LETTERS

PROMOTING CULTURALLY COMPETENT CARE FOR THE LESBIAN, GAY, BISEXUAL, AND TRANSGENDER POPULATION

I am writing to express my support for the critical information that the Journal presented in its June issue on lesbian, gay, bisexual, and transgender health care. As you know, this is a diverse population that has historically received inadequate, if not discriminatory, care in American medicine.

I am a pediatrician and a member of Kaiser Permanente's National Diversity Council. The Council and Kaiser Permanente's Diversity Department have made our focus the creation of educational information for providers, so that they can provide culturally competent care for the diverse populations we serve. In 1996, we published *A Provider's Handbook on Culturally Competent Care: Latino Population* (second edition forthcoming), and in May 1999 we published *A Provider's Handbook on Culturally Competent Care: African American Population* and *A Provider's Handbook on Culturally Competent Care: Asian and Pacific Islander Population.*

I had the great opportunity, starting in June 1999, to be the Physician Champion for *A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered Population,* which was published in June 2000. We have since worked on a plan to introduce the handbooks internally through a continuing medical education format. Late last year we mailed copies of all the currently available handbooks to every medical school in the United States for their evaluation and use. Our goals in all of these efforts is to ensure that all our members have access to good health care and to have an impact on the care provided in the community. Since we provide care to 8.1 million members, we will have a significant impact on the care given to many Americans. As a nonprofit health care delivery system, we also have a commitment to increase the quality of care to all communities. A limited number of copies of our handbooks are available to health care providers in the community. For information on how to request these, please call 510-271-6663.

Again, thank you for your efforts to improve the health care services that lesbian, gay, bisexual, and transgender individuals receive in this country. ■

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ON ENCOMPASSING SEXUALITY

Dr Meyer should be commended on his organization of the special issue of the Journal (June 2001), focused on lesbian, gay, bisexual, and transgender (LGBT) health, which should raise awareness and bring new interest to LGBT concerns. My hope is that this issue enables the call for proposals and programs of which Meyer wrote[1] and the examination, free of stigma and discrimination, of LGBT health concerns. In "Why Lesbian, Gay, Bisexual, and Transgender Public Health?" Meyer addresses the intersection of sexual identity and gender identity with public health concerns.[1] With this letter I hope to address one issue in Meyer's editorial.

Meyer discusses 3 categories for LGBT health issues—unique exposures, high prevalence not associated with unique exposures, and the need for culturally competent approaches. As an example, he notes that "the area most often addressed under this category [unique exposures] is risk related to sexual behavior (e.g., anal intercourse, which places men who have sex with men [MSM] at risk for HIV and other sexually transmitted diseases)."[1(p857)] However, anal intercourse is not unique to MSM. Prevalence estimates in the United States show that over one fourth of heterosexual men, as well as over one fifth of heterosexual women, have ever engaged in anal intercourse.[2] Furthermore, almost 10% of heterosexual men and 9% of heterosexual women have engaged in anal intercourse over the previous year,[2] and 6.7% of heterosexuals engage in anal intercourse at least once per month.[1] The frequency of anal intercourse among heterosexuals has been shown in other countries as well, particularly in Latin America, where the female anus is eroticized more than elsewhere.[4–7] Women who engage in anal intercourse are at increased risk for HIV and STD transmission.[8] Thus, anal sex is prevalent among and poses risk for HIV infection to heterosexuals, particularly women.

The labeling of anal intercourse as a homosexual act occurs regularly. Yet, sexual acts do not define a person's sexuality. Men and women, gay and straight, largely partake in the same sexual acts, albeit to varying degrees dependent on the manner in which such acts are socially constructed in a given cultural milieu and the physiologic equipment that a person has to work with. Classifying sexual practices creates further divisions between the LGBT community and heterosexuals. When we are able to view sexuality and sexual practices in a more fluid manner, rather than in a

gay–straight dichotomy, we will be able to further reduce stigma and discrimination. ■

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CDC PROMOTES THE FEMALE CONDOM FOR HIV/STD PREVENTION

Erica Gollub wrote, in her commentary in the September 2000 issue of the Journal, "[T]he CDC [Centers for Disease Control and Prevention] lags considerably . . . in promoting [the female condom]. . . . This has contributed to the undermining of confidence in this method."[1(p1379)]

Acceptable and effective prevention methods are desperately needed to fight the global pandemics of HIV and sexually transmitted diseases (STDs). The CDC first recommended female condoms for HIV and STD prevention in 1993 for couples who do not abstain from sex, are not mutually monogamous with an uninfected partner, or do not use male condoms.[2] At that time, only 1 small trial showed that consistent female condom use prevented reinfection with *Trichomonas.*[2]

In 1998, the CDC reiterated the 1993 recommendation after experts reviewed the relevant new data.[3] One Thai trial described the female condom's "marginal effectiveness": women who were offered female and male condoms were less likely to become infected with STDs than women who were offered male condoms alone.[4] In the only US trial of female condom effectiveness in preventing STD transmission, few women consistently used female condoms; most preferred male condoms for long-term use.[5] Effectiveness data from this study are not yet published. The CDC disseminated the 1993 and 1998 recommendations in print (including consumer fact sheets and provider training materials), electronic format, and hotline messages to thousands of governmental and nongovernmental prevention programs, health care providers, and consumers.

The CDC has provided at least $5 million in funding for female condom research and has actively sought new funds to evaluate female-controlled prevention methods.[6] Research has addressed determinants of condom use, slippage, breakage, and leakage and comprehension of hierarchical HIV/STD prevention messages. For more than a decade, the CDC has also funded HIV/STD prevention programs to purchase and distribute female condoms and to counsel clients about the condoms' use.[7]

Available data indicate that for many women who do not abstain from sexual intercourse, do not have a mutually monogamous relationship with an uninfected partner, or do not use male latex condoms consistently and correctly, the female condom is the most effective HIV and STD prevention method. In the face of devastating epidemics of HIV and STD, the CDC will continue to promote female condoms and other methods for HIV/STD prevention and will support development of other HIV/STD prevention strategies for women. ■

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GOLLUB RESPONDS

The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have printed an 80-page program and planning guide for the female condom that has been distributed in more than a dozen countries,[1] as well as a 40-page summary of 42 studies of female condom acceptability.[2] WHO/UNAIDS has funded large effectiveness trials[3] and many field projects dedicated to optimal introduction of this method. From 1997 to 2001, 12.9 million female condoms were purchased for global use under a UNAIDS–Female Health Company partnership (personal communication; M. Warren, The Female Health Company; June 2001). In late May, UNAIDS executive director Peter Piot stated that "both male and fe-

male condoms need to be more readily available . . . to increase the options for women to protect themselves—and increasing means from zero to one."[4]

In contrast, the 1993 and 1998 publications Green cites give cursory treatment—only 8 to 9 lines—to the female condom, mentioning neither the consistently positive behavioral data nor the data showing that the device tears less easily than a male condom.[5] In these advisories, instead, between 22 and 44 lines are dedicated to the male condom, with user tips, information on breakage and slippage, and recommendations for carriage and storage. No Centers for Disease Control and Prevention (CDC) updates have been issued since 1998 regarding the more than 20 US published studies of the female condom or the contraceptive study data indicating 6-month female condom failure rates as low as 0.8% to 3.2%.[6,7,8] No technical assistance is routinely offered by CDC to health departments to integrate the female condom into HIV counseling and testing programs. No partnership activities exist with the manufacturer. A CDC head has yet to publicly endorse the female condom as an important infection-fighting tool.

Green states that in a recent study at a sexually transmitted disease clinic, few women consistently used the female condom. If "consistent use" were the criterion to measure a method's contribution to HIV prevention efforts, the male condom—now, after vigorous promotion for 15 years—would fail. In high-risk groups, only 4% to 17% report consistent use,[9] and in national surveys, the figure rises to no more than 33%.[10]

But such a standard undermines our immediate goal of risk reduction—the appropriate response to the public health emergency of HIV in women. Overlooked by Green in the STD clinic study she cites is that the proportion of protected acts increased substantially with the introduction of the female condom, from less than 40% to nearly 70%.[11,12] The latter result was found in other studies, too—from double to triple the baseline rate of protection.[13,14]

In the view of many of us, a major CDC investment in training health workers to introduce and promote the female condom would signal a desperately needed change from indifference or skepticism to proactive support and would have a real and lasting impact on public health. ■

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MATERNAL SMOKING CESSATION INTERVENTION: TARGETING WOMEN AND THEIR PARTNERS BEFORE PREGNANCY

Pollack recently analyzed the relationship between maternal smoking and sudden infant death syndrome (SIDS) and the cost-effectiveness of smoking cessation programs.[1] We fully agree that smoking cessation interventions should remain an important policy goal, but we wish to emphasize that such programs should especially be targeted at women *before* conception in order to protect the developing embryo from tobacco exposure during organogenesis and to minimize other risks.[2-4]

We carried out a study on preconception care in the Netherlands in which we evaluated the impact of smoking cessation advice given before pregnancy on smoking behavior of both women and their partners. Two limitations of Pollack's study, self-reported maternal smoking and lack of data on smoking by other household members,[1] were accounted for in our study design: we confirmed smoking by serum cotinine assay and also assessed paternal smoking behavior.

Our findings were similar to previous findings of maternal underreporting of smoking.[5,6] In our cohort of 111 women followed over a 1-year time period, 16 women reported smoking, whereas 24 were identified as smokers (serum cotinine>5 μg/L, 33% underreporting). Moreover, we found a similar trend in men who were questioned on smoking habits; only 20 admitted tobacco use vs 36 men identified as smokers via serum cotinine assay (44% underreporting). Using a linear model for repeated measurements to analyze data collected up to 12 months after counseling, we found that the estimated mean serum cotinine concentration of smoking women decreased significantly after intervention (from 214 μg/L to 99 μg/L; $P=0.016$). Although none of the women stopped smoking, 75% of cotinine-validated smokers and 88% of self-reported smokers reduced smoking after the preconception counseling intervention. The men, however, neither reduced nor stopped smoking.

In contrast to Pollack's study population, our small sample of smokers did not allow further analyses of pregnancy outcome. Our findings emphasize the significant underreporting of smoking by both sexes, however, and underscore the great difficulty in changing smoking habits. A single preconceptional intervention is not enough to stimulate couples planning pregnancy to stop smoking. We found a more prominent post-intervention decrease in cotinine levels of self-reported smokers than in cotinine-validated smokers, which may indicate that prevaricators are more resistant to changing smoking habits. Influencing prevaricators and their partners to give up smoking will pose a continuing challenge for obstetricians and other health care workers seeking to reduce the occurrence of SIDS and other adverse pregnancy outcomes. ■

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POLLACK ET AL. RESPOND

De Weerd and colleagues raise the important issue of validity of maternal self-reported smoking. Their contribution highlights existing findings that some pregnant women underreport their tobacco use.[1,2,3] De Weerd et al. add to this literature by offering the interesting finding of underreports among women receiving preconception counseling.

A primary issue for researchers is the direction and magnitude of the bias that results from underreporting of tobacco use. In epidemiologic studies attempting to demonstrate the association between maternal smoking and poor birth outcomes, the likely overarching effect is one of attenuation bias, that is, an underestimation of the effect of tobacco use on birthweight and other pregnancy outcomes. This probably applies to our research regarding the impact of maternal smoking on adverse birth outcomes among singletons and twins.[4]

In intervention studies, researchers should be especially concerned that patterns of underreporting may depend on specific context and may also differ across study groups. For example, in an evaluation of a low-intensity intervention in public health clinics, Kendrick et al. found that self-reported quit rates were higher among pregnant women at intervention clinics than at control clinics, whereas cotinine-verified quit rates were not significantly different.[2] Apparently, women who received the cessation intervention were more likely to underreport their tobacco use.

It is important that smoking cessation interventions be targeted at women before conception, during pregnancy, and during the postpartum period. In research studies regarding the effectiveness of programs and policies, biochemical validation of self-reported smoking behavior—although invasive and expensive—is necessary for accurate estimates of intervention effects.[5,6] Studies of the impact of smoking cessation interventions on birthweight highlight the utility of such validation.[7]

Unfortunately, direct chemical testing is generally not feasible in epidemiologic studies that scrutinize the impact of smoking on rare outcomes. The particular analysis that de Weerd and colleagues discuss examines the cost-effectiveness of smoking cessation interventions to prevent sudden infant death syndrome.[8] Given the syndrome's baseline incidence of less than 1.0 per 1000 live births, this type of analysis requires extremely large, vital statistics datasets to obtain adequate power. Developing techniques to scrutinize the impact of underreporting in such analyses, where direct biochemical data are unavailable, remains an important statistical challenge for researchers concerned with tobacco use. ■

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