Module 10 Sexual and Reproductive Health Services for Adolescents

Session 10.1:	**Values Clarification and Introduction**
Session 10.2:	**Adolescent Sexuality**
Session 10.3:	**Supporting Adolescent Clients to Practice Safer Sex**
Session 10.4:	**Integrating Sexual Risk Screening, Risk Reduction Counseling, and STI Services into Adolescent HIV Services**

Learning Objectives

After completing this module, participants will be able to:

- Reflect on their own attitudes, values, and beliefs about adolescent sexuality, and discuss how these may affect their work with adolescents
- Define key terms related to sex, sexuality, sexual orientation, and sexual identity
- Identify potential effects of HIV on adolescents' sexuality
- Define safer sex and discuss how to empower adolescent clients to practice safer sex
- Conduct sexual risk screening and reduction counseling with adolescent clients
- Explain the importance of and provide STI screening and treatment to adolescent clients
- List ways to make sexual and reproductive health (SRH) and other clinical examinations more adolescent-friendly

Session 10.1 Values Clarification and Introduction

Session Objectives

After completing this session, participants will be able to:

- Reflect on their own attitudes, values, and beliefs about adolescent sexuality, and discuss how these may affect their work with adolescents

Adolescent Sexuality – Introduction

Sexuality emerges during adolescence and, for many people, mid-late adolescence is also a time when sexual activity begins.

- Health workers should never assume that adolescent clients are not sexually active. Instead, they should assume that adolescent clients already are sexually active (or will become sexually active at some point in the future).
- It is important that all members of the multidisciplinary team feel comfortable talking about sexuality and sexual and reproductive health (SRH) with adolescent clients, and that they be able to offer them non-judgmental sexual education and SRH counseling and services.

Exercise 1: SRH Values Clarification: Large group exercise	
Purpose	To help participants begin to explore their values, attitudes, and prejudices related to adolescent sexuality and SRH, and to also help them think about how these might affect their work with adolescent clients
The trainer will read out a series of statements out loud. After each statement is read, move to the "agree" or "disagree" sign, depending on your opinion. If you are not sure whether you agree or disagree with a particular statement, you can somewhere in-between the 2 signs.	

Session 10.2 Adolescent Sexuality and HIV

Session Objectives

After completing this session, participants will be able to:

- Define key terms related to sex, sexuality, sexual orientation, and sexual identity
- Identify potential effects of HIV on sexuality among adolescents

Exercise 2: Key Terms about Sex, Sexuality, and Sexual Orientation: Small group work and large group discussion	
Purpose	To provide participants with the definitions of words used to describe sexual expression and sexual orientation
This exercise consists of 2 parts: • Part 1: Small Group Work • Part 2: Large Group Discussion	

Sex and Sexuality

Sex (as in sexual activity)
Sex can be a normal part of life for many older adolescents and adults. Sex means different things to different people, including:

- Vaginal sex (when the penis or fingers go into the vagina)
- Anal sex (when the penis or fingers go into the anus)
- Oral sex (when a person kisses or licks his or her partner's penis, vagina, or anus)
- Inserting fingers or objects into the vagina or anus
- Masturbating (alone or with a partner)
- Having sex with men, women, or both men and women

Sex as a verb is also referred to as "intercourse" or "sexual intercourse."

Unsafe sex

- HIV is mainly spread to adolescents and adults through unsafe sex. **Unsafe sex** is any kind of sex that puts a person or a person's sexual partners at risk of getting a sexually transmitted infection (STI), including HIV, or unwanted pregnancy.
- It is very important for health workers to be comfortable talking about sex and reproduction with their adolescent clients. Honest, factual discussions about sex and sexuality can provide adolescents with the information they need to protect themselves and their partners from STIs and unplanned pregnancy.
- Some adolescents acquire HIV, or are at risk of acquiring HIV, because of sexual abuse. Although sexual abuse is often unsafe, unsafe sex due to sexual abuse is not something that the victim has control over. Therefore, when discussing sexual abuse with adolescents, the focus of the discussion must be on stopping the abuse, counseling the victim, identifying ways to support healing and possibly punishing the perpetrator, instead of on unsafe sex.

Sexuality

- Is more than sex and sexual feelings
- Includes all the feelings, thoughts, and behaviors of being a girl, boy, man, or woman, including feeling attractive, being in love, and being in relationships that include sexual intimacy and physical sexual activity
- Exists throughout a person's life and is a component of the total expression of who we are as human beings (male or female)
- Is a part of us from birth until death
- Is constantly evolving as we grow and develop

See *Appendix 10A: Journal Article,* which presents data on sexual behaviors and desires among perinatally infected ALHIV in Uganda.

Sexuality: Key Terms

The following are some aspects of sexuality. Each of these aspects is connected to one other and contributes to making a person who he or she is.

- **Body image:** How we look and feel about ourselves and also how we appear to others
- **Gender roles:** The way we express being either male or female, and the expectations people have for us based on our sex
- **Intimate relationship**: A romantic and/or sexual involvement with another person
- **Intimacy:** Sharing thoughts or feelings in a close relationship, with or without physical closeness
- **Love:** Feelings of affection and the ways we express those feelings for others
- **Sexual arousal:** The arousal of sexual desires and the state of sexual readiness in preparation for sexual behavior. Sexual arousal has mental and physical components.
- **Social roles:** How we contribute to and fit into society
- **Genitals:** The reproductive and sexual organs: the testicles and penis of a male or the labia, clitoris, and vagina of a female
- **Sexual abuse:** Sexual abuse is forced, unwanted, improper, or harmful sexual activity inflicted on another person. Sexual abuse will be discussed further in the next section.
- **Ways we can express our sexuality:** Through dancing, talking, wearing attractive clothes, experiencing sexual dreams or daydreams, feeling sexual near others, masturbating, etc.

Remember:

- In many places, "sex" is often thought to mean only penis-vagina sex between a man and a woman. However, sexual behaviors include much more than just penis-vagina sex.
- If health workers do not talk about sex and sexual behaviors with clients, they may not get the information, skills, and supplies they need to protect themselves and their partners and to reduce their risk of HIV, STIs, sexual violence, discrimination, and unplanned pregnancy.
- While we all hold our own opinions about different sexual behaviors, we cannot — as health workers — project our own values onto clients. Adolescent clients should always be made to feel comfortable talking about their sexual concerns, questions, and behaviors — and that there is no risk of judgment.

Sexual Orientation and Identity

- Adolescence is a time of sexual experimentation and defining one's sexual identity.
- Health workers need to stress that homosexual, bisexual, and transsexual/transgendered behavior is NORMAL (regardless of their own personal views).
- Adolescence is a period of change — and an adolescent's sexual identity may not be his or her permanent identity.
- Adolescence is a period when sexual identity starts to be defined. An adolescent who realizes that he or she may be gay, bisexual, or transgendered may feel isolated and depressed. It is the health worker's responsibility to help the adolescent cope with his or her sexual orientation and accept his or her feelings.
- The health worker does not have to be an expert on sexual orientation. The most important thing is that the health worker be willing to listen to adolescent clients in a non-judgmental way and provide them with any necessary referrals.

Creating a gay-friendly atmosphere

Although most adolescents are heterosexual, some are homosexual or bisexual. Adolescents who are not heterosexual are particularly vulnerable because they often experience profound isolation and fear of discovery. They are more likely to experience harassment and violence and are at higher risk of dropping out of school, being kicked out of their homes, and experimenting at an early age with tobacco, alcohol, and illegal drugs. It is important that health workers make sure homosexual and bisexual youth know they will not be judged and that they are welcome in the clinic. Health workers are obligated to ensure that all youth, regardless of sexual orientation, feel comfortable and are provided with the care, treatment, and support that they need (including safer sex counseling). If clinic staff do not feel qualified to counsel gay youth about homosexuality, they should know where to refer them for peer support or other forms of support and counseling.

Sexual Orientation and Identity: Key Terms

- **Sex (as a noun):** Refers to the physiological attributes that identify a person as male or female (e.g. genital organs, predominant hormones, ability to produce sperm or ova, ability to give birth, etc.)
- **Gender:** Refers to widely shared ideas and norms about women and men, including common beliefs about what characteristics and behavior are "feminine" or "masculine." Gender reflects and influences the different roles, the social status, as well as the economic and political power of women and men in society.
- **Heterosexuality:** The sexual orientation in which a person is physically attracted to people of the opposite sex
- **Homosexuality:** The sexual orientation in which a person is physically attracted to people of the same sex
- **Bisexuality:** The sexual orientation in which a person is physically attracted to members of both sexes
- **Transvestism:** When a person dresses and acts like a person of the opposite gender
- **Transsexual:** A person who desires to change or has changed his or her biological sex because his or her body does not correspond to his or her gender identity
- **Transgendered:** A person who lives as the gender opposite to his or her anatomical sex (for example, a male living as a female, while retaining his penis and sexual functioning).

Effects of HIV on Sexuality Among ALHIV

HIV affects everyone differently and depends on how long a person has been infected, how others respond to the person and his or her diagnosis, his or her level of self-esteem, etc. Some of the effects of HIV on sexuality are listed below. Some ALHIV may experience 1 or more of these effects, and others may not experience any. Also, many of these effects are experienced only in the months following diagnosis, as a necessary phase in a person's journeys to redefine who he or she is.

- Approaching puberty, adolescents become preoccupied with their developing bodies and body image.
- Adolescents compare their bodies to those of their peers of the same sex. They have an intense need to "fit in."
- Adolescents wonder and worry about their level of sexual attractiveness.
- ALHIV may have lower self-esteem than their peers.
- ALHIV may have increased anxiety about their sexuality, sexual relationships, and sexual and reproductive health.
- ALHIV often have concerns about whether/how they can have sexually intimate relationships. They also often have fears related to disclosing their status to sexual partners and the possibility of transmitting HIV to them.
- ALHIV may have concerns and questions about being able to have safe sexual relationships and, in the future, children.
- Not 'fitting in' can be very traumatic for adolescents, especially when it involves 'looking different.'
- ALHIV, especially those who were perinatally infected and those who went a long time without HIV treatment, may begin puberty later and may grow and develop more slowly than their HIV-uninfected peers.
- ALHIV are subject to many illnesses, conditions, and drug side effects that may affect the way they look (for example, lipodystrophy, wasting, skin conditions, stunting, and short stature). These physical characteristics and changes may affect an adolescent's body and self-image.
- Adolescents who acquired HIV through sexual abuse may have unresolved issues from the trauma related to the abuse (see next section).

Sexual Abuse[1]

Many victims of sexual abuse are adolescents. Research in many countries has documented that 7–34% of girls and 3–29% of boys experience sexual abuse (ranging from harassment to rape and incest). Sexual abuse can happen inside or outside the home; it can be perpetrated by a partner, family member, family friend, or stranger. It can also include domestic violence.

Health workers should teach young people that it is a basic human right to grow up and live in an environment that is free of physical and sexual violence. Violence should never be considered a "normal" part of everyday life.

Recognizing sexual abuse can be difficult and is rarely a straightforward task:

- Sexual abuse in young people requires careful investigation and assessment because there are very few conclusive signs and symptoms of sexual abuse.
- Often, there is no physical evidence that an adolescent has been sexually abused — changes in the adolescent's behavior are a far more common result.

- The most reliable and common indicator of sexual abuse is an adolescent's disclosure of the abuse. When adolescents report that they are being or have been sexually abused, there is a high probability that they are telling the truth. Only in rare circumstances do adolescents have any interest in making false accusations.
- Sexual abuse, including signs and symptoms of abuse, how to interview an adolescent who may have been abused, and follow-up, is further discussed in *Appendix 10B: Adolescent Sexual Abuse.*

Sexual abuse should be investigated using a multidisciplinary team approach:

- The team should consist of at least 3 people and, when possible, should include a representative from law enforcement, a person from social welfare, and a health worker.
- The purpose of the multidisciplinary team is to ensure that the physical, mental, and social support needs of the adolescent and family are met through a coordinated effort, thereby reducing the burden and distress faced by the adolescent.

See box on the following page for additional information on sexual and gender-based violence (SGBV) and what health workers can do to support a victim of SGBV.

Sexual and gender-based violence (SGBC)

- SGBV is a problem throughout the world.
- The most frequent victims of coerced sex are adolescent girls.
- Reducing the frequency of coerced sex requires efforts in the community to promote non-violent norms, to pass and enforce laws against sexual violence, to encourage the reporting of sexual violence, and to teach self-defense skills to girls.
- When the perpetrator is an adult, sexual assault of an adolescent is also considered child abuse.
- Following an episode of sexual assault, a comprehensive package of SGBV services is needed to address the acute medical needs of the victim. This includes:
  - HIV testing and post-exposure prophylaxis (PEP), following national guidelines (note that if the adolescent is already known to be HIV-infected and on ART, this is not necessary)
  - A medical examination that includes the collection of forensic evidence and an assessment for STIs
  - The provision of needed medical treatment
  - Pregnancy testing and the provision of emergency contraception (for females)
  - Counseling and support
  - A temporary place to stay, if needed for safety
  - A link to the police for an investigation of the assault

Exercise 3: OK For Me?: Large group exercise and discussion	
Purpose	To allow participants to examine their own values about sexual behaviors, and to discuss how these values and attitudes can affect the services they provide to adolescents
This exercise consists of 2 parts: • Part 1: Individual Work • Part 2: Large Group Discussion	

Session 10.3 Supporting Adolescent Clients to Practice Safe Sex

Session Objectives

After completing this session, participants will be able to:

- Define safer sex and discuss how to empower adolescent clients to practice safer sex

Understanding Risk

HIV is transmitted from 1 person to another through **4 body fluids**: semen, vaginal secretions, blood, and breast milk. Any activity during which 1 or more of these body fluids is passed from 1 person to another could pose a theoretical risk of HIV transmission if:

- The body fluid is from a person infected with HIV
- The body fluid enters the bloodstream of another person

Given the mechanism by which HIV is transmitted from 1 person to another, sexual activities that present no risk of transmission are those during which none of these 4 body fluids (semen, vaginal secretions, blood, or breast milk) is exchanged. Sexual activities that present a risk involve semen, vaginal secretions, or blood.

Applying this to counseling sessions, health workers should encourage clients who are sexually active to abstain from activities that are high risk and probably even medium risk. They should encourage ALHIV to substitute any risky activities with others that are considered "no risk" or low risk. If a client is sexually active, it is probably inappropriate to expect that he or she will avoid all physical contact, but only practicing no or low risk activities may actually be a very achievable goal.

No risk

There are many ways to share sexual feelings that are not risky. These include:

- Hugging
- Kissing (even "French kissing," or kissing with the tongue, carries no risk of HIV transmission)
- Holding hands
- Massaging
- Bathing or showering together
- Rubbing against one other with clothes on
- Sharing fantasies
- Self-masturbation

Low risk

- Masturbating your partner or masturbating together, as long as males do not ejaculate near any opening or broken skin of their partner
- Using a male or female latex condom during **every** act of sexual intercourse (penis in vagina, penis in anus, penis in mouth, etc.)
- Using a barrier method for oral sex on a male or female, or for any mouth-to-genitals or mouth-to-anus contact
- Sharing sexual toys (rubber penis, vibrators) without cleaning them

Medium risk

- Oral sex without a latex barrier (some STIs, like gonorrhea, are easily passed through oral sex, while others, like chlamydia, are not. The risk of HIV transmission through oral sex is generally low, but there is some risk, especially if the person has an STI or cuts/sores in the mouth or on the genitals)

High risk

- Unprotected (no male or female condom) anal or vaginal sex

What Do We Mean by "Safer Sex?"

Safer sex includes the range of ways that people can protect themselves and their partner(s) from HIV (or HIV "re-infection"), other STIs, and unintended pregnancy.

- Safer sex involves choosing sexual practices and protection methods that prevent body fluids from passing from 1 person to another.
- Because ARVs reduce the amount of virus in body fluids (including blood, semen, vaginal secretions, and breast milk), safer sex includes maintaining excellent adherence to ART.
- Safer sex reduces the risk of transmitting HIV without reducing intimacy or pleasure.
- Safer sex includes the activities listed under "No risk" and "Low risk" in the previous section.

ART and safer sex

- An important study was released in 2011 (referred to as HPTN 052)[2] that showed that people living with HIV who are taking ART are much less likely to pass HIV to their uninfected partners than those who are not on ART. The study showed a 96% reduction in risk of HIV transmission when the partner living with HIV was taking ART.
- *"**Altruistic adherence**"*: Now there is yet another important reason to adhere to ART — to protect sexual partners from HIV.
- PLHIV on ART should still practice safer sex — even when taking ART, there is still a risk of HIV transmission.

Role of health workers:

- During adherence counseling, health workers should inform clients of the additional benefits of excellent adherence: not only does good adherence improve the quality and length of the client's life, but it reduces the risk of transmission to his or her uninfected sexual partner(s).

More on condoms

- Not having sex at all (abstinence) is one way to be completely safe. However, for some adolescents, this may not be practical. For people who are sexually active, using condoms is a reliable way to prevent STIs, HIV, and unwanted pregnancy.
- There are a lot of myths about condoms, like that they are only for sex workers or promiscuous people. Health workers should promote condoms as a way for young people to protect themselves and their partners from HIV and other STIs.
- Some people feel that condoms make sex less enjoyable. Health workers should respect everyone's personal experiences with condoms, but should also try to reframe condoms as part of pleasurable foreplay and sex. They should emphasize that condoms can relieve worries about an unplanned pregnancy or guilt related to risking HIV transmission.
- Some people think that if both partners are living with HIV, they do not need to use condoms. It is important that health workers explain to clients that even if both partners are living with HIV, they should still use condoms to reduce the risk of transmitting new strains of HIV to one another (re-infection). Such transmission is particularly risky if the strain of HIV that is transmitted is resistant to the ART regimens used locally.
- Some health workers may think that giving young people condoms encourages them to have sex. However, this is not true! It is important that male and female condoms are available and offered to adolescent clients in multiple settings — in the clinic waiting area, in examination rooms, in the lab, in the pharmacy, offered by Peer Educators, etc. Remember: health workers must remove as many barriers as possible to condom use among adolescents.

Dual protection

Dual protection means preventing STIs, HIV, and unwanted pregnancy at the same time. Various strategies offer dual protection, including abstinence and the "no risk" and low risk activities listed previously in this session. Other strategies include:

- Dual method use — i.e., using male or female condoms to protect against STIs **and** a second method to protect against unplanned pregnancy (often a hormonal method). This is a very reliable method of dual protection.
- Being in a monogamous relationship in which both partners have been tested and know they do not have any STIs, and in which at least 1 partner is using effective contraception
- Using male or female condoms

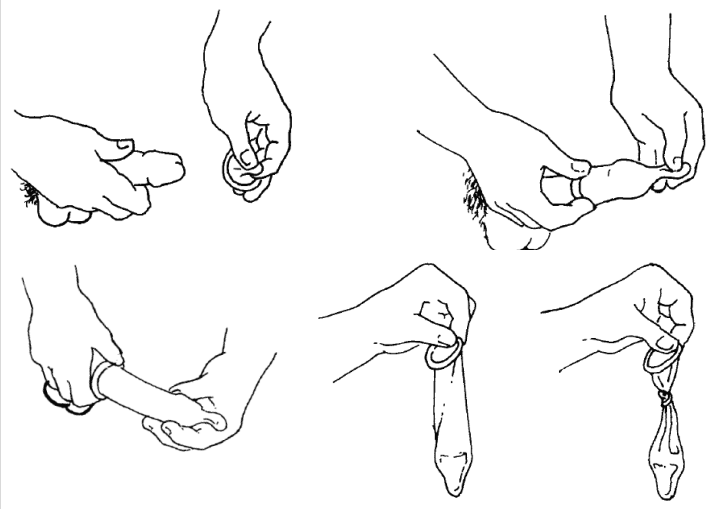
"If we're both HIV-positive, why do we need to use a condom?"
"What is re-infection?"

Some people think that if a PLHIV has a partner who is also HIV-infected, he or she does not need to worry about protection with condoms anymore. However, this assumption is incorrect. It is important that PLHIV practice safer sex, even if their partner also has HIV.

- Using condoms prevents both unwanted pregnancy and the transmission of other STIs.
- Different strains or types of HIV can be passed between two HIV-infected people. This transfer of a particular HIV strain from one HIV-infected person to another is called **re-infection.** Being re-infected can make treatment more difficult because the new strain of HIV might not respond to the ART regimen the person is currently taking (in other words, the strain might be drug resistant).

How to use a male condom

These are the basic steps you should know in order to use or demonstrate how to use a male condom. If penis models are not available, you can use a banana, corncob, or bottle for the demonstration. Only condoms made out of latex protect against HIV.



Steps to use a male condom:

- Look at the condom package to make sure it is not damaged and check the expiration date to make sure the condom is still good.
- Open the packet on one side and take the condom out. Do not use your teeth to open the package.
- Pinch the tip of the condom to keep a little space at the tip. This tip will hold the semen and prevent the condom from breaking.
- Hold the condom so that the tip is facing up and so the condom can be rolled down the penis. (Make sure it is not inside out!)
- Put it on the tip of an erect (hard) penis (only use condoms on an erect penis) and unroll it down to the bottom of the penis.
- After ejaculation (coming), hold the rim of the condom while the man removes his penis, without spilling the semen. The penis must be removed while it is still hard to make sure the condom does not fall off.
- Remove the condom and tie it in a knot to avoid any spilling. Throw it away in a latrine or bury it. Do not put it in a flush toilet.

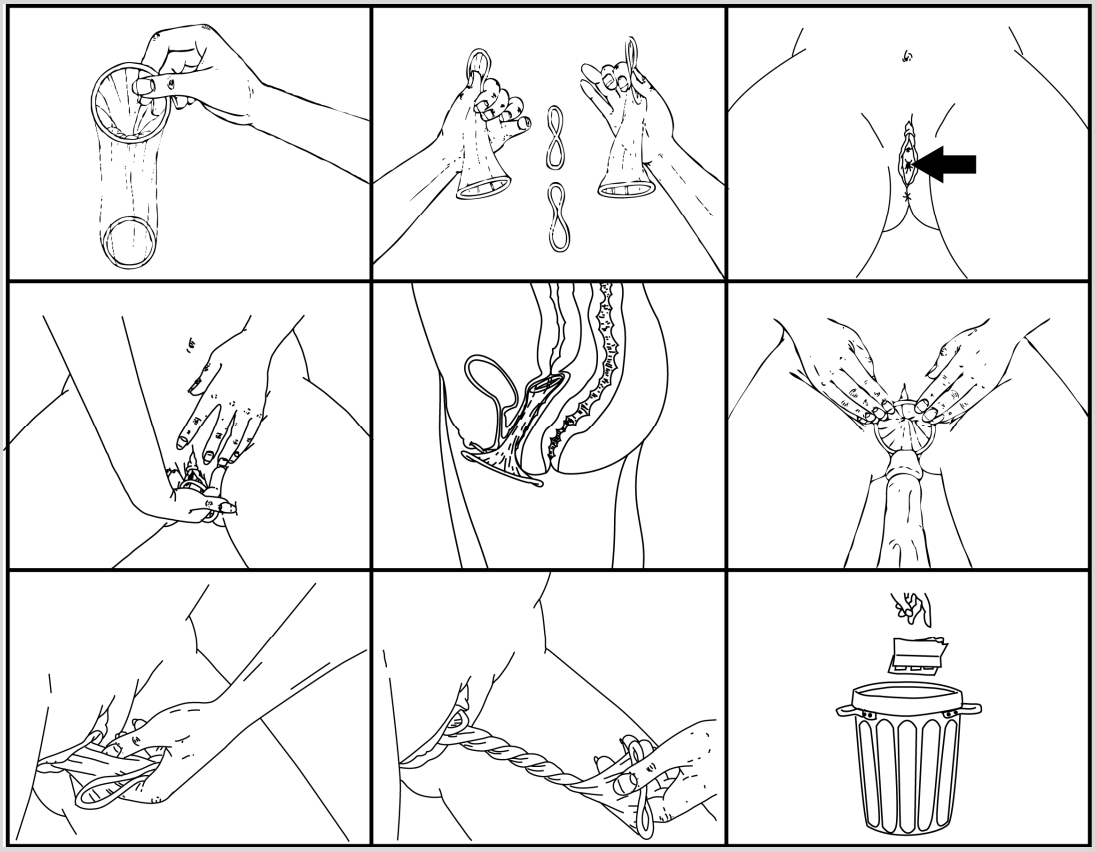
Also, it is important to:

- Use a condom every time you have sex — whether it is oral, anal, or vaginal sex. Use a new condom every time! Never reuse a condom!
- Only use water-based lubricants (instead of oil-based lubricants).
- Store condoms in a cool, dry place that is away from the sun. Do not keep them in a wallet.
- Do not use condoms that seem to be sticky, a strange color, or damaged in any way — instead, throw them away.

Adapted from: Burns, A., Lovich, R., Maxwell, J., & Shapiro, K. (1997). *Where women have no doctor: A health guide for women.* Berkeley, CA: The Hesperian Foundation.

How to use a female condom

Some women like using female condoms because these condoms give them more control over their own bodies and over sex. Some men like using them because then they do not have to use a male condom. The female condom is becoming more affordable and available. These are the basic steps you should know in order to use or demonstrate how to use a female condom. If no vaginal model is available for demonstration, you can use a box with a round hole cut in it or your hand.



Steps to use a female condom:

- Look at the condom package to make sure it is not damaged and check the expiration date to make sure the condom is still good.
- Open the packet. Do not use your teeth.
- Find the inner ring at the closed end of the condom. The inner ring is not attached to the condom.
- Squeeze the inner ring between your thumb and middle finger.
- Guide the inner ring all the way into the vagina with your fingers. The outer ring should stay outside the vagina, covering the vagina's lips.
- When you have sex, guide the penis through the outer ring so that the penis is inserted into the female condom.
- After the man ejaculates (comes) and before the woman stands up, squeeze and twist the outer ring to keep the semen inside the pouch and pull the pouch out.
- Put the used condom in a latrine or bury it. Do not put it in a flush toilet.

Adapted from: Burns, A., Lovich, R., Maxwell, J., & Shapiro, K. (1997). *Where women have no doctor: A health guide for women.* Berkeley, CA: The Hesperian Foundation.

Exercise 4: Condom Demonstration: Return demonstration and large group discussion	
Purpose	To help participants feel comfortable demonstrating how to use a male and female condom
This exercise consists of 3 parts: • Part 1: Male Condom Demonstration • Part 2: Female Condom Demonstration • Part 3: Large Group Discussion	

Reasons Why Adolescents May Not Practice Safer Sex[3]

Ignorance

- They think they are not vulnerable to HIV, HIV re-infection, pregnancy, or STIs. "*It cannot happen to me*" or "*I do not have sex often enough to get pregnant.*"
- They do not have adequate or accurate information about safer sex:
  - Many adults are embarrassed to talk about sex with adolescents or they may not know the facts themselves.
  - Some adults believe that adolescents should not be having sex.
  - School sex education is often inadequate or non-existent.
  - Parents and other adults are often reluctant to provide practical information about sex to adolescents. Some believe that providing such information encourages sexual activity, even though this has been proven to be untrue.
  - The media portrays sexuality unrealistically and usually does not include any mention of protection.
- They have heard misinformation or myths about contraceptive methods and their side effects.
- They do not know that methods are available or know which methods can be used by ALHIV.
- They do not know where, how, or when to get condoms or other contraceptive methods.
- They do not know how to use condoms correctly.
- They have heard myths about the dangers of using contraceptive methods, which are common and difficult to defuse.
- They are not aware of pleasurable alternatives to risky sex, such as mutual masturbation, etc.

Denial

- "*It just happened.*" (They did not expect to have sex).
- "*I only had sex once.*"
- "*Sex should be spontaneous.*"
- "*My friends are not using protection, so why should I*?"
- They do not think they will get pregnant or an STI, or think that there is only a small chance of passing HIV to a partner during sex.

Lack of access

- Access to contraceptive services for adolescents is often limited by law, custom, or clinic/institutional policy.
- Availability and cost of contraceptive methods may restrict access.
- There may be an irregular supply of contraceptive methods available.
- Sex happened spontaneously and a contraceptive method was not available when needed.
- Health worker attitudes toward contraception may prevent them from distributing protective methods to adolescents.

Coercion

- One of the partners wants to get pregnant.
- One of the partners will not let the other use protection.
- One of the partners forces the other to have sex.
- One of the partners has the attitude that condoms ruin sex or are unromantic.
- There is pressure from family members to conceive.

The "I don't care" effect

- ALHIV may feel that because they are already HIV-infected, there is no need to protect themselves. This might be especially true if both sexual partners are HIV-infected.
- ALHIV may be depressed and may have lost hope. This may cause them to think: *"I don't care, I already have HIV, so why not take risks?"*

Fear

- They fear rejection by their partner.
- They fear people knowing their HIV-status (if they use condoms or request that their partner use condoms).
- They fear a lack of confidentiality at the place methods can be obtained.
- They fear using something new — they fear the unknown.
- They fear side effects.
- They fear not being able to find a place to keep protective methods so that no one sees them.
- They fear something going wrong if they start using a certain contraceptive method, like oral contraceptive pills, too early in life.
- They fear that their parents will find out they are having or planning to have sex.
- They fear that their peers or parents will know they are sexually active.
- They fear being asked questions by a pharmacist or health worker if they request condoms or other contraceptive methods.
- They fear being labeled "cheap" or "loose."

Embarrassment

- Service providers and pharmacists are sometimes judgmental and/or moralistic about adolescent sexual activity. This is especially true for ALHIV, since many people think it is irresponsible for people living with HIV to have sex at all.
- They are embarrassed to buy condoms.
- Retail outlets often place contraceptive methods behind the counter so that customers have to ask for them.
- They are embarrassed to suggest using condoms in the "heat of the moment."

Other factors

- They lack the communication and negotiation skills and/or expertise to discuss protection or to negotiate condom use.
- They stopped using oral contraceptives because of the side effects.
- They are impulsive and sexual activity is often unplanned. Even when sex is anticipated, they often do not have protection available.
- They believe that suggesting using protection implies mistrust of their partner and his or her faithfulness.
- They desire conception. For a girl, it may be a way to keep a relationship or a boyfriend; for a boy, conception may be a way to prove manhood; or, for a married couple, both partners may want to start a family.
- They think their partner "is taking care of the protection."
- They have not made a firm decision about whether or not they would like to get pregnant.
- They do not know how to dispose of condoms or do not have a place to dispose of them properly and privately.

Session 10.4 Integrating Sexual Risk Screening, Risk Reduction Counseling, and STI Services into Adolescent HIV Services

Session Objectives

After completing this session, participants will be able to:

- Conduct sexual risk screening and reduction counseling with adolescent clients
- Explain the importance of and provide STI screening and treatment for adolescent clients
- List ways to make SRH and other clinical examinations more adolescent-friendly

Positive Prevention

Although information alone cannot be expected to change the sexual behavior of adolescents, health workers can support positive prevention.

- Adolescent clients need access to accurate information about HIV and STI transmission to address their concerns about sexuality, dating, future childbearing, disclosure, and transmission risk.
- Health workers can help adolescent clients understand the transmission risk of certain activities and provide guidance to help them reduce risky behavior, to maintain good SRH, and to prevent new HIV infections. (See Session 9.2 in Module 9 for more information on positive prevention)
- In general, adolescents want their health provider(s) to give them accurate information and to sensitively, confidentially, and without any judgment ask them personal questions about HIV-related risk behavior.
- In order for these discussions to be effective, adolescent clients must feel that their providers will talk to them in a comfortable and supportive way about any topic, no matter how uncomfortable it may seem.
- Young people can sense when health workers are out of their element or are passing judgment while talking about sensitive issues and this perception will likely prevent honest communication about risk behaviors.

Sexual Risk Screening and Counseling

The process

- Start asking adolescent clients routine screening questions as early as possible.
- Build trust with clients:
  - Start addressing sexuality with them before they become sexually active.
  - Begin with safer topics, such as the physical changes of puberty. Educate clients and caregivers about what to expect in terms of sexual, physical, emotional, and social development during puberty and adolescence.
  - When meeting with caregivers, begin by exploring their expectations about their child's sexual activity and then use these expectations to begin providing guidance to both the caregivers and the adolescent client.
- By the time clients are 12 years old, begin meeting with them separately from their caregivers for at least part of each appointment.

Overview of the discussion

- Explain to adolescent clients and caregivers what information can and cannot be kept confidential, emphasizing that health workers will protect client confidentiality unless there is an emergency or a health risk that requires intervention.
  - A health worker might need to disclose information about a patient if this information needs to be shared with another health worker, so that appropriate care can be provided to the client.
  - Local law may require disclosure under other circumstances. For example, most countries require that discussions about child sexual abuse be reported to authorities. Also, some countries/localities (but not all), require health workers to disclose their client's HIV-status to the client's sexual partner, if the partner is known to the health worker.
- Use good communication and counseling skills (see Module 4).
- Avoid making assumptions about the client, including about his or her knowledge, behavior, sexual orientation, etc.
- Always ask about sexual behavior, rather than sexual identity.
- Avoid using any labels not first used by the client.
- If a discussion is awkward, respect a client's cues that further talk is unwanted.
- Table 10.1 summarizes the elements of a sexual risk screening.
- Table 10.2 summarizes the risk reduction counseling session, which should follow the sexual risk screening.

Table 10.1: Sexual risk screening

✓	Questions for the client:
	1. Is the client sexually active?
	• *Some adolescents have sex with their partners. Are you having sex?* If the response is "no," go to Table 10.2. If "yes," proceed to section 2 of this table.
	2. If yes, with whom?
	• *Are you having sex with males, females, or both?* • *How many partners do you have right now? How many partners have you had in the past year?* • *What is the HIV-status of your partner(s)?* • *Does your partner know you have HIV?*
	3. What are the client's sexual practices?
	• *Do you have vaginal sex? Oral sex? Anal sex?* • *What family planning method did you use the last time you had sex?* • *When was the last time you used a condom?* • *Has anyone caused you harm in the past; for example, hurt you physically or made you have an unwanted sexual encounter?* • *Have you ever used cigarettes, alcohol, or other drugs? If so, how often in the last week have you used cigarettes, alcohol, or other drugs?*

Table 10.2: Risk reduction counseling

✓	Questions for the client:
	1. Assess knowledge
	• *How is HIV transmitted from one person to another?* • *How can a person prevent transmission of HIV during sex?* • *What is your plan to protect your partner from getting HIV when you have sex?* • *Did you know that even if both partners have HIV, it is important to practice safer sex and use condoms? Do you know why?*
	2. Discuss options for sexual risk reduction

	• *There are a number of ways to your reduce risk of HIV, other STIs, and unwanted pregnancy, including:*
	  ◦ *Abstinence*
	  ◦ *Intimate touching without exchange of bodily fluids*
	  ◦ *Reducing your number of sexual partners*
	  ◦ *Disclosing your HIV-status and negotiating sexual practices*
	  ◦ *Correctly and consistently using condoms (for male-female couples, ideally with another form of hormonal contraception)*
	  ◦ *STI screening and treatment (HIV is transmitted more easily in the presence of other STIs)*
	  ◦ *Maintaining maximal suppression of HIV through excellent adherence to ART, if eligible*
	  ◦ *Avoiding alcohol, marijuana, party drugs, and other substances that impair good judgment and prevention*

	3. If an option, discuss abstinence
	• *Abstinence means not having sex. If you are abstinent, you cannot get STIs or get re-infected with HIV, and you cannot have an unplanned pregnancy.* • *Is abstinence an option for you?* • *If you choose abstinence, you should have a backup plan as well, just in case you change your mind. What will be your backup plan?*
	4. Discuss condoms

	• Demonstrate steps for putting on a condom (male and female) and offer to supply the client with condoms
	• Help client improve condom negotiation skills by:
	  ◦ Responding to the clients questions and concerns
	  ◦ Reassuring the client that it can be difficult to bring up the topic of condoms with a partner
	  ◦ Suggesting that he or she discuss condoms BEFORE they are needed (rather than in the heat of the moment)

	5. Role play to encourage condom use
	• If partner asks: "*But you have never suggested we use condoms before.*" • Client can say: "*I went to the clinic today and my health worker told me that I really need to use condoms for my health and so that we can prevent an unintended pregnancy.*" (Or, the client may have another reason to explain changing his or her mind.) • If partner asks: "*You don't love me enough to have sex without a condom?*" • Client can say: "*It is because I love you and I love myself that I want to keep us both safe.*" • If partner says: "*You must want to use a condom because you have been messing around with other people.*" • Client can say: "*Before we met, we both had other partners and I want to be sure that neither of us brings anything into this relationship.*"

✓	Questions for the client:
	6. Encourage disclosure
	• Encourage disclosure to partners, work with clients to facilitate the disclosure process, and offer the possibility of meeting with the client and partner together to help the client disclose (see Module 7).

What Makes Adolescents Vulnerable to STIs?[4]

Having an STI increases the risk of HIV transmission/acquisition. Many of the things that make adolescents vulnerable to HIV also make them vulnerable to STIs, including:

Biological factors

- The adolescent female genital tract, which is not yet fully mature, is more biologically susceptible to STIs than that of older women.
- ALHIV who have low CD4 counts may have weakened immune systems, which make them more susceptible to STIs.
- Females often do not show signs or symptoms of chlamydia and gonorrhea, so infection may go untreated, which increases the risk of HIV acquisition.

A lack of knowledge

- Adolescents often lack basic knowledge about STI symptoms, transmission, and treatment.
- Adults are often uneasy talking with adolescents about STIs and sexual health. They often think adolescents should not be having sex in the first place.

Factors related to adolescence

- For adolescents, sex is often unplanned and spontaneous. This makes condom use less consistent and increases the risk of STIs. Adolescents may also have multiple, short-term sexual relationships, which further increases their STI risk.
- Young women are more at risk of sexual violence and exploitation and are more likely to lack formal education (including SRH education), the ability to negotiate safer sex with partners, and access to SRH information and services.
- Adolescents may be subject to high-risk behaviors that increase the risk of STIs, such as anal sex to preserve virginity, dry sex, and scarification.
- Young men may have their first sexual experiences with commercial sex workers and young women may have their first sexual experiences with older men, which can increase the risk of STIs if condoms are not used consistently and correctly.
- Adolescents may be afraid to seek treatment for STIs because they fear stigma and discrimination. This is especially true for ALHIV because many adults feel they should not be having sex at all.

Making SRH and Other Clinical Procedures More Adolescent-Friendly[4]

There are many ways health workers can make physical examinations less stressful for adolescent clients. Health workers should be sure to:

- Explain what is going to happen during each visit.
- Respect the adolescent client's privacy. For example, leave the room and close the door if he or she needs to remove clothing or change into a gown. Try and expose only the parts of the body you are examining and leave the rest covered. Do not leave any part of the body exposed when not being examined.
- Explain what you are going to do before you begin each step of the examination.
- Reassure the client about confidentiality.
- Give the client reassurance throughout the examination.
- Give feedback in a non-judgmental manner. For example, *"I see you have a small sore here, does it hurt?"*
- If possible, offer to have the exam performed by a doctor or nurse who is the same sex as the client. Otherwise, offer to have someone of the same sex in the room during the examination.
- Conduct pelvic exams only when recommended. Pelvic exams are recommended annually for sexually active females and for young virgins (under 21 years of age) only if there is a medical indication. If not sexually active by age 21 (or as recommended in national guidelines), start annual pelvic exams. Regardless of age or sexual history, pelvic exams are indicated if there is suspected abuse, abnormal vaginal discharge, vaginal bleeding, amenorrhea, trauma, unexplained pelvic pain, etc.
- If a pelvic exam is necessary, address all of the client's concerns. For example, adolescent girls who are virgins may fear that the procedure will be uncomfortable or tear their hymen. Health workers can reassure clients that the hymen only partially covers the vaginal opening and that the vagina will stretch if the client can relax. Let the client see and touch the speculum, try to use a small speculum (sometimes called a "virgin speculum"), always explain what is going to happen, and ask permission before touching the client with your hand or the speculum. Take great care to carry out all parts of the exam gently and smoothly, so as to minimize the client's discomfort and anxiety. Remind the client to breathe deeply and to try to relax during the exam.

STI Screening and Treatment for ALHIV

Screening and physical examination
At every visit, ask adolescent clients who are sexually active adolescents (and **ALL** older adolescents clients — health workers should assume they are sexually active or will be sexually active soon) about STI symptoms (see *Appendix 10C: Screening and Examining Adolescent Clients for STIs*). If the answer to any of the screening questions is *'yes,'* conduct a physical examination that includes the steps outlined in *Appendix 10C*. Ensure that there is privacy during all physical examinations and follow the tips provided in the previous section to make examinations more adolescent-friendly.

Health workers should provide routine cervical screening (using PAP or visual inspection of acetic acid, as per national guidelines) to all sexually active women with HIV. Routine cervical screening is especially important as females living with HIV are at greater risk for cervical cancer than HIV-uninfected women.

See national STI guidelines for additional information.

Diagnosis and treatment
A thorough physical examination is key to diagnosing STIs. Health workers should use information from the physical examination, in combination with the client's history, to make a ***syndromic diagnosis*** and should manage and treat according to the flow charts included in the national STI guidelines.

Treat clients diagnosed with an STI syndrome for all of the possible STIs that could cause that syndrome. In addition:

- Counsel clients to avoid sex while being treated for STIs and to use condoms with every sexual encounter after sexual activity resumes.
- Counsel clients diagnosed with STIs to inform their sexual partner(s) that they should seek medical care so they can be evaluated and treated for STIs.
- Conduct risk reduction counseling to help adolescent clients avoid STIs in the future, including counseling on safer sex and consistent condom use during every sexual encounter.

Module 10: Key Points

- An important part of adolescent HIV care and treatment is assessing and responding to the SRH needs of clients.
- In order to do this, health workers must be comfortable talking about sexuality and SRH with their clients, and must be knowledgeable about the common SRH issues faced by adolescents.
- Health workers need to stress that all types of sexual orientation — heterosexual, homosexual, bisexual, and transsexual/ transgendered — are NORMAL (regardless of the health worker's personal views). Health workers do not have to be experts on sexual orientation — a willingness to listen, be understanding, and refer adolescent clients to resources is often enough.
- Safer sex describes the range of sexual activities that reduce the risk of STIs (including HIV) and protect against unintended pregnancy. Safer sex includes sexual practices and protection methods that prevent body fluids (semen, vaginal secretions, blood, and breast milk) from passing from 1 person to another.
- Using condoms is a reliable way to practice safer sex and to prevent HIV, other STIs, and unwanted pregnancy. For people who are living with HIV, condoms also prevent re-infection.
- ALHIV should have free, easy, and non-embarrassing access to condoms in the clinic setting.
- Safer sex also includes excellent adherence to one's ART regimen — a study released in 2011 showed that people living with HIV who are taking ART are much less likely to pass HIV to their partners than those who are not taking ART.
- Sexual risk screening should start before a client is sexually active and includes questions to help the health worker assess if the client is sexually active and, if so, with whom and what risks he or she is taking.
- Risk reduction counseling focuses on reducing clients' risk of HIV, other STIs, and unwanted pregnancy by helping them choose a strategy that is right for them.
- All adolescents who are sexually active should be screened for STI symptoms. If there is suspicion of an STI, the health worker should conduct a physical examination and follow national STI guidelines.

Appendix 10A: Journal Article

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Adolescent health brief

Sexual Behavior and Desires Among Adolescents Perinatally Infected with Human Immunodeficiency Virus in Uganda: Implications for Programming

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See Editorial p. 101

Abstract Counseling programs for adolescents living with human immunodeficiency virus (HIV) encourage abstinence from sex and relationships. This Uganda study, however, found that many of these adolescents are sexually active or desire to be in relationships but engage in poor preventive practices. Programs for HIV and acquired immunodeficiency syndrome (AIDS) programs therefore need to strengthen preventive services to this group.

Keywords: Adolescents; HIV infection; Perinatal; Sexual behavior; Program implications; Uganda

The number of children living with human immunodeficiency virus (HIV) in Africa continues to escalate despite the advances made in prevention of mother-to-child transmission. Sub-Saharan Africa accounts for 90% of the estimated 3 million children living with HIV [1]. At the same time, the roll-out of anti-retroviral treatment (ART) programs has made it possible for perinatally HIV-infected infants to live through adolescence and adulthood thereby engaging in dating and sexual relationships. However the sexual and reproductive health needs of this unique and growing group of the population are largely unmet [2]. In Uganda, for example, treatment, care, and support programs for HIV and acquired immunodeficiency syndrome (AIDS) are organized around adult and pediatric care. This implies that adolescents who no longer fit under pediatric care and who feel uncomfortable with adult services lack programs to address their specific needs. Moreover the programs assume that HIV-infected young people remain sexually inactive and therefore hardly address their need for sexual and reproductive health information and services. Service providers and counselors, for instance, usually advise perinatally infected adolescents not to engage in sexual relationships [3,4]. In its efforts and continued commitment to care for people living with HIV, The AIDS Support Organization (TASO) in Uganda supported by the Population Council's Frontiers in Reproductive Health Program initiated a study in 2007 to understand the sexual and reproductive health needs of adolescents born with HIV. The study involved both survey and qualitative interviews with HIV-infected girls and boys aged 15–19 years. Its aim was to better understand the sexuality (desires, experiences, beliefs, and values) of this segment of the population, and to identify anxieties or fears they have around growing up, love and loving, dating, pregnancy, fatherhood, motherhood, relationships and intimacy. This brief describes some of the key findings from this study and discusses their programmatic implications.

Methods

Study respondents were identified and recruited through existing HIV/AIDS treatment, care and support centers in four districts of Uganda, that is, Kampala, Wakiso, Masaka, and Jinja. Access to the client registers was granted by the management of the centers while the data officers working at the centers assisted with identifying clients falling within the desired age bracket. The counselors then helped with identifying those clients who were recorded as being perinatally infected with HIV or presumed to be so (that is, those who had been living with HIV since infancy) and to whom HIV sero-status had been disclosed.

Table 10.3: Distribution of Study Respondents by Sociodemographic Characteristics

Characteristic	Male (n = 263)	Female (n = 469)	Both genders (n = 732)
Mean age (y)	**17**	**16**	**17**
Age, y (%)			
15	35	33	34
16	14	17	16
17	8	10	9
18	25	23	24
19	18	17	17
District (%)			
Jinja	32	21	25
Kampala	24	29	27
Wakiso	18	35	29
Masaka	26	15	19

A total of 740 young girls and boys were identified for the survey and 732 were successfully interviewed. Female respondents comprised about two-thirds (64%) of the study sample (Table 10.3). There was, however, no significant difference in the mean ages of male and female participants. Survey data were collected using a structured questionnaire in both English and either of the two other local languages, *Luganda* or *Lusoga*. A wide range of issues were covered including socio-demographic characteristics, access to sexual and reproductive health information, sexual behavior, preventive knowledge and practices, contraceptive knowledge and use, pregnancy and childbearing intentions and experiences, self-esteem, worries, and sexual and physical violence.

Another 48 young people were identified to participate in focus group discussions (FGDs) and 12 others were identified for in-depth interviews and ethnographic case stories. Seven FGDs were conducted, with each FGD having an average of six participants. In-depth interviews and case stories were conducted with all the 12 informants. Informed consent to participate in the study was sought at two levels: the parents/guardians first, followed by the individual adolescents. Parents/guardians of respondents aged 15–17 years were asked to provide written permission for their children to participate in the study. Subsequently, the respondents were asked to indicate their own willingness to participate by assenting to the study. Only individual written consent was obtained from respondents aged 18 –19 years and those considered to be emancipated minors.[1]

[1] Adolescents not living under the control of parents or guardians, i.e., those who are married or are taking care of their siblings or their own children. In Uganda the National Council of Science and Technology allows emancipated minors to consent to participating in research as long as they are thoroughly informed about the risks involved.

Results

Key findings are summarized in Table 10.4. Contrary to the emphasis by service providers on refraining from or postponing sexual initiation, the findings indicate that these adolescents are beginning or do desire to explore their sexuality. Of all interviewed respondents, 44% reported a desire to have sex, and 41% believed that there was no reason why someone who living with HIV should not have sexual intercourse. About 40% of all respondents had ever been in a relationship with a significantly higher proportion of male than female participants reporting having been in a relationship. In addition, 33% of the respondents reported having had sexual intercourse. Slightly more male than female respondents reported having had sex though the difference is not significant. It is also worth noting that of those who had had sex, close to three-quarters (73%) had consensual first sex, with significantly more male than female respondents reporting consensual first sex.

Discussion

These patterns raise a number of questions that have implications for HIV transmission. First, what kinds of partners do young people living with HIV desire to have? Our findings show that over one-third (37%) of the respondents would prefer a partner who is HIV-negative with significantly more male than female respondents reporting such preference. Another 29% indicated no preference, suggesting that the proportion of respondents who would prefer HIV-negative partners could even be higher. Indeed, of those who were currently in a relationship and knew the HIV status of the partner, 39% were in discordant relationships. The major reason given for preferring HIV-negative partners was to avoid HIV re-infection. Another interesting pattern is that significantly more female than male respondents reported no partner preference yet more female than male adolescents who knew the HIV status of the partner were in discordant relationships. This is further indication that the proportion of respondents preferring HIV-negative partners could be higher than what was reported.

The second question raised by the observed patterns is the extent to which young people living with HIV, who know their sero-status, and who are in relationships engage in safe sexual practices in order to avoid spreading the virus. The study findings show that among those who had ever had sex, only about one-third (37%) reported using a method to prevent HIV infection or re-infection at first sex with no significant difference between male and female respondents. Among current users of condoms, the proportions reporting usage to prevent infecting the partner with HIV and other sexually transmitted diseases (STDs) and to avoid self re-infection remained low. Much of current use of condoms was for pregnancy prevention. Moreover, less than half of those currently using condoms reported consistent use.

Table 10.4: Percent distribution of respondents by their views about sex and sexual experiences

	All respondents			
	Male (n=263)%	Female (n=469)%	Significance test[e]	Both genders (n=732)%
Ever had a boyfriend/girlfriend	46	37	*	41
Ever had sex	37	31	NS	33
Desires to have sex	55	38	**	44
HIV-positive person should have sex[a]	54	34	**	41
Partner preference				
• HIV-negative partner	42	34	*	37
• HIV-positive partner	35	34	NS	34
• No preference	23	32	**	29
Main reason for preferring HIV-negative partner[b]				
• Avoid re-infection	68	60	*	63
• Have HIV-negative children	14	13	NS	14
• Other	18	27	**	23
Worried about				
• Disclosing HIV status to friends	44	54	**	51
• Becoming pregnant/causing pregnancy	75	74	NS	74
• Infecting someone else with HIV	75	83	**	80
Sexually active respondents[f]				
• Had consensual first sex[c]	89 (n=98)	63 (n=144)	**	73 (n=242)
• Used a method to prevent HIV infection/re-infection at first sex	35 (n=98)	39 (n=138)	NS	37 (n=236)
• Currently using a condom to prevent[d]	(n= 49)	(n= 65)		(n= 114)
• Infecting partner with HIV/STDs	35	26	NS	30
• HIV re-infection	25	26	NS	25
• Pregnancy	61	54	NS	57
Frequency of current condom use	(n=49)	(n=65)		(n= 114)
• Always	45	43	NS	44
• Sometimes	33	31	NS	32
• Rarely	8	21	NS	16
• Missing	14	5	NS	9
Respondents currently in a relationship				
• Knows partner's HIV status	35 (n=63)	32 (n=96)	NS	33 (n=159)
• In discordant relationship	24 (n=21)	50 (n=30)	NS	39 (n=51)
• Disclosed HIV status to partner	42 (n=62)	35 (n=96)	NS	38 (n=158)

HIV = human immunodeficiency virus; NS = not significant; STDs = sexually transmitted diseases.

[a] Proportion of respondents who believed that there is no reason why a person living with HIV should not have sex.

[b] Participants who reported preference for HIV-negative partners. This was an open-ended question whose responses were re-coded after data entry.

[c] Both partners were willing or wanted to have sex.

[d] Multiple responses were allowed.

[e] Significance test of difference between male and female proportions: *p <.05; **p <.01.

[f] Participants who had ever had sex.

There is also evidence suggesting that risky sexual practices are affected by the disclosure of HIV status [5] though other studies have found otherwise [6]. The study findings show that disclosure of HIV status to the partner is low. Just over one-third (38%) of the respondents who were currently in a relationship disclosed their HIV status to their partners. In addition, disclosing one's sero-status was one of the greatest fears of the adolescents: 51% of all respondents feared disclosing their status to friends. Qualitative data further suggest that even in the event of

disclosure, the partners do not mind engaging in the relationship even if they are discordant, as illustrated by the following examples:

"I asked her to leave me and find someone else-negative. She told me that she was not going to leave because of my status." (Case Study No. 7)

"If you have a sign people may leave you alone. But if no sign, they come after you even if you tell them, they say you are lying . . ." (FGD No. 5)

"I have a boyfriend. He knows my HIV sero-status. I disclosed to him and he said that he did not mind." (FGD No. 3)

These research findings have several implications. Of importance, the findings suggest that many of the HIV-positive adolescents are sexually active or desire to be in relationships. In addition, many prefer HIV-negative partners. However, preventive practices, including disclosing one's HIV status to the partner, are poor. Some of these experiences apply to the general population as well [7,8]. Although not directly comparable, available Uganda data on young people aged 15–19 years who had ever had sex shows that the percentage that knew the HIV status of their partner was even lower (8% for males and 10% for females) with similar patterns being observed among adults (ages 15–49 years; 11% for males and 9% for females) [8]. Nonetheless, the case of those living with HIV is unique because they stand the greatest chance of transmitting the virus. HIV/AIDS programs therefore need to appreciate that perinatally infected adolescents have similar desires as of those of other children maturing into adolescence and adulthood. Thus, there is need to provide preventive sexual and reproductive health information and services to HIV-positive adolescents in order to prevent further HIV transmission and unwanted pregnancies. This should entail empowering these adolescents with skills to negotiate disclosure and consistent condom use.

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Appendix 10B: Adolescent Sexual Abuse

The highest probability indicators of sexual abuse

As previously mentioned, in many cases of abuse, there are no physical symptoms. There are, however, often some specific indications that abuse has occurred. These can include:

- Unexplained pregnancy
- Unexplained sexually transmitted infections; pain, swelling, bleeding, or irritation of the mouth, genital, or anal area; of urinary tract infections
- Hints, indirect comments, or statements about the abuse
- Problem sexual behaviors: Some adolescents who have been sexually abused may become sexually provocative and copy adult behavior, displaying sexual knowledge (through language or behavior) beyond what is normal for their age. Others may merge sexual behavior and aggression and become the victimizers of others.

Some of these symptoms can result from consensual sexual activity. When pregnancy or sexually transmitted infections are found in adolescent clients, the age of the adolescent should be taken into consideration. In many countries, the age of consent for sexual activity is 16 years; however, adolescents younger than 16 may also have consensual sex (sex in which they willingly engage). In some cases, therefore, it may be necessary for health workers to make a judgment call about whether the sexual activity was forced or not. The younger the adolescent, the more likely it is that the activity was forced — adolescents under 12 are generally considered incapable of consenting to sexual contact. For adolescents between the ages of 12 and 16 (or older adolescents), the determination of whether or not abuse occurred may require interviewing the client and making a clinical judgment.

Recognizing the signs and symptoms of sexual abuse in adolescents

The table below presents a checklist of physical and behavioral signs and symptoms that may be associated with sexual abuse in adolescents. This checklist is not a diagnostic tool, and these signs and symptoms may result from other causes. Also remember that the absence of any of these signs or symptoms does not indicate that no sexual abuse occurred. Each individual survivor of sexual abuse reacts differently and a determination of sexual abuse cannot be based on signs or symptoms alone. Behavioral signs of sexual abuse, for example, are more common than physical signs, but they can also be indicators of other types of trauma. Therefore, it is always necessary to gather information beyond just signs and symptoms to conclude whether or not sexual abuse has occurred.

Signs and symptoms associated with sexual abuse in adolescents

Physical signs	Yes	No
Difficulty walking or sitting		
Cuts or bruises		
Signs of physical abuse (for example, punch marks, restraint marks on the wrist, torn eardrums — all should be investigated as a possible indication abuse)		
Complaints of pain with urination or with bowel movements		
Irritated or itching genitals or anus		
Bleeding from the genital area or anus		
Urinary tract infection, blood in urine, or difficulty with urination		
Vaginal or penile discharge		
Pregnancy (younger than 16)		
Sexually transmitted infection, warts, or ulcers in genital area		
Unusual or offensive odors from genital area or anus		
Fresh or healed tears of the hymen or vaginal mucosa		
Development of frequent, unexplained health problems		
Changes in behavior	**Yes**	**No**
Nonsexual indicators		
Avoidance of specific caregivers or caregiving situations		
Sleep disturbances, such as nightmares or bedwetting in younger adolescents		
Withdrawal from family, friends, or usual activities		
Unexplained fear of physical or gynecologic examination		
Significant increase or decrease in appetite (eating disorders)		
Excessive bathing or poor hygiene		
Reluctance to be with a certain person		
Mood changes, such as anger, outbursts, or depression		
Becoming worried when clothing is removed		
Academic problems		
Lowered self-esteem		
Symptoms of post-traumatic stress disorder, such as panic attacks		
Excessive crying		
Sexual indicators		
Age-inappropriate knowledge of sex		
Imitating sexual acts or copying adult sexual behavior with younger children, toys, or pets		
Excessive masturbation		
Sexual experimentation with age-inappropriate partners		
Note: This is not a diagnostic tool — these signs and symptoms may result from other causes.		

Additional signs of sexual abuse that may be present in older adolescents include:

- Drug or alcohol use
- Delinquency
- Running away
- Depression
- Early sexual involvement/activity
- Promiscuity
- Criminal activity
- Self-destructive behavior (for example, attempting suicide or self-mutilation)
- Eating disorders (anorexia/bulimia)

As adolescents mature, they become aware of societal responses to their sexual activity and overt sexual indicators, such as those listed in the table above, become less common. In addition, some level of sexual activity is considered normal for older adolescents. **There are three sexual indicators, however, that *may* signal sexual abuse in this population:**

- Among girls, sexual promiscuity
- Among girls, being sexually victimized by peers or nonfamily members — in other words, repeated victimization when an adolescent is older may be evidence of earlier unrecognized sexual abuse
- Adolescent prostitution

Of these three indicators, the last is most compelling. One study found that 90 percent of female adolescents involved in sex work had been sexually abused at some point in their lives.[5] Although there has not been comparable research on adolescent male sex work*, clinical observation suggests that adolescent males also become involved in the exchange of sexual services for goods or money as a result of sexual abuse.[6]

Interviewing an adolescent who may have been sexually abused

Talking about sexual abuse is extremely difficult for most adolescents. They are afraid, may feel embarrassed or ashamed, and often do not know how to talk about what has happened to them. Sometimes, they have been bribed, threatened, or made to feel responsible for their abuse. The ideal location to interview an adolescent about sexual abuse is in a quiet, comfortable, and private setting, either alone or with an adult of the adolescent's choice. Sit at the adolescent's level and use the listening and learning skills described in Module 4.

Be very patient and take plenty of time. Keep in mind that if a young person is feeling defensive, he or she is not feeling safe. Do not push and prod. Stay as calm as possible — adolescents often stop talking if they think that what they are saying is upsetting you.[7] It is also important that health workers not to appear to lead clients to answer their questions in a particular way. Be careful not to plant ideas in an adolescent's mind or to suggest what you expect to hear because then he or she will be more likely to give you the answers he or she thinks you want. Instead, encourage clients to be open and honest.

Above all, reassure adolescents that the abuse was not their fault. Tell them that there is nothing that they did to deserve what happened. Help clients understand that it is all right to feel angry and help them express their anger in ways that are healthy for themselves and others.

Health workers will get further, and will get a more accurate account, if they ask open-ended questions. An open-ended question requires an explanation/description for an answer, instead of a simple yes/no one-word answer. For example, rather than asking, *"That man touched you on your private parts, didn't he?,"* it would be better to ask, *"Tell me about what happened when you were out with that man."* As a general rule, health workers should not ask questions that start with "why" because they may come across as accusatory. See Module 4 for more information on open-ended questions.

* Please note that UNAIDS Editors' Notes for authors (August 2006) preferred the term "juvenile prostitution" for this group.

How to begin questioning related to suspected sexual abuse[8]

Always introduce the principle of shared confidentiality and explain your obligations as a health worker if disclosure of sexual abuse occurs during the conversation.

Try to make the adolescent comfortable by explaining that you would like to ask him or her some questions. Explain that he or she should be honest and should not be afraid. Begin by normalizing the topic. For example: *"Because I want to help my clients, I ask everyone about issues that may be sensitive. It is important that I know some things in order to help you."*

Begin the interview with open-ended questions. Ask questions in a non-judgmental way and avoid technical or medical language:

- *It looks like something might be bothering you. Can you tell me about it? I'd like to know more about this.*
- *Can you tell me if someone has ever touched you in a way you didn't like? How did they touch you?*
- *Has anyone ever hurt you or made you feel bad? How so?*
- *Has anyone ever touched your private areas? Where?*
- *What happened?*
- *Tell me more.*
- *When was last time this happened?*

Other possible questions for younger adolescents:

- *Did you ever see an adult's private parts? Whose did you see?*
- *Did anyone ever ask you to touch their private parts? Who?*
- *Did anything that you didn't like ever happen to your private parts? What?*

For older adolescents:

- *How long have you been sexually active?*
- *Has anything sexual that you didn't like ever happen between you and a friend, date, or someone you know? How about something that made you uncomfortable? Anyone at home? Anyone at school? Any other adult?*
- *Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?*

Always validate the adolescent's response:

- *Thank you for telling me about such a difficult experience.*
- *I'm sure that was hard for you to tell me. It is good that you told me.*
- *When someone hurts you, it is devastating in many ways. Let's talk about some of the ways you need support.*

Evaluate and follow up:

- Immediately evaluate the present-day level of danger, other violence, drug or alcohol use, and health habits. Mention the adolescent's disclosure again during another visit and continue to ask about his or her needs. Request a 1- to 2-week follow-up appointment with the adolescent.

Use a multidisciplinary team approach:

- Health workers should always seek the counsel and support of multidisciplinary team members when working with clients who have experienced sexual abuse. Discuss sexual abuse cases and how they can best be managed in multidisciplinary team meetings.
- Ensure that health workers know where to seek and refer clients for additional expert help, advice, counseling, and resources.

Other clinical follow-up after the interview

If an adolescent discloses sexual abuse, a thorough physical and gynecological examination should be conducted, with the adolescent's consent (procedures described in Session 10.4).

Respect for privacy during physical examinations is extremely important for adolescents who have experienced sexual abuse. Health workers can demonstrate this respect and can help the adolescent regain a sense of control over his or her body by covering the client with a sheet and allowing him or her to stop the examination at any time if feeling uncomfortable. Health workers should also model sensitive, respectful physical examination techniques to other members of the clinical team.

Follow national testing guidelines when providing HIV counseling and testing to adolescents of unknown HIV-status who have experienced sexual abuse.

Follow-up for psychosocial and mental health issues

Adolescents need support to deal with what happened to them and to discharge and cope with their feelings. As above, it is important to take a multidisciplinary approach with clients who have experienced sexual abuse. Health workers should know where to refer clients for additional counseling, peer support, and community-based services.

At a minimum, health workers should conduct a psychosocial assessment to determine the impact the abuse had on the adolescent, the level of family support available to assist him or her with coping, and the ability and willingness of the family to ensure the adolescent's continued safety. The initial assessment should be accompanied by a mental health intervention to reduce the immediate impact of the trauma. There should also be a discussion with the adolescent (or with the caregiver, if the adolescent is too young to understand and if the caregiver is not the perpetrator of sexual violence) of what to expect. Helping the adolescent and caregiver understand what behaviors and emotions are likely to follow the abuse, and assisting them in understanding that these are a natural result of the abuse, will help them cope more effectively with the impact of the abuse.

Provide follow-up for assessment and treatment of mental health issues. Follow-up should take place at 7 days and 1, 2, 3, and 6 months after the abuse, or according to national policy. Health workers should be knowledgeable of the resources available within the facility and the community to treat the adolescent. If the facility does not have the capacity to provide mental health services, the adolescent should be referred to a facility that does have mental health resources. For more information about assessment and treatment of mental health problems and disorders, refer to Module 6.

Legal follow-up

Health workers must understand any relevant laws and must report cases of sexual abuse in accordance to these laws. Having formal referral linkages to police and legal services is recommended.

In most countries, the police are required by law to be notified of suspected cases of abuse or neglect of adolescents under the age of 16 years. The police are responsible for working with representatives from social welfare and health services as part of a multidisciplinary team. Their duties include investigating the report, determining whether abuse has occurred, ensuring the continued safety of the adolescent, and prosecuting the person who committed the abuse. Where sexual abuse is a criminal offense, health workers may be responsible for reporting findings in a court of law. Therefore, it is vital that health workers who have had contact with the adolescent or with evidence gathered from the adolescent maintain the chain of evidence; that is, collecting, storing, and documenting all the gathered material for possible presentation in court proceedings.

Appendix 10C: Screening and Examining Adolescent Clients for STIs

Screening questions	Physical examination steps
For adolescent women:	
• Do you have vaginal discharge that is not normal for you (color, amount, smell)? • Do you have any pain when you urinate (pee)? • Do you have any sores or bumps in or around your genitals? • Do you have any pain in your lower abdomen?	Ask the young woman to undress from the waist down and to lie on an exam table (or, if she is wearing a skirt, she can leave it on and take off her underpants). Be sure to cover her with a sheet and only expose the parts that you examine. **External exam:** • ***Skin exam:*** Inspect the skin of the genitals, perineum, inguinal areas, thighs, lower abdomen, buttocks, chest, back, soles of feet, and palms of hands. Look for vesicles, ulcers, warts, other growths, and rashes. • ***External genital exam:*** Inspect and palpate the external genitalia, then inspect the perineum and anus. Look for ulcers, vesicles, warts, and discharge. • ***Inguinal exam:*** Examine the inguinal area and palpate for lymph nodes. • ***Abdominal exam:*** Palpate the abdomen, checking for guarding, tenderness, rebound tenderness, and masses. **Internal exam:** • ***Internal genital exam:*** Have the woman lie with her legs bent at the knees, keeping her feet and knees separated. Separate the labia and insert a bivalve speculum* lubricated with warm water. With a bright light shining on the area, inspect the vaginal walls and the cervix. Look for ulcers, warts, and cervical and vaginal discharge. • ***Bimanual pelvic exam:*** Remove the speculum and insert the lubricated index and middle fingers of your hand into the vagina. Place your other hand on the lower abdomen and examine the pelvis for swelling and tenderness. Move the cervix laterally and check for cervical motion tenderness. Check for tenderness and masses around the uterus and ovaries. * Some health workers prefer to not use a speculum, or to use a smaller speculum, in women who are virgins.
For adolescent men:	
• Do you have any discharge from your penis? • Do you have any pain when you urinate? • Do you have any sores or bumps around your genital area or your anus?	Ask the man to undress from the waist down and to lie on an exam table. Be sure to cover him with a sheet and only expose the parts that you examine. • ***Skin exam:*** Inspect the skin of the genitals, perineum, anus, inguinal areas, thighs, lower abdomen, buttocks, chest, back, soles of feet, and palms of hands. Look for vesicles, ulcers, warts, other growths, and rashes. • ***External genital exam:*** Inspect the penis, including the opening of the urethra, by retracting the foreskin. Look for ulcers, vesicles, and urethral discharge. If the patient complains of discharge and none is present, give the urethra a gentle squeeze and massage it forward to try and express any discharge. Inspect in and around the anus. Palpate the scrotal contents and note presence of ulcers or buboes. • ***Inguinal examination:*** Palpate the groin, feeling for enlarged lymph nodes and the presence of buboes.

Adapted from: WHO (2003*). Guidelines for the management of sexually transmitted infections.* Available at: http://whqlibdoc.who.int/publications/2003/9241546263.pdf

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