SEXUAL HEALTH
An Adolescent Provider Toolkit

Illustrations by Jordan Zioni, 17
HOW TO OBTAIN A COPY OF THIS TOOLKIT
The Sexual Health Module of the Adolescent Provider Toolkit can be downloaded for free from the following website:
Please visit our website for information on purchasing hard copies of the Sexual Health Module.
Additional AHWG materials including Chinese and Spanish handouts for youth and parents/caregivers are available for free download.

ADOLESCENT HEALTH WORKING GROUP
The Adolescent Health Working Group (AHWG) was formed in 1996 by a group of adolescent health providers and advocates concerned about the lack of age-appropriate health services for young people in the city of San Francisco. Today, the AHWG remains the only group of its kind in San Francisco. The AHWG’s vision is that all youth have unimpeded access to high quality, culturally competent, youth friendly health services. The AHWG’s mission is to support and strengthen the network of providers working to improve adolescent health. The AHWG works to fulfill its vision and mission through the following core functions: 1) develop tools and trainings that increase providers’ capacity to effectively serve youth, 2) advocate for policies that increase access to care and utilization of services, and 3) convene stakeholders and coordinate linkages across systems to improve information sharing, networking, and referrals for youth services.

SUGGESTED CITATION
Dear Colleagues:

We are pleased to present you with the new Sexual Health Module of the Adolescent Provider Toolkit series. The production of the new Sexual Health Module was made possible through the generous support of the San Francisco Department of Children, Youth, and Their Families, and through the UCSF University Community Partnership program.

The new Sexual Health Module is an updated and expanded version of the 2003 Sexual Health-CA Version. The new module champions a paradigm shift from a deficit/risk based perspective to one that embraces adolescent sexuality as positive and normative in this stage of development. This comprehensive guide:

- Focuses on healthy sexuality and healthy relationships.
- Integrates information regarding the sexual health of all young men and women, LGBT youth, and youth with disabilities.
- Is designed for primary care providers and is applicable to many others including school-based and youth program providers.
- Is written from a national perspective.
- Is updated with links to the most current evidence based research.
- Includes many unique resources in the format of handouts for youth and families.

Designed for busy providers, the new Sexual Health Module includes materials that you are free to copy and distribute to your colleagues, adolescent patients, and their parents/caregivers. The new Sexual Health Module is not intended to replace clinical practice protocols. It does provide evidence based practice guidelines to enhance provider’s ability to meet the sexual health needs of adolescents. This module includes:

- Practice readiness tools.
- Screening, assessment, and referral tools such as taking a client-centered sexual health history and screening for sexual dysfunction.
- Resource sheets on various sexual issues including menstrual suppression and male involvement.
- Health education handouts for teens and their parents/caregivers on topics including sex and technology and safer sex toy use.
- Online resources and hotlines.

We did not repeat information/tools that are included elsewhere in the Adolescent Provider Toolkit series. General screening and counseling techniques can be found in the Adolescent Health Care 101 Module. Information and treatment algorithms on California specific minor consent and confidentiality laws can be found in the Understanding Minor Consent and Confidentiality in CA Module. We have also opted to refer the reader to regularly updated website for information that changes frequently such as treatment protocols for STIs, etc.

We encourage you to visit our website, www.ahwg.net, for free downloads of the entire Adolescent Health Toolkit series, including health education handouts for youth and parents/caregivers available in Chinese and Spanish. We hope the Adolescent Provider Toolkit series will be a useful resource for you as you improve the health of adolescents.

Regards,

Erica Monasterio, MN, FNP
Alicia St. Andrews, MPH
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ACKNOWLEDGEMENTS

The Adolescent Health Working Group has so many people to thank for their generous contributions of time, energy, expertise, encouragement, and financial support. The Sexual Health Module of the Adolescent Provider Toolkit has been made possible due to every individual and organization mentioned below. We are incredibly grateful to you.

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Guided by the expertise of the first Adolescent Sexual Health Advisory Toolkit Council, we would like to acknowledge the original authors of the Sexual Health Toolkit Module: Allison Young, Janet Shalwitz, MD, Sara Pollock and Marlo Simmons, MPH.

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Special mention goes to Amy Schalet, Arik Marcell, and Carla Valdez who contributed their many gifts of guidance, expertise, wisdom, and encouragement to the redesign and development of the updated edition of the Sexual Health Module of the Adolescent Provider Toolkit.
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### C. For Parents/Caregivers

**Use these handouts as a guide for counseling parents/caregivers of your teen patients.**
- How to Talk with Your Children and Teens about Healthy Relationships [C-66]
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- Supporting Your Pregnant and Parenting Teen [C-71]

### D. Internet Resources

Click on This! [C-72]
Are You Prepared to Address Adolescent Sexual Health?

Creating a safe, non-judgmental, and supportive environment can help teens feel more comfortable sharing personal information. There are many things that can be done to ensure that your practice is youth friendly. Here are some questions to consider as you read through Sexual Health Module of the Adolescent Provider Toolkit.

Does your office/clinic have…

- Information on where and how to access condoms? While all clinic settings may not be appropriate for displays, having a small sign near the intake area is recommended.
- Teen-friendly sexual health education materials with age-appropriate language in your waiting room? Do these materials contain positive imagery of teen relationships which do not portray sex only in terms of the risks and negative consequences? Are your educational materials inclusive of a diverse audience including LGBT youth and youth with disabilities?
- Confidentiality policies posted in areas that can be viewed by both patients and their families?
- Gender inclusive language on intake/history forms and questionnaires?
- A procedure for dealing with emergency and crisis situations including rape, sexual assault, and intimate partner violence?
- A policy regarding teens scheduling their own appointments? Not all health services require consent from the parent/caregiver.
- Policies regarding talking to a teen alone without his/her parent/caregiver?
- Financing options for teens accessing confidential services under minor consent?
- Clinic/practice hours that are convenient for teens?
- A network of referrals for adolescent-friendly providers in the area?

Is your staff…

- Friendly and welcoming toward teen patients?
- Knowledgeable about the laws of minor consent and confidentiality and consistent in upholding those laws?
- Aware of privacy concerns when adolescents check in?
- Careful to avoid making assumptions about gender or sexual orientation?
- Ready to maintain sensitivity for the age, race, ethnicity, gender, sexual orientation, disability, family structure, and lifestyle choices of your patients and their loved ones?

Are you…

- Aware of your own biases toward sexual health and how your own experiences have shaped your opinions toward sexually active adolescents?
- Confident, comfortable, and non-judgmental when addressing adolescent sexuality?
- Prepared to take a strengths-based approach when working with youth?
- Aware of the characteristics/features of positive adolescent sexual development and relationships?
- Ready to provide medically accurate information about sexual and reproductive health while also emphasizing the importance of healthy relationships?
- Familiar with the legal and confidentiality issues dealing with teen sexual activity and reproductive health services including access to birth control options, STI testing, abortion, sexual assault services; parent/caregiver involvement; and releasing medical records?

Provider’s role in providing adequate care for adolescents:

- Make every interaction an opportunity
- Support healthy relationships
- Provide a framework for positive adolescent sexual development
- Promote health and reduce risk

Sources:
## Adolescent Sexual Development

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<thead>
<tr>
<th>STAGE</th>
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| **EARLY ADOLESCENCE** | - Puberty/Concern with body changes and privacy.  
- Development of first crush as a milestone to sexual orientation.  
- Concrete thinking, but beginning to explore new ability to think abstractly.  
- Sexual fantasies are common.  
- Masturbation is common.  
- Movement towards defining sexual identity.  
- Sexual intercourse is not common. 4.9% of high school females and 13.5% of high school males had first intercourse before the age of 13.\(^1\) | - Begin discussing healthy relationships using examples from friendships or concepts such as, “what are you looking for in a friend?”  
- Focus on current issues facing the teen instead of future possibilities. Relate decision-making techniques to everyday situations instead of having him/her visualize what may happen in the future. Avoid asking questions framed with “why.”  
- Use health education materials with lots of pictures and simple explanations. Typically, males are not receiving as much information about puberty and body development as girls at this age.  
- Focus on issues that most concern this age group (weight gain, acne, physical changes). |
| Females: 9-13 years  
Males: 11-15 years |                                                                                                                                                                                                        |                                                                                                                                                                           |
| **MIDDLE ADOLESCENCE** | - Increasing concern with appearance.  
- Peer influences are very strong in decision making.  
- Experimentation with relationships and sexual behaviors is common.  
- Concerned about relationships.  
- Sexual intercourse is increasingly common. 44% of high school tenth graders and 56% of high school eleventh graders had had sexual intercourse.\(^2\)  
- Increased abstract thinking ability.  
- Full physical maturation is attained.  
- Dating is common.  
- Sexual behaviors do not always match sexual orientation.  
- Often aware of theoretical risk but do not see self as susceptible. | - Listen more and talk less.  
- Help teens identify the characteristics of a healthy relationship and assess their own relationship quality.  
- Peer counseling can be effective with this age group.  
- Focusing on health promotion, prevention and harm reduction is key.  
- Avoid making assumptions about sexual orientation and behaviors.  
- Help provide gay and lesbian youth with positive role models and support systems. Assess family response to youth’s sexual orientation.  
- Be aware youth with disabilities, like their non-disabled peers, may be engaging in sexual behaviors and have questions around their sexual orientation  
- Reinforce parent-child communication about sexual decision making and forming healthy relationships. |
| Females: 13-16 years  
Males: 15-17 years |                                                                                                                                                                                                        |                                                                                                                                                                           |
| **LATE ADOLESCENCE** | - Firmer and more cohesive sense of identity.  
- Attainment of abstract thinking.  
- Ability to establish mutually respectful/trusting relationships.  
- Firmer sense of sexual identity.  
- Concern for the future.  
- Feelings of love and passion.  
- Increased capacity for tender and sensual love. | - More abstract reasoning allows for more traditional counseling approaches.  
- Acknowledge and support healthy relationships or the choice to not be in a relationship. |
| Females: 16-21 years  
Males: 17-21 years |                                                                                                                                                                                                        |                                                                                                                                                                           |

\(^2\)Ibid.
Adolescent Sexual Development cont.

The stages of adolescent development can be used as a guide to approaching counseling techniques in an age-appropriate/developmentally appropriate manner. Keep in mind that these age delineations are generalized and that actual development is affected by culture, abuse, and socialization.¹

When considering the stages of development, be sure to….

- Appreciate that the transition from childhood to adulthood may be a difficult and overwhelming. Healthcare providers can make these transitions easier by providing guidance and information to teen patients and their parents. For example, research has shown that menarche is less stressful when the teen knows what to expect.

- Assess social, biological, and cognitive stages of development. Keep in mind that physical development does not always match cognitive and social development. Asking a question like, “when do you think a person is ready to have sex,” can help identify where the teen is developmentally. When working with youth with disabilities be age appropriate unless cognitive delays are evident. Even if a person needs extra time to process information or has difficulty with language and expression, this does not mean he/she doesn’t understand at an age appropriate level.

- Educate both adolescent girls and boys about the stages of development. Boys generally receive less information than girls about developmental changes and puberty can be a confusing, uncomfortable time for everyone.

- Support your teen patients in developing healthy sexual relationships and healthy attitudes toward sex. Ensuring that teens have a supportive adult in their life who can guide the teen while he/she builds relationships is extremely important for their overall development into adulthood. The provider can help the teen identify adults they can turn to.

- Pay attention to how a teen feels about his/her development. Teens that develop earlier or later than average are vulnerable to health and social problems. If you feel that a teen is developing faster/slower than average, provide anticipatory guidance.

- Realize that social pressures surrounding development are a reality for many teens. Girls who mature earlier are at greater risk of becoming sexually active at a younger age than their female peers. Teen boys who develop later can be bullied and are at higher risk for substance and/or tobacco abuse problems than their peers who develop earlier.


Sources:
2) Getting Organized: A Guide to Preventing Teen Pregnancy
Provider-Youth Communication

Providers play a critical role in encouraging healthy behaviors in adolescents. Encouraging teens to practice making healthy decisions requires clear, nonjudgmental, confidential guidance or communication.

**TIPS FOR TALKING TO TEENS**

- **Remove distractions.** Spend part of every visit with adolescent patients alone. By asking teens in private if they want their parent and/or partner involved in their care, they will be more likely to give a comfortable answer. Also request that cell phones and pagers are turned off - both yours and the teen’s.

- **Begin by discussing confidentiality and its limits.** This helps build trust and explains the basis for mandated reporting. These requirements differ by state; if you are unclear on the limits to confidentiality, contact your county’s child protective services for more information.

- **Negotiate the agenda.** Make an effort to address the issue(s) that brought your patient through the door, and explain what you need to cover during the visit. You can address their concerns and yours while building trust along the way. Don’t neglect to include a sexual history for a youth with a disability.

- **Avoid jargon or complex medical terminology.** Teens are often hesitant to ask for clarification. Simple, straightforward language ensures effective communication of important information. Check for mutual understanding by asking open-ended questions, and clarifying your patients’ slang in a nonjudgmental manner (e.g., “Tell me what you know about how a person can get HIV?”; “I’ve never heard that term before, do you mind explaining what ___ means?” Unless it is natural for you, try to avoid using slang to relate.

- **Use inclusive language.** Language that includes LGBTQ or gender variant youth builds trust and indicates acceptance. Instead of ‘do you have a boyfriend/girlfriend?’ try saying ‘are you seeing anyone?’ or ‘are you in a relationship?’ The language we use when speaking of disabilities is important. For example, the term “disability” is preferred over “handicap” and “wheelchair user” over “wheelchair bound”. Listen to the language your patients use and, when in doubt, ask what is preferred.

- **Listen.** This not only builds trust, but may give insight that affects the healthcare and advice you provide.

- **Respect an adolescent’s experience and autonomy.** Many young people feel that adults and people in positions of authority discount their ideas, opinions and experiences. Health care providers, together with parents, can help patients make wise, healthy decisions.

**RISK vs BLAME**

Healthcare providers generally assess risk and protective factors when treating and providing guidance to teen patients. There are many factors that put an individual at risk of negative health outcomes including living in poverty, a violent neighborhood, a single parent home, etc. Many of these risks, however, are not by the choice of the individual. When assessing risk and counseling on behavior change, avoid communicating blame to the patient.
FOR PROVIDERS: PRACTICE READINESS

Provider-Youth Communication cont.

FRAMEWORKS FOR WORKING WITH YOUTH

Reinforcing Health Promoting Behavior (Harm Reduction)

While healthcare providers cannot control the decisions made by their patients, they do play an important role in encouraging and reinforcing healthy decision-making. For example, when teens are engaging in risky sexual behaviors, teach them to use a condom or other birth control methods correctly and consistently rather than solely focusing on trying to talk them out of a sexual behavior that is deemed as risky. When teens are having oral sex, encourage them to use protection and abstain from such an activity when they have a cold sore in their mouth, genital lesions or bleeding gums.

Motivational Interviewing

While many teens make healthy decisions, sometimes it’s clear that teens would benefit from changing their behavior. Motivational Interviewing offers brief and effective methods for intervention and uses behavior change as a foundation for working with youth. Motivational interviewing techniques have been effective for alcohol or substance use counseling. There is increasing evidence of its usefulness for counseling around sexual health issues. For more information, see Behavioral Health Module of the Adolescent Provider Toolkit.

The basic framework for Motivational Interviewing is as follows:

1. **ASK PERMISSION** to engage in the topic of discussion.

2. **ASSESS READINESS** for change and the youth’s belief in his/her ability to make a change.

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   - On a scale of 0 to 10, how ready are you to get some help and/or work on this situation/problem?
   - Straight question: Why did you say a 5?
   - Backward question: Why a 5 and not a 3?
   - Forward question: What would it take to move you from a 5 to a 7?

3. **RESPOND TO PATIENT’S READINESS**
   - NOT READY FOR CHANGE (0-3): Educate, Advise and Encourage
   - UNSURE (4-6): Explore Ambivalence
   - READY FOR CHANGE (7-10): Strengthen Commitment and Facilitate Action

4. **KEEP “FRAMES” IN MIND** when counseling for behavior change
   - **F:** Provide **FEEDBACK** on risk/impairment (e.g. it sounds like your fear of getting pregnant is causing you a lot of anxiety)
   - **R:** Emphasize personal **RESPONSIBILITY** for change (e.g. I’d like to help you, but it’s also very important that you take responsibility for changing things. What steps can you take to help yourself?)
   - **A:** Offer clear **ADVICE** to change (e.g. I believe the best thing for you would be to…)
   - **M:** Give a **MENU** of options for behavior change and treatment (You could try…)
   - **E:** Counsel with **EMPATHY** (I know that these things can be very difficult…)
   - **S:** Express your faith in the adolescent’s **SELF-EFFICACY** (I believe in you, and I know that you can do this, when you decide the time is right)

**Resource**

- Motivational Interviewing – Resources for clinicians, researchers and trainers:
  
  http://www.motivationalinterview.org
FOR PROVIDERS: PRACTICE READINESS

The Role of Providers in Parent-Child Communication

Providers play an important role in educating entire families on sexual health, sexual orientation and gender identity and facilitating communication between adolescent patients and their parents. Healthy communication about sex between parents and children is extremely important in ensuring that young people have the support and information they need to make healthy decisions about sex and sexuality. Although it may seem difficult to encourage communication while still respecting the teen’s privacy, it is possible to maintain confidentiality and at the same time promote parent-child communication.

The Benefits of Parent-Child Communication

- Young people who feel connected to home and to their parent(s)/caregiver(s) delay initiation of sexual activity.1
- Young people who have conversations with their parents about sex are also more likely to have conversations with their partners about sex.2
- Young people who regularly use contraception are more likely to report having had discussions about sex with their parents than sexually active young people who are not using contraception.3
- Young people whose parents talked to them about condoms are more likely to use a condom at first intercourse and more consistently thereafter.4
- Young people whose families and caregivers openly talk about their sexual orientation are at lower risk for health problems and risky sexual behavior.5

TIPS FOR ENCOURAGING PARENT-CHILD COMMUNICATION

With Youth:

- Reiterate the importance of parent-child communication each time you talk with the teen.
- Ask why they do not want to involve a parent and try and get a sense of what they are afraid of. You can’t force a teenager to talk to their parents, but you can probe further when a young person says they don’t want to or can’t talk to their parent about sensitive issues.
- Let LGBT teens know that families that reject their LGBT identity may be motivated by care and concern for their teen and can become more supportive when they learn how to provide support to their teen.5
- Ask if they need help talking to their parent about a particular issue and offer to meet with the youth and their parent together.
- If they feel uncomfortable talking to their parent, identify other caring adults in their immediate or extended family that they can talk to.
- Offer examples of ways that talking to parents/caregivers can help to ensure that they get support. E.g., help getting to appointments or someone to talk to when confusing things happen with their peers.
- Share examples of young people who were afraid to talk to their parent about a sensitive issue and how it went better than they expected.

With Parents:

- Reiterate the importance of parent-child communication each time you talk with parents.
- For parents of LGBT teens, tell them that family support decreases risk for HIV, STIs, suicide and promotes well-being while family rejection increases these risks.5
- Teach them medically accurate information, so that they can reinforce this at home.
- Ask if they need help talking to their children or if there are particular issues they find hard to discuss at home.
- Remind parents that teens are often afraid of disappointing their parents.
- Encourage taking advantage of teachable moments, such as when a young person asks a question or something is witnessed while watching TV together, for example, where a bigger discussion and line of communication can be opened up.
- Help parents find ways to be involved while respecting a young person’s privacy and confidentiality.
- Encourage parents to initiate and sustain open dialogues about health and sexuality with their children. Help parents put themselves in the shoes of a young person, to understand how difficult it is for their child to open up about sexuality and health.
- Offer educational materials and resources about parent-child communication. See pg. 66 and pg. 68.

Resources

- Advocates for Youth - http://www.advoatesforyouth.org/
- Guttmacher Institute - http://www.guttmacher.org/

FOR PROVIDERS: PRACTICE READINESS

Minor Consent and Confidentiality

Adolescents list confidentiality concerns as the number one reason for delaying or forgoing medical care. During a visit, teens are more likely to disclose sensitive information if consent and confidentiality is explained to them and they have time alone with a provider. Providers should reclarify the laws and limits of confidentiality during each visit.

LEARN THE MINOR CONSENT AND CONFIDENTIALITY LAWS IN YOUR STATE

Every state has different minor consent, confidentiality and mandated reporting laws. Almost all states allow teens to consent to STI testing and treatment, as well as medical care for a minor’s child. Contrarily, most states require some form of parental consent or notification before a minor can obtain an abortion.

Below is a link to an overview of minor consent laws for each state. This chart is updated regularly, but should only be used for a quick reference. More specific information about the laws in each state can be found in the resources and links listed at the bottom of this section.

OVERVIEW OF MINOR CONSENT LAWS
http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf

ENSURE CONFIDENTIAL BILLING FOR ADOLESCENT SEXUAL HEALTH SERVICES

- Most private health insurance plans send home an explanation of benefits (EOB) to the primary policy holder detailing services that have been received by the minor. Confidentiality may be breached if a parent/caregiver receives an EOB detailing their child’s reproductive or sexual health services.
- City, county, and/or state low- or no-cost family planning programs and Title X clinics do not send EOBs therefore disclosures regarding confidential care are avoided. Many of these programs cover services for to males too.
- Sometimes a referral to a Title X clinic is most appropriate if confidentiality can’t be ensured through insurance billing.

TIPS

- Be clear with minor patients up front about confidentiality and its limits. Be as specific as possible, so that they know what to expect and do not feel betrayed if something needs to be reported to a parent or child protective services.
- Explain that mandated reporting exists. Though it can cause confusion at times, it is ultimately for their protection.
- Explain early on the importance of confidentiality between providers and minor patients to parents. Rather than adversaries, parents can be allies in the provision of confidential healthcare for adolescents.

RESOURCES

Office of Population Affairs
Lists all Title X clinics by city, state, and zip code
http://www.opaclearinghouse.org/db_search.asp

National Center for Youth Law
Minor Consent and Confidentiality Information (AZ, CA, HI, IL, MI, NV, OH)
http://www.youthlaw.org/publications/minor_consent/

Healthy Relationships

The physiologic and cognitive impacts on romantic interest make adolescence an optimal time for providers to begin conversations about trust, communication, and respect. Regardless of whether a teen looks mature or displays a rebellious attitude towards authority, teens need to hear positive messages reinforced by adults who demonstrate an interest in their health and wellbeing. An assessment of relationships may also serve as a vehicle for exploring topics such as sexual activity, condom and birth control use, and intimate partner violence.

**DISCUSSING HEALTHY RELATIONSHIPS WITH ADOLESCENTS:**

Using the Healthy Relationships Wheel as a visual tool, ask the following four open-ended questions to begin a conversation about Healthy Relationships:

1. Can you find any areas on the wheel that match what your relationship with your girlfriend/boyfriend/partner is like?
2. Which areas on the wheel are the most important to you when you think of respect? Why?
3. How do you handle a disagreement in your relationship? Which ideas on the wheel can help you deal with conflict?

**MESSAGES FOR HEALTHY RELATIONSHIPS**

- The two people are equal in the relationship.
- Each shows some flexibility in role behavior.
- Each avoids assuming an attitude of ownership toward the other.
- They encourage each other to become all that they are capable of becoming.
- Each avoids manipulation, exploiting and using the other.

**RESOURCES**

  This site contains links to a variety of healthy relationship publications and data.
- [http://www.cdc.gov/Features/ChooseRespect/](http://www.cdc.gov/Features/ChooseRespect/)
  The CDC’s issue brief on healthy relationships.

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Sexual Decision-Making

Healthcare providers play an important role in influencing the decisions that teens make surrounding sex. However, adolescents are equally as likely to get information on sexual decision-making from television than from providers (60% and 62% respectively).¹ By encouraging communication between teens and their parents and educating youth about the responsibilities, benefits, and risks involved with sexual activity, healthcare providers can facilitate healthy choices. Some of these choices may include initiating sexual activity at an appropriate time or using condoms consistently.

### THEMES INFLUENCING ADOLESCENT SEXUAL-DECISION MAKING²

<table>
<thead>
<tr>
<th>Theme</th>
<th>Provider Intervention Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Desire for Intimacy</strong> - Teens often report that desire for intimacy/love and sexual attraction significantly influence sexual decisions.</td>
<td>1. Encourage thinking about sexual intimacy in the context of healthy relationships and suggest using experience of pleasure (or lack thereof), level of partner communication, and the importance of safer sex as measures of sexual readiness.</td>
</tr>
<tr>
<td><strong>2. Perceived Relationship Safety</strong> - Teens equate longer term relationships with trust and safety. This often results in the use of hormonal methods for pregnancy prevention and decreased or inconsistent condom use.</td>
<td>2. Raise the issue of consistent condom use if there is risk for STIs. Discuss approaches to STI risk reduction (condom use, condom use with side partners, limiting number of partners, etc.) as well as pregnancy risk reduction.</td>
</tr>
<tr>
<td><strong>3. Problem Solving and Cognitive Ability</strong> - Higher cognitive and reasoning ability may imply the ability to be more thoughtful and mature with decision-making. Lower problem-solving skills and cognitive ability is associated with earlier age of sexual debut. 50% of females with learning disabilities will be mothers within 3-5 years of leaving high school.³</td>
<td>3. Drugs and alcohol can impair decision-making skills. Encourage teens to discuss sexual decisions with their partners before drinking; go to parties with a friend and designate one to stay sober for the night; watch their drinks to avoid date rape drugs.</td>
</tr>
<tr>
<td><strong>4. Family and Peer Influence</strong> - The decision to initiate sexual intercourse is often influenced by parents, peers and sexual partners. For example, teens who talk to their parents about sex are more likely to have conversations with their partners about sex.⁴</td>
<td>4. Identify peer and parent attitudes toward sex. Affirm positive influences and dispel myths. For example, “it is great that you and your friends always use condoms. However, using two condoms at the same time does not increase your safety and can cause condoms to break.”</td>
</tr>
<tr>
<td><strong>5. Concern for Pregnancy or STI</strong> - Many teens underestimate their personal vulnerability for pregnancy and STIs.</td>
<td>5. If not using contraceptives, explore why. Identify barriers to use and try to identify solutions. For example, if a teen is worried about confidentiality, revisit confidentiality with the teen.</td>
</tr>
</tbody>
</table>

### TIPS

- Revisit the teen’s sexual history during each visit. Try and understand the social, cultural and cognitive circumstances of the sexual activity. Use this as an opportunity to either educate or remind the teen of safer sexual behaviors and risk reduction strategies.
- Acknowledge and reaffirm positive behaviors and choices. Whenever possible, deliver some positive feedback to the teen.
- Applaud teens for making an informed decision to remain abstinent or become sexually active.
- Use harm reduction and motivational interviewing techniques to encourage behavior change. For more information on motivational interviewing, refer to pg. 6.
- Encourage parent child communication. For more information on parent-teen communication, refer to pg. 7.
- Discuss the importance and meaning of healthy relationships. For more information on healthy relationships, refer to pg. 9.
- Keep in mind that some teens may be having sex for reasons not outlined about (sex to get pregnant or test fertility, survival sex). Use motivational interviewing and harm reduction techniques to explore these issues.

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Sources:

3) Planned Parenthood. Sex and Alcohol: Some Sobering Thoughts.
Male Involvement

Young men are often not actively included in pregnancy and parenting discussions. They are sent the message early and often by friends, parents, and healthcare providers that their role is fairly limited when it comes to pregnancy prevention and parenting. Though there are realistic and legal limits to the role of young men in terms of decision-making about birth control and pregnancy options, the provider plays an important role in helping young men (and young women) understand the responsibilities and rights of fathers.

FAST FACTS

- Teen boys and girls whose fathers are involved in their lives do not initiate sexual activity as early and are less likely to get pregnant.
- Children who live with their fathers are 5 times less likely to live in poverty than children who live separately from their fathers.
- Young people without involvement of their fathers are twice as likely to drop out of school, twice as likely to abuse alcohol and other drugs, twice as likely to serve time in jail, and two to three times as likely to need support for behavioral and emotional problems.

Source: National Campaign to Prevent Teenage Pregnancy

MALE INVOLVEMENT IN PREGNANCY PLANNING

Healthcare providers can help young men understand their role in pregnancy prevention. Encourage male adolescents to:

1. **Take responsibility to prevent pregnancy.** Help him learn how to use condoms correctly through a condom demonstration in the office or other resources (video, handouts). Teach him what to do if the condom breaks. Specifically, explain that he should tell his partner if the condom breaks and share with her information about EC, if she is not on a hormonal birth control method. If he is 17 or older, he can buy EC over the counter.

2. **Learn about hormonal birth control methods including Emergency Contraception (EC) using supportive handouts or other resources.** See pg. 26 for more information on EC and pg. 22 for information on hormonal birth control options.

3. **Talk about pregnancy and pregnancy prevention with his female partner(s).** Provide the consistent message that using both condoms and hormonal contraception is the best way to prevent pregnancy and getting STIs. If the young man is interested in having children, ask him how he will determine when the time is right to become a father. Encourage him to have these conversations with his partner and intentionally plan for pregnancy.

4. **Understand that he is in control regarding when and how his sperm is released.** Explain that he can choose not to have sex if he does not want to and that there are alternatives to penetrative sex. Masturbation on one’s own or together with a partner are additional ways to avoid pregnancy and/or STI risk. Advise him that once his sperm has left his body, he may not be able to control the outcome if a condom was not used. Remind him that outcomes from unprotected sex, e.g., pregnancy, may be associated with unexpected legal and economic responsibilities.
Male Involvement cont.

5. **Estimate the costs of being a parent**, especially for young men who are ambivalent about condom use and fatherhood timing, using established worksheets or web-based resources. The following website, [http://www.babycenter.com/babyCostCalculator.htm](http://www.babycenter.com/babyCostCalculator.htm), provides an estimate for first year baby costs.

**ADDITIONAL STEPS PROVIDERS CAN TAKE INCLUDE:**

1. **Review condom use barriers** – e.g. why is it difficult to use, issues related to sensation, knowledge about various condom shapes and sizes and that not one condom is made for all, variation by partner in use and suggestions how to reintroduce condoms in relationships without impacting trust issues.

**MALE INVOLVEMENT IN PARENTING**

Assist young men who are fathers to understand their role in parenting. Providers should:

- Ask all young men whether they have ever made someone pregnant and if they are a father.
- Assess the degree to which they are involved in their child(ren)’s life including emotional, physical, financial support and barriers/facilitators to involvement.
- Identify community resources such as parenting classes geared to young men, educational support, job training, etc. that can positively assist young men in the parenting role.

<table>
<thead>
<tr>
<th><strong>Tips For Encouraging Male Involvement:</strong></th>
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<tbody>
<tr>
<td>➢ Approach young men as partners and assets rather than adversaries.</td>
</tr>
<tr>
<td>➢ Conduct education with female clients to encourage them to involve their partners in reproductive health and family planning, as well as pregnancy options.</td>
</tr>
<tr>
<td>➢ Increase ‘male-friendliness’ of clinics and medical offices. For example, display posters with images of young men, use language that is inclusive of young men in pregnancy prevention educational materials.</td>
</tr>
</tbody>
</table>

**Paternity Laws**

For information on paternity and paternity laws, please see pg. 43.
FOR PROVIDERS: SCREENING, ASSESSMENT & REFERRALS

Taking a Client-Centered Sexual History

At a teen’s first visit or at ages 11-12, it is important to initiate discussion about sexuality. Teens want their healthcare providers to ask these questions!

General Tips

- Begin the sexual history AFTER you have established rapport with the adolescent.
- Think about taking the sexual history in the context of a HEADSSS assessment: Home, Education/Employment, Activities, Drugs, Sexuality/Suicide/Depression/Self-Image, Safety.
- Remember! Restate the parameters of confidentiality before you take a sexual history.
- Use open ended questions that start with “what,” “how,” “when,” or “tell me”.
- Be aware of judgmental questions (ex. “you don’t have unprotected sex, do you?”) and behaviors (ex. shaking your head as you ask questions).
- Frame some questions in the third person. (ex. Are you noticing that your peers/friends are starting to have sex?)
- Use understandable language - avoid clinical terms. (e.g. substitute “having sex” for “intercourse”)
- Ask adolescents for clarification when they say things you don’t understand.
- Use reflective listening. Paraphrase what the young person has said and repeat it back to him/her.
- Do not make any assumptions, particularly about initiation of sexual activity, type of activity, gender identity, and sexual orientation.
- Always acknowledge positive behaviors and assets particularly establishing healthy relationships, proper use of contraceptives and safer sex methods, etc.
- Educate teens about their options so they are in a position to make informed choices.
- Refer teens to other resources based on their individual needs.

Guidelines For Sexual History Taking

The following is an outline for taking a sexual health assessment based on the Five P’s Assessment (Partners, Prevention of Pregnancy, Protection from STIs, Practices, and Past History of STIs). Taking a sexual history should always be embedded in a general psycho-social assessment like “Annotated HEADSSS”.1 Consider these statements, questions, and tips as a guide to assessing your teen patients.

INTRODUCTION

I’m going to take a few minutes to ask you some sensitive questions. This information is important and will help me provide better health care to you. Let’s first discuss what information will be kept will be kept private and what information I might have to share with other people (see. pg. 8 for information on minor consent and confidentiality).

STAGES OF DEVELOPMENT

Initial Questions

☐ Do you have any questions or concerns about your looks or appearance?
☐ Do you have any questions or concerns about your sexual development?
☐ Do you have any questions, thoughts, or rules about masturbation?

Tips

- During the onset of puberty, advice about hygiene can become very important. Include discussions on bathing, deodorant, and proper shaving techniques.
- Normalize the changes that happen during puberty. Assure patients that they shouldn’t feel ashamed about having wet dreams and masturbation.
- See pg. 3 for more information on the stages of adolescent sexual development

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Sources:
2) Marcell AV, Bell DL. Making the most of the adolescent male health visit Part 1: History and anticipatory guidance. Contemp Pediatrics. 2006;23(6):38-46
FOR PROVIDERS: SCREENING, ASSESSMENT & REFERRALS

Taking a Client-Centered Sexual History cont.

SEXUAL ORIENTATION/SEXUAL ATTRACTION

Initial Questions
☐ Some of my teen patients are exploring new relationships. Do you have a crush on anyone? Are you dating or seeing anyone?*
☐ Are you attracted to guys, girls, or both?

Follow-Up Questions:
☐ How long have you been dating this person?*
☐ Are you having sex with anyone else?*
☐ Is your partner having sex with anyone else?*
☐ Have you thought about having sex with him or her?*
☐ Who do you talk to about sex?*

Follow-Up Questions for Lesbian/Gay/Bisexual Teens:
☐ Who have you told about your sexual orientation?*
☐ What are your family’s reactions to your sexual orientation/identity?*

Tips
» Use gender neutral terms until the teen has established a preference for male/female sexual partners.
» Become familiar with resources for LGBT youth in your area. Refer to community support programs for supportive counseling as needed.
» Provide anticipatory guidance to LGBT teens who report family rejection.
» With younger teens, start by asking questions in the 3rd person, ie. Are any of your friends...?
» Sometimes teens, especially young teens, don’t use the word dating. Keep this in mind when discussing their relationships.
» Don’t forget to address these issues with teens with disabilities.

SEXUAL ACTIVITY

Initial Questions:
☐ Sexuality and relationships are things that many teens are dealing with; and different people are at different points in exploring these issues. Have these issues come up for you? How?*

Follow-Up Questions:
☐ What do you consider “having sex”?*
☐ When do you think it is OK to have sex?*
☐ Have you ever had sex? (intercourse/outercourse)?*

If yes:
⇒ How old were you the first time you had sex?
⇒ Do you have sex with guys, girls or both?
⇒ Do you want to be having sex right now?
⇒ How often do you have sex?
⇒ How may people have you had sex with in the last 3 months? In your life?
⇒ For some people sex is generally a fun experience, for others it is not all that fun and may even hurt most of the time? What is usually your experience with sex?
⇒ Has there ever been a time that you had sex but didn’t want to?
⇒ Have you ever had sex when you were high on drugs or alcohol?

If no:
⇒ When do you see yourself making the decision to have sex?*
☐ Who do you talk to about sex?*
☐ How do feel about having sex? Is it a good thing or bad thing for you?*

Tips
» Use the follow-up questions to determine if STI/pregnancy prevention methods have been used and which methods might be most appropriate for him or her.
» When sex is not enjoyable, assess whether this is because they don’t want to be sexually active, have a physical problem, or are having problems with sexual function, as the counseling messages are different.

Protective Factors
» Sexual debut after 15 years of age.
» Has a trusted adult to talk to about sexual issues.
» For LGBT youth, have parents/caregivers/families that support their LGBT identity.²

*Ask every adolescent patient regardless of sexual activity.

FOR PROVIDERS: SCREENING, ASSESSMENT & REFERRALS

SAFER SEX PRACTICES

Initial Questions:
- Tell me some of what you know about STIs and HIV.*

Follow-Up Questions:
- Have you or your partner ever been tested for STIs/HIV? had an STI?*
- Does your partner have other sexual partners that you know of? Do you?
- What questions do you have about STIs and HIV?

Initial Questions:
- Are you doing anything to protect yourself against STIs/HIV and pregnancy? What are you doing?

Follow-Up Questions:
If the teen indicates that he/she has not been using protection, ask:
- Have you used some sort of protection in the past?
- What keeps you from using protection now?

If the teen indicates that he/she sometimes uses protection, ask:
- With whom and when do you use protection?
- What would help you to always use protection?

Tips
- Use this opportunity to counsel teens about methods. Congratulate those who are using contraception for doing so, and encourage those who are not to initiate use.
- Remind them that condoms are most effective when they are used correctly with every sexual encounter.
- Teens may be more likely to use protection with casual rather than steady partners. Remind them to use STI and pregnancy protection with all partners.
- Screen for other risks, such as alcohol and substance use and sexual abuse.
- Refer teens to health education materials.

Protective Factors:
- Discussing contraception with partner before first sex
- Not currently sexually active or using reliable methods to reduce pregnancy/STI/HIV risk
- Using dual methods – condoms in addition to a contraceptive method dedicated to the prevention of pregnancy (IUD, birth control pills, etc.).

SEXUAL ASSAULT AND RELATIONSHIP VIOLENCE

Introduction:
Teens usually form healthy relationships. Unfortunately, some teens are hurt by strangers, people they know or the people they date. I am going to ask you a couple questions to make sure that you are safe.

Initial Questions:
- Have you ever been hurt in a sexual way or forced to have sex when you didn’t want to?*
- Have you ever traded sex for money, drugs, a place to stay or other things that you need?
- Do you feel safe in your relationships?

Follow-Up Questions:
- There are things people can do that may reduce their risk of sexual assault. Do you know how to reduce your risk of sexual assault?*

Tips
- Remind teens that you ask these questions because you’re concerned about their safety. As a mandated child abuse reporter you must report abuse to your county child protective services or law enforcement agencies.
- Be aware that youth with disabilities (particularly non-verbal and intellectually disabled youth) report higher incidence of sexual abuse.4
- For more information on healthy relationships, see pg. 9.
- For more information on relationship violence, see pg. 30.
- For more information on sexual assault, see pg. 33.

CLOSURE

At the end of the conversation, review what you learned and what you discussed.

For Example:
So, you’ve just told me that you’re taking birth control pills to prevent pregnancy with your partner. And that you two have talked about using condoms if either of you have side partners. You’re making really good decisions and I encourage you to continue this smart behavior.

*Ask every adolescent patient regardless of sexual activity.

3The American College of Obstetrics and Gynecologists suggests screening all patients at every visit for sexual assault. This following questions should be asked of all patients whether or not they are currently sexually active.


Source:
FOR PROVIDERS: SCREENING, ASSESSMENT & REFERRALS

STI Screening and Treatment
An Overview

SCREENING

A complete and accurate sexual history is needed to determine sexual risk based on practices and gender of partners. Because STIs and HIV can remain asymptomatic, it is imperative that providers assess all sexually active teens for risky sexual and drug-use behavior at health maintenance visits. For guidance on assessing risk and taking a sexual health history, please refer to pg. 13.

✔ Screening for Chlamydia and Gonorrhea (CT and GC)
  → Annual screening for CT in all sexually active females 25 years of age and younger and men who have sex with men is recommended by the Center for Disease Control and Prevention (CDC).
  → Annual screening for GC in all sexually active females 25 years of age and younger is recommended by the U.S. Preventive Services Task Force, and supported by the CDC. Annual screening of men who have sex with men is also recommended by the CDC. Screening in very low prevalence populations (<1%) is generally not indicated.
  → More frequent screening based on sexual risk. For adolescents, screening every 6 months in young women and every 3-6 months for men who have sex with men may be indicated. CT and GC screening can be performed at any visit type, regardless of reason for visit.
  → If the test is positive for either CT or GC, repeat screening 3-4 months after treatment.

✔ Screening for HIV
  → The CDC currently recommends an HIV test for all persons aged 13-64 once, and periodic testing for those with on-going behavioral risks. See pg. 18 for more information on HIV testing and counseling recommendation.

✔ Screening for HPV
  → See pg. 20 for more information on HPV and HPV-related cancer screening recommendations.

✔ Screening for other STIs
  → Any positive test for an STI is an indication to screen for all other STIs. For example, if a patient has trichomoniasis, he/she should be screened for CT, GC, syphilis and HIV.
  → Men who have sex with men should be screened annually for syphilis.

TREATMENT

♦ For the most up-to-date treatment recommendations, refer to the CDC’s guidelines:
  
  http://www.cdc.gov/STD/treatment/default.htm

♦ Chlamydia, gonorrhea, and syphilis are reportable STIs in every state. Other reportable STIs vary by state and sometimes by county. See the CDC’s Fastats from A to Z for individual state data:
  
  http://www.cdc.gov/nchs/FASTATS/map_page.htm

Sources:
STI Screening and Treatment cont.

TIPS

- Contact your local health department for prevalence rates and trends to help you tailor STI screening. STI trends can vary significantly by state and county.
- Keep in mind patient consent/confidentiality and let the patient know that you are screening him/her for STIs. This is a great opportunity to educate teens about common STIs and safer sex methods.
- Be aware that patient confidentiality may be compromised by mandated reporting of STIs. Even if the healthcare provider does not file a report, laboratories will report any positive Chlamydia, gonorrhea or syphilis test. Become familiar with local reporting practices around contacting patients and partners and advise patients accordingly.
- Be aware of billing practices. Insurance claims sent home may breach confidentiality especially if tests for STIs are listed.
- Nucleic acid amplification tests (NAATs) are recommended for screening, and can be used on urine and self-collected vaginal swab specimens, making a pelvic exam unnecessary.
- NAATs can also be used on pharyngeal and rectal specimens.

EXPEDITED PARTNER THERAPY (EPT) AND PARTNER NOTIFICATION

- Expedited partner therapy (EPT) is the empirical treatment of sexual partners of an individual who tested positive for a sexually transmitted disease without provider evaluation. Under most circumstances, the patient will deliver the medication to his/her sexual partners.
- Partner notification is the act of informing one’s sexual partner(s) that he/she has potentially been exposed to an STI. There are three routes of partner notification: provider, patient, or contact referral.
- EPT has been shown to be more effective than referring sexual partners for treatment of Chlamydia and gonorrhea and has reduced rates of persistent or recurring infections in individuals including adolescents.
- EPT for gonorrhea and Chlamydia is safe, effective and should be considered standard medical practice.
- Providers need to consider the issues surrounding EPT use and partner notification in adolescents. Dispensing EPT can breech patient confidentiality via insurance billing for medication and both EPT and partner notification can result in mandated reporting if the partner’s birth date is required for prescriptions.

Resources:

- CDC’s full review of EPT: http://www.cdc.gov/std/EPT/. Guidance for use of EPT can be found on page 34.
- InSpot.org: This website allows individuals who have tested positive for an STI to anonymously tell their sexual partners through an ecard. The ecard then links the individual to resources for STI testing and treatment in their area. Currently, InSpot is only available in 10 states and 9 metropolitan areas.

Sources:

RESOURCES

Centers for Disease Control and Prevention

- Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 2006: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

US Preventive Services Task Force

- Screening for Chlamydia Infection: http://www.ahrq.gov/clinic/uspstf/uspschlm.htm
- Screening for Gonorrhea: http://www.ahrq.gov/clinic/uspstf/uspsgono.htm
HIV Testing and Counseling

Background

BASIS FOR UNIVERSAL HIV TESTING

Up to 30% of all new HIV infections occur in adolescents and young adults 13 to 25 years old. 25% of individuals with HIV are unaware of their HIV diagnosis and account for approximately 54% of new infections. The Centers for Disease Control and Prevention recommend that all persons ≥13 years of age be tested for HIV at least once during their lifetime. More frequent testing is recommended based on risk for acquiring HIV.

HIV TESTING METHODS

Usually, HIV infection is screened for by an EIA (enzyme immunoassay), from a blood sample, to look for HIV antibodies. A positive or reactive EIA requires a confirmatory test (such as the Western blot) to make the diagnosis of HIV. Depending on the lab, it may take up to 2 weeks to receive results. There are limitations to this option. First, it may limit the ability to counsel patients. Second, because the patient must return in person, it may limit some people in receiving results.

The 2006 CDC guidelines recommend that HIV testing should be: 1) opt-out, with the opportunity to ask questions and the option to decline testing; 2) performed without a separate written informed consent for HIV testing; and 3) prevention counseling should not be required with HIV diagnostic testing or part of HIV screening programs in health-care settings. The CDC does recommend counseling in nonclinical settings, such as at community-based organizations. There continues to be controversy around these areas and many state laws are incongruous with the recommended guidelines.

The ACTS (Advise, Consent, Test, Support) program can be used to prepare an adolescent to have an HIV test, receive results and elicit discussion around ways to prevent HIV quickly and efficiently. For more information about ACTS go to www.adolescentaids.org. Adolescents may also be referred out to receive pre-test counseling using www.hivtest.org.

HIV Counseling

The reasons for screening, assessment, and referral are manifold, and the reasons to counsel or to not counsel are equally varied. The CDC does not recommend counseling in health-care settings, there are times or situations that may warrant counseling.

REASONS FOR COUNSELING

- Adolescents prefer to receive STI/HIV information from their provider and studies have demonstrated that provider recommendation remains one of the strongest predictors of testing.
- Identifies personal risk of HIV infections.
- Reduces anxiety by preparing client for a positive diagnosis.
- Decreases cost of repeat testing and stress for clients with no or low risk for HIV.
- Opens discussion for additional testing and counseling.
- Assesses social support.

REASONS AGAINST COUNSELING

- Routine or universal HIV testing (by itself without counseling) was cost-effective even in low prevalent settings (prevalence >0.1%).
- Normalizes HIV and makes it a part of regular STI screenings.
- Time constraints for primary care physicians.
- Counseling for HIV can be integrated into risk-reduction counseling for all clients when discussing other STIs and drug use.
- Client has already been counseled before and does not need more information.

2Marks G, Crepaz N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS. 2006; 20:1447-50.
FOR PROVIDERS: SCREENING, ASSESSMENT & REFERRALS

HIV Testing and Counseling cont.

WHEN A CLIENT DECIDES TO TEST

- **Praise client for considering HIV testing**
  - “It is great that you are being proactive about your health and taking the initiative to test for HIV today.”
- **Remove distractions** (cell phones, partners, parents, etc.).
- **Discuss confidentiality laws** specifically pertaining to testing, results, and parental/partner notification. Check for testing site and state specific protocols and laws.
- **Assess risk** (intravenous drug users, men who have sex with men, anal sex, inconsistent condom use, sex with a known positive, history of STIs, sex in high prevalence community/network) and ways to reduce risk – this can be included in discussing ways to reduce risk for other STIs; Hepatitis and HIV.
  - “What types of sex are you having? What are some ways that you could have safer sex in your relationships?”
- **Discuss the window period.** HIV antibodies take anywhere from 2 weeks to 6 months to be detected with the majority being detected at 3 months. Depending on risk level and state of exposure, retesting may be indicated.
- **Prepare for a positive or negative diagnosis.** Discuss the meaning (from patient’s perspective) of a positive or negative test, what their life looks like moving forward, and who they can talk to when the appointment is over.

AFTER TESTING

In some states, giving HIV screening results over the phone is illegal, even in the case of a negative screening. Providers should refer to state laws for more information.

If **NEGATIVE**, review the risk reduction plan, window period, and need to retest. Answer any questions the client may have.

If **POSITIVE**, refer to state-specific laws for follow-up. Many states require additional screening before diagnosis, and reporting laws vary by state. Review the results, allowing additional time if the result is positive. You may want to have a social worker, counselor, or nurse provider available to assess the client and assist with post-test counseling and link to HIV/AIDS services. Discussion of partner notification and a risk reduction plan may need to be performed during a follow up visit. The first visit should be used to repeat HIV testing, and give the client time to receive their result, to process and to assess the client’s safety.

Giving HIV results can be stressful. Make sure to take a break to clear your mind and talk with another health care provider about the experience.

Resources

- [http://www.adolescentaids.org](http://www.adolescentaids.org)  
  HIV educational materials for youth.
- [http://www.thebody.com](http://www.thebody.com)  
  Online resource for HIV/AIDS.
- [http://www.hivplus.com](http://www.hivplus.com)  
  Discusses issues related to HIV/AIDs.
- [http://www.poz.com](http://www.poz.com)  
  Popular magazine catered to HIV positive individuals.
- [http://www.mpowerplus.com](http://www.mpowerplus.com)  
  Popular magazine for HIV positive LGBT community.
- [http://www.hivtest.org](http://www.hivtest.org)  
  CDC sponsored website that provides information on HIV test centers by going to the website or texting a zip code to KnowIt or 566948.

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Human Papillomavirus (HPV) Related Cancers
Screening and Follow-Up

BACKGROUND
The new recommendations for cervical cancer screening are based on a growing understanding about the Human Papillomavirus (HPV) and its causal relationship to 99% of cervical cancer. However, the actual incidence of the virus causing neoplastic cervical lesions, particularly in young, healthy women, is extremely low. While over 80% of sexually active people have the virus, most young women will clear the virus before pre-cancerous cervical lesions occur. With this understanding the new recommendations are endorsed by the American Society of Colposcopy and Cervical Pathology (ASCCP) and include new management guidelines specific to adolescent women age 20 and younger with abnormal cervical cytology and histology.

2. Ibid

Screening

WHEN TO START SCREENING FOR CERVICAL CANCER1,2:
All women should begin Pap tests at the age of 21. All women, regardless of sexual orientation should undergo pap test screening using current national guidelines. The data on cervical cancer incidence and the natural history of HPV infection and of low- and high-grade cervical lesions suggest that a cervical lesion significant for neoplasm would take 5 to 10 years to develop after initial exposure to HPV.

- **Victims of sexual abuse**: little to no data is available on victims of sexual abuse, however, no evidence suggests that earlier screening would be beneficial, however abuse victims who have had vaginal intercourse, especially post puberty, may be at increased risk of HPV infection and cervical lesions and should be referred for screening once they are psychologically and physically ready (i.e., postpuberty) by a provider who has experience and sensitivity working with abused adolescents.

- **Adolescents engaging in sexual activities excluding vaginal intercourse**: the risk of HPV transmission to the cervix is low for other types of sexual activity.

- **Concurrent STIs**:  
  - HIV infection: obtain two Pap tests in the first year after initial diagnosis of HIV infection and if results are normal, annually thereafter.
  - All other STIs including genital warts: follow 2002 ACS recommendation

- **Anal HPV infection or anal cancer**: precancerous lesions and HPV infection are common in HIV-positive individuals and MSM. Because these populations may be at higher risk of developing anal cancer, some health care providers recommend yearly anal pap tests. Currently, however, the CDC does not recommend anal pap tests due to lack of evidence supporting their use in preventing anal cancer. HPV tests have not been approved for either anal use or use in men and are likely not to be clinically helpful.4,5

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1. 2002 American Cancer Society Recommendations can be accessed from the CDC’s website at http://www.cdc.gov/std/hpv/ScreeningTables.pdf.
FOR PROVIDERS: SCREENING, ASSESSMENT & REFERRALS

Human Papillomavirus (HPV) Related Cancers cont.

SCREENING FOR CERVICAL CANCER:

Screening Intervals for normal cervical cytology and histology:

- **Conventional cervical cytology smears**: After the initiation of cervical cancer screening, continue with Pap tests every two years until the age of 30.

- **Liquid-Based Cytology (Thin Prep)**: After the initiation of cervical cancer screening, continue with Pap tests every two years until the age of 30.

Intervals for screening women under 30 are more frequent due to the increased likelihood of high-risk HPV acquisition.

*In women 20 or younger, HPV testing is not recommended due to the likelihood of this population clearing the virus.*

Follow-Up

Recommendation for management of abnormal cervical cytology and histology in the event that the provider decides to screen a young woman under 21

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>RECOMMENDATIONS FOR ADOLESCENTS (AGED 20 OR YOUNGER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atypical Squamous Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)</td>
<td>Repeat Pap test in 12 months for up to two years; then, if remains abnormal or HSIL at any visit refer to colposcopy</td>
</tr>
<tr>
<td>Atypical Squamous Cells, Cannot Exclude High-grade Squamous Intraepithelial Lesion (ASC-H)</td>
<td>Colposcopy</td>
</tr>
<tr>
<td>High-grade Squamous Intraepithelial Lesion (HSIL)</td>
<td>Colposcopy</td>
</tr>
<tr>
<td>Atypical Glandular Cells* (AGC)</td>
<td>Colposcopy, endocervical assessment, possible endometrial evaluation</td>
</tr>
<tr>
<td>Cancer</td>
<td>Colposcopy, endocervical assessment</td>
</tr>
<tr>
<td>Cervical Intraepithelial Lesion - mild cervical dysplasia (CIN I)</td>
<td>Repeat Pap at 12 month intervals, if HSIL or greater, refer back to Colposcopy.</td>
</tr>
<tr>
<td>Cervical Intraepithelial Lesion - moderate cervical dysplasia (CIN II)</td>
<td>Close follow-up at 4-6 month intervals, with cytology and colposcopy; treatment is recommended if CIN II remains at two years</td>
</tr>
<tr>
<td>Cervical Intraepithelial Lesion - severe cervical dysplasia (CIN III)</td>
<td>Ablative or excision therapy</td>
</tr>
</tbody>
</table>

*Associated with malignant or pre-malignant lesions in up to 40% of women (age over 35 confers greater risk)

For further recommendations regarding management of colposcopy results and/or the management of pregnant adolescents with abnormal cervical cytology and histology refer to CDC website at http://www.cdc.gov/std/hpv/default.htm#resources and refer to the "Clinician’s Resources" section.

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Things to Consider When Prescribing Birth Control

**WHEN COUNSELING ABOUT CONTRACEPTION OPTIONS:**

- First ascertain what methods the teen knows about and is interested in.
- Briefly describe all options. Guide them in their decision based on their comfort level, needs and behaviors.
- Describe the chosen method in greater detail to ensure that the teen knows how to use it effectively.
- Have the teen repeat back and demonstrate the correct use of the method.
- Schedule a future visit to ensure that the method is working right for him/her.
- Always re-emphasize the importance of condom use to prevent STIs in addition to choosing an alternative method of birth control.
- Suggest ways to include the teen’s partner in discussions about contraception.

**IS THE INTRAUTERINE DEVICE (IUD) AN OPTION FOR YOUTH?**

Health care providers trained since the 1970’s have generally considered IUDs to be contraindicated in adolescents. The Dalkon Shield, a popular IUD with young women in the 1960’s and early 70’s was associated with severe pelvic infections, ectopic pregnancies and infertility and effectively created an association between any IUD and poor outcomes in adolescents. Recent data shows that the association between IUD’s and pelvic infections is primarily related to infections in the first few weeks after insertion and likely reflects insertion in women already infected with Gonorrhea or Chlamydia.

**Contraindications for IUD initiation: World Health Organization medical eligibility criteria**

- Current purulent cervicitis, chlamydia or gonorrhea infections
- History of an STI in the past three months
- Very high individual likelihood of chlamydial and gonorrhoea exposure
  - More than 1 sexual partner in past 3 months
  - Partner who has multiple sexual partners
  - Partner who has been diagnosed with an STI or has STI symptoms in past 3 months

Some, but not all, adolescents have these risks; therefore this method should not be categorically considered inappropriate for all adolescents. Even in the presence of an STI, currently available IUCs are not independently associated with pelvic infections or tubal infertility.

**The following are NOT IUD contraindications:**

- Remote history of STI if no longer at increased risk
- Nulliparity
- History of PID
- History of ectopic pregnancy

Although the expulsion rate of recently inserted IUCs is slightly higher in women who have never borne a child, nulliparity is not a contraindication. IUDs are highly effective, long acting (5 years for the levonorgestrel intrauterine system, Mirena; 10 years for the intrauterine copper contraceptive, Paragard), invisible, reversible and easy to maintain – all attractive characteristics for adolescents. In particular, adolescent mothers, a group at very high risk for repeat pregnancy, may benefit from this contraceptive option.

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Things to Consider When Prescribing Birth Control cont.

**FDＡ BLACK BOX WARNINGS AND OTHER SAFETY INFORMATION**

**Depo-Provera – Depot medroxyprogesterone acetate (DMPA)**
- In 2004, the FDA placed a black box warning label on the Depo-Provera Contraceptive Injection concerning the risk of bone density loss after prolonged use. The warning states that “Depo-Provera CI should be used as a long term birth control only if other birth control methods are inadequate.”
- The Society for Adolescent Medicine recommends that providers continue prescribing DMPA to adolescent girls along with providing an explanation of both the benefits and risks. Evidence has shown increased bone mass accrual after discontinuing use of DMPA and therefore, the benefits prescribing an effective contraception can outweigh the risk of bone density loss.
- For teens receiving DMPA, the Society for Adolescent Medicine recommends daily calcium supplements, vitamin D and daily exercise. While calcium and vitamin D have not been proven to offset bone density loss, these supplements are known to have broad health benefits for this population. Estrogen supplementation may be considered in girls with osteopenia.  


**Ortho Evra and the birth control patch**
- In 2006, the FDA amended the label for Ortho Evra to warn women of potential increased risk for venous thromboembolism (VTE) when using the patch. The warning was based on the results of two epidemiological studies with conflicting data on potential for increased risk for VTE.
- Given the lack of substantive safety data for the use of the birth control patch, the World Health Organization Medical Eligibility Criteria for Contraceptive Use (WHOMEC) suggests using the same guidelines for combination oral contraceptives when prescribing the birth control patch.

Sources:

**QUICK START ALGORITHM**
Initiation and continued use of hormonal contraception is more likely if a teen can initiate the method right away, rather than waiting for her next menses. Providers can feel reassured regarding the safety of this approach, as studies have shown the inadvertent exposure to the hormones used in combined oral contraceptives early in pregnancy has no detrimental effect on the developing fetus. This approach, known as “Quick Start” has been evaluated for a variety of hormonal methods, including OCPs, DMPA, the transdermal contraceptive patch and the contraceptive ring.

The principles of quick start regimens are to:
1. Rule out a detectable pregnancy prior to method initiation
2. Provide Emergency Contraception if indicated
3. Initiate the method immediately
4. Counsel the youth to use condoms for 1 week and obtain a follow-up pregnancy test in 2 weeks if the method was initiated after day 6 of the menstrual cycle.

This approach is easily followed using the very clearly outlined “Quick Start Algorithm” on the next two pages.

Quick Start Algorithm
Woman requests a new birth control method

1. PILL, PATCH, RING, INJECTION

First day of last menstrual period (LMP) is:

≤5 days ago

Start method today, use back up method 1st week

Urine pregnancy test: negative**

Unprotected sex since LMP:

≤5 days ago

Offer hormonal EC today*

>5 days ago

Advise that negative pregnancy test is not conclusive but hormones will not harm fetus

Both <and> 5 days ago

Offer hormonal EC today*

None

Start pill/patch/ring/injection today, use back-up method 1st week

Patient wants to start new method now?

YES

Start pill/patch/ring/injection, use back up method 1st week

TIMING:
Start new method TODAY if not taking EC; start new method TOMORROW if taking EC today

Two weeks later, urine pregnancy test is negative;** continue pill/patch/ring/injection

NO

Give prescription for chosen method; advise patient to use barrier method until next menses

Start pill/patch/ring on 1st day of menses; return for injection within 5 days of menses

* Because hormonal EC is not 100% effective, check urine pregnancy test 2 weeks after EC use.

**If pregnancy test is positive, provide options counseling.

Source:
Quick Start Algorithm

2. PROGESTIN IUD OR IMPLANT

First day of last menstrual period (LMP) is:

- ≤5 days ago
  - Insert IUD/implant today
- >5 days ago
  - Urine pregnancy test: negative**
    - Unprotected sex since LMP?
      - YES
        - Offer pill/patch/ring as bridge to IUD/implant
          - Patient accepts pill/patch/ring
            - Two weeks later, urine pregnancy test is negative**
              - Insert IUD/implant today
          - Patient declines pill/patch/ring, uses barrier instead
            - Insert IUD/implant within 5 days of next menses
      - NO
        - Insert IUD/implant today

3. COPPER IUD

First day of last menstrual period (LMP) is:

- ≤5 days ago
  - Insert IUD/implant today
- >5 days ago
  - Urine pregnancy test: negative**
    - First episode of unprotected sex since last LMP:
      - ≤5 days ago
        - Insert IUD today
      - >5 days ago
        - Insert IUD within 5 days of next menses*
      - None
        - Insert IUD today

* Pill/patch/ring may be started as a bridge to copper IUD.
**If pregnancy test is positive, provide options counseling.

Source:
Emergency Contraception

FAST FACTS

- **EC is safe and effective birth control** that can be used after unprotected intercourse (including sexual assault) or underprotected sexual intercourse.

- **EC comes in the form of pills** which are most effective when taken immediately, but reduce the risk of pregnancy when taken within 120 hours. EC also comes in the form of a copper IUD, which must be inserted within 5 days of unprotected intercourse.* (Please refer to pg. 22 for recommendations for use of IUDs with adolescents).

- **EC pills work by** delaying or inhibiting ovulation, inhibiting fertilization, or preventing implantation of a fertilized egg (although this mechanism has never been clinically demonstrated). It will not interrupt a pregnancy that has already begun, like RU-486, “the abortion pill”. This is an important point for many teens!

- **EC pills significantly reduce the risk of pregnancy** after one instance of unprotected intercourse and are more effective the sooner they are taken.

- **EC pills may cause side effects** such as nausea, vomiting, and breast tenderness. If a patient vomits within one hour of taking EC, the dose should be repeated. Levonorgestral only products generally cause less side effects than the combined estrogen-progestin EC.

- **There are no state or federal laws that require parental consent or parental notification for the provision of EC.** Some healthcare providers, however, have their own parental notification policies for prescribing EC to patients under 18. Patients should ask their healthcare provider about these policies before receiving care.

- **Think about prescribing EC in advance with refills** to all of your sexually active teen patients. Educate them about its use, so they are prepared for an emergency.

*Currently, the efficacy of progesterone receptor modulators as an alternate form of EC is being studied.

### TYPES OF EMERGENCY CONTRACEPTIVE PILLS

<table>
<thead>
<tr>
<th>TYPE OF PILL</th>
<th>PRODUCTS</th>
<th>DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated Progestin-only (Levonorgestral)</td>
<td>Next Choice (Generic EC)</td>
<td>1 pill each dose¹ (Repeat in 12 hours)</td>
</tr>
<tr>
<td>Dedicated Progestin-only (Levonorgestral)</td>
<td>Plan B One Step</td>
<td>1 pill</td>
</tr>
</tbody>
</table>

The dedicated Levonorgestral products are generally the most appropriate form of EC for teens. The side effects are usually minimal and dosing instructions are simpler than with other EC methods.

<table>
<thead>
<tr>
<th>ORAL CONTRACEPTIVES USED AS EC</th>
<th>PRODUCTS</th>
<th>DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progestin-estrogen combined (in 28 day packs, only the first 21 pills can be used)</td>
<td>Various combined birth control pills²</td>
<td>Dosage depends on type of pill²</td>
</tr>
</tbody>
</table>

Only 16% of self-identified sexually active students nationwide reported use of oral contraceptive (OC) pills by themselves or their partner, therefore, use of OCs as EC is less utilized in teens.³ For teens that need EC while using OCs, this may indicate that they are on the wrong contraceptive method. This is a great opportunity to discuss alternate contraceptive options.

¹ Although it conflicts with instructions on the box, current practice also includes administering 2 pills at one time up to 5 days after unprotected sex, but sooner is always better: Allen RH, Goldberg AB. Emergency Contraception: A Clinical Review. Clin Obstet and Gynecol. Dec 2007; 50(4).

² Refer to NOT-2-LATE.com: http://ec.princeton.edu/questions/dose.html for specific dosages for common birth control pills.

### ACCESS TO PLAN B

- **Over the counter:** In 2009, the FDA approved Plan B for over the counter use by men AND women 17 years and older. In the future, the generic product may be available for over the counter use.

- **Prescribing EC pills:** Women under 17 can access Plan B with a prescription from a healthcare provider. Women under 18 can access the generic product with a prescription. **Counsel young men about EC even though they cannot receive a prescription.**

- **Pharmacy Access:** In nine states (AK, CA, HI, MA, ME, NH, NM, VM, WA) women of any age can obtain Plan B directly from a pharmacist. Patients should be advised to call their local pharmacy to see if they participate in the Pharmacy Access Program. Access without a prescription can be limited due to pharmacists’ willingness or unwillingness to dispense Plan B. Pharmacy Access may increase the cost of Plan B because an extra “counseling fee” is added onto the cost.

- **Cost:** The average cost of Plan B without insurance is $31 per package*. This cost may vary and patients should contact their insurance companies to find out whether or not it is covered. Many states also have family planning funding programs that subsidize the cost of Plan B and other contraceptives. However, the generic product may be the least expensive option.

Emergency Contraception cont.

When assessing a patient for emergency contraception, ask:

1. When was the last time you had unprotected intercourse? Was it the last 3-5 days?
2. Why do you think you need EC?
   - If the teen’s last unprotected intercourse happened in the last 3-5 days, prescribe EC pills.
   - If the response to the first question indicates increased likelihood of pregnancy, or you question the accuracy of the history, you can still prescribe the pills, but there is a greater chance the patient might be pregnant. (Run a preg test to assure appropriate care.)

If you prescribe EC pills, YOUR PATIENT SHOULD BE AWARE THAT:
- She might still get pregnant.
- She might experience side effects such as nausea, vomiting, and breast tenderness.
- If she vomits within an hour of taking EC, she should repeat the dose. Side effects are less common with Plan B or generic.
- EC will not protect against pregnancy related to unprotected intercourse occurring after she takes the pills.
- Her next menstrual period might not start at the expected time or be of the usual flow or duration.
- ECPs do not protect against STIs.
- ECP should not be used as a regular form of birth control because they do not prevent pregnancy as effectively as other forms of contraception.

CONSIDER THE FOLLOWING:
- Patients should be counseled further about consistent and reliable birth control use.
- Patients should be counseled further about the risks of STIs involved with unprotected sex.
- Patients should return for a follow-up appointment to confirm they did not become pregnant, if they do not get their period within two weeks of the expected date. Use this as an opportunity to reinforce regular contraceptive practices.

If you prescribe the copper IUD

CONSIDER THE FOLLOWING:
- Ascertain if the patient desires long term contraception (method is effective up to 10 years)
- Rule out Chlamydia or gonorrhea infection.
- Rule out other contraindications for use of the IUD.
- If a patient does not have health insurance, the cost of the IUD may be prohibitive unless the teen is in a locale with a public family planning program.
- Refer to pg. 25 for the quick start algorithm for the copper IUD.

Resources:
- [http://www.not2late.com](http://www.not2late.com)
- [http://www.go2planb.com](http://www.go2planb.com)
- [http://www.ec-help.org](http://www.ec-help.org)

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Tips and Follow-Up Questions
- Have you been screened recently for Chlamydia and gonorrhea? If not, offer screening. See pg. 16 for STI screening guidelines.
- Was this a sexual assault? If so, see pg. 33 for more information on sexual assault and abuse.
- How often are you having unprotected sex? If unprotected sex is frequent, counsel on different methods and see pg. 39 for more information on BC.

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Sources:
FOR PROVIDERS: SCREENING, ASSESSMENT & REFERRALS

Pregnancy Test Counseling

BEFORE DELIVERING THE TEST RESULTS:

☐ What brings you here today?
☐ How would you feel if you were pregnant?
☐ I know you’re sexually active right now. Is this something you are enjoying? Do you feel comfortable with your partner?
☐ What are you hoping the test result will be?
☐ Are you doing anything to prevent getting pregnant or getting STIs? Are you happy with this method?

IF THE TEST IS NEGATIVE:

Explore personal beliefs and attitudes about pregnancy:

☐ How would you have felt if the test were positive?
☐ What do you think is the best age to get pregnant?
☐ What are your goals and ideas for the next year? For the future?

Screen for risks of unprotected sex including pregnancy, STIs and forced sex:

☐ Conduct a HEADSSS’ assessment.

Discuss relationships and support of family/friends/partners:

☐ Who knows you came here today? Who knows that you think you might be pregnant?
☐ How would/do your parents feel about your sexual activity?
☐ How does your partner/boyfriend feel about pregnancy, birth control and safer sex?
☐ Do you have friends or family members who are pregnant or have babies?

TIPS

☐ Remind her that just because she did not become pregnant this time, it does not mean she will never get pregnant. Identify successful female role models and goals and plans for the near and distant future.
☐ Use these responses to assess contraceptive methods that would work best for the teen given her readiness, motivation and method of choice. It may help to role-play scenarios to deal with this issue. For example, if she begins oral contraceptives, act out how she might handle her mother finding her pills. Role-play discussing contraceptives with her partner/boyfriend.
☐ Based on her answers, counsel on consistent and effective contraceptive use, and/or the realities of pregnancy (financial, physical, personal, emotional). Write her an advance prescription for emergency contraception and discuss its effects and uses (see pg. 26 for more details on EC).
☐ Contact your patient by phone to see how things are going if she does not return for a follow-up. 56% of teens with a negative pregnancy test become pregnant in the next 18 months, so follow up care is vital.2

IF THE TEST IS POSITIVE:

Explore knowledge and beliefs about parenting, abortion, and adoption:

☐ Did you plan to get pregnant?
☐ How do you feel about being pregnant?
☐ What options have you considered (adoption, abortion, etc.)?
☐ What does your family, religion or culture think about pregnancy? abortion?
☐ What is your experience with pregnancy and parenting?
☐ Have any of your friends or relatives been pregnant recently? What did they decide to do about their pregnancies?

Assess social and family history:

☐ Who do you confide in?
☐ Who knows that you might be pregnant?
☐ How are you doing in school?
☐ What do you want to do in 1 year? 5 years?
☐ Do you have insurance? Can you use it without worries of confidentiality?

1For a full HEADSSS Assessment refer to the Basics of Adolescent Health Toolkit Module: Adolescent 101.
Pregnancy Test Counseling cont.

Conduct medical history:
- Do you have any medical problems or are you taking any medications?
- What methods have you used to prevent pregnancy or STIs?
- Have you had a pregnancy test before?
- Have you been pregnant before? Do you have children? What did you do about your past pregnancies?
- Have you had any STIs before?
- Have you had any bleeding/spotting or abdominal pain since your last period?

Discuss family/friends/partner influences:
- What adults in your life will be supportive?
- Does anyone know you came for a pregnancy test today?
- What is your relationship with the man you are pregnant by? Do you still see him? Do you think he will be supportive?
- How would/do your parents feel about your sexual activity?
- How does your partner/boyfriend feel about pregnancy, birth control and safer sex?
- How do you think your family and friends will react?
- Do you have friends or family members who are pregnant or have babies?

Discuss concrete options including health risks and costs of the options.
- Who will you talk to about this?
- Do you need any help in talking about your pregnancy plans with your boyfriend, parent(s), or other significant adults?
- Do you have someone to accompany you to your appointments? (prenatal or abortion)
- Do you know what your options are? What do you think you would like to do?

### TALKING POINTS

<table>
<thead>
<tr>
<th>Parenting</th>
<th>Abortion</th>
<th>Adoption</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Emphasize the importance of prenatal care</td>
<td>- Medical</td>
<td>- Closed adoption</td>
</tr>
<tr>
<td>- Medicaid enrollment/health coverage options</td>
<td>- Surgical</td>
<td>Birth mother and father remain anonymous to adoptive parents</td>
</tr>
<tr>
<td>- Impact on finishing school</td>
<td>- Access to abortion</td>
<td>- Open Adoption</td>
</tr>
<tr>
<td>- Finances</td>
<td>- Timing</td>
<td>Birth mother chooses the adoptive parents and they may stay in touch</td>
</tr>
<tr>
<td>- Relationship with father of the baby</td>
<td>- Cost</td>
<td></td>
</tr>
<tr>
<td>- Social support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Schedule follow up appointment(s), as needed, for physical exam, additional counseling and referrals.

### Medical v. Surgical Abortion: Which is more appropriate for teens?

<table>
<thead>
<tr>
<th>MEDICAL ABORTION</th>
<th>SURGICAL ABORTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROs</strong></td>
<td><strong>CONs</strong></td>
</tr>
<tr>
<td>Doesn’t require surgery</td>
<td>Requires a follow-up appointment</td>
</tr>
<tr>
<td>Can be more private</td>
<td>Causes heavy bleeding for several hours and bleeding may continue for ~2 weeks</td>
</tr>
<tr>
<td>Can feel more “natural”</td>
<td>Bleeding timing and duration is unpredictable</td>
</tr>
<tr>
<td></td>
<td>Limited to weeks 4-9 of pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Resources:

  State policies on parental involvement in the abortion of minors.
  State policies on minor’s access to prenatal care.

### Safe Haven Laws

Safely Surrendered Baby Law allows parents to confidentially give up their baby, 72 hours or younger. As long as the baby has not been abused or neglected, parents may give up their newborn without fear of arrest or prosecution.

- [http://www.nationalsafehavenalliance.org](http://www.nationalsafehavenalliance.org)

### Sources:

2) Thinking About Adoption. Planned Parenthood. [http://www.plannedparenthood.org/health-topics/adoption-4261.htm](http://www.plannedparenthood.org/health-topics/adoption-4261.htm)
Adolescent Relationship Violence (ARV)

Adolescents should be routinely screened for relationship violence; and, providers should help youth/parents understand and develop healthy relationships. By learning about local resources and how to support victims, healthcare providers can ensure that their patients are safe and/or have a strategy to deal with partner violence or abuse.

**FAST FACTS**

- Adolescent relationship violence is defined as the intentional violent or controlling behavior by a person who is currently or was previously in an intimate relationship with the victim. Sexual abuse or assault can be associated with intimate partner violence but is not always an issue.
- 1 in 3 teens experience some kind of abuse in their romantic relationships, including verbal and emotional abuse.¹
- 1 in 5 female students report physical and/or sexual abuse by “dating partner.”²
- Teens in same sex relationships are just as likely to experience relationship violence. Studies show that 20%-50% of same sex relationships may be abusive.³
- A recent study found significant levels of abusive behavior in “tween” (ages 11-14) dating relationships, and teens report that abusive behavior increases dramatically in the later teen years.⁴
- Youth perpetrators are equally likely to be female or male: girls more likely to be victims of physical abuse and boys victims of psychological abuse and mutual aggression is common.⁵

**RISK FACTORS FOR VICTIMS**

- Poor self-esteem
- Younger age with older partner(s)
- History of prior ARV
- Substance abuse
- Initiation of sex before 15 years old
- Multiple partners
- Pregnancy

**RISK FACTORS FOR PERPETRATORS**

- Aggressive behavior, jealous, blaming
- Poor interpersonal skills/problem solving
- Substance abuse
- Personal history of physical abuse
- Growing up in a household where DV is occurring

**The Cycle of Violence**

Adolescent relationship violence generally follows a progression that is referred to as the cycle of violence. The cycle usually starts with the tension phase followed by a violent or abusive episode followed by the honeymoon or apology phase. With each repetition of the cycle, the acts of violence/abuse tend to escalate and transition time between episodes decreases. It is important to explain this cycle when you are counseling a youth who may be involved in ARV.

⁴Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, Feb 2008.
Screening Tips and Guidelines
It is important to look for signs and symptoms of ARV. Many of these signs and symptoms may surface during a HEADSSS assessment.

### SIGNS OF POSSIBLE ARV

<table>
<thead>
<tr>
<th>Clinical Complaints</th>
<th>Behavioral</th>
<th>Partner Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Chronic complaints of abdominal pain, headaches, vaginitis, fatigue, pelvic pain</td>
<td>▶ Hostile and secretive</td>
<td>▶ Is possessive, jealous of others, including friends and family</td>
</tr>
<tr>
<td>▶ Acute complaints genital urinary/gynecological (vaginal bleeding, STIs, UTI, vaginitis, amenorrhea)</td>
<td>▶ Moody, withdrawn, or depressed</td>
<td>▶ Uses alcohol or other drugs</td>
</tr>
<tr>
<td>▶ Sleep problems, anorexia, anxiety symptoms (shortness of breath, chest pain, palpitations, hyperventilation, syncope)</td>
<td>▶ Has stopped seeing friends or has given up favorite activities</td>
<td>▶ Sabotages birth control methods/use</td>
</tr>
<tr>
<td>▶ Injuries not consistent with history and at different stages of healing</td>
<td>▶ School problems</td>
<td>▶ Refuses to leave the room during health exams</td>
</tr>
<tr>
<td>▶ Psychiatric: depression, PTSD, anxiety disorders, suicidal ideation/attempts and substance abuse</td>
<td>▶ Frequent cancelled appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▶ Delayed care for injuries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▶ Seems afraid of partner and fears breaking up with him/her</td>
<td></td>
</tr>
</tbody>
</table>

**Tools for Screening**
While there are many relationship violence screening tools, none are adolescent focused or appropriate. Asking questions within HEADSSS can help identify signs/symptoms to elucidate ARV:

**HEADSSS**
Ask questions related to teen’s relationships (under “Sex” or “Safety”)

- “I ask all my patients about their relationships. Are you now, or have you ever been in a relationship with a person who physically hurts or threatens you?”
- “What happens when you and your partner disagree? Does it ever get physical?”
- “Do you feel safe in your relationship/at home?”

**ADDITIONAL SCREENING QUESTIONS FOR SUSPECTED ARV**

- Does your partner get jealous when you go out or talk with others?
- Does your partner put you down, but then tell you he/she loves you?
- Have you been held down, shoved, pushed, hit, kicked, or had things thrown at you by your partner?
- Does your partner frighten or intimidate you?
- Does your partner make you choose between him/her, or family and friends?
- Has your partner forced or intimidated you into having sex?
- Are you afraid to break up with your partner because you fear for your personal safety?

---

*For a full HEADSSS Assessment refer to the Basics of Adolescent Health Toolkit Module: Adolescent 101*
FOR PROVIDERS: SCREENING, ASSESSMENT & REFERRALS

Adolescent Relationship Violence (ARV) cont.

What is the provider’s role once ARV has been identified?

<table>
<thead>
<tr>
<th>ASSESS SAFETY</th>
<th>INTERVENTION AND REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Are you currently safe where you are now?”</td>
<td>Convey Key Messages.</td>
</tr>
<tr>
<td>“What has been the worst fight? Were weapons used?”</td>
<td>➤ No excuse for violence</td>
</tr>
<tr>
<td>“Have you thought about hurting or killing yourself or others?”</td>
<td>➤ Not the victim’s fault</td>
</tr>
<tr>
<td>“Do you have an adult you can confide in?”</td>
<td>➤ You are not alone</td>
</tr>
<tr>
<td>“Have you tried to leave your relationship before? If so, what happened?”</td>
<td>➤ Changing a relationship can be difficult</td>
</tr>
<tr>
<td>“In a crisis/unsafe situation, where would you go/who could you turn to for help?”</td>
<td>➤ We can find you help and support</td>
</tr>
<tr>
<td>See safety Plan Checklist below.</td>
<td>Utilize a harm reduction approach.</td>
</tr>
<tr>
<td></td>
<td>Inform on resources/safety plan (see resources and safety plan below).</td>
</tr>
<tr>
<td></td>
<td>Empower the youth, point out strengths.</td>
</tr>
<tr>
<td></td>
<td>Respect what they want to disclose and how (while considering legal issues re: reporting).</td>
</tr>
<tr>
<td></td>
<td>Educate the victim about ARV (i.e. the cycle of violence).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPORTING</th>
<th>DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting depends on state laws.</td>
<td>Safeguard confidentiality.</td>
</tr>
<tr>
<td>Consider contacting CPS if parents are unwilling to protect teen (possible neglect).</td>
<td>Document physical injuries (take photographs or describe in detail).</td>
</tr>
<tr>
<td>Reporting mandates are based on age of victim.</td>
<td>Detailed documentation is important in case there are court proceedings but evidence collection can only be done by a certified examiner</td>
</tr>
<tr>
<td>➤ 17 and younger - child abuse report</td>
<td>➤ Abuse Centers can help with evidence collection if reporting/pressing charges (e.g. DNA of bite marks, sexual abuse exams photo documentation).</td>
</tr>
<tr>
<td>➤ 18 and older - domestic violence report mandated in some states</td>
<td></td>
</tr>
</tbody>
</table>

Safety Plan Checklist

- Ensure immediate safety
- File necessary reports
- Discuss notifying parents (if they don’t already know).
- Know shelters that take teens
- Discuss considering a temporary restraining order (TRO). In most states a minor cannot request a TRO independently.
- Be familiar with counselors knowledgeable with trauma and conflict resolution to help teen negotiate out of a relationship safely
- Advise changing locks/alarms
- Urge removing/safeguarding weapons

Resources

- The Safe Space teen safety plan worksheet:
- National Domestic Violence Hotline 1-899-SAFE

Sources:
FOR PROVIDERS: SCREEnING, ASSESSMeNt & ReFeRRALS

Sexual Assault

Adolescents and young adults are the primary age group at risk for sexual violence. Providers play an important role in identifying instances of sexual abuse or violence experienced by their teen patients. Routine screening for sexual assault should be done at every visit and providers need to be knowledgeable about the steps to take if a sexual assault is reported by one of their patients.

Fast Facts

- Sexual assault is defined as any non-consensual sexual contact that may or may not include rape. This includes sexual touching and fondling. The exact definition varies from state to state.
- 2/3 to 3/4 of victims of sexual assault knew the perpetrator
- 44% of rape victims are under the age 18
- More than 40% of adolescent victims report using drugs or alcohol before the assault
- 80% of rape victims experience post-traumatic stress disorder

Recommendations for the Care of Adolescent Sexual Assault Victims

Providers should:

1. Be familiar with the epidemiology of sexual assault in adolescents.
2. Be familiar with local reporting requirements for sexual assault. Keep in mind that survivors may not want to file a police report, and the law may mandate filing a child abuse report if they are a minor.
3. Learn about community sexual assault resources and where to refer teen patients for a forensic examination/evidence collection. Hospitals that have Level 1 trauma units, a rape treatment center, or SANE (Sexual Assault Nurse Examiners), are usually set up to handle a thorough examination.
4. Screen for a history of sexual assault and potential sequelae
5. Be ready to provide psychological support or counseling referrals to the teen that has been assaulted.
6. Provide preventative counseling to adolescents regarding avoidance of high-risk situations that could lead to sexual assault. Emphasize the difference between risk and blame, (i.e. even if an individual engages in high-risk situations, it does not mean they are responsible for being assaulted).

Evidence Collection and Prophylaxis

If patients report sexual assault in the last 72 hours, advise them not to bathe and refer for a forensic examination immediately. Evidence can only be collected within the first 72 hours. Depending on the jurisdiction, evidence collection will not automatically result in a police report. Most hospitals will hold the evidence for a few months to give survivors time to decide whether or not they want to file criminal charges. Prophylactic treatment for Chlamydia and Gonorrhea is recommended and emergency contraception is recommended for female victims when indicated. HIV prophylaxis may be provided with mucosal exposure (oral, vaginal, anal).

Tips for Supporting Victims of Assault:

- Validate survivors’ feelings. Explain that what they are feeling and experiencing is completely normal, acceptable and that what happened was not their fault.
- Listen non-judgmentally. Ask survivors what kind of support they want and need. Honor and respect these needs.
- Make sure the survivors are safe and physically well. If there is an immediate concern for well-being, create a safety plan and/or refer to temporary emergency housing (particularly when domestic violence/intimate partner abuse is also present).
- Suggest medical, psychological and/or other assistance, but let them decide which action to take.

Resources

- Rape, Abuse & Incest National Network (RAINN), local rape crisis centers and comprehensive information on statistics and related articles
  http://www.rainn.org
- National Sexual Violence Resource Center, sexual violence organizations in each state
  http://www.nsvrc.org/organizations

Footnotes:

5Ibid.
6Ibid.
Sexual Dysfunction

It is important to consider the implications of sexual dysfunction in teens. While data on sexual dysfunction in teens is scarce, teens experience erectile dysfunction, loss of desire, pain with penetration and other problems that affect sexual function. Sexual function and dysfunction is a topic area that is often overlooked and it is important to be prepared to provide adequate guidance to teens who report sexual concerns.

Sexual Dysfunction in Adolescent Females

Forty-three percent of women report experiencing some sort of sexual concern in their lifetime. Among these concerns, younger women report higher frequencies of orgasmic disorders and sexual pain disorders including vaginismus and dyspareunia, particularly vulvodynia. Change or decrease in libido is a known and common listed adverse reaction to hormonal contraception, including all combination and progestin-only methods.

<table>
<thead>
<tr>
<th>FEMALE ORGASMIC DISORDER (FOD)²</th>
<th>VAGINISMUS³</th>
<th>VULVODYNIA (AKA VULVAR VESTIBULITIS DISORDER)⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent or recurrent delay in, or absence of orgasm following a normal sexual excitement phase.</td>
<td>Recurrent, involuntary spasm of the outer third of the vagina which interferes with entry of a penis, finger, tampon, etc into the vagina.</td>
<td>Chronic discomfort and burning of the vulva not attributable to infection or neurological disorder.</td>
</tr>
<tr>
<td>29% of women aged 18-73 reported difficulty with orgasm.</td>
<td>Estimated 1-6% of women report symptoms of vaginismus.</td>
<td>Etiology linked to pro-inflammatory response of the vestibular mucosa.</td>
</tr>
<tr>
<td>Can be caused by drugs that increase serotonergic activity: antidepressants, antipsychotics.</td>
<td>Sexually abused females are more likely to develop vaginismus</td>
<td>Women who report symptoms of vulvodynia range from 16-80 years old.</td>
</tr>
<tr>
<td>Younger women report higher instances of delayed or absent orgasm.</td>
<td>The gynecological exam can be a source of extreme anxiety and discomfort for women with this disorder.</td>
<td>50% of women with vaginismus are also diagnosed with vulvodynia.</td>
</tr>
<tr>
<td>Factors associate with FOD include age, education, religion, personality, and relationship issues.</td>
<td></td>
<td>Common co-morbidities include fibromyalgia, irritable bowel syndrome and interstitial cystitis.</td>
</tr>
</tbody>
</table>

Sexual Dysfunction in Adolescent Males

Despite a lack of data, sexual dysfunction in adolescent males appears to be common and is generally caused by performance anxiety and in some cases, condom use. Common dysfunctions include premature ejaculation and erectile dysfunction. Delayed ejaculation is a less common disorder; and is most likely to be caused by psychoactive drugs (see Antidepressant/SSRI-induced Sexual Dysfunction in Teens on the next page).

<table>
<thead>
<tr>
<th>PREMATURE EJACULATION⁷</th>
<th>ERECTILE DYSFUNCTION⁸</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent or recurrent ejaculation with minimal sexual satisfaction before, or shortly after penetration and before the person wishes.</td>
<td>The inability to achieve or maintain an erection.</td>
</tr>
<tr>
<td>31% of American men aged 18-59 reported premature ejaculation at least once in the last 12 months.</td>
<td>Caused by common substances of abuse, many psychoactive medications, mental health issues and/or physical illness.</td>
</tr>
<tr>
<td>Can be caused by psychological factors or underlying medical conditions such as pelvic injury, neurological disease, prostatic hypertrophy and hypogonadal hypertrophy.</td>
<td>12-32% of college students report erection loss associated with condom use.</td>
</tr>
<tr>
<td></td>
<td>Most cases of erectile dysfunction in teens are transient.</td>
</tr>
</tbody>
</table>

²Ibid.
³Ibid.
⁵Marcell AV, Bell DL. Making the most of the adolescent male health visit Part 1: History and anticipatory guidance. Contemp Pediatrics. 2006; 23:6(38-46).
Assessment
Include sexual function in a thorough sexual health assessment (see pg. 13). The extended PLISSIT model is useful for screening for sexual problems. Conduct a thorough medical history and medication history. Alcohol, tobacco, recreational drugs, some psychotropic medications, and β blockers and many others are all associated with sexual dysfunction in both females and males (see insert). Review the sexual side effects of medications when prescribing them an assess medication use in the sexual dysfunction work up.

Interventions
⇒ Reassurance
⇒ Stress reduction techniques
⇒ Refer the teen to appropriate local resources

Ex-PLISSIT®
The extended PLISSIT model takes a stepwise approach to addressing sexual health concerns. Permission-giving is part of each step and reflection and self-awareness are key skills for the provider. When going beyond levels one and two (Permission and Limited Information) a greater level of expertise may be required. If this level of care is outside the comfort zone of the provider, a referral should be made to someone more knowledgeable about sexual dysfunction.

P PERMISSION GIVING: Creates a safe environment to address sexual health concerns by screening for a problem.
Ex. Young men and women often have questions and concerns about sex and how their bodies are functioning during sex– do you have any?”

L LIMITED INFORMATION: Gives the patient limited information about the sexual problem. This is a great opportunity to discuss causes, normalize and dispel myths about the dysfunction.
Ex. “Many young men may have trouble getting or maintaining an erection at some point. Sometimes it can happen if a man is having problems with his relationship or if he is nervous about having sex with someone. Sometimes men lose their erection when they put on a condom.”

S SPECIFIC SUGGESTIONS: Take a problem-solving approach and make specific suggestions in response to problems discussed.
Ex. If the teen reports loss of erection with condom use, suggest adding a couple drops of lubricant inside the condom before putting it on.

IT INTENSIVE THERAPY: Assess whether or not the primary care provider can effectively treat the health concern and offer referrals as required.

Resources for Female Sexual Dysfunction
⇒ http://www.obgyn.net/women/women.asp?page=/CPP/articles/Cracchiolo_0499
Symptoms, causes, treatment options, and resources for vulvodynia.
⇒ http://www.nva.org/
National Vulvodynia Association. Has links to research articles related to vulvodynia.
Vaginismus Awareness Network. Has information geared toward providers, partners, and women.

For resources for teens, refer to Click on This, pg. 72.

ANTIDEPRESSANT/SSRI-INDUCED SEXUAL DYSFUNCTION IN TEENS
SSRI induced sexual dysfunction is not as well documented in teens as it is in adults. The low number of cases, however, may be attributed to discomfort surrounding reporting dysfunction to the prescribing health care provider or clinicians failing to ask the teen about sexual side-effects.

Tips:
⇒ Be aware of the side effects of all the medications the teen may be taking.
⇒ Always reassure patients of confidentiality and let them know that they can feel comfortable discussing sexual function at any time.
⇒ Incorporate questions that address sexual function into assessment tools and questionnaires.
⇒ Refer to the Ex-PLISSIT model for guidance surrounding sexual interventions.

Resources for teens:
An article geared toward mid to late adolescents about sexual dysfunction caused by antidepressants.

Source:
Counseling Youth About Sexual Function and Pleasure

Sexual pleasure is an integral part of sexual function and behavior and is often not discussed by healthcare providers. While some providers may feel uncomfortable discussing the details of sexual pleasure and function, it is an important topic that should be discussed with all teen patients. For example, discussing pleasure promoted with condom use in addition to safer sex messaging results in increased condom use and safer sex.¹

Lack of sexual enjoyment may indicate that a teen is not ready to be sexually active. Encourage teens to think about how comfortable they are with their current sexual behaviors. If a sexual function problem persists, you may need to evaluate whether a patient is experiencing sexual dysfunction. (See pg. 34).

**TIPS**

<table>
<thead>
<tr>
<th>Improving Female Satisfaction</th>
<th>Postponing Male Ejaculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Encourage use of lubrication as it improves the quality of sex. Refer her to over-the-counter, water-based lubricants.</td>
<td>➢ Reassure that this problem diminishes with time. Premature ejaculation is very common in adolescent boys, but decreases with age.</td>
</tr>
<tr>
<td>➢ Educate young women about their erogenous zones. Encourage female patients to explore their bodies and seek stimulation from erogenous zones: nipples, clitoris, vagina, arms, back, buttocks, ears, feet, fingers, legs, and neck.</td>
<td>➢ Suggest using adequate stimulation. If males perform longer foreplay on partner, they are more likely to reach orgasm simultaneously during sex.</td>
</tr>
<tr>
<td>➢ Suggest using adequate stimulation. Longer foreplay, oral or manual stimulation of clitoris and other erogenous zones improves a woman’s chances of orgasm and/or satisfaction.</td>
<td>➢ Promote condom use. Condom use for hyper-sensitive males may postpone ejaculation.</td>
</tr>
<tr>
<td>➢ Promote condom use. Females report added clitoral stimulation when using the female condom and increased relaxation when stress of potential STIs or pregnancy is reduced.</td>
<td>➢ Recommend finding a safe, private environment and comfortable sexual position. Awkward environments may negatively impact male performance.</td>
</tr>
<tr>
<td>➢ Recommend finding a safe, private environment and comfortable sexual position. Position is an important factor to consider in maximizing pleasure and minimizing discomfort. Often youth may be in an awkward environment, may be rushed or afraid of discovery which can reduce pleasure and satisfaction.</td>
<td>➢ Advise trying kegel exercises. Not all young men know about their pubococcygeus (PC) muscles and how exercising them can postpone ejaculation. Inform males about anatomy and advise that squeezing PC muscles for seconds at a time will help postpone ejaculation.</td>
</tr>
<tr>
<td>➢ Suggest using the “Stop and Start” method. This involves temporarily pulling out and resuming sex when feelings of imminent ejaculation subside.</td>
<td></td>
</tr>
</tbody>
</table>
Safer Sex and Lubrication

**FAST FACTS**

- **Lubrication promotes a safer sex experience by decreasing abrasive friction.**
  - Abrasive friction, the result of dry penetration (can include a sex toy) can cause condom breakage or vaginal and anal tears increasing the chances of transmitting an STI.
  - Abrasive friction also increases the risk for Herpes outbreaks in those infected.

- **Using lubrication enhances pleasure during sex.**
  - Lubricants makes sex feel wetter and better.
  - Dropping a little lubricant in the condom increases sensitivity and erections in adolescent males who have difficulty maintaining an erection when using condoms.
  - Dropping a little lubricant outside the condom promotes pleasure for the receptive partner.
  - Adding flavored lubricant to the outside of condoms promotes a pleasant oral sex experience for both the giver and the receiver.

- **Additives in lubricants such as glycerin can create an environment that is friendlier to yeast infections.**
  - If a teen reports recurring yeast infections, ask about lubricant use and advise to avoid glycerin-based lubricants.

*A Note on Benzocaine:* Benzocaine lubricant may have clinical indications (i.e. vulvodynia) but it is not advisable for anal sex or anal stimulation as it masks the body’s signals of pain and use can result in fissures and other anal tears.

<table>
<thead>
<tr>
<th>TYPE OF LUBRICATION</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Water-Based Lubricant</strong>&lt;br&gt; Astroglide, KY Jelly, etc.</td>
<td>- Latex, polyurethane, and nitrile friendly&lt;br&gt;- Female condom friendly&lt;br&gt;- Easily washes off skin, clothes or sheets&lt;br&gt;- Easy to rinse off with water&lt;br&gt;- Sex toy friendly</td>
<td>- Can contain parabens and glycerin&lt;br&gt;- Cannot be used in water&lt;br&gt;- Can vary in how long it stays slippery</td>
</tr>
<tr>
<td><strong>Oil-Based Lubricant</strong>&lt;br&gt; Baby oil, Vaseline, hand lotion and men’s cream (designed for male masturbation), etc.</td>
<td>- Polyurethane or nitrile friendly (i.e. female or Avanti condom)&lt;br&gt;- Particularly effective for male masturbation</td>
<td>- Cannot be used with latex condoms&lt;br&gt;- Not as easy to wash off with soap and water, leaving one susceptible to bacterial infection</td>
</tr>
<tr>
<td><strong>Silicone-Based Lubricant</strong>&lt;br&gt; Wet Platinum, Eros Body-glide, etc.</td>
<td>- Latex, polyurethane, and nitrile friendly&lt;br&gt;- Stays slippery for a long period of time&lt;br&gt;- Can be used in water</td>
<td>- Can be expensive&lt;br&gt;- Must be washed off with soap and water&lt;br&gt;- Harder to remove from clothes or sheets&lt;br&gt;- Can’t be used with some silicone sex toys</td>
</tr>
<tr>
<td><strong>Saliva</strong></td>
<td>- Latex, polyurethane, and nitrile friendly&lt;br&gt;- Free&lt;br&gt;- Easily washes off skin, clothes, or sheets.</td>
<td>- Cannot be used in water&lt;br&gt;- Usually doesn’t stay slippery for long</td>
</tr>
</tbody>
</table>

**Resource**


Planned Parenthood’s informational handout for teens on lube.

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FOR PROVIDERS: RESOURCES

Safer Sex Toy Use

When addressing the sexual behaviors of adolescents use of sex toys is often not taken into consideration. The use of sex toys can increase the sexual pleasure of the user, but the different sex toy materials may have implications for the spread of sexually transmitted infections. For example, porous toys retain bacteria and can transmit infections when used without a condom while non-porous toys can be thoroughly cleaned and do not retain bacteria.

<table>
<thead>
<tr>
<th>FAST FACTS¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>53% of women and almost half of all men have used a vibrator.</td>
</tr>
<tr>
<td>Late adolescent women (age 18-22) represented 15.5% of vibrator users and 30% of women in that age group have used a vibrator to masturbate.</td>
</tr>
<tr>
<td>81% of women and 91% of men who have used a vibrator used it with a partner.</td>
</tr>
<tr>
<td>More lesbian and bisexual identified women have used vibrators and dildos compared to heterosexual women.</td>
</tr>
<tr>
<td>Vibrator users scored higher on measures of positive sexual function, reporting higher rates of sexual pleasure and fared better than their counterparts when considering natural lubrication, pain and erectile function.</td>
</tr>
</tbody>
</table>

Sex Toy Guidelines for Safety and Minimizing Infection of Viruses, Bacteria, or Yeast:

- Sex toys should be thoroughly cleaned and dried after each use.
- Condoms should be used when sex toys are:
  - Shared between partners.
  - Used vaginally and anally and the condom should be changed when switching from anal to vaginal penetration.
  - Made out of porous materials such as jelly rubber and “soft skin.”
- Some silicone and silicone blend toys are porous and cannot be used with silicone lube. Advise patients to read labels to be sure.
- If recurring infections occur, ask about sex toy use and advise on safer practices.
- **ANAL TOYS SHOULD ALWAYS HAVE A FLARED BASE TO PREVENT IT FROM GETTING STUCK IN THE RECTUM.**

<table>
<thead>
<tr>
<th>MATERIAL OF TOY</th>
<th>CLEANING RECOMMENDATIONS</th>
<th>SAFER SEX TIPS</th>
</tr>
</thead>
</table>
| **Glass**  
*Non-porous* | Mild liquid soap and warm water | Use a condom when sharing the toy or when using the same toy vaginally and anally. |
| **Silicone**  
*Usually non-porous (can vary in porosity the product is if it is not 100% silicone)* |  
- Anti-bacterial soap and warm water; rinse well and dry thoroughly or  
- Dishwasher or  
- Boil to disinfect | Use a condom when sharing the toy or when using the same toy vaginally and anally. |
| **Elastomer and Vinyl**  
*Less Porous* | Mild liquid soap and warm water | Always use a condom whether or not the toy is being shared. |
| **Jelly Rubber, Polyvinyl Chlorides**  
*Porous* | Mild soap and hot water or a washcloth for non-waterproof vibrators; remove soap residue before next use | Always use a condom whether or not the toy is being shared. |

# Pregnancy Prevention Options

<table>
<thead>
<tr>
<th>METHOD</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td>- Requires no supplies.</td>
<td>- Requires motivation and self-control from both partners.</td>
</tr>
<tr>
<td></td>
<td>- Natural.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Only definite way to prevent pregnancy/STIs.</td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td>- Requires no supplies.</td>
<td>- Unreliable.</td>
</tr>
<tr>
<td></td>
<td>- Natural.</td>
<td>- Requires motivation and self-control from both partners.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Difficult for male to predict ejaculation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No control by women – need to rely completely on men to prevent pregnancy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Poor protection against STIs.</td>
</tr>
<tr>
<td>Condoms</td>
<td>- Immediate protection.</td>
<td>- Requires planning.</td>
</tr>
<tr>
<td></td>
<td>- Easily accessible.</td>
<td>- Both partners must be cooperative.</td>
</tr>
<tr>
<td></td>
<td>- Protects against pregnancy/STIs.</td>
<td>- Partner may be allergic to latex.</td>
</tr>
<tr>
<td></td>
<td>- Male partner can “last longer” when using a condom.</td>
<td></td>
</tr>
<tr>
<td>Cervical Cap/Diaphragm</td>
<td>- Some protection against STIs.</td>
<td>- Much more effective with condom or diaphragm use.</td>
</tr>
<tr>
<td></td>
<td>- Non-visible.</td>
<td>- Can be expensive if not covered by insurance.</td>
</tr>
<tr>
<td>Spermicides</td>
<td>- Easily accessible.</td>
<td>- Best used when intercourse can be predicted.</td>
</tr>
<tr>
<td>Emergency Contraception (not intended to be a regular form of birth control)</td>
<td>- Effective and safe for teenagers.</td>
<td>- Must be comfortable inserting/removing.</td>
</tr>
<tr>
<td></td>
<td>- Back-up method for unprotected intercourse.</td>
<td>- Not usually popular among teens.</td>
</tr>
<tr>
<td></td>
<td>- Reduces pregnancy risk after unprotected or under-protected intercourse.</td>
<td></td>
</tr>
<tr>
<td>Progestin only Injectables (Depo-Provera)</td>
<td>- Non-visible.</td>
<td>- Side effects such as nausea and vomiting if using OCPs, but levonorgestrel only (Plan B) is well tolerated.</td>
</tr>
<tr>
<td></td>
<td>- Only requires injection every 12 weeks.</td>
<td>- Should be taken ASAP, but reduces pregnancy risk up to 120 hours after intercourse.</td>
</tr>
<tr>
<td></td>
<td>- Many stop getting their period during use.</td>
<td>- Menstrual period is disrupted (may come earlier or later than usual).</td>
</tr>
<tr>
<td></td>
<td>- Helps protect against uterine cancer.</td>
<td>- No protection against STIs.</td>
</tr>
<tr>
<td></td>
<td>- Highly effective with proper user</td>
<td>- Less effective than regular hormonal contraception.</td>
</tr>
</tbody>
</table>
### Pregnancy Prevention Options cont.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
</table>
| **Oral Contraceptives (Birth Control Pills)** | - Few contraindications.  
- Safe use after menarche.  
- May improve acne, dysmenorrhea and cycle control.  
- Highly effective with proper use. | - Requires consistent daily use.  
- Forgetfulness increases failure.  
- Break through bleeding worries and upsets many teens.  
- No protection against STIs.  
- Might cause nausea, breast tenderness, moodiness, and weight gain.  
- Contraindicated for migraines with auras.  
- Can be costly if not covered by insurance. |
| **Vaginal Ring (NuvaRing)** | - Non-visible.  
- Highly effective with proper use.  
- Does not require consistent daily use. | - Requires inserting new ring every 4 weeks.  
- The ring stays in for 3 and is taken out for 1 week.  
- Must be comfortable inserting/removing ring.  
- Contraindicated for migraines with auras.  
- No protection against STIs. |
| **Birth Control Patch (Ortho Evra)** | - Highly effective with proper use.  
- Does not require consistent daily use. | - Requires applying a new patch once a week for 3 out of 4 weeks.  
- Visible – particularly on people of color.  
- Side effects include breast tenderness and nausea.  
- Contraindicated for migraines with auras  
- No protection against STIs. |
| **Hormonal Implant (Implanon)** | - Good for 3 years.  
- Barely visible.  
- Highly effective.  
- Capsule can be removed any time.  
- May cause light to no periods. | - Must be inserted/removed by a provider.  
- Side effects may include headaches, irregular bleeding patterns and arm discomfort (initially post-insertion).  
- No protection against STIs. |
| **Intra-Uterine Device (IUD)** | - Non-visible.  
- Minimal maintenance is needed.  
- Very effective against pregnancy.  
- Levonorgestrel IUD lasts for 5 years, the copper IUD lasts for 10 years.  
- Levonorgestrel IUD lessens menstrual flow and can be used to treat heavy periods. | - Slightly higher expulsion rate in nulliparas.  
- Not recommended for teens with a high risk for contracting CT/GC.  
- Must be screened for STIs prior to insertion.  
- Copper IUD sides effects include menstrual cramping, longer and/or heavier menstrual periods and spotting between menstrual periods.  
- No protection against STIs. |

Pg. 57 includes a brief chart to distribute to teens about different types of contraceptives. See pg. 22 for tips for talking with teens about contraception and sexual health.
Menstrual Suppression

As dedicated products for menstrual suppression become more available and gain popularity, more women are interested in learning how they can suppress menstruation. Extended cycling of the combined hormonal birth control methods to suppress menstruation is comparable in safety and effectiveness as the traditional birth control regimen.¹

FAST FACTS

- The average modern women will have four times as many lifetime periods as pre-agricultural women.¹
- Monthly bleeding with combined hormonal contraceptive use is not a “true” period. This “withdrawal” bleeding is the body’s reaction to not having a sustained level of hormones.
- “Off label” extended cycling was used for years before the first dedicated product was approved by the FDA in 2003.³
- Most adult women consider menstruation to be an inconvenience.⁴

²New Yorker, 2000
³Steinauer, et al 2007

Extended Hormonal Contraception

Extended hormonal contraception used to delay or eliminate menstruation provides many menstrual and non-menstrual benefits to users.²

**MENSTRUAL BENEFITS**

- Dysmenorrhea
- Menorrhagia
- Premenstrual syndrome
- Irregular monthly periods

**NONMENSTRUAL BENEFITS**

- Menstrual migraines
- Endometriosis
- Acne
- Improved sense of well-being

Extended cycling is most often recommended in adult women and teens for:³

- Inducing amenorrhea for a specific event
- Women in the military
- Accommodating patient preference for fewer menses
- Managing menses related problems such as dysmenorrhea, menorrhagia, cyclic headaches
- Managing problematic menses in women with developmental and/or physical disabilities or behavioral problems

**Extended Methods⁴**

<table>
<thead>
<tr>
<th>METHOD</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined oral contraceptives</td>
<td>Extended or continuous use with elimination of the placebo pills Can use multiple packs or dedicated products</td>
</tr>
<tr>
<td>Vaginal contraceptive ring*</td>
<td>Extended or continuous use</td>
</tr>
<tr>
<td>Transdermal contraceptive patch*</td>
<td>Extended or continuous use</td>
</tr>
</tbody>
</table>

*Currently, there are no FDA recommendations for the use of the vaginal ring or transdermal patch.

²Sulak PJ, Kuehl TJ, Ortiz M, Shull BL. Acceptance of altering the standard 21-day/7-day oral contraceptive regimen to delay menses and reduce hormone withdrawal symptoms. Amer J Obstet Gynecol. 2002; 186:1142-1149.
Menstrual Suppression cont.

Menstrual suppression can also occur with long-term use of progesterone contraceptive methods including the levonorgestral intrauterine system (Mirena) and the depot medroxyprogesterone injection (Depo-Provera). For more information on prescribing considerations for these methods, see pg. 22.

**Prescribing Considerations**

- Clarify client’s expectations for withdrawal bleeding
  - Frequency
  - Predictability
- Use monophasic pills or dedicated products
- Keep it simple and straightforward
- Start with 3 21/7 (conventional) cycles if history of heavy bleeding
- Discuss cost of extra pills (up to 4 cycles extra per year); most insurance plans will not cover extra cycles
- Extended regimen as effective in preventing pregnancy as conventional OCs
- Withdrawal bleeding is comparable to a conventional withdrawal bleed
  - Frequency of breakthrough bleeding (unscheduled bleeding episodes) initially higher with extended OC regimen but declines over time
  - One study has shown that frequency of sustained amenorrhea may be lower in patients using the extended use of the transdermal contraceptive patch
- No endometrial pathology noted
- Nonmenstrual side effects are comparable to conventional dosing


Common Patient Questions and Concerns

- **Is it safe to use hormonal birth control continuously?**
  Taking the birth control pill continuously is not any riskier than taking monthly birth control pills. Studies have also shown that use of Seasonale, the dedicated product, did not cause any health problems in users. If you have high blood pressure or a history of problems with blood clots you may not be able to use birth control pills.

- **How often do I need a period?**
  Women who are on hormonal birth control pills do not need to get a period ever. In fact, the bleeding that occurs when you are on the pill isn’t even a real menstrual period.

- **What should I do if I have spotting?**
  Spotting is normal as your body gets used to the new hormone levels. Spotting can happen on and off in the first months, sometimes longer. If your spotting becomes heavy or doesn’t stop after the first few months, call your healthcare provider.

- **How will I know if I am pregnant?**
  If you take your birth control pills correctly, pregnancy is very rare. If you start to feel any abnormal symptoms like breast tenderness, feeling overly tired, and nauseated, you may want to take a pregnancy test. You can either schedule an appointment for a pregnancy test with me or buy one from the drug store.

Establishing Paternity and Paternity Laws

Many teens do not know the laws about paternity or what paternity implies. Generally, paternity is presumed if the parents are married. However, if the parents are not married, paternity needs to be established. Paternity can legally impact a lot of things; and, depending on the relationship between the mother and the father, establishing paternity can either be an appropriate or inappropriate choice.

<table>
<thead>
<tr>
<th>PROs</th>
<th>CONs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can request custody</td>
<td>Establishing paternity may compromise the safety of the mother and the child in the following situations:</td>
</tr>
<tr>
<td>Can request child support</td>
<td>▶ If physical, emotional or sexual abuse of the mother is suspected</td>
</tr>
<tr>
<td>Inheritance</td>
<td>▶ If the pregnancy is a product of rape</td>
</tr>
<tr>
<td>Eligibility for father’s insurance benefits</td>
<td>▶ If coercion is suspected</td>
</tr>
<tr>
<td>Can obtain father’s medical history</td>
<td>▶ If the father is involved in criminal activity</td>
</tr>
<tr>
<td>Usually a child wants to know the identity of his/her father.</td>
<td></td>
</tr>
</tbody>
</table>

Despite the fact that unmarried parents are not legally required to establish paternity, young parents may be inappropriately pressured to establish paternity before leaving the hospital or in order to be eligible to file for social services. Encouraging both married and unmarried teen patients to think about paternity before the child is born can help prevent teens from making uninformed decisions about paternity and long-term implications if established. Refer teen parents to local legal counsel organizations to receive guidance on paternity laws.

Testing Paternity: Blood and DNA Testing

A parent may request blood or DNA testing when paternity is ambiguous or being contested. In other situations, if the mother is applying for social services or benefits, the state may require that paternity be determined with a DNA test before benefits are awarded. When faced with the question of paternity testing, however, it is often unclear who is financially responsible for the test and this responsibility can vary state to state.

**TIPS:**

While the healthcare provider’s role may be relatively limited in this matter, it is important to know the correct referrals and resources in your area.

- Contact local legal aid or other public counsel option.
- Contact the local court. Generally it is the court that may force paternity testing and often determine who will pay for the test.

**RESOURCE:**

- [http://family.findlaw.com/paternity/paternity-tests.html](http://family.findlaw.com/paternity/paternity-tests.html)
  This site outlines basic information on paternity testing.

Sources:
1) [http://family.findlaw.com/paternity/chronology-establishing-paternity.html](http://family.findlaw.com/paternity/chronology-establishing-paternity.html)
HPV Vaccine

The quadrivalent HPV vaccine types 6, 11, 16, 18 (GARDASIL™, manufactured by Merck and Co., Inc.) is licensed for use among females and males aged 9–26 years for prevention of vaccine HPV-type–related cervical cancer; cervical, vaginal and vulvar cancer precursors; and anogenital warts. Currently its use in males is optional and at the discretion of providers. The bivalent HPV vaccine types 16, 18 (Cervarix™, manufactured by GlaxoSmithKline) was recently licensed for use among females aged 10–25 years for prevention of vaccine HPV-type–related cervical cancer; and cervical, vaginal and vulvar cancer precursors.

Recommendations for use of HPV Vaccine:

OPTIONAL VACCINATION OF MALES AGED 9-26 YEARS
♦ Currently (10/2009) the HPV quadrivalent vaccination in males is optional and at the discretion of providers. There are no recommendations for the use of the bivalent HPV vaccine in males.

ROUTINE VACCINATION OF FEMALES AGED 11-12 YEARS
♦ Ideally, the vaccine should be administered before sexual debut and subsequent potential exposure to HPV through sexual contact.
♦ Advisory Committee on Immunization Practices (ACIP) recommends routine vaccination of females aged 11–12 years with 3 doses of quadrivalent or bivalent HPV vaccine.
♦ The quadrivalent vaccination series can be started as young as age 9 years and the bivalent as young as 10 years.

CATCH-UP VACCINATION OF FEMALES
♦ The quadrivalent is also recommended for females aged 13–26 years who have not been previously vaccinated or who have not completed the full series, the bivalent is recommended for females aged 13–25 years who have not been previously vaccinated or who have not completed the full series. The American Cancer Society states there is no evidence of benefit for vaccinating the general population after the age of 19 years.
♦ Sexually active females who have not been infected with any of the HPV types included in the vaccine would receive full benefit from vaccination.
♦ Vaccination provides less benefit to females if they have already been infected with one or more of the HPV types included in the vaccine. However, females in this age bracket should still receive the vaccine regardless of potential exposure since there is no cost effective way to determine previous exposure to the different HPV types.

DOSAGE AND ADMINISTRATION
♦ The vaccine should be shaken well before administration.
♦ The dose of quadrivalent HPV vaccine is 0.5 mL, administered IM, preferably in the deltoid muscle.

RECOMMENDED SCHEDULE
♦ Both the bivalent and quadrivalent HPV vaccines are administered in a 3-dose schedule.
♦ The second and third doses should be administered 2 and 6 months after the first dose.

MINIMUM DOSING INTERVALS AND MANAGEMENT OF PERSONS WHO WERE INCORRECTLY VACCINATED
♦ The minimum interval between the first and second doses of vaccine is 4 weeks.
♦ The minimum recommended interval between the second and third doses of vaccine is 12 weeks.
♦ Inadequate doses of quadrivalent or bivalent HPV vaccine or vaccine doses received after a shorter-than-recommended dosing interval should be readministered.

INTERRUPTED VACCINE SCHEDULES
♦ If the quadrivalent or bivalent HPV vaccine schedule is interrupted, the vaccine series does not need to be restarted.
♦ If the series is interrupted after the first dose, the second dose should be administered as soon as possible, and the second and third doses should be separated by an interval of at least 12 weeks.
♦ If only the third dose is delayed, it should be administered as soon as possible.

Resources for Patient & Parent Education:

The Center for Disease Control (CDC) has excellent handout resources that explain the current understanding about HPV and cervical cancer, the function of Pap screening tests, HPV prevention, and information about the HPV vaccine.

HPV: Prevention & Abnormal Pap Results PDF Handouts
♦ http://www.cdc.gov/std/hpv/common

HPV Vaccine: Fact sheets & Information
♦ http://www.cdc.gov/std/hpv/
FOR YOUTH

Sex, Virginity & Abstinence

People have sex for many reasons – to feel close to their partner, to show and receive affection, and to experience the physical pleasure of sex. There are also many reasons that people choose not to have sex – religious beliefs, they don’t feel ready, or they have not found the right person yet. In the end, it is always your decision to have sex or not have sex, the first time and every time after.

Here are some common sexual behaviors...

- Masturbation - touching yourself in a sexual way. Partners can masturbate together and watch each other.
- Finger Sex - touching your partner’s sexual organs with your hands.
- Sex talk or “talking dirty” - people saying things to each other about sexual feelings, fantasies, and acts. Sex talk can be used during sexual touching or intercourse.
- Phone sex - people talk sexually to each other over the phone.
- Anal intercourse - a penis, finger, sex toy, or other object is put inside the anus.
- Vaginal intercourse - a penis, finger, sex toy, or other object is put inside the vagina.
- Oral sex - a mouth or tongue is used to sexually stimulate someone. The tongue is used on the penis, scrotum, clitoris, vagina, anus, etc.

Am I a Virgin?

Virginity refers to never having had sex. For some people, being a virgin means someone has not done any sexual activities with another person. For others, being a virgin just means that someone has not had vaginal intercourse.

Myths and Facts about Virginity

- There is a virginity test. Myths! There is no medical test to tell if you are a virgin.
- If a girl breaks her hymen, she can still be a virgin. Facts! The hymen, also known as “the cherry,” is a thin tissue that covers the vaginal opening. This tissue can break from sexual or non-sexual activities. These non-sexual activities could be riding a bike or climbing a tree.
- You can tell if someone has had sex by the way he or she looks or acts. Myths! You cannot tell if someone is sexually active by how he or she looks or acts. Everyone is different.

Other Important Terms

- Abstinence – some people use the word “abstinence” to refer to not having sex. They may mean that they are not doing any sexual activities with another person at all. It can also mean that they are doing some sexual activities, just not having vaginal intercourse.
- Periodic Abstinence – when someone decides to take a break from sex. People can decide to take a break from sex for a few days or a few years.
- Sexual Self-Reliance – when you rely on yourself to make yourself feel sexually satisfied. This is often through masturbation. Relying on yourself is different from relying only on a partner for sexual pleasure. You can use self-exploration and masturbation to get to know your body and show your partner what you like. Being sexually self-reliant can also make sex with someone else better.
Having Sex on Your Own Terms

**Quiz: Do You Have to Say Yes to Sex If...**

- you have already **lost** your virginity?
- you have had sex with someone before?
- someone spends money on you?
- you are a female and your cleavage is showing? your clothes are tight fitting? you are wearing a short skirt?
- you are a male and want to be a real man? your friends say you need to have sex to be a man?
- your partner is really horny?
- you want someone to like you?
- you are a female and you have been called a ho? whore? slut?
- you are a straight male and a female is offering?
- someone is your boyfriend or girlfriend?
- someone is a teacher, policeman, or boss at your job? That person has power over you?
- someone is in your family?
- someone is really popular and wants to have sex?
- someone is older than you and wants to have sex?
- you are a female and it is late at night?
- you are a female and you are naked in bed with your partner?
- you are a male and a 15-year-old virgin? 17? 19?
- you have been raped, or forced to have sex before?
- you are at a place you shouldn’t be?
- you have been drinking or smoking?
- you love sex and think it feels good?

The answer to all of these questions is **NO**.

**YOU NEVER HAVE TO SAY YES** to sex. Sex is always a choice, the first time and every time!

**AND REMEMBER:** Sex is something **YOU CAN SAY YES TO** when you and your partner are ready, feel safe and comfortable with each other, and are using protection against pregnancy and STIs

---

**Thinking about having sex? Ask yourself these questions...**

- Am I in a healthy, trusting, respectful and honest relationship? Do we treat each other as equals and communicate well?
- Do my partner and I agree on the nature of our relationship (friendship, steady romantic relationship, etc.?)
- Do we have the same ideas about sex and love?
- Can I explain my decision to have sex if parents or friends ask why?
- Is having sex my idea, or am I being pressured? Is having sex something my partner really wants, or am I pressuring him or her?
- Am I OK talking with my partner about what I do and don’t want to do sexually?
- Do I know how to use birth control and condoms to prevent pregnancy and STIs?
- If sex leads to pregnancy or getting an STI: Do I know where to get treated for an STI? Do I feel ready to make decisions about a pregnancy? Will my partner be there for me?

**Tips for Having Sex on Your Own Terms:**

- **Always have a safe way to get home** when on a date or out with friends.
- **Pick friends you can trust.** A true friend will respect your sexual decisions.
- **Be prepared with a safer sex method.** Get condoms or talk to your provider about picking a birth control method before you start having sex.
- **Get tested for STIs.** Go to the clinic with your partner before you have sex.
- **Ask your partners about their sexual desires.** Be sure to share your own desires, too. Your sexual decisions should be what you both want, every time.
- **Pay attention to your partner.** If he or she seems unsure always stop and ask, “Is this OK?”
The following are some tips for deciding what you should look for in a relationship. These should also help you know when you are in an unhealthy relationship. Healthy dating and sex habits now lead to healthy sex and dating habits in the future. If you think you might be in an unhealthy or abusive relationship, talk to a trusted and caring person in your life. Most people need support when they are in these situations.

**The Relationship Bill of Rights**

I hereby declare that I have the right to...

- Trust my feelings.
- Be with who I want, when I want, and how I want.
- Say no or leave a situation if I feel uncomfortable.
- Disagree with my partner.
- Have sex when my partner and I both want to.
- Have sex that feels good to me.
- Feel good about myself whether I am in a relationship or not.
- Accuse someone of hurting me physically or sexually.
- Receive emotional support and understanding.
- Control my own future.

**Resources/Links:**

- Planned Parenthood: http://www.plannedparenthood.org/health-topics/relationships-4321.htm
- Planned Parenthood’s Teenwire: http://www.teenwire.com/topics/relationships-friends-and-family.php
### The Relationship Spectrum

<table>
<thead>
<tr>
<th>A HEALTHY RELATIONSHIP</th>
<th>AN UNHEALTHY RELATIONSHIP</th>
<th>AN ABUSIVE RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communicating</strong> - You talk openly about problems and listen to one another. You respect each other’s opinions.</td>
<td><strong>Not communicating</strong> - When you talk about problems you fight, or you don’t talk about them at all.</td>
<td><strong>Communicates in a way that is hurtful or insulting.</strong></td>
</tr>
<tr>
<td><strong>Respectful</strong> - You value each other as you are.</td>
<td><strong>Disrespectful</strong> - One or both of you is not considerate of each other.</td>
<td><strong>Mistreats the other</strong> - One or both partners does not respect the feelings and physical safety of the other.</td>
</tr>
<tr>
<td><strong>Trusting</strong> - You believe what your partner says.</td>
<td><strong>Not trusting</strong> - You don’t believe what your partner says.</td>
<td><strong>Accuses the other of flirting or cheating when it’s not true</strong> - The partner that accuses may hurt the other in a physical or verbal way as a result.</td>
</tr>
<tr>
<td><strong>Honest</strong> - You are honest with each other but can still choose to keep certain things private.</td>
<td><strong>Dishonest</strong> - One or both partners is telling lies.</td>
<td><strong>Denies that the abusive actions are abuse</strong> - They may try to blame the other for the harm they’re doing.</td>
</tr>
<tr>
<td><strong>Equal</strong> - You make decisions together and hold each other to the same standard.</td>
<td><strong>Trying to take control</strong> - One or both partners feel their desires and choices are more important.</td>
<td><strong>Controls the other</strong> - There is no equality in the relationship. What one partner says goes.</td>
</tr>
<tr>
<td><strong>Enjoying personal time</strong> - You both enjoy spending time apart and respect when one of you needs time apart.</td>
<td><strong>Feeling crowded or not spending time with others</strong> - Only spending time with your partner.</td>
<td><strong>Isolates the other partner</strong> - One partner controls where the other one goes, and who the other partner sees and talks to.</td>
</tr>
<tr>
<td><strong>Making mutual sexual choices.</strong> You talk openly about sexual choices together. You both consent to sexual activity and can talk about what is ok and what isn’t. You discuss using condoms or other birth control methods.</td>
<td><strong>Pressured by the other into sexual activity</strong> - One partner tries to convince the other that they should have sex, or more sex.</td>
<td><strong>Forces sexual activity</strong> - One partner forces the other to have sex.</td>
</tr>
</tbody>
</table>

Adapted with Permission from CORA (Community Overcoming Relationship Abuse). [http://www.teenrelationships.org](http://www.teenrelationships.org); 24 hour hotline 800.300.1080
Love Shouldn’t Hurt

Dating and being in a romantic relationship can be fun and exciting. Unfortunately, too many teens are hurt by the people they date. Dating or relationship violence is a pattern of violence someone uses against their boyfriend, girlfriend, or date and it includes emotional, verbal, physical, and sexual abuse.

Quiz: Are you In an Abusive Relationship?

1. Are you afraid of your partner or afraid of what your partner will do if you end your relationship?
2. Does your partner call you names, make you feel stupid, or tell you that you can’t do anything right?
3. Is your partner extremely jealous?
4. Does your partner try to limit where you go or who you talk to?
5. Do you feel cut off from your friends or family because of your partner?
6. Do you feel threatened by your partner if you say no to touching or sex?
7. Has your partner ever blamed you for his/her violent actions?
8. Has your partner ever shoved, hit, kicked, held you down, or physically hurt you on purpose?
9. Is your partner really nice sometimes and really mean other times as if she/he has 2 different personalities?
10. Does your partner make frequent promises to change and never hurt you again?

If you answered “YES” to any of the above questions, your partner is being abusive towards you. It is very important for you to be safe and reach out for help.

Safety Tips:

☞ Do not meet or hang out with the abusive person by yourself. Go to a public place or a location where your family or friends are nearby.
☞ Avoid being alone at school, at work, or on the way to and from places.
☞ Always tell someone you trust where you are going and when you will be back.
☞ Make sure you can get home or get to a safe place on your own. Bring your own car, money for the bus or taxi, or go to a public place and call friends/family for a ride.
☞ Memorize the addresses and phone numbers of people you trust. Go to these people for help if your date or partner becomes violent or abusive. Call 911 if you are in an emergency situation.

Where to Go for Help:

☞ Educate yourself about dating/relationship violence. Search for information on the internet or at your local public library.
☞ Talk with your parent, family member, teacher, counselor, doctor/nurse, clergy member, or other trusted adult. The less isolated you are, the less opportunity the abusive person has to hurt you.
☞ Seek help from professionals. Go to places such as school health centers or counseling offices, clinics, youth or faith-based organizations, community centers and/or call a hotline.

Resources:

◆ National Teen Dating Abuse Helpline: 1-866-331-9474
◆ Rape Abuse Incest National Network: 1-800-656-HOPE
◆ Love is Not Abuse: www.loveisnotabuse.com

You Deserve healthy relationships!

Source:
Wetter Makes It Better

Did You Know???

- Lube can make condom use more pleasurable for both sexual partners
- Lube can decrease pain and discomfort from dryness and friction during sex
- Lube can prevent condoms from breaking
- Lube can be put on the inside of a condom before rolling it down the penis, and on the outside of a condom before having sex

Got Lube?

Vaginal Lubrication:
- The vagina gets wet or lubricated when sexually stimulated
- If the vagina does not get wet enough before a finger, penis, or sex toy is inserted, it can be painful or irritating
- Lube can be put on the opening of the vagina and on the outside of a finger, penis, or sex toy before inserting into the vagina to increase pleasure during sex
- Sometimes you need to reapply lube

Anal Lubrication:
- The anus does NOT get wet or lubricated when sexually stimulated
- Lube should **always** be applied to the opening of the anus and on the finger, penis, or sex toy that is inserted into the anus to increase pleasure and decrease pain, friction, and tearing of the anus
- Sometimes you need to reapply lube

What Type of Lube Should I Use?

- **Always use water-based lubricants with pre-lubricated latex condoms.** Common types of water-based lubes include Astroglide and K-Y Jelly
- **If you or your partner are irritated by a lubricant, stop using it and try one that does not contain parabens or glycerin. Check the labels!**
- **If you or your partner are irritated by latex condoms, try using polyurethane condoms instead**
- **Do NOT use oil-based lubricants (baby oil, lotion, olive oil, or Vaseline) with latex condoms.** Oil-based lubricants can cause condoms to break

Forgot To Pick Up The Lube?

Use plenty of saliva (spit)! It’s free and always available!
Be Safe With Sex Toys

☐ **Keep them Clean.** Toys are made from all different types of materials. They can be really hard to clean or really easy to clean. Follow the directions on the labels for cleaning and storing. Dry your toys well after you clean them.

☐ **Know the Difference Between sex toy materials:**

- **100% silicone** - Can be washed with antibacterial soap or in a dishwasher.
- **Glass** - Can be washed in mild liquid soap and warm water.
- **Elastomer and Vinyl** - Bacteria remain after it’s washed in mild liquid soap and warm water.
- **Jelly Rubber and Polyvinyl Chlorides (PVC)** - Bacteria remain after it’s washed in mild liquid soap and warm water.

☐ **Always use a condom when using sex toys with a partner and when they are hard to clean.**

☐ **Remember to put on a new condom when you are:**
  - Done using a toy and want to share it with a partner
  - Going from one hole to another (especially from anus to vagina)

☐ **Read labels.** Avoid toys that have substances like “phthalates.” Look for phthalate-free toys. They are safer for your health.

☐ **Only use toys that are flared at the bottom for anal sex.** This way, it won’t get stuck.

---

**What if you don’t have time or money to buy sex toys?**

Cucumbers, carrots, and bananas (with the peel) make great dildos. Just remember to use a condom!
Sex, Technology & You

So, You Met Someone Online...

Some questions to ask yourself are:

1. Does their story stay the same about their age and background?
2. If sex is brought up, are they respectful about it?
3. Are they ok when you say you don’t want to give out personal information? Are they ok when you say you don’t want to meet face to face?

If **YES**, these are some of the signs of a healthy relationship - online.

If **NO**, then you may want to consider meeting other new people.

---

**DID YOU KNOW... sending a naked picture can be illegal?**

This includes pictures you post online and text messages. You can get in trouble with the law for sending or receiving a sexual text message. You may send your picture to someone you trust. But some pictures are forwarded during a break up or an argument. Think about where your picture might end up before you press SEND.

---

**Tips for Keeping Your Information Private**

- Make sure your messages are private. Add this at the end of your e-mail: “This email message and any files transmitted with it are private and intended only for the individual to whom they are addressed.”
- Prevent IM forwarding. Set your chats to “off the record.” This means no record of your conversation will be saved. Keep in mind that a text can still be copied and pasted.
- If you want to make sure that your text is private, send anonymous messages through services such as www.anontxt.com.
- Use a screen name different from your real name when in chat rooms.
- Check out the privacy settings for your social networking site. You can control who can see your profile. Also, never post your phone number or address so it can be seen publicly.
Am I Normal? A Tour of The Female Genitals

**KEY TERMS**

- **Pubic Hair** - hair that surrounds the sex organs for protection.
- **Labia Majora** - also called the outer lip. Pubic hair grows here.
- **Labia Minora** - also called the inner lip. It may vary in texture, size, and color. It covers the urethra and vaginal opening.
- **Clitoris** - the pleasure center of the vulva. It is a tissue that fills with blood and becomes erect when sexually aroused.
- **Urethra** - a tube that carries your urine, or pee, to your urethral opening. It is a tiny hole under the clitoris.
- **Hymen** - the thin layer of tissue that covers the vaginal opening. The hymen can break at any time in many different ways.
- **Vaginal Opening** - the passage from the uterus to the outside of the body. Contains the pleasure center called the g-spot.
- **Anus** - the opening of the rectum where waste leaves the body.

**Fact Check: Female Genitals**

- Female genitals come in different sizes, colors, and shapes.
- The vagina releases discharge to keep itself clean and healthy. Everyone has a natural smell that is different.
- Some families decide to circumcise (remove parts of the female sex organs). Some people think this is OK for cultural reasons. Others think it’s violent and should be stopped. This practice can cause problems with sex, hygiene, and childbirth.

**How to Keep your genitals healthy:**

- Wear cotton underwear and change them every day.
- Wipe from front to back.
- Wash with warm water and mild soap.
- Avoid douching.
- Try to learn what your genitals look like. If you notice anything that’s not normal (lumps, bumps, changes in discharge) let your healthcare provider know.

**Resources**

Am I Normal? A Tour of Male Genitals

KEY TERMS
- **Pubic Hair** - hair that surrounds the sex organs.
- **Penis** - the male sex organ that is made up of the glans and the shaft.
- **Shaft** - the long part of the penis below the glans. It grows longer when sexually aroused.
- **Glans** - the tip or head of the penis. At the tip of the glans is the urethral opening. The urethral opening is a small opening that releases urine, semen, and pre-ejaculate fluid.
- **Testicles** - reproductive glands that make sperm and testosterone. They are covered by a loose skin called the scrotum.

Fact Check: The Male Genitals
- Male genitals come in different sizes, colors and shapes.
- Penises can change a lot in size. They can go from flaccid (soft) to erect (hard).
- Some penises are circumcised. Circumcision is when the foreskin or loose skin that covers the glans of the penis is cut. Parents often decide whether or not to circumcise their boys.

How to Keep Your genitals Healthy:
- Wear clothes that fit loosely. This prevents Jock Itch, irritation or chapping in the genital area.
- If you play sports, wear an athletic supporter to protect your sex organs.
- Wear cotton underwear and change them every day.
- Wash with warm water and mild soap.
- If you are uncircumcised, gently pull back the skin on the head of your penis. Wash that area with soap and water.
- Try and learn what your genitals looks like. If you notice anything that’s not normal (lumps, bumps, changes in discharge) let your healthcare provider know.

Diagram reproduced with permission from www.Avert.org
What to Expect at Your First Women’s Health Exam....

As you get older, your provider may tell you that you need a gynecological or pelvic exam. This means that he or she will take a closer look at your reproductive system. You may need this exam if you...

- are sexually active and have symptoms of an infection
- have any changes or questions about your sexual health
- have never had a gynecological exam and are 21 years of age or older
- you are pregnant
- don’t start your period or stop having your period

Your provider will ask questions about your period. He or she will also ask about sex, pregnancy and STIs. It’s important to answer these questions truthfully. The provider will not tell anyone what you tell him or her unless he thinks that someone has hurt or abused you.

You will undress and cover up. You will probably be left alone in the room to undress and cover up with a sheet or a gown.

You will lie on the exam table and will be asked to scoot to the edge of the table and open your legs. Usually you will be asked to put your feet in foot rests that will help keep your legs apart while the exam is done. If you have mobility problems, use a wheelchair, or have tight legs, your provider will work with you to find a comfortable position. There are usually three parts of the exam:

- **External Exam** — The provider looks at the outside of your vulva for bumps or other problems.
- **Speculum Exam** — A tool called a speculum is inserted into your vagina. The speculum is used to look at your vagina and cervix. The cervix is the opening to your uterus. Samples of vaginal or cervical discharge will be taken with a large Q-tip. These samples are used to check for vaginal infections, STIs and cancer.
- **Bimanual Exam** — Your provider will put one or two gloved fingers inside your vagina. He or she will then press with the other hand on the outside of your lower belly. This is to check the size and position of your cervix, uterus and ovaries. Sometimes the provider will also perform a rectal exam and insert a finger in your anus. This is to check for tumors, and is not usually done on teens.

The provider will let you ask any questions and then leave the room so you can change. If the results of the test are normal you won’t hear anything. If the results of the tests are not normal, someone from your provider’s office will contact you within a week.

Some Tips

- Come prepared to this visit by knowing the dates of your very first period and your last menstrual period.
- Do not come when you are on your period unless you are having a discharge, burning when you pee, abdominal pains or irregular bleeding.
- It is your right to ask for a different provider if you do not feel comfortable with the one you have, or ask for a female to be in the room if you have a male provider.
- It is almost always ok to bring someone into the exam room with you, like a relative or a friend.
- The exam might be uncomfortable but shouldn’t hurt. The best way to deal with this discomfort is to take some slow deep breaths. Breathe in through your nose and blow out through your mouth. If you feel any pain during the exam, tell your provider.
- If you want, ask for a mirror during the exam so you can see what’s happening.
- Be familiar with your body so you know when anything changes.
- Ask questions! This is an especially great opportunity to ask about your body, sex, STIs and birth control.
- If you don’t want to be contacted at your home with your test results, make sure you speak up about this!
- You can call your provider to find out the results of your tests.
What to Expect at Your First Men’s Health Exam....

To make sure that you are healthy, your healthcare provider will check your genitals. This can seem uncomfortable or embarrassing, but exams are important for your health. A provider needs to check your anatomy to make sure you are developing normally. If you are sexually active they will check for sexually transmitted diseases. They may also check your testicles for signs of testicular cancer, which is rare but can effect young men.

1. Your health care provider will ask you some questions about your body. He or she will ask if you have noticed any changes, and if you are sexually active. It is important to tell the truth when you answer the questions. The provider will not tell anyone what you tell him or her unless he thinks that someone has hurt or abused you.

2. You will be asked to undress and put on a gown. You will probably be left alone in the room to change your clothes.

3. Your provider will start by looking at your genital hair. He or she will then gently touch your testicles, penis and the surrounding areas. He or she is looking for anything that looks or feels unusual. Your provider may also teach you how to give yourself a testicular exam.

4. You may be asked to “turn your head and cough.” This is to check for hernias.

5. Your provider might perform a rectal exam. This is done by inserting a gloved finger in your anus. This is not usually performed on teens.

6. Your provider may test for sexually transmitted infections. He or she will test you if you are sexually active or if you have STI symptoms. You can also ask for STI tests. This may be done by asking you to pee in a cup. Sometimes this is done by inserting a Q-tip into the small hole at the tip of your penis, the urethra and in the anus if you have anal sex. If you are worried about the Q-tip exam, ask if they offer a urine test when you schedule the appointment.

7. Your provider will usually leave the room so you can change. Ask your provider any questions about the exam and your health.

Some Tips...
- It is your right to ask for a different health care provider if you do not feel comfortable with the one you have.
- It is almost always ok to bring someone, like a relative or a friend, into the exam room with you.
- The exam might be uncomfortable but it shouldn’t hurt. If you feel any pain during the exam, tell your provider.
- Be familiar with your body so you know when anything changes.
- Ask questions! This is a great opportunity to ask about your body, sex, STIs and birth control.
- If you don’t want to be contacted at your home with your test results, make sure you speak up about this!
- You can call your provider to find out the results of your tests.

Other Resources/Links:
- Sexual Health Exams
  http://www.youthresource.com/health/features/what_to_expect.htm
  http://www.youngmenshealthsite.org
- Self-Testicular Exams
  http://www.usrf.org/video_tomgreen/tcexam.html
### Your Safer Sex Options:
**Preventing Pregnancy & Protecting Against STIs**

<table>
<thead>
<tr>
<th>METHOD</th>
<th>HOW IT WORKS</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Condom</td>
<td>Piece of plastic/rubber covers penis and stops cum from entering vagina or anus.</td>
<td>Protects against STIs (latex are the best) and pregnancy. Don’t need a prescription.</td>
<td>You have to be prepared. A new one is needed after every act of sexual intercourse.</td>
</tr>
<tr>
<td>Female Condom</td>
<td>Piece of plastic shaped like a sock that goes in the vagina or anus and stops cum from entering.</td>
<td>Provides protection against STIs and pregnancy. Can be use by people with latex allergies. Don’t need a prescription.</td>
<td>Condom can be noisy or feel uncomfortable.</td>
</tr>
<tr>
<td>Cervical Cap</td>
<td>Rubber cup that covers the opening to the womb or uterus and blocks sperm.</td>
<td>Can put it in several hours before sexual intercourse.</td>
<td>No protection against STI and has to be fit by a health care provider. It can cost a lot without insurance.</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>Dome shaped rubber cup that covers the cervix and blocks sperm.</td>
<td>Don’t have to take it out between acts of sexual intercourse. Works for about 6 hours, but need to reapply spermicide.</td>
<td>No protection against STIs and can be messy or awkward to use.</td>
</tr>
<tr>
<td>Spermicides</td>
<td>Gel that is put in vagina before intercourse and kills the sperm.</td>
<td>Don’t need a prescription.</td>
<td>It’s messy. Not the best protection against STIs.</td>
</tr>
<tr>
<td>Injection (Depo-Provera)</td>
<td>A hormone shot taken every 3 months</td>
<td>Can’t see it. You don’t have to worry about birth control for 3 months once you get the shot. Can stop periods.</td>
<td>No STI protection and need to go to see a provider every 3 months for next shot. Can stop periods.</td>
</tr>
<tr>
<td>Oral Contraceptives</td>
<td>Hormone pills taken everyday that stops release of egg from ovary</td>
<td>24/7 protection. Can make periods lighter and more regular</td>
<td>Need to remember or remind your partner to take the pill everyday. No STI protection.</td>
</tr>
</tbody>
</table>

⇒ Depo-provera (the hormonal injection) and the IUD are the most effective types of birth control.
⇒ It is best to use condoms and another method that protects against pregnancy (birth control pills, IUD, depo-provera, etc.).
⇒ Condoms come in many shapes, sizes, colors, flavors and varieties. Try a different shapes or styles if a condom feels uncomfortable. Check out condomania.com for different options.
⇒ New birth control products come out all the time. To learn about new methods, ask your health care provider.
### Your Safer Sex Options cont.

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<tbody>
<tr>
<td>Vaginal Ring (Nuva Ring) 99% effective</td>
<td>Plastic ring that’s put inside the vagina and left in for three weeks. A new ring is reinserted 1 week later.</td>
<td>Can’t see it. You only have to insert and remove it once a month.</td>
<td>No protection against STIs. Have to feel comfortable putting in and taking out the ring or help your partner put it in and take it out.</td>
</tr>
<tr>
<td>Birth Control Patch (Ortho Evra) 99% effective</td>
<td>A patch that is worn on the skin in a certain area that must be changed every week.</td>
<td>Does not require taking a pill. Can be hidden by clothing.</td>
<td>No protection against STIs. Must change it every week. Can cause side effects like breast tenderness and nausea.</td>
</tr>
<tr>
<td>Hormonal Implant (Implanon) 99% effective</td>
<td>A small tube with hormones is inserted in the women’s upper arm.</td>
<td>Barely visible and works for 3 years.</td>
<td>No protection against STIs. Can cause irregular periods.</td>
</tr>
<tr>
<td>Emergency Contraception 75-88% effective</td>
<td>Hormone pills taken 3-5 days after unprotected sex. Stops ovulation or prevents egg from being fertilized.</td>
<td>Can be taken after intercourse.</td>
<td>Not a regular form of birth control. Does not protect against STIs.</td>
</tr>
<tr>
<td>Intra-Uterine Device (IUD) 97-99% effective</td>
<td>A plastic device is put in the woman’s uterus.</td>
<td>Hormonal IUD is good for 5 years. The copper IUD is good for 10 years.</td>
<td>No protection against STIs. Risk of serious infection shortly after insertion. Can make your periods irregular.</td>
</tr>
<tr>
<td>Withdrawal 81-96% effective</td>
<td>During intercourse, the man pulls his penis out of the vagina or anus before he cums.</td>
<td>Is natural and no supplies are needed.</td>
<td>Pulling out in time can be difficult to predict. Pre-ejaculation fluids can transfer HIV and other STIs.</td>
</tr>
<tr>
<td>Abstinence 100% effective</td>
<td>A couple does not have sex.</td>
<td>Only definite way to prevent pregnancy and STIs.</td>
<td>Requires motivation, self-control and communication from both partners. Only works if it is used 100% of the time.</td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION ON ANY OF THESE METHODS, CHECK OUT THESE WEBSITES:

- **Young Women’s Health:**
  - [http://www.youngwomenshealth.org/contra.html](http://www.youngwomenshealth.org/contra.html)
- **Teen Talk:**
### A Teen’s Guide to Sexually Transmitted Diseases and Other Infections

<table>
<thead>
<tr>
<th>Infection</th>
<th>What are the symptoms?</th>
<th>How is it spread?</th>
<th>Is it Curable?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chlamydia</strong> Bacterial</td>
<td>Most often there are NO SYMPTOMS. Yellowish discharge, burning with urination, bleeding between periods, swollen or tender testicles.</td>
<td>Through unprotected vaginal, oral, or anal sex.</td>
<td>Yes, but it must be treated to prevent Pelvic Inflammatory Disease (PID), or damage to the reproductive organs.</td>
</tr>
<tr>
<td><strong>Gonorrhea</strong> Bacterial</td>
<td>Most often there are NO SYMPTOMS in women. Yellowish discharge, burning with urination, stomach pain.</td>
<td>Through unprotected vaginal, oral, or anal sex.</td>
<td>Yes, but it must be treated to prevent other problems, like PID, or damage to the reproductive organs.</td>
</tr>
<tr>
<td><strong>Genital Herpes</strong> Viral</td>
<td>Blister-like sores in the genital region or mouth.</td>
<td>By touching an infected area (which may not be noticeable), or having unprotected vaginal, oral, or anal sex.</td>
<td>No. Herpes is treatable, but does not go away. People with herpes can be contagious even if they are not having an outbreak.</td>
</tr>
<tr>
<td><strong>Human Papillomavirus</strong> (HPV or Genital Warts) Viral</td>
<td>One type of HPV causes genital warts. Another type can cause cervical and anal cancer.</td>
<td>By touching or rubbing an infected area (which may not be noticeable), or having unprotected vaginal, oral, or anal sex.</td>
<td>No. HPV is treatable but does not go away. The most common types of HPV can be prevented by a vaccination of three doses. Make sure you’re up to date!</td>
</tr>
<tr>
<td><strong>Pubic Lice (Crabs)</strong> Parasite</td>
<td>Severe itching, small red bumps.</td>
<td>Through any direct physical contact and rarely through indirect contact such as a shared object.</td>
<td>Yes. Clothes and bedding must also be cleaned to get rid of the bugs.</td>
</tr>
<tr>
<td><strong>Trichomoniasis</strong> Parasite</td>
<td>Most often there are NO SYMPTOMS in men. Itching, irritation, redness, discharge, bad smell, frequent and/or painful urination, discomfort during intercourse, stomach pain.</td>
<td>Through unprotected vaginal sex.</td>
<td>Yes.</td>
</tr>
<tr>
<td><strong>Syphilis</strong> Bacterial</td>
<td>First stage: painless open sore on the penis, vagina, or mouth. Second stage: rash, fever, swollen lymph glands, sore throat, muscle aches. Final stage: damaged internal organs and central nervous system.</td>
<td>Through unprotected vaginal, oral, or anal sex, and also through kissing if there is a lesion on the mouth.</td>
<td>Yes.</td>
</tr>
</tbody>
</table>
## A Teen’s Guide to Sexually Transmitted Diseases and Other Infections cont.

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>Poor appetite, nausea/vomiting, headaches, fever, jaundice (yellow skin), dark urine, light-colored bowel movements. Sometimes there are no symptoms.</td>
<td>Through oral contact with feces. Through unprotected anal/oral sex, drinking contaminated water or eating contaminated food.</td>
<td>Does not cause a long-term infection, but symptoms can last 6-9 months. Once you have had Hepatitis A you cannot get it again. It can be prevented by two doses of a Hepatitis A vaccine.</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Poor appetite, nausea/vomiting, headaches, fever, jaundice (yellow skin), dark urine, light-colored bowel movements. Sometimes there are no symptoms.</td>
<td>Through unprotected vaginal, oral, and anal sex and through sharing dirty needles. It is spread by blood, semen, vaginal secretions and breast milk.</td>
<td>No highly successful treatment, but can be prevented by a Hepatitis B vaccination of three doses. Make sure you’re up to date!</td>
</tr>
<tr>
<td><strong>HIV/AIDS</strong></td>
<td>Weight loss, fatigue, night sweats/fever, dry cough, diarrhea, swollen glands, memory loss/confusion, depression. Sometimes there are no symptoms.</td>
<td>Through unprotected vaginal, oral, and anal sex, and dirty needles. Can also pass from mother to child during pregnancy or child birth, or breast-feeding.</td>
<td>No. Although there are many treatments which have greatly improved the health and survival of people with HIV. No proven vaccine at the current time.</td>
</tr>
<tr>
<td><strong>Bacterial Vaginosis (BV)</strong></td>
<td>Fishy or unpleasant vaginal odor, milky-white or gray vaginal discharge, vaginal itching and burning. Sometimes there are no symptoms.</td>
<td>The cause of BV is not completely understood. Having multiple sex partners and douching increases your risk.</td>
<td>Yes, but it must be treated to prevent increased risk of other pelvic illnesses or chance of having problems with a pregnancy.</td>
</tr>
<tr>
<td><strong>Vaginal Yeast Infection</strong></td>
<td>Thick curd-like vaginal discharge (like cottage cheese), vaginal itching and burning, redness and irritation.</td>
<td>Through an imbalance of the healthy organisms in the vagina. May occur while on antibiotics.</td>
<td>Yes.</td>
</tr>
<tr>
<td><strong>Urinary Tract Infection (UTI)</strong></td>
<td>Burning or pain during urination, urge to urinate frequently or after you’ve just urinated, fever, lower abdominal or back pain.</td>
<td>Through bacteria coming in close contact to the vulva or urethra. It can also be caused by an STI.</td>
<td>Yes, it must be treated to prevent kidney infection.</td>
</tr>
</tbody>
</table>

Genital Warts and HPV-Related Cancer

What is HPV?

- Human Papillomavirus (HPV) is a common virus that infects men and women. It is passed through sexual contact.
- The body usually fights off HPV before it causes any health problems.
- There are two types of the virus: wart-causing HPV and cancer-causing HPV. You can get one or both.
- Cancer-causing HPV can cause cervical cancer in women and anal cancer in both men and women.
- Warts caused by HPV may look like bumps of varying shapes and colors. The warts may disappear or return.

I might have HPV. What now?

- If you have what look like genital warts, get checked by your provider. If you have warts, your provider can recommend treatments to remove them from your genital area. DO NOT TRY TO REMOVE THEM BY YOURSELF!
- If you have one type of HPV you can still get other types. Keep using condoms to lower your chance of getting other types of HPV.
- Many people who have HPV want to know who gave it to them. There is no way to know for sure unless a person has had only 1 sexual partner.

At least 50% of sexually active men and women will be infected with HPV.

How Can I Prevent HPV and its effects?

- There are vaccines that can prevent some of the common types of HPV. They are approved for both men and women. Ask your provider about it.
- Using condoms and other latex barriers every time you have sex helps lower chances of HPV exposure.
- Women over 21 should get regular pap tests to check for cervical cancer. If you’re 21 talk to your provider about getting a pap test.
- If you have HPV, smoking can increase your risk of developing cervical cancer.

HPV can be prevented by getting vaccinated.

Using condoms helps prevent HPV but not 100%.

Ask your Provider for more information on how you can prevent or treat HPV.
What You Need To Know About Condoms...

How to Put on a Condom

1. Before having sex...
   - Discuss using condoms with your partner
   - Buy latex or polyurethane condom
   - Check the expiration date. Do not use an expired condom!
   - Open condom package carefully. Don’t use your teeth.

2. When the penis is erect...
   - Squeeze the air out of the tip of the condom and place rolled condom on the tip of the penis or dildo. If you use lube, add a couple drops of water-based lube inside the tip of the condom.
   - Leave a half inch space at the tip of the condom to collect semen.
   - Hold the tip of the condom and unroll it until the penis or dildo is completely covered.
   - Smooth out the air bubbles and put more lube on the outside of the condom after putting it on.

3. After Ejaculation and when the penis is still erect...
   - Hold the condom at the base of the penis.
   - Carefully remove the condom without spilling any semen.
   - Wrap up the condom in tissue and throw it away. (Don’t flush condoms down the toilet - the toilet might clog.)
   - Use a new condom every 20 minutes or for every act of vaginal, oral, and anal intercourse from start to finish.

Condom Talk

Talking about condoms can be a lot harder than learning how to use a condom. Here are some tips on how to bring up condoms with your partner:

- Don’t be shy. Be direct about your feelings. There’s no reason to be embarrassed!
- Don’t wait until the heat of the moment to bring it up. Talk about condom use before you are in a situation where you might need one.
- Don’t be afraid of rejection. If a partner doesn’t care enough about you to use a condom and protect your health, then she or he probably isn’t worth your time. As 18-year-old Ari says, “If your partner turns condom use into a trust issue instead of a health issue, why would you want to have sex with that person anyway?”
- Be positive! Many people find sex more enjoyable when they’re protected because they don’t have to worry about pregnancy and infections.
- Talking about condom use is easier if you are in a healthy relationship that makes you feel good about yourself. And it gets easier with time, as well. But no matter what, it’s very important to communicate with partners about condoms. It’s all about protecting your health!

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FOR YOUTH

What You Need To Know About Female AKA Insertive Condoms...

How to use a Female Condom

Before having sex...
- Talk to your partner about using a condom.
- Buy a female condom.
- Check the expiration date. Do not use an expired one!
- Carefully tear at the top right of the package. Never use scissors or your teeth.

When you are wet...
- Get into a comfortable position: sit, squat, lie down or raise one leg.
- Add extra lubrication inside condom so it will stay in place during sex.
- Grab the inner floating ring and squeeze it with the thumb and pointer finger.
- Take one hand and spread out the lips of your vagina.
- Put the pointer finger of your other hand in the condom push the inner ring in your vagina as far as it will go. You can also use a sex toy to insert the condom.
- Make sure the condom is not twisted. The outer ring should be sticking outside of the vagina.
- Hold onto the outer ring while having sex to make sure the condom doesn’t get pushed into the vagina.

After sex while you are lying down
- Twist the outer ring and carefully pull it out.
- Put it in the wrapper and throw away, but don’t flush — toilet will get clogged.
- Use a new condom for every act of vaginal and anal intercourse.

A Word about the Female Condom...
- Is also called the “insertive condom” because it is used internally.
- Can be used in the anus. The ring can be taken out or left in for prostate stimulation.
- Can be used by people with latex allergies because it is made out of polyurethane.
- During vaginal sex, the outside ring rubs against the clitoris. This can make having an orgasm easier.
Do I Need a Period Every Month?

Sometimes, your period can come at the worst times, like before a sporting event, party, or night out with your boyfriend/girlfriend. For years, women have used birth control pills to stop their periods for important events and vacations.

Most forms of hormonal birth control (the pill, patch or ring) can be used to stop a women’s period, but it is VERY IMPORTANT that you talk with your healthcare provider before making any changes in the way you use your birth control. There are even brands of birth control pills packaged to take for 3 months or even a year without having a period. For more information about stopping your periods, talk to your health care provider.

Do I have to bleed every month?

There is no evidence that shows women need to bleed monthly. Studies have found that using the pill for two or more cycles in a row without taking the sugar pills is safe and effective. It prevents pregnancy just as well as taking the pill in the usual way.

What are the Benefits of Skipping your Period?

- Less pain with monthly bleeding
- Less heavy bleeding
- Fewer PMS symptoms
- Reduced menstrual migraines and acne
- An increased feeling of well-being

What are the side effects or Disadvantages of skipping your period?

Some women have breakthrough bleeding or spotting in the first few months. This is less common once your body has gotten used to the new routine. Blood from spotting may be dark brown from being in the uterus longer.

Just like when you take pills in the usual way, you should contact a health care provider if you experience ACHEs—Abdominal pain, Chest pain, Heavy bleeding, Eyesight or vision changes, or Severe leg pain.

Adapted with permission from ARHP Health Matters Fact Sheet: Understanding Menstrual Suppression
I'M PREGNANT, WHAT SHOULD I DO?

Choosing what to do when you are pregnant is difficult and none of the options is the “easy” or “right” choice. Each choice comes with its own set of challenges. Consider all your options and how each one will fit with your life and beliefs. When possible, talk this over with your parent(s) or another trusted adult. Your health care provider can also assist you in learning about and discussing your options.

WHAT ARE YOUR CHOICES?

1. Parenting

Being a parent is a hard job for anyone. It can be even harder if you are a young parent. It is a 24-7 responsibility for at least 18 years. These questions may help you think about whether or not you want to be a parent at this time in your life:

- Where will you live?
- What will you do about money? How will you support yourself and your child?
- What will you do about school?
- Who will provide childcare while you are at work or school?
- What do you want out of life for yourself? What do you think is important?
- What are your goals and how will you meet them? (a college degree, a job, a family?)
- How will having a baby change your social life?
- How will the baby’s father be involved in your pregnancy and parenting?

2. Abortion

If you are not ready to be a parent or go through a pregnancy, abortion might be something to consider. An abortion is a medical procedure that ends a pregnancy. Your health care provider can tell you the names of providers and clinics that are covered by your insurance plan. You can also call Planned Parenthood to discuss this option further or visit their website (see the resources box above).

If you have had an abortion, you may consider calling Exhale, a counseling service for women who have experienced abortions, at 1-866-4-EXHALE. Visit their website at www.4exhale.org.

3. Adoption

Adoption is another choice if you do not want an abortion but are not ready to become a parent. There are a lot of different types of adoption. In an open adoption, you know who the adoptive parents are. In a closed adoption, you do not know who they are. For more information about adoption, call the National Council for Adoption hotline, 1-866-21-ADOPT. Also check out http://www.childwelfare.gov/adoPTION/ for more information and resources.
FOR PARENTS

How to Talk with Your Children and Teens about Healthy Relationships

◆ Talk to your children and teens about friendship, dating, and love before they start to ask questions about these important issues.

◆ Listen to your children and teens and try to understand their point of view.

◆ If you can’t answer a question, help your children talk to other trusted adults.

◆ Use daily experiences like watching TV, to talk with your children and teens. It is a chance to share your values and messages with them.

◆ Find out what schools are teaching your children and teens about these topics.

◆ Stay active in the lives of your children and teens and help them plan for the future.

Keep these talks going! When you talk about relationships with your teen, you can hear about what is going on in your teen’s life. You can also teach your teen about your family’s values and beliefs.

Adapted from SEICUS. Families Are Talking; Volume 3, Number 1, 2004.
Should I Worry About My Teen?

The Facts about Teen Dating Violence:

Teen dating violence is when a teen:

- Hits, punches, slaps, or kicks their partner.
- Forces or pressures their partner to have sex.
- Teases, controls, or intimidates their partner.
- Isolates their partner from friends and family.
- Stops their partner from doing normal activities.

Warning signs for Teen Dating Violence

Know the warning signs of when a teen is being abused or is abusing others. Ask yourself the following questions:

Has your teen or your teen’s dating partner...

- Lost interest in activities that used to be enjoyable?
- Stopped hanging out, talking on the phone, or staying in contact with friends?
- Acted extremely jealous?
- Violently lost their temper and hit or broke objects?
- Tried to control their partner’s behavior?
- Check up constantly on their partner and demand to know who their partner is with?
- Had a sudden change in weight, appearance, or school performance?
- Had injuries that cannot be explained, or gave an explanation that did not make sense?

If you notice any of the above warning signs, talk with your teen about his/her relationship. Try and stay supportive and non-judgmental. Contact a domestic violence agency or call 1-800-799-SAFE for advice on the situation.

Did you know there are ways to prevent teen dating violence? Here are some of the things that help:

- Talk to your teen about their friends and relationships.
- Listen to your teen and be open to their experiences.
- Support your teen in pursuing their interests.
- Help your teen get involved in school and after school programs such as clubs and sports.
- Encourage your teen to join religious, spiritual, or community groups.
- Assist your teen with volunteering in the community.

Source:
Parent-Child Communication

Many parents freeze when they are faced with talking to their children about sex. Many teens prefer to talk to their parents rather than doctors about sex. It can feel awkward, but you can help your child make healthy choices. They need you, and if you are not talking to them, somebody else will. Think about what you want them to know.

Why should you talk to your child about sex?

- Teens who feel connected to their home and families wait to have sex.²
- Teens whose parents talk to them about condoms are more likely to use them.³
- Teens who said they talked to their parents about sex are more likely to use contraception.⁴
- Teens who have talks with their parents about sex are more likely to have talks with their partners about sex.⁵
- Teens whose parent talk to them about their sexual orientation have lower risk for STIs, including HIV.⁶

It’s not just what you say, but how you say it. Healthy communication means:

- Openness to all topics and ideas.
- Each party talks and also listens.
- Being warm and caring.
- Trying not to fight.

Tips for Talking with Your Teen

✔ Even if your teen does not want to talk, let them know there is an open door if and when they do.

✔ Many teens are afraid that they will disappoint their parents. Praise your teen’s healthy choices. This may lessen these fears.

✔ If your teen comes to talk to you about something, as scary as it may be, do not run away or simply tell them not to have sex. This may be perceived as uncaring or discomfort and can set the stage for how they think you will respond every time.

✔ Make the most of ‘learning moments’. Learning moments are when something you and your child see can be used as a chance to start a talk. For example:
  - When you and your child see a sex scene in a movie or on television, or when you see a sexual advertisement
  - When a young person or adult you both know gets pregnant.

²Resnick, MD et al. Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health, JAMA; 1997; 278:823-32.
**FOR PARENTS**

### Sex, Technology & Your Teen

<table>
<thead>
<tr>
<th>Technology</th>
<th>Sexual Use</th>
<th>Privacy Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E-mail</strong></td>
<td>Emails can have sexual content. This content can either be sexual language or attached sexual pictures.</td>
<td>Email and all attachments can be widely forwarded, or sent to others. Talk to your teen about this privacy risk.</td>
</tr>
<tr>
<td><strong>Instant Message (IM)</strong></td>
<td>IMs can have sexual content. This content can be sexual language.</td>
<td>To prevent forwarding IMs, your teen can set chats “off the record.” This means no record of the conversation will be saved. Text can still be copied and pasted.</td>
</tr>
<tr>
<td><strong>Text Message</strong></td>
<td>Text messages can have sexual content. This content can be sexual language or attached sexual pictures.</td>
<td>Your teen can send anonymous text messages through services such as <a href="http://www.anontxt.com">www.anontxt.com</a>. This will keep their identity private.</td>
</tr>
<tr>
<td><strong>Chat Rooms</strong></td>
<td>Chats can have sexual content. Users can also be invited to chat in a private room.</td>
<td>Remind your teen to keep his/her identity private by choosing a screen name. A screen name is an alias or name different from your real name.</td>
</tr>
<tr>
<td><strong>Social Networking Websites</strong></td>
<td>Social networking sites can be used to meet people for sexual relationships.</td>
<td>Your teen can control what profile information is viewed by the public. Talk to your teen about changing the privacy settings to limit viewers of their site. Remind your teen not to post phone numbers or home addresses publicly.</td>
</tr>
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**An Update on Text Messaging:**

Sexual text messaging (sending naked and partially naked pictures through texts) can be illegal in the US for minors. Some teens who have sent or received sexual text messages have been charged with child pornography. This can lead to expulsion from school, possible jail time or getting registered as a sex offender. Talk to your teen about the legal consequences of sexual text messaging.

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What Parents of Preteens/Adolescents Should Know About the HPV Vaccine

There are now vaccines that protect against some types of the human papillomavirus (HPV). HPV is the common virus that causes most cervical cancers and genital warts. The vaccine is a series of three shots.

- **The HPV vaccine is safe for males and females between the ages 9 to 26.** The HPV vaccine is usually given when girls are 11- or 12-years old. Currently, one of the vaccines is optional for boys.

- **It is best to get vaccinated before becoming sexually active.** This vaccine works best in girls/women who have not been exposed to HPV.

- **The vaccine works against certain types of HPV.** It is nearly 100% effective in girls/women who have not been infected with any of those types of HPV. It works by preventing precancers of the cervix, vulva, and vagina. It also prevents genital warts.

- **The vaccine is a series of three shots over a six-month period.** It is very important that she/he receive all three shots. It is not yet known how much protection she would get from receiving only one or two shots of the vaccine.

- **The vaccine causes no serious side effects.** The most common side effect is soreness where the shot was given.

- **The HPV vaccine costs about $120 per dose ($360 for the series).** You may be able to get it for free or at low-cost. Check with your health insurance plan or federal or state programs. The vaccine is free through the Vaccines for Children (VFC) program. You can also get more information about these programs at your provider’s office or the local health department.

Adapted with permission from What Parents of Preteens/Adolescents Should Know About the HPV Vaccine, CDC.
Supporting Your Pregnant and Parenting Teen

Finding out that your child is pregnant or made someone pregnant can cause you to feel a wide range of emotions. If your teen has made the decision to become a parent, the following tips raise considerations to help you and your family through the challenges that lie ahead.

- **It is normal to feel angry, disappointed and overwhelmed.** Just remember that your teenager needs you now more than ever. Being able to communicate with each other – especially when emotions are running high – is essential to the health of your teen.

- **Explore resources available to your son or daughter and your family.**

- **Stay involved with the pregnant teen’s medical treatment.** The earlier your teen gets prenatal care, the better her chances are for a healthy pregnancy.

- **When the baby is born, remember you are the grandparent to that child, not the parent.** This may be especially difficult if they live with you, but it is important to support your son or daughter in parenting the newborn.

- **Help financially if you are able to, but also remember that as a parent, you are not financially responsible for the child.** Encourage your son or daughter to find a part-time job and be as financially responsible for the child as possible. This is sometimes very difficult for a full-time student and parent, but in the long run it will be best for the new family.

- **Communicate with your other children early about sexuality, pregnancy and STIs.** Sisters of teenage parents are more likely to become pregnant at a young age.

- **Find someone outside the situation that you can talk to.** This is a difficult situation, and you will be a better parent and grandparent if you have your own support system for handling the issues involved.

### SUPPORTING YOUR TEEN DAUGHTER

- Keep in mind that this is the pregnant teen’s decision. Do your best to respect the decisions that she makes.
- Encourage the involvement of the baby’s father and his family.
- If your daughter decides to continue the pregnancy, encourage and help her to stay in school so that she can secure a better job and create a better life for herself and the baby. Go to the school and assist your daughter if there are school related issues. Explore school and community programs that offer special services for teen mothers, such as child care, rides, or tutoring.

### SUPPORTING YOUR TEEN SON

- Support him in taking responsibility for his actions, both financially and emotionally.
- Encourage your son to take interest in the pregnancy. Encourage your son to be available for appointments and read about pregnancy. Encourage him to also set aside time for the weeks leading up to the birth.
- Encourage your son to understand his legal rights and responsibilities surrounding fatherhood.
INTERNET RESOURCES: Click on This!

GENERAL SEXUAL HEALTH

Association of Reproductive Health Professionals (ARHP), www.arhp.org/
- Contains information on many sexual health topics. Also has a section on adolescent sexual health.

Go Ask Alice
www.goaskalice.columbia.edu
- Provides extensive information on sexual health and relationships.

Kaiser Family Foundation (KFF)
www.kff.org
- Contains general health information and also provides fact sheets and summaries on adolescent sexual health.

Physicians for Reproductive Choice and Health (PRCH)
www.prch.org
- Provides information on sexual health care for providers in the form of minor access cards, policy statements and fact sheets.

Planned Parenthood
- Provides healthcare, sex education and advocates for sexual and reproductive health. Teen-Talk is the youth-oriented version of the site.

Scarleteen
www.scarleteen.com
- Provides information about sexual health based on requests from youth.

Sex, Etc.
www.sexetc.org
- Provides informal information about sexual health online. They also have a large glossary on many different sex terms.

Sexuality Information and Education Council of the United States (SIECUS)
www.siecus.org
- Provides resources for providers and youth on adolescent sexuality, STIs and reproductive health. They focus on sexual and reproductive health research and policy analysis.

Young Women’s Health
www.youngwomenshealth.org
- Comprehensive website addressing female sexual and general health issues.

Young Men’s Health
www.youngmenshealthsite.org
- Comprehensive website addressing male sexual and general health issues.

HEALTHY RELATIONSHIPS

CDC, Healthy Relationship Website
http://www.cdc.gov/Features/ChooseRespect/
- Contains fact sheets and an article on aspects of a healthy relationship and identifying when intimate partner violence is taking place.

Choose Respect
www.chooserespect.org
- Contains articles on building a healthy relationship and understanding the difference between a healthy and unhealthy relationship.

Love is Respect
www.loveisrespect.org
- Contains interactive quizzes, an application that allows teens to make movies on healthy relationships and other resources on dating and violence.
INTERNET RESOURCES: Click on This!

TEEN DATING VIOLENCE

Teen Relationships
http://www.teenrelationships.org/
Provides informal resources on building a healthy relationship in the form of quizzes and forums that provide advice.

Break the Cycle: Empowering Youth to End Domestic Violence, www.breakthecycle.org
Provides domestic violence and dating violence facts as well as information on the warning signs of abuse.

Family Violence Prevention Fund
www.endabuse.org/programs/teens
Provides facts for teens and immigrant women on intimate partner violence, resource lists, and safety planning.

Love is Not Abuse, Liz Claiborne Inc.
www.loveisnotabuse.com
Contains informative handbooks, wallet cards, links to online resources and quizzes on teen dating violence.

National Youth Violence Prevention Resource
www.safeyouth.org
This sector of the CDC provides fact sheets and information on violence in English and Spanish.

SEXUAL ABUSE

Rape Abuse and Incest National Network
www.rainn.org
Provides information about sexual assault and abuse. Find information here on domestic violence, abuse, prevention, how to seek counseling, legal rights, and state and local sexual assault organizations.

Good Vibes
www.goodvibes.com
Toy distributor that offers educational information about sex toys and lubricant ranging from cleaning recommendations to how toys can best be used for pleasure.

SEXUAL PLEASURE AND FUNCTION

Sexuality and U: What Is Sex?
www.sexualityandu.ca/teens/what-5.aspx
This site outlines different aspects of sexuality and sexual function.

CIRCUMCISION

Guttmacher Institute
www.guttmacher.org
Contains research articles on female circumcision and male circumcision.

Kids Health
www.kidshealth.org/parent/system/surgical/circumcision.html
Provides information on the pros and cons of male circumcision. They also provide information on caring for circumcised and uncircumcised penises.

PREGNANCY PREVENTION

The National Campaign to Prevent Teen and Unplanned Pregnancy
www.thenationalcampaign.org/
The National Campaign provides resources on potentially negative adolescent sexuality outcomes in the form of reports and resources. They have an entire section of their website in Spanish.

Stay Teen
www.stayteen.org
Sponsored by the National Campaign to Prevent Teen Pregnancy and offers informal information on building self-confidence, questions to ask yourself when falling in love and sexual decision-making.

The Emergency Contraception Website
www.not-2-late.com
Information about Emergency Contraception and where to obtain it.

= Resource for Providers  = Resource for Youth  = Resource for Parents
INTERNET RESOURCES: Click on This!

PREGNANCY OPTIONS
- **Backline**
  www.yourbackline.org/
  - This site provides information for pregnant women who need support making a decision to either abort or continue the pregnancy. Contains a pregnancy options workbook to assist in the decision-making process.

- **Abortion Access**
  www.abortionaccess.org
  - Abortion Access provides resources and information on challenges to accessing abortion in various states.

- **Exhale**
  www.4exhale.org
  - This is a national organization that provides non-judgmental post-abortion counseling through a nationwide, multilingual talkline.

- **Planned Parenthood**
  www.plannedparenthood.org
  - Provides information of pregnancy options including details on the different types of abortion.

MALE INVOLVEMENT
- **US Dept of Health and Human Services**
  http://fatherhood.hhs.gov/
  - Provides a list of resources spanning from pregnancy to legal services to promote responsible fatherhood regardless of the socioeconomic background.

- **The National Campaign to Prevent Unplanned Pregnancy**
  www.thenationalcampaign.org/resources/males.aspx
  - Contains policy briefs, and fact sheets on the importance of male involvement in pregnancy prevention and parenting.

STI/HIV INFORMATION
- **Center for Disease Control (CDC)**
  www.cdc.gov
  - Provides STI screening and treatment protocols, fact sheets and resources in English and Spanish on various sexual and reproductive health topics.

- **Iwannaknow.org**
  www.iwannaknow.org
  - Provides information to youth, parents and providers about STIs.

- **American College of Obstetricians and Gynecologists (ACOG)**
  www.acog.org
  - Provides screening recommendations and educational resources on sexual health for women and adolescent girls.

- **American Society for Colposcopy and Cervical Pathology (ASCCP)**
  www.asccp.org
  - Provides educational resources and materials on HPV and cervical cancer screenings for women and girls.

- **U.S. Preventive Services Task Force (USPSTF)**
  - Website for a government appointed panel that provides recommendations on testing and screenings. Their recommendations cover adolescent sexual health.

- **Adolescent AIDS**
  www.adolescentaids.org
  - HIV educational materials for youth.

- **The Body**
  www.thebody.com
  - Contains online resource for HIV/AIDS.

YOUTH OF COLOR
- **MySistahs**
  www.mysistahs.org
  - This site is created by and is for young women of color. Contains information and support on sexual and reproductive health issues.

- **Ambiente Joven**
  www.ambientejoven.org/
  - A bilingual web site for gay, lesbian, bisexual, and transgender Latino/a youth. Provides resources and other aid to an underrepresented community.
INTERNET RESOURCES: Click on This!

**LGBT YOUTH**
- **Gay, Lesbian and Straight Education Network**
  www.glsen.org
  Provides news, resources and links aimed at promoting school and community safety and respect for youth regardless of sexual orientation or gender identity.
- **Youth Resource**
  www.youthresource.com
  A web site by and for gay, lesbian, bisexual, transgender and questioning (LGBTQ) young people, takes a holistic approach to sexual health and overall wellness.
- **OutProud**
  www.outproud.org
  Offers tons of resources for queer youth including links to current relevant news headlines, support groups, online brochures, literature, magazines, and more.

**YOUTH WITH DISABILITIES**
- **National Dissemination Center for Children with Disabilities**, www.nichcy.org
  Provides community and support for young adults dealing with disability or illness and their parents, siblings and friends.
- **Common Thread**
  www.commonthread.org/home.html
  Provides information and resources to help adolescents with special health care needs, chronic illness, physical and developmental disabilities become informed participants in their health care.
- **The Adolescent Health Transition Project**
  http://depts.washington.edu/healthtr/Teens/intro.htm
  Provides information on how sexual health is impacted by a variety of disabilities both developmental and physical.
- **Sexual Health Network**
  www.sexualhealth.com/channel/view/disability-illness/
  Provides act sheets are in English and Spanish. They have a sexual education center for parents and tip sheets for providers.
- **Pro-Choice Public Education Project (PEP)**
  www.protectchoice.org/
  Offers advocacy, and information on HIV-positive youth, in the form of an informal question and answer section on HIV and AIDS.
- **Guttmacher Institute**
  www.guttmacher.org
  Provides resources on adolescent sexual and reproductive health. They focus on sexual and reproductive health research, policy analysis and public education. The provide fact sheets in English, Spanish and French and information on healthcare policies in each state.

**SEXUAL HEALTH ADVOCACY**
- **Advocates for Youth**
  www.advocatesforyouth.org
  Provides act sheets are in English and Spanish. They have a sexual education center for parents and tip sheets for providers.
- **Pro-Choice Public Education Project (PEP)**
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**TALKLINES AND HOTLINES**
- **Planned Parenthood**
  1-800-230-PLAN
  Planned Parenthood Clinic locator.
- **Gay, Lesbian, Bisexual, Transgender (GLBT)**
  **National Youth Talkline, GLBT National Help Center**
  1-800-246-PRIDE
  Mon to Fri 5-9 PM (Pacific Time), English Confidential peer counseling on coming-out issues, relationships concerns, school problems, HIV/AIDS anxiety, and safer sex.
- **National Teen Dating Abuse Helpline**
  1-866-331-9474 (TTY: 1-866-331-8453)
  24/7, English
  Free and confidential helpline and online chat room for teens (13 to 18 years old) who experience dating violence or abuse.
- **RAINN: Rape, Abuse & Incest National Network**
  1-800-656-HOPE
  24/7, English and other languages
  Connects callers to their nearest rape crisis center to speak with a counselor.
- **National AIDS Hotline**
  1-800-342-AIDS (Spanish: 1-800-344-SIDA)
  24/7, English; 8AM-2AM, Spanish
  Information and referrals to local hotlines, testing centers, and counseling

|= Resource for Providers | = Resource for Youth | = Resource for Parents |