanne Leipzig, MD, PhD (Mount Sinai School of Medicine, New York, New York); Michael L. LeFevre, MD, MSPH (University of Missouri School of Medicine, Columbia, Missouri); Carol Loveland-Cherry, PhD, RN (University of

Michigan School of Nursing, Ann Arbor, Michigan); Lucy N. Marion, PhD, RN (Medical College of Georgia, Augusta, Georgia); Virginia A. Moyer, MD, MPH (University of Texas Health Science Center, Houston, Texas); Judith K. Ockene, PhD (University of Massachusetts Medical School, Worcester, Massachusetts); George F. Sawaya, MD (University of California, San Francisco, California); and Barbara P. Yawn, MD, MSPH, MSc (Olmsted Medical Center, Rochester, Minnesota).

**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm*.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. Task Force members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 62, Counseling to prevent HIV infection and other sexually transmitted diseases. p. 723-37. [111 references]

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and from the Annals of Internal Medicine Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Lin J, Whitlock E, O'Connor E, Bauer V. Behavioral counseling to prevent sexually transmitted infections. Evidence Synthesis No. 64. AHRQ Publication No. 08-05123-EF-1. Rockville, Maryland: Agency for Healthcare Research and Quality, 2008 Oct. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.
- Lin JS, Whitlock E, O'Connor E, Bauer V. Behavioral counseling to prevent sexually transmitted infections: a systematic review for the U.S. Preventive

Services Task Force. Ann Intern Med. 2008;149. Electronic copies: Available from the Annals of Internal Medicine Web site.
- Behavioral counseling to prevent sexually transmitted infections: clinical summary of U.S. Preventive Services Task Force recommendation. Rockville (MD): Agency for Healthcare Research and Quality, 2008. Electronic copies: Available from the U.S. Preventive Services Task Force Web site.

Background Articles:

- Barton M, et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-127.
- Guirguis-Blake J, et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-122. [2 references]
- Sawaya GF, et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875. [5 references].

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

The following is also available:

- The guide to clinical preventive services, 2008. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2008. 249 p. Electronic copies available in English and Spanish from the AHRQ Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Summaries for patients. Counseling during primary care visits to prevent sexually transmitted infections: U.S. Preventive Services Task Force recommendations. Ann Intern Med 2008 Oct 7; 149(7):493. Available from the Annals of Internal Medicine Web site.
- Men: Stay Healthy at Any Age – Checklist for Your Next Checkup. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP006-

A. February 2007. Electronic copies: Available in English and Spanish from the USPSTF Web site.

- Women: Stay Healthy at Any Age – Checklist for Your Next Checkup. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP005-A. February 2007. Electronic copies: Available in English and Spanish from the USPSTF Web site.

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI Institute on September 23, 2008. The updated information was verified by the guideline developer on October 10, 2008.

COPYRIGHT STATEMENT

Requests regarding copyright should be sent to: Randie A. Siegel, Electronic Dissemination Advisor, Division of Print and Electronic Publishing, Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research), 540 Gaither Road, Rockville, MD 20850. Facsimile: 301-427-1873. E-mail: Randie.siegel@ahrq.hhs.gov.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2008 National Guideline Clearinghouse

Date Modified: 11/3/2008