STD Community Interventions Program (SCIP)

STD/HIV Update for Educators

Participant Manual

May 2012

The STD Community Interventions Program (SCIP) is a primary prevention program within the California Department of Public Health, STD Control Branch, Disease Prevention Section that works in collaboration with the California STD/HIV Prevention Training Center (PTC). The CA STD/HIV PTC is funded by the Centers for Disease Control and Prevention and is a joint project of the CA STD Control Branch, the University of California San Francisco (UCSF) School of Medicine, and the University of California, Berkeley (UCB) School of Public Health.

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STD Community Interventions Program (SCIP)

The STD Community Interventions Program (formerly Chlamydia Awareness and Prevention Program or CAPP) was founded in 2000 to increase local capacity of staff to promote awareness and prevention of *chlamydia trachomatis* (CT) among the youth and young adults who suffer the highest CT and STD morbidity rates in California.

Funding for SCIP marks the first time that state monies have been earmarked for the *primary prevention* of STDs other than HIV. Funds are currently awarded to public health STD Programs in 45 of 61 health jurisdictions in California to enhance the effectiveness of activities related to increasing STD knowledge, risk reduction behaviors and sexual health seeking behaviors among youth and young adults aged 12-24 years.

By establishing partnerships with youth-serving community based programs, government programs and schools, SCIP focuses on building the skills and techniques of planning and conducting appropriate STD primary prevention activities. While SCIP emphasizes STD prevention, we also promote and implement an approach that recognizes the larger context of sexual and reproductive health for STD prevention. Inclusive in this approach is the promotion of cross-training and interagency collaborations with pregnancy prevention, alcohol and drug, violence prevention and youth development programs.

SCIP follows the classic model of program planning which emphasizes assessment prior to development of interventions. Much of the first phase of SCIP has been spent on working with local jurisdictions to conduct a community assessment and increase networking with youth serving agencies in their jurisdiction. The results of this assessment in a database provides local SCIP staff and their partners access to a community-wide view of the assets and gaps among programs serving adolescents and young adults at risk for STDs, HIV, and pregnancy. Other projects lead by the SCIP staff include the development of a sexual behavioral questionnaire tool kit for local agencies, youth-focused trainings, STD Lesson Plans for school teachers, STD 101 teen power points tools, STD fact sheets and a primary prevention resource guide for local health departments.

SCIP encourages the integration of community health education “Best Practices” into all components of STD prevention and control efforts. SCIP Regional Health Education Coordinators are available for consultation and technical assistance to state and local community agency staff who are interested in applying community health education techniques to community-based programs, including screening and treatment activities. In addition to these resources, SCIP staff work in conjunction with the CA STD/HIV Prevention Training Center to deliver localized courses on an as needed basis, and then provide follow up technical assistance as appropriate.

There is no set time limit on SCIP funding, thus we have a rare opportunity to establish an effective and systematic program planning approach to enhancing and implementing STD educational and behavioral interventions throughout local jurisdictions. The health department-community relationships built through networking will also help provide
community ownership of STD prevention as part of a long-term, sustainable effort integrated into programs throughout each local health jurisdiction. The long-term goals of SCIP are to increase the overall capacity to conduct primary prevention of STDs and to establish community networks that will serve to strengthen a variety of community and public health efforts in the future.

For more information about SCIP or to inquire about consultation, training, technical assistance, or free SCIP materials please contact any of the following SCIP staff.

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About the California STD/HIV Prevention Training Center

The California STD/HIV Prevention Training Center (CA PTC) is part of the National Network of STD/HIV Prevention Training Centers (NNPTC) and is funded by the Centers for Disease Control and Prevention. CA PTC is a joint project of the California Department of Health Services, Sexually Transmitted Disease Control Branch; the University of California, Berkeley, School of Public Health; and the University of California, San Francisco, School of Medicine.

The CA PTC provides training courses that are designed to meet the needs of a wide array of health professionals. *Clinical* courses are provided primarily for health professionals in federal Health and Human Services Region IX, which includes:

California    Nevada
Arizona       Hawaii

The following Pacific Islands: American Samoa, the Federated States of Micronesia, Guam, the Northern Mariana Islands, the Republic of the Marshall Islands, and the Republic of Palau.

The CA PTC is one of four national training centers which also provides training courses on *Behavioral Intervention, Partner Services and Program Support*. These courses are designed to develop the skills necessary for planning, implementing and evaluating effective STD/HIV prevention programs and are intended for health practitioners and professionals from community-based organizations and local and state public health programs. Behavioral, Partner Services and Program Support courses are open to audiences within HHS Region IX and also to those in the Region X States, including:

Oregon       Idaho
Alaska        Washington

Courses can be delivered outside of these regions upon request, and are tailored to meet local needs.

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**For information regarding course offerings and schedules, please contact the California STD/HIV Prevention Training Center at (510) 625-6000 or visit our website at [www.stdhivtraining.org](http://www.stdhivtraining.org).**

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We would like to thank the following people for their assistance in the creation of this training course and course participant manual: Michelle Savelli, Jasmin F. Delgado, Paul Gibson, Joyce Lisbin, Amy V. Smith, Lidia Carlton, Behnoush Aghili, Tammy Hill, Sharla E. Smith and Erin Touslee.
HIV/AIDS Instruction

California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act

*Education Code* sections 51930 – 51939
http://www.leginfo.ca.gov/

Education Codes

- **Article 1. General Provisions**
- **Article 2. Authorized Comprehensive Sexual Health Education**
- **Article 3. Required HIV/AIDS Prevention Education**
- **Article 4. In-service Training**
- **Article 5. Notice and Parental Excuse**

Education Code 51931 Terminology

a) “Age appropriate”
b) “Comprehensive sexual health education”
c) “English learner”
d) “HIV/AIDS prevention education”
e) “Instructors trained in the appropriate courses”
f) “Medically accurate”
g) “School district”

Purpose of this Act:

*To encourage a pupil to develop healthy attitudes concerning adolescent growth and development, body image, gender roles, sexual orientation, dating, marriage, and family.*

*Education Code* Section 51930

Purpose of this Act:

*To provide a pupil with the knowledge and skills necessary to protect his or her sexual and reproductive health from unintended pregnancy and sexually transmitted diseases.*

*Education Code* Section 51930

HIV/AIDS instruction **is mandated.**

Comprehensive sexual health instruction is **not mandated.**
**Authorized vs. Required**

**EC 51933**
- School districts may provide comprehensive sexual health education in any kindergarten to grade 12, inclusive.

**EC 51934**
- All pupils in grades 7 to 12, inclusive, receive HIV/AIDS prevention education at least once in middle school and at least once in high school.

**Education Code 51931**

b) "Comprehensive sexual health education" means education regarding human development and sexuality, including education on pregnancy, family planning, and sexually transmitted diseases.

d) "HIV/AIDS prevention education" means instruction on the nature of HIV/AIDS, methods of transmission, strategies to reduce the risk of human immunodeficiency virus (HIV) infection, and social and public health issues related to HIV/AIDS. "HIV/AIDS prevention education" is not comprehensive sexual health education.

**Education Code 51936**

**Guest Speakers**

- Use of guest speakers is permissible.
- Their materials must comply with the Education Code 51930-51939.
- Materials must be available for parental review.
- Checklist for Guest Speakers:
  [http://www.cde.ca.gov/ls/he/se/guestspeak ercheck.asp](http://www.cde.ca.gov/ls/he/se/guestspeak ercheck.asp)

**Education Code 51938**

**Parental Notification**

- HIV/AIDS instruction costs can be reimbursed. Claims submitted to State Controller Office:
- HIV/AIDS education is included in Categorical Program Monitoring (CPM).
- Parent/guardian notification is required for HIV/AIDS prevention education at the beginning of the school year or at least 14 days prior to instruction (passive consent).
- Parent/guardian notification with either passive or active consent may be used for comprehensive sexuality education.
- Sample parent/guardian notification letter can be found:
  [http://www.cde.ca.gov/ls/he/se/parentnotifylett er.asp](http://www.cde.ca.gov/ls/he/se/parentnotifylett er.asp)
Education Code 51931

f) “Medically accurate” means verified or supported by research conducted in compliance with scientific methods and published in peer-reviewed journals, and recognized as accurate and objective by professional organizations.

Centers for Disease Control and Prevention
American Public Health Association
American Association of Pediatrics
American College of Obstetricians and Gynecologists

Education Code 51934

(b) Medically accurate information may also be obtained from:
- United States Surgeon General
- National Academy of Sciences.

HIV/AIDS Instruction Must Include:

1. Information on the nature of AIDS and its effects on the body
2. The manner in which HIV is and is not transmitted, including information on high-risk activities

3. Discussion of methods to reduce the risk of HIV infection:
   a) Instruction shall emphasize sexual abstinence, monogamy, avoidance of multiple sexual partners, and abstinence from intravenous drug use
   b) Instruction shall include the latest statistics on the success and failure rates of condoms and other methods of contraception to prevent sexually transmitted HIV
   c) Information on other methods that may reduce the risk of HIV transmission from intravenous drug use

4) Discussion of the public health issues associated with HIV/AIDS
5) Information on local resources for HIV testing and medical care
**HIV/AIDS Instruction Must Include:**

6. Development of refusal skills and effective decision-making skills to assist students in overcoming peer pressure and to avoid high-risk activities.

7. Discussion about societal views on AIDS, including stereotypes and myths regarding persons with AIDS and emphasizing compassion for people living with HIV/AIDS.

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**Requirements for Instruction in HIV/AIDS and Comprehensive Sexual Health**

1. Instruction and materials shall be age appropriate.

2. All factual information presented shall be medically accurate and objective.

3. Instruction shall be made available on an equal basis to a pupil who is an English learner, consistent with the existing curriculum and alternative options for an English learner pupil as otherwise provided in this code.

4. Instruction and materials shall be appropriate for use with pupils of all races, genders, sexual orientations, ethnic and cultural backgrounds, and pupils with disabilities.

5. Instruction and materials shall be accessible to pupils with disabilities, including, but not limited to, the provision of a modified curriculum, materials and instruction in alternative formats, and auxiliary aids.

6. Instruction and materials shall encourage a pupil to communicate with his or her parents or guardians about human sexuality.

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**If local educational agencies do conduct** comprehensive sexual health education, the LEA must abide by all tenets of *Education Code 51933*. The LEA may not pick and choose topics.

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**EC 51933 and EC 51934 Where is the line in the sand?**

- If instruction is related to HIV/AIDS – required.
- If instruction veers away from HIV/AIDS – may be beginning comprehensive sexual health.
- Example: Some types of contraception.

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**Education Code 51933:** Comprehensive Sexual Health Education Requirements

- Instruction and materials shall teach respect for marriage and committed relationships.
If comprehensive sexual health education is taught, commencing in grade 7, all instruction and materials shall teach:

8) Abstinence from sexual intercourse is the only certain way to prevent pregnancy and STDs, while providing medically accurate information on other methods to prevent pregnancy and STDs.

9) How STDs are and are not transmitted; safety and effectiveness of all FDA approved methods to reduce the risk of STD transmission; and local resources for STD testing and treatment.

10) Safety and effectiveness of all FDA approved contraceptive methods, including emergency contraception.

11) Provide skills for making and implementing responsible decisions about sexuality.

12) Provide information on safely and legally surrendering physical custody of a minor child under 72 hours old.

(d)(1) Instruction and materials may not teach or promote religious doctrine.

(d)(2) Instruction and materials may not reflect or promote bias against any person on the basis of any category protected by EC Section 220.

"Hate crime" means a criminal act committed, in whole or in part, because of one or more of the following actual or perceived characteristics of the victim:

1) Disability
2) Gender
3) Nationality
4) Race or ethnicity
5) Religion
6) Sexual orientation
7) Association with a person or group with one or more of these actual or perceived characteristics
### Resources

**California Law:**
http://www.leginfo.ca.gov

**Curriculum Guidance:**
http://www.californiahealthykids.org

**Centers for Disease Control and Prevention – STD Information:**
http://www.cdc.gov/nchstp/dstd/aboutdiv.htm

**Centers for Disease Control and Prevention – HIV Information:**
http://www.cdc.gov/hiv/dhap.htm

**Centers for Disease Control and Prevention – STD Fact Sheets for Youth (English & Spanish):**

**Teaching Resources:**
http://www.advocatesforyouth.org

**Youth Advocacy Information:**
http://www.siecus.org

**Sample School Board Policies:**
(membership required)
http://www.csba.org

**STD Data by County**
http://www.dhs.ca.gov/ps/dcdc/STD/datayears.htm

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**If you have questions regarding HIV/STD Prevention Education, contact:**

*Sharla E. Smith, MPH*
**HIV/STD Prevention Education Consultant**
(916) 323-2570
shsmith@cde.ca.gov

For additional resources, please see the California Department of Education Web site
http://www.cde.ca.gov/ls/he/se
Learning Objectives

Goal:
Participants will be able to successfully integrate STD risk-reduction into teaching or counseling about sexual and reproductive health.

By the end of the training, participants will be able to:

1. Understand what is required regarding HIV/AIDS and sexuality education in the CA Education code
2. Describe common STDs among youth;
3. Explain the health consequences of STDs for young adults, teens and newborns;
4. Describe which behaviors are high risk for STD and HIV transmission;
5. Summarize STD trends locally and nationally
6. Describe the similarities, differences, and inter-relationship between HIV and other STDs;
7. Provide clear and simple risk-reduction messages about STDs to diverse teens and young adults.
8. Appropriately facilitate difficult sexuality questions asked by teens and young adults
# Major STDs Among Teens

<table>
<thead>
<tr>
<th>Major STDs Among Teens</th>
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<tbody>
<tr>
<td>Syphilis</td>
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<tr>
<td>Chlamydia - (PID) - Gonorrhea</td>
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<td>Trichomonas</td>
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<tr>
<td>Herpes Simplex Virus (HSV)</td>
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<td>Human Immunodeficiency Virus (HIV)</td>
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<tr>
<td>Hepatitis B Virus (HBV)</td>
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<tr>
<td>Hepatitis C Virus (HCV*)</td>
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**Other STDs include:** crabs or pubic lice; scabies

**Not sexually transmitted:** yeast infections (*candida*); bacterial vaginosis (BV)
STD Overview

I. **Viral STDs**

- **Herpes Simplex Virus (HSV) – Genital Herpes**
  - Common STD caused by Herpes Simplex Virus 2 (HSV 2) or less often, Herpes Simplex Virus 1 (HSV 1).
  - Can be transmitted by vaginal, anal or oral sex through direct contact with a lesion, sore, or infected tissue.
  - Symptoms do not have to be present for HSV to be passed.
  - Transmission without symptoms is very common because of asymptomatic viral shedding, especially during the first couple years of a new herpes infection.
  - Up to 90% of infections are asymptomatic, or mildly symptomatic and unrecognized.
  - Most common symptoms include blisters on the skin, or pain, itching or a tingling of the skin in the genital or rectal area before an outbreak occurs.
  - There is no cure for HSV, but treatment can minimize the length and pain of outbreaks.
  - Daily treatment may also decrease asymptomatic viral shedding and transmission to others. However, shedding does not stop completely and condoms are still recommended.
  - Condoms are a good barrier to HSV when they cover the infected area.
  - HSV increases chance for HIV transmission by three to six times.

**Asymptomatic viral shedding** is when live virus is produced and released through infected skin, even though there is not a visible sore or lesion.
• Human Papillomavirus (HPV)

➢ There are over 100 different viruses that are a part of the HPV family of which about 40 types are sexually transmitted to genital tissues.

➢ Certain HPV types can cause cervical cancer and do not cause genital warts. Over 95% of cervical cancers are associated with HPV.

➢ Some HPV types have also been linked to anal cancers, especially among people living with HIV.

➢ Some clinical providers are doing anal pap testing though at this time it is not recommended by the CDC.

➢ A few HPV types cause warts to grow in the genital and anal area, however only 7% of HPV cases have visible warts.

➢ Common sites of infection are the cervix, vagina, vulva, perineum, anus, rectum, penile shaft, corona of penis, scrotum.

➢ Most people with genital HPV infections will show no symptoms (no visible warts, normal Pap tests).

➢ HPV can shed from infected skin/membranes and can be transmitted without the presence of any warts through direct contact.

➢ The vast majority of people (probably greater than 90%) with HPV will self-resolve the infection within two years.

➢ There is no cure for HPV, but there are treatments for removal of warts and abnormal cell growth. These treatments remove the visible wart and/or abnormal cell growths but they do not clear the underlying HPV infection. Warts and abnormal Paps can come back even after treatment.

➢ Regular Pap tests for women are extremely important for prevention of cervical cancer.

➢ Condoms are a good barrier to HPV for areas they cover. Transmission occurs when infected areas are not covered by condoms – or with viral shedding to areas not covered with condoms.
- **Hepatitis B Virus (HBV)**
  - Infection that can cause liver inflammation and cell damage and lead to liver scarring and liver cancer.
  - Transmitted via sexual fluids, blood (sharing needles, razors, toothbrushes) or mother to baby.
  - HBV is 100 times more infectious than HIV.
  - Can be asymptomatic or can cause abdominal pain, flu-like symptoms, dark urine, light-colored feces, jaundice, fatigue and fever.
  - About 95% of persons who become infected as adults will self-resolve the virus with their own immune system; only 5% become chronically infected.
  - Persons who were infected with HBV at birth or as children have much higher rates of chronic infection (90% of infants and 25-50% of children ages 1-5 will develop chronic HBV infection).
  - HBV is able to remain infectious even when outside the body for long periods of time (such as in dried blood).
There is a vaccine that prevents HBV (required for kids entering school; series of 3 shots).

Condoms may reduce the risk of sexual transmission of HBV when they cover areas exposed to infected blood or sexual fluids.

- **Hepatitis C Virus (HCV)**
  - Transmitted by blood to blood contact; most new infections are transmitted through sharing of equipment for injection drug use.
  - Not easily sexually transmitted – but risk may be increased if there is physical trauma (i.e. tears, micro-abrasions, or damage to the skin) or blood present during sex.
  - New research shows that persons who are HIV-positive and have multiple sex partners may be at increased risk for sexual transmission of hepatitis C.
  - Can cause inflammation of the liver and cell damage leading to liver scarring and liver cancer; HCV is the leading reason for liver transplantation nationwide.
  - There is no vaccine for HCV.
  - Hepatitis C can be successfully treated in as many as one-half to three-quarters of persons with HCV. Many new treatment drugs are in development. Treatment for HCV may have side effects: depression, nausea, fatigue, anemia, and rash.
  - Up to 80% of persons with HCV have no signs or symptoms and 75% of people with HCV are unaware of their infection.
  - 25% of people infected with HCV as adults will self-resolve the virus with their own immune system; 75% will develop chronic infection.
  - Effectiveness of condoms in preventing sexual transmission of HCV is unknown, but it is biologically plausible that condoms would be effective.
• Hepatitis A Virus (HAV)
  ➢ Liver infection transmitted mainly via fecal-oral contact (i.e. poor hand washing after contact with anus/feces or oral-anal sex - “rimming”). The organism must be ingested in order to infect.
  ➢ HAV can be asymptomatic or can cause the same symptoms as HBV and HCV. Usually HAV infections self-resolve and it seldom causes long-term liver damage.
  ➢ Once a person has developed antibodies for HAV they are immune for life.
  ➢ There is a vaccine for HAV (series of 2 shots).
  ➢ Use of latex gloves or dental dams for rimming can reduce chances for transmission of HAV.
  ➢ The three types of Hepatitis mentioned (A, B & C) are not closely related viruses – their main commonality is that they attack the liver.

Some viruses like HAV are usually more **acute** infections, meaning they only affect the body for a short period of time (less than 6 months) before they self-resolve.
Other viruses are **chronic** infections that can remain in the body and affect organs, tissues or cells for a long time. If someone has a chronic STD infection, they can pass it to others.

Some viruses, like HSV, have acute symptoms (outbreaks with sores) that come and go, but the virus itself is in the body for life, and is, therefore, chronic.

• Human Immunodeficiency Virus (HIV)
  ➢ HIV is found in several types of white blood cells (WBCs) in blood, semen, vaginal fluids, and possibly breast milk.
  ➢ Sexual transmission of HIV occurs mainly through vaginal and anal sex.
HIV can be transmitted from mother to infant during gestation, birth or breast feeding.

A person can have HIV for many years before developing symptoms or other serious complications.

HIV disease is characterized by a gradual deterioration of immune functions that may lead to opportunistic infections or AIDS (Acquired Immunodeficiency Syndrome)

There is no cure for HIV, only anti-retroviral treatment. Anti-retroviral treatments control the replication of HIV and slow down disease progression.

People may have acute symptoms (fever, malaise, skin rash) after the first few weeks of HIV infection but before the HIV antibody test shows a positive.

Condoms are a good barrier to HIV.

II. Bacterial STDs

- Chlamydia (CT – Chlamydia trachomatis)
  - Very common STD that infects the cervix, urethra, rectum, or throat.
  - Up to 80% of women have no signs or symptoms. Untreated or under-treated chlamydia can lead to PID in women.
  - Up to 50% of men have no signs or symptoms.
  - Chlamydia can be transmitted even when symptoms are absent.
  - New, accurate, non-invasive (urine) tests, can be used to diagnose chlamydia.
  - Curable with antibiotics.
  - Condoms are a good barrier to chlamydia.
  - Chlamydia increases the chance for HIV transmission by three to five times.
• **Gonorrhea (GC – Gonococci or Neisseria gonorrhoeae)**
  - Common STD that infects the cervix, urethra, rectum or throat
  - Up to 50% of women have no signs or symptoms.
  - Many men have no signs or symptoms.
  - New, accurate, non-invasive (urine) tests, can be used to diagnose gonorrhea.
  - Gonorrhea can be transmitted even when symptoms are absent.
  - Curable with antibiotics.
  - Gonorrhea is becoming resistant to many medications; the guidelines for treatment have changed recently as a result.
  - Condoms are a good barrier to gonorrhea.
  - Gonorrhea increases the chance for HIV transmission by two to five times.

• **Non-gonococcal urethritis (NGU)/Non-specific urethritis (NSU)**
  - NGU/NSU can be caused by chlamydia, or other organisms.
  - Some of the organisms that cause NGU/NSU in men can cause vaginitis and cervicitis in women.
  - Treated with antibiotics.
  - Condoms are a good barrier to the organisms that cause NGU/NSU.
  - Having NGU/NSU might increase the chances of HIV transmission during sex.

• **Syphilis (Treponema pallidum)**
  - A complex STD which can spread to all organs of the body after the bacteria enters the blood at the initial site of infection.
  - Transmitted through direct contact with syphilis sores or lesions during vaginal, anal or oral sex.
Untreated syphilis progresses in “stages”, with periods of no symptoms (called “latency”) occurring between the symptomatic stages. The symptoms that appear through the different stages of syphilis may go away on their own, even without treatment, however the infection is still present and may progress.

**Primary Stage:**
- A painless sore (called a chancre) appears at the site of infection, which is highly infectious by direct contact. It goes away on its own (without treatment) after a couple of weeks.

**Secondary Stage:**
- A few weeks after the primary chancre has disappeared, a variety of other symptoms can appear – including a rash on the body (trunk), palms of the hands and soles of the feet; hair loss; sore throat; swollen glands; wart-like growths on the genitals; and lesions in the mouth or in other areas with mucous membrane tissue. These lesions (mucous patches) and wart-like growths are the only secondary symptoms infectious to other people. The bacteria are passed through direct contact with these symptoms. These symptoms too will go away on their own without treatment.

**Tertiary Stage**
- Five to twenty years after untreated infection, syphilis begins to affect the internal organs (heart, lungs, brain) or cause large, destructive skin sores. In this stage the person is no longer infectious to other people.

Syphilis stages generally follow the above order and timeline. However, for some people (including those who are HIV positive), the first, second and third stages may overlap and/or occur at a much faster pace.
A pregnant woman with untreated syphilis can pass the infection to her fetus – causing serious damage to the baby’s internal organs, resulting in stillbirth or permanent birth defects.

Syphilis is curable at every stage with antibiotics—but damage done to the body (i.e. organs) may not be reversible with treatment.

Condoms are a good barrier to syphilis when they cover the chancre or the mucous patches.

Symptomatic syphilis increases the chance for HIV transmission by three to four times.

III. **Protozoan STDs**

- **Trichomoniasis** *(Trichomonas vaginalis i.e. Trich)*
  
  - Usually transmitted through vaginal sex; but can be transmitted by objects (sex toys), and transmission between women who have sex with women is documented.
  
  - Most common site of infections are the vagina and male urethra.
  
  - Up to 50% of women are asymptomatic.
  
  - Men are usually asymptomatic.
  
  - Trichomoniasis can be transmitted when symptoms are absent.
  
  - Curable with medication.
  
  - Condoms are a good barrier to trichomonas organisms.
  
  - Trichomoniasis increases the chances for HIV transmission by two to five times.
Questions and Answers about STDs

What do some STDs have in common?

- **Which are generally incurable** (medication can treat but not get rid of it)?
  - Viruses

- **Which cause sores or ulcers on the genitals (Genital Ulcer Diseases – or G.U.D.s)?**
  - Syphilis and HSV

- **Which are protozoal?**
  - Trichomonas, Giardia, Entamoeba, and Cryptosporidium

- **Which are the most common?**
  - HSV, HPV, Trichomonas, and Chlamydia

- **Which are curable with medication?**
  - All bacterial and protozoal STDs
**What are some common signs and symptoms of STDs?**

Most people with STD infections do not have any obvious signs or symptoms and are likely unaware of their infection. The most common sign or symptom of STD infection is to have NO signs or symptoms. However, if symptoms are present, they may include:

- discharge (genitals/anus)
- itching/burning
- blisters
- abdominal pain
- abnormal bleeding
- painful intercourse
- open sores (pain/no pain)
- burning w/ urination
- warts (on genitals/anus)
- rash (body, palms, soles)

If a client describes any of the above symptoms, **do not try to tell them which STD they might have**, instead, refer them to a doctor or clinic for the appropriate tests.

**Sources**


HPV- www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts; www.cdcnpin.org/scripts/News/NewsList.asp#54101

Hepatitis B and C - Hepatitis Foundation International: www.hepfi.org and the Centers for Disease Control and Prevention: www.cdc.gov

Hepatitis A - National Network Prevention Training Centers, Clinical Curricula 2002


Syphilis, Chancroid, Gonorrhea, Chlamydia and Trichomonas - National Network Prevention Training Centers, Clinical Curricula 2002
Impact of Untreated STDs

I. What are some long term consequences and/or complications of STDs?

Infants

- Eye infection (CT or GC) – may lead to blindness if not treated
- Lung infection (CT)
- Warts in throat (HPV)
- Chronic infections (HIV, HBV, HCV)
  - (Ex. 90% of infants born to a mother infected with HBV will be chronic carriers)
- Brain infections (HSV)
- Birth defects (HSV or Syphilis)
- Stillbirth/neonatal death (HSV or Syphilis)

Young Girls or Women

- Cervical cancer (HPV)
  - Around 4,000 deaths annually
- Infertility (CT or GC)
  - Occurs in 14-20% of women with PID
- Tubal pregnancy (CT or GC)
  - Occurs in 9% of women with PID
- Permanent pelvic pain (CT or GC)
  - Occurs in 18% of women with PID

Anyone with an STD can get

- Damage to aorta, nervous system, skin, and/or internal organs (Syphilis)
- Anal cancer (HPV)
- Oral or throat cancer (HPV)
- Liver problems
  - Cirrhosis (HBV or HCV)
  - Liver Cancer (HBV or HCV)
- Death (HIV, Syphilis, HBV, or HCV)

II. Pelvic Inflammatory Disease (PID)

Pelvic Inflammatory Disease (PID) is caused when bacteria ascends from the cervix (often during menstruation or as a result of douching) into the uterus and up into the fallopian tubes, ovaries or abdominal cavity. PID can result in scar tissue, adhesions, abscess formation, and can lead to infertility, ectopic pregnancy, painful periods, painful intercourse or chronic pelvic pain.

- 80% of women with chlamydia are asymptomatic
- PID can occur in women who have not been treated, or were inadequately treated, for gonorrhea or chlamydia.
- The chance of infertility increases with each time a woman has PID (even if she is treated for each case).
- PID affects 1.5 million women each year in the U.S.
- Complications of PID cost the U.S. medical system $1.06 billion a year.
- 100,000 women become infertile every year due to PID.
- Scarring from PID causes 40,000 tubal pregnancies per year. (That’s half of all tubal pregnancies.)
Chlamydia Sequelae in Females:

II. STD Related Deaths in U.S. Women

In 2008 in the United States there were…
3,510 deaths due to AIDS in women

In 2011 there will be an estimated
4,290 deaths due to cervical cancer

Death rate of cervical cancer has declined 3% each year.

III. Pap Tests – Early Detection of Cervical Cancer

- A pelvic exam allows for examination of the female genitals and genital tract (using an instrument called a speculum), and may include various tests, including STD tests and Pap tests
- The Pap test is a test to detect abnormal cells on the cervix (called dysplasia). It is the same thing as a pap smear; the name change is a reference to a new lab method that does not require a smear sample
- The Pap test itself is **not** a STD test.
- STD tests are **not** done with every pelvic exam. Patients need to discuss their desire for STD testing with their clinician before a pelvic exam.

- Pap tests are recommended every 2-3 years for women under age 30. The frequency of testing for women over 30 depends on previous Pap results. Pap tests should be started by age 21. (ACOG)

### IV. HPV Vaccine

- Both vaccines are best if given **before** first sexual intercourse.

- Efficacy studies have been conducted in older women 26-45 years old. While the HPV vaccine also appears to be effective in these age groups, women over 26 are not FDA approved to receive this vaccine.

**Gardasil made by Merck**

- Gardasil protects against **4** HPV types that cause about **70%** of cervical cancer and **90%** of genital warts

- Nearly 100% effective in clinical trials

- Recommended for girls & boys 11-12 years old (approved for up to age 26 & as young as 9) for prevention of genital warts as well as cervical, vulvar, vaginal cancer in females and anal cancer in both males and females

- Cost for Gardasil is very expensive for series of 3 shots. Covered by State Vaccines for Children (VFC) Program and some private insurance (not FamilyPact). Medi-Cal also covers costs for those who qualify between the ages of 19-26. Merck (manufacturer) also has some financial assistance programs through clinics: [http://www.merck.com/merckhelps/](http://www.merck.com/merckhelps/)

**Cervarix made by GlaxoSmithKline (another HPV vaccine)**

- The FDA approved (10/2009) the use of Cervarix for females 10-25 years old to prevent against **2** HPV types that cause **70%** of cervical cancer (HPV 16 & 18).
• Cervarix does not protect against the HPV types that cause genital warts
• 93% effective in clinical trials
• Cost of Cervarix very expensive as well

VI. More Problems caused by STDs

➢ The difficulty in telling current or past sex partners they need to get tested and possibly treated
➢ Having an STD for the rest of your life (Herpes and HIV are incurable, life-long infections).
➢ The difficulty in telling future sex partners that you have an incurable STD – and they could get it from you
➢ The worry about the long-term effect of an incurable STD on your body and health

Sources

PID

CDC PID Fact Sheet. www.cdc.gov/std/pid


STD Related Deaths

HPV Vaccine
CDC Fact Sheet: HPV and Men, Dec. 2011; HPV Vaccine Information for Young Women, Sept 2011; www.cdc.gov/std

Pap tests
American College of Obstetrics and Gynecology (ACOG)
I. Mucous Membrane Sites

- **Oral**
  - Mouth – Squamous Epithelium
  - Throat – Columnar Epithelium

- **Vaginal**
  - Vagina – Squamous Epithelium
  - Cervix – Columnar Epithelium

- **Urethral**
  - Urethral Opening (Meatus) – Squamous Epithelium
  - Urethra – Columnar Epithelium

- **Rectal**
  - Anus – Squamous Epithelium
  - Rectum – Columnar Epithelium
II. Direct Contact with Lesion, Sore or Infected Tissue

- Rubbing, sliding, grinding, licking and/or friction contact between: penis – anus – mouth, lips, tongue – scrotum – rectal area – genital area – vagina – vulva
  - Lesion → Mucous Membrane (MM) or damaged skin (micro-cut, tear, scrape, puncture)
  - Infected skin w/ no symptoms → MM or damaged skin

**Diseases:** Herpes, Syphilis and Human Papillomavirus

*Friction increases the chances of transmission*

III. Transfer of Infected Sexual Fluids¹, Discharge², Blood³

- Through exchange of infected fluids: vaginal fluids, semen, rectal secretions, blood and/or discharge (pus) from STD infection:
  - penis (urethra) ↔ anus
  - penis (urethra) ↔ throat
  - penis (urethra) ↔ cervix (far end of vagina) or in vagina
  - cervix, anus, or throat <____________> cervix, anus, or throat

**Diseases:** Gonorrhea¹,², Chlamydia¹,², NGU¹,², Hepatitis B¹,³, Hepatitis C³, HIV¹,³, Trichomonas¹,²
## STD Transmission Table

### Modes of Transmission

<table>
<thead>
<tr>
<th>STDs</th>
<th>Lesion Sore or Wart</th>
<th>Infected Tissue (no lesion)</th>
<th>Semen, Vaginal fluids</th>
<th>Infectious Discharge: abnormal penile, vaginal, anal discharge (pus)</th>
<th>Blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herpes</td>
<td>√</td>
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<td></td>
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<tr>
<td>HPV</td>
<td>√</td>
<td>√</td>
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<td></td>
<td></td>
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<tr>
<td>Syphilis</td>
<td>√</td>
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<td></td>
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<td>√ **</td>
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<tr>
<td>Chlamydia</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea</td>
<td></td>
<td>√</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGU/NSU</td>
<td></td>
<td>√</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trichomonas</td>
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<td>√</td>
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<tr>
<td>HIV</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Hepatitis C</td>
<td></td>
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<td>√</td>
<td></td>
</tr>
</tbody>
</table>

* In a HIV + person with a co-infection of another STD, HIV may be passed through open lesions and/or discharge from the STD infection.

** Syphilis may be passed through blood to blood contact (i.e. needles) only during a very small and specific time period during the infection – and this is not common.
IV. How is STD transmission reduced?

- Abstinence from sexual activity is the only guarantee to avoid infection.
- Good communication and mutual agreement among sex partners who only have sex with each other and have been tested for STDs.
- Using condoms (male or female) with lubrication and changing condoms between different sexual activities and/or partners can reduce STD risk.
- Latex gloves with lubrication and/or dental dams may also reduce risk of STD transmission for some forms of sex (i.e. rimming, fisting, cunnilingus).
- Reducing the number of partners to one or as few as possible also lowers the risk of STD infection.
- Remember, STD prevention involves more than not sharing blood, semen, or sexual fluids, since transmission of some common STD organisms occurs by direct contact with STD sores, lesions or infected skin. Condoms help reduce transmission of most STDs during sex.

The spermicide Nonoxynol-9 is not recommended for STD prevention, alone or with condoms, due to the possible irritation of the genital tissues resulting in an increase chance for HIV infection.

Why don’t we get STDs just anywhere on our bodies?

- External skin is covered with Keratin (wax-like coating)
- Mucous membranes (or internal squamous cells) do not have keratin
IV. Condom Effectiveness

There is increasing evidence that when used “consistently and correctly” latex condoms are:

- Highly effective in reducing the sexual transmission of HIV
- Very effective in reducing the transmission of fluid-based STDs: gonorrhea, Chlamydia, and trichomonas
- Effective in reducing transmission of direct contact STDs (herpes, HPV and syphilis) from or to the areas that are covered by a latex condom
- Highly effective in preventing pregnancy (98%)

Cannot quantify protective effect of condoms for these research methodology reasons:

- Unethical to withhold treatment for treatable STDs
- Condom use cannot be directly measured or observed

Despite limitations there is still strong empirical evidence that condoms considerably reduces the risk of most sexually transmitted infections

Use the words “Safer Sex” and “Risk Reduction” instead of “Safe Sex” and “Prevention” when discussing condom use

Sources

Condom Effectiveness
CDC Fact Sheet on the NIH Condom Report 2000
http://www.cdc.gov/condomeffectiveness/latex.htm

http://www.ucsfhealth.org/adult/medical_services/infect/hiv/conditions/aids/diagnosis.html
Introduction to Data & Disease Reporting

I. Different Ways We Report Data

- **Number** = a count of the number of cases or infections
  
  *Example:* 30 cases

- **Percent** = the fraction of the whole that one group represents multiplied by 100. For example, out of all the cases, how many are?
  
  *Example:* 20 out of 30 cases are women
  
  \[
  \frac{20}{30} = 0.6666 \times 100 = 67\%
  \]
  
  67% of cases are women

  *Example (For a larger population):*
  
  335 out of 500 cases are women
  
  \[
  \frac{335}{500} = 0.67 \times 100 = 67\%
  \]
  
  67% of cases are women

- **Rate** = the number of cases in a specific group based on a standard population size of 100,000 (in order to account for differences in population size). In other words, how much disease per population?
  
  *Example:* 30 cases among Town A (3,000 in total population of Town A) * 30 cases among Town B (20,000 in total population of Town B.)

  Town A rate = \( \frac{30}{3,000} = 0.01 \times 100,000 = 1,000 \) cases per 100,000 population

  Town B rate = \( \frac{30}{20,000} = 0.0015 \times 100,000 = 150 \) cases per 100,000 population

  *Town A rate is 6.7 times higher than Town B rate (1,000 / 150 = 6.7) even though the number of cases are both 30.*

- **Ratio** = a number that represents the proportion of something in one group compared to another group.

  *Example:* 150 male cases compared to 100 female cases

  \[
  \frac{150}{100} = 1.5. \text{The ratio of male to female cases is 1.5:1}
  \]
  
  In other words, for every 1 case among females, there are 1.5 cases among males.

  (The numerator is the larger number stated first in the sentence).

- **Incidence** = the number of newly diagnosed cases in a population of individuals during a specific time period (i.e. one year).

- **Prevalence** = the total number of people who have a disease at a specific point in time (including previously and newly diagnosed cases).
II. **What do we mean by a reportable STD?**

It is mandated by law that certain communicable (infectious) diseases be reported to the local health department (LHD) when there is a positive test or disease diagnosis. By documenting age, gender, ethnicity, and addresses for all reportable STDs, local (County or City) and State health departments can establish a database for monitoring disease trends and planning interventions.

Although the personal information of the patient is attached to the diagnosis, **the reporting process is highly confidential.** All identifying information is removed from disease data that is sent to the Centers for Disease Control (CDC). This way patient confidentiality is maintained while CDC is still able to monitor State and local trends.

**Positive Test ➔ Patient ID to LHD ➔ Patient ID to State without IDs to CDC**

The Health Department disease database has several critical purposes, including to:

1. monitor the trends of different diseases;
2. plan appropriate responses to disease outbreaks or epidemics;
3. target the distribution of resources to the most critical geographical areas (i.e., build clinics, distribute vaccines, apply for grants, etc.);
4. monitor and evaluate the effectiveness of these responses, and if need be,
5. declare a public emergency to protect the public’s health.
In California the following STDs are reportable and non-reportable:

<table>
<thead>
<tr>
<th>Reportable</th>
<th>Not Reportable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>Human Papillomavirus (HPV)</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Genital Herpes (HSV)</td>
</tr>
<tr>
<td>Pelvic Inflammatory Disease (PID)</td>
<td>Trichomoniasis</td>
</tr>
<tr>
<td>Non-Gonococcal Urethritis (NGU)</td>
<td></td>
</tr>
<tr>
<td>- (NGU) is no longer reportable as of January, 2007</td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td></td>
</tr>
<tr>
<td>Chancroid</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
</tr>
<tr>
<td>HIV Infection (as of April, 2006)</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* Shigella, Hepatitis A, Giardia, Entamoeba, and Cryptosporidium are also reportable and can be sexually transmitted.

*Acute* is an infection of 6 months or less and *Chronic* is an infection of more than 6 months.

**III. Benefits of Data Collection**

STD data are used to:

- Track trends over time
- Allocate funds for testing, treatment, prevention, and research
- Assure correct treatment of individual cases
- Notify sex and needle sharing partners of exposure for testing and treatment
- Identify and fight outbreaks when they happen
- Conduct program planning & community advocacy
IV. Limitations of Data

- Reported data only includes those patients who seek care, get diagnosed and tested, and have a provider and/or laboratory who reports that diagnosis. **It is estimated that there may be 2 to 5 times more cases per year than are actually reported.**

- Race and ethnicity data are not as well captured in STD reporting. Race and ethnicity are not specified in about one fourth of all the reported cases in California and even up to two thirds of the cases in some health jurisdictions.

- Sometimes an increase in incidence can be due to increased screening or better reporting. Therefore, although the numbers go up, it doesn’t always necessarily mean there is more disease transmission, sometimes just more detection of disease that is already present in the population.

- Estimates for STDs that are not reportable are based on studies and then calculated for larger populations. Depending on how the study was conducted, this can affect the estimated verses actual rates. Some national data (like NHANES) may be extrapolated for state data based on percent of population alone.
### Ten Most Commonly Reported Communicable Diseases in California, 2010

<table>
<thead>
<tr>
<th>Rank</th>
<th>Disease</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Chlamydia</td>
<td>155,300</td>
</tr>
<tr>
<td>2.</td>
<td>Gonorrhea</td>
<td>26,840</td>
</tr>
<tr>
<td>3.</td>
<td>Pertussis</td>
<td>9,156</td>
</tr>
<tr>
<td>4.</td>
<td>Campylobacteriosis</td>
<td>6,704</td>
</tr>
<tr>
<td>5.</td>
<td>Salmonellosis</td>
<td>5,098</td>
</tr>
<tr>
<td>6.</td>
<td>Coccidioidomycosis</td>
<td>4,589</td>
</tr>
<tr>
<td>7.</td>
<td>Syphilis</td>
<td>3,864</td>
</tr>
<tr>
<td>8.</td>
<td>Tuberculosis</td>
<td>2,329</td>
</tr>
<tr>
<td>9.</td>
<td>Giardiasis</td>
<td>1,785</td>
</tr>
<tr>
<td>10.</td>
<td>Shigellosis</td>
<td>1,036</td>
</tr>
</tbody>
</table>

- STDs account for 86% of these cases
- Chlamydia accounts for 72% of these cases

*Note:* The STDs in the above list are in bold.
I. **U.S. National Data on Viral STDs**

- **Herpes Simplex Virus (HSV) – data on HSV 2**
  - estimated prevalence: 45 million infected, or 1 in 6 people
  - estimated incidence: 1.6 million new cases each year

- **Human Papillomavirus (HPV)**
  - estimated prevalence: 20 million infected, or 1 in 8 people
  - subgroups may have 50% or more infected, 20 to 24 year old women have highest prevalence
  - estimated incidence: 6.2 million new cases each year

- **Hepatitis C Virus (HCV) – not commonly transmitted sexually**
  - estimated prevalence: 3.9 million chronically infected
  - estimated incidence: 16,000 new cases each year

- **Hepatitis B Virus (HBV)**
  - estimated prevalence: 1.4 million chronically infected
  - estimated incidence: 38,000 new cases each year

- **Human Immunodeficiency Virus (HIV)**
  - estimated prevalence: 1.2 million infected
  - estimated incidence: 48,100 new cases each year

HSV is a life-long STD. Cases build up as the pool of infected people gets larger over time.

Some viruses like HBV and HPV self-resolve in most cases. Therefore, the prevalence may not be as high over time, even though they may have a high incidence rate each year.
II. **U.S. National Data on Bacterial STDs**

(Note: Prevalence data is not generally shown for curable STDs.)

**Chlamydia (CT) – 2.8 million estimated new cases in 2010**

- Most chlamydia cases go undiagnosed
- Reported cases of CT continue to increase; this may reflect continued expansion of CT screening programs, complete reporting and increased use of more sensitive diagnostic tests.
- CT testing is recommended for all sexually active females under the age of 26.

**Gonorrhea (GC) - 700,000 estimated new cases in 2010**

- Up until 2009 GC rates were on a downward trend. However during 2009-2010, GC rates have increased across all ethnic/racial groups & among both genders
- There still exists disproportionate rates among African-Americans
- The South continues to have the highest rates of GC, followed by the Midwest, Northeast & the West
- Increase of GC among MSM continues
- Antimicrobial resistance remains an important consideration in the treatment of GC
  - Over the years, GC has become resistant to various antibiotics
  - As with any asymptomatic STD that is not treated, a GC infection that is not fully treated (including by antibiotic resistance), can remain in the body and be transmissible to others and possibly lead to PID and infertility
  - Knowing about the existence of antibiotic resistant GC may increase someone’s perception of severity of this STD (i.e. certain strains of GC may not be able to be treated with certain types of antibiotics)
  - It’s important for clinicians to keep updated on the latest effective treatments for GC
Syphilis – 27,378* estimated new cases in 2010

- Rate of 1° & 2° syphilis decreased 1.6% from 2009-2010
- Most syphilis is found in the South and certain urban areas
- Highest rates among MSM: In 2010, 67% of 1° & 2° syphilis cases from reporting states were among MSM
- Disproportionate rates among African-Americans and Native Americans
- There were a total of 377 congenital syphilis cases in the U.S. (not included in the above number).

(note: *Total Syphilis: primary, secondary, early-latent)
Annual New Cases of STDs, 2010 (estimated incidence in U.S. = 19 million)

- Trich: 7.4 million
- HPV: 6.2 million
- CT: 2.8 million
- Herpes: 1.6 million
- GC: 700,000
- HIV: 48,100*
- Hep B: 38,000*
- Syphilis: 27,378
- Hep C: 16,000*

*Total Includes infections as a result of sexual and non sexual transmission
III. The 4 Most Common STDs in the U.S. (and in California)

(In order of the most common using prevalence for the viruses and incidence for the bacteria & protozoa)

1. HSV-2
2. HPV
3. Trichomonas
4. Chlamydia

- Account for at least 90% of all STD cases in U.S.
- Top 3 STDs are not reported in the United States
II. In CA 62% of Reported STDs Are Among Youth

- According to the national YRBS survey, almost half (46%) of all high school students in the U.S. have had sexual intercourse.
- Therefore, of the 3 million high school age students in CA, if we assume half of them are sexually active (1.5 million).
- If 1 of every 4 (25%) of sexually active teens will get an STD this year…
  - Nearly 375,000 sexually active 15-19 year olds in CA will get a STD this year.

What are the Chances of STD Exposure for CA Youth?

- More than 1 out of 3 (36%) sexually active persons 15 – 24 years old in California is infected with Human Papillomavirus (HPV)

* Most reported STDs are chlamydia, gonorrhea, and early syphilis
Prepared by CDPH STD Control Branch, 2010 Data; December, 2011
At least 1 out of 6 (17%) sexually active persons 15 - 24 years old in California is infected with Genital Herpes.

1 of every 10 sexually active teens has Chlamydia

III. Teen Sexual Health and Behavioral Data

- 4 of every 10 (40%) 15-17 year old females have had some type of intimate sexual experience (oral, anal or vaginal sexual contact).
- Nearly 5 of every 10 (47%) 15-17 year old males have had some type of intimate sexual experience (oral, anal or vaginal sexual contact).
- Nearly 8 of every 10 (82%) teen males have had sex by age 19.
- Nearly 9 of every 10 (88%) teen females have had sex by age 19.
- Almost 3 of every 5 (58%) sexually active teens have had 2 or more sexual partners by age 19.
- Nearly 2 of 5 (39%) sexually active teens (15 – 19 years of age) did not use a condom the last time they had sexual intercourse.
- 1 of every 9 female and 1 of every 22 male high school students have been forced to have sexual intercourse.
- In 2010, the teen birth rate for California was 29.0 per 1000 teen females. This is nearly four times higher than the median teen birth rates for Australia, Canada, France, Germany, Spain, Italy, Sweden, the United Kingdom and Japan!
- Although 15-24 year-olds represent only one-quarter of the sexually active population, they account for nearly half of all new STDs each year.
- In 2009, young persons (aged 13-29) accounted for 39% of all new HIV infections in the US. For comparison's sake, persons aged 15–29 comprised 21% of the US population in 2010.
- 1 of every 5 sexually active teen female will get pregnant this year.
- Nearly 4 of every 5 teen pregnancies are unplanned.
IV. **Why Teens Need to Know About STDs**

According to a national survey, almost half (46%) of all high school students in the U.S. have had sexual intercourse.

Therefore, of the ~3 million 15-19 year olds (2009 est., assuming most are in high school) in CA, approximately half of them (1.5 million) are sexually active.

If 1 of every 4 (25%) of sexually active teens will get an STD this year…

**Nearly 375,000** sexually active 15-19 year olds in CA will get a STD this year.

V. **The Good News…**

- Among teens who are sexually active, condom use has increased from 41% between 1991 to 2009.
- The number of teens who have had sexual intercourse has declined from 54% in 1991 to 46% in 2009.
- The teen birth rate has decreased nationwide from 56.8 (per 1,000) in 1995 to 34.3 (per 1,000) in 2010.

---

**Why Teens and Young Adults Have High Rates of STDs**

- Immature cells on the cervix of younger women
- High prevalence of STDs among young sex partners
- Almost 3 out of 5 (58%) sexually active teens have had two or more sex partners—short duration relationships common
- Lack of assertiveness and communication skills essential for maintaining sexual health
- Power dynamics involved in dating older people
- Lack of access to appropriate health information & services
Sources


I. Information on the nature of AIDS and its effects on the body

What is HIV? (Human Immunodeficiency Virus)

- People living with HIV are infected when the virus enters the body and gets into the white blood cells. Most HIV tests look for antibodies created by the immune system to fight the virus. The time between a new HIV infection and a positive HIV test could be a window of up to 3 months (for the antibodies to develop).

What is AIDS? (Acquired Immune Deficiency Syndrome)

- People who are diagnosed with AIDS have HIV as well as the following:
  1. Less than 200 CD4+ T white blood cells per cubic millimeter of blood (compared with 1,000 CD4+ T cells for healthy people).
  2. CD4+ T cells accounting for less than 14 percent of all lymphocytes, a type of white blood cell.
  3. One or more opportunistic infections or illnesses caused by a weakened immune system.

II. How HIV works in the body?

- By attacking the immune system, particularly white blood cells (WBCs)
- By continuing to infect other WBCs, eventually leaving few cells to fight off any disease or infection.
- The virus replicates itself RAPIDLY!

Note: CD4+ T cells are white blood cells that play an important role in the body's immune system. These cells are destroyed by HIV. Even when a HIV-positive person feels well and is not experiencing any symptoms of the disease, CD4+ T cells are being infected by HIV.
III. **Body Fluids**

**Infectious**

1. Blood (including menstrual blood),
2. Semen (including pre-ejaculate),
3. Vaginal secretions and rectal secretions,
4. Breast milk

**Non-infectious**


IV. **The transmission routes:**

- **Sexual Route.**
  - The great majority of infections are acquired through unprotected sexual contact, specifically anal and vaginal sex.

- **Blood to blood contact.**
  - Intravenous drug users – sharing needles and/or drug “works”, including those used to inject hormones, steroids and other body shape enhancers. Sharing diabetes needles.

- **Mother to child transmission.**
  - HIV infection can occur from an infected woman to her fetus – vertical or perinatal transmission, and through breast milk
Sources:
AIDS Data
California Department of Public Health, Office of AIDS, HIV/AIDS Case Registry Section, data as of July 6, 2010.
For more information, call the HIV/AIDS Case Registry Section at (916) 449-5866.
Prepared by: California Department of Public Health, STD Control Branch, January 2011
The STD – HIV Connection

I. What is the STD – HIV connection?

Some sexual behaviors, like vaginal and anal sex, that put one at risk for HIV, also put one at risk for many other STDs.

- **STD infections increase** the chance of **acquiring** HIV infection:
  - Open sores and breakdown of cell layers provide easy **entry** for HIV into the body
  - White blood cells go to the STD site of infection to fight act as HIV receptors
  - Infections change natural defenses in vagina (pH, & loss of good bacteria)
  - STD infections in throat and mouth may increase HIV transmission via this route.

- **STD infections increase** the chance of **transmitting** HIV infection to others:
  - Open sores and breakdown of cell layers provide easy **exit** for HIV out of the body
  - White blood cells containing HIV are closer to skin surface, fighting at the STD infection site
  - Increase in the amount of HIV in semen (Ex. 8x higher w/ gonorrhea)

- Underlying HIV infection increases disease progression and complications of Hepatitis C, HPV-related cancers, etc.

- Underlying HIV infection alters symptoms of HSV, Syphilis, Hepatitis, etc.

- Treatment of STDs can help prevent HIV transmission
II. STDs and HIV: What are the differences in transmission?

- Some STDs can be passed by direct lesion-to-skin or lesion-to-mucous membrane contact, with no blood, semen, or vaginal secretions involved.

- Some STDs are relatively easy to transmit by oral sex, whereas HIV is not easily transmitted this way. (Gonorrhea can be passed through fellatio and Herpes and Syphilis can be passed through fellatio, cunnilingus, and analingus/rimming).

- Although it has not been proven, it may also be possible that STD infections in the throat or mouth may increase the chances for HIV infection via this route.

- Most STDs are much more sexually infectious than is HIV for any sexual route of transmission.

- STDs are much more common than HIV.

<table>
<thead>
<tr>
<th>For example:</th>
</tr>
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<tbody>
<tr>
<td>- In the U.S. each year there are about:</td>
</tr>
<tr>
<td>- 48,100 new cases of HIV</td>
</tr>
<tr>
<td>- 19 million new cases of STDs</td>
</tr>
<tr>
<td>- Total # of persons infected with either a STD or HIV in the U.S.:</td>
</tr>
<tr>
<td>- 1.2 million with HIV</td>
</tr>
<tr>
<td>- 100 million with STDs</td>
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III. **STDs Increase the Chances for HIV Infection**

- **STDs Increase the Risk of Acquiring HIV**
  - Chlamydia \( \uparrow \) risk 3 – 5 times
  - Genital Herpes \( \uparrow \) risk 3 – 6 times
  - Gonorrhea \( \uparrow \) risk 3 – 5 times
  - Syphilis \( \uparrow \) risk 3 – 4 times
  - Trichomoniasis \( \uparrow \) risk 2 – 4 times

- **Immune Response to Invading Organisms**

  **Systemic:** blood circulating antibodies, immune cells, immune factors

  **Mucosal:** Langerhans Cells, Monocytes, Macrophages, T Lymphocytes
  - skin
  - mucus layer
  - outer mucosal tissue
  - submucosal tissue

V. **How Common STDs Affect Mucosal Immunity**

- Gonorrhea and Chlamydiabacteria destroy columnar cells on the cervix, in the urethra, rectum, or throat;

- Trichomonas organisms destroy squamous cells of vaginal walls;

- When certain STDs are present, the WBC are closer to the surface of the skin (in the submucosa), therefore putting someone at more risk for HIV infection

- Herpes and Syphilis create lesions which are openings into the submucosa of the vaginal walls, cervix, urethra, anus, rectum, lips, and mouth.
Resulting in greater access to target cells for HIV.

Remember…

- If HIV (via blood, semen, vaginal fluids) contacts these surfaces, and the protective cell layers are removed, monocytes, macrophages, and T Lymphocytes are left exposed to be directly attacked by HIV.

- Successful STD treatment does not replace the destroyed mucosa right away. This may take a couple of weeks or more.

- This is one reason why patients are asked to abstain from sexual activity during STD treatment.

Sources

STD-HIV Connection
Cohen et al., "Reduction of concentration of HIV-1 in semen after treatment of urethritis: implications for prevention of sexual transmission of HIV-1" Lancet (349:9069) 6/97, p. 1868
Anderson K., et al. “Hepatitis C Virus Coinfection Increases Mortality in HIV-Infected Patients in the Highly Active Antiretroviral Therapy Era: Data from the HIV Atlanta VA Cohort Study” Clinical Infectious Diseases 2004; 39:1507-13
CA Department of Health Services, STD Control Branch surveillance data (10/2009)

STDs Increase the Chances for HIV Infection
Institute of Medicine, The Hidden Epidemic: Confronting Sexually Transmitted Diseases (1997)
Structure of Mucous Membranes

Urethra | Rectum | Cervix | Throat

Mucous Layer

- **C**
- **O**
- **L**
- **U**
- **M**
- **N**
- **A**
- **R**

**SQUAMOUS EPITHELIUM** (3-5 cell layers thin)

- **monocytes**
- **macrophages**
- **T-lymphocytes**

Submucosa (immune system white blood cells)

Vascular System (blood vessels)
I. Pregnancy versus STD/HIV Prevention

- Effective & consistent condom use are a good form of pregnancy prevention and STD/HIV prevention
- Hormonal methods of contraception are effective pregnancy prevention methods but not STD/HIV prevention
- Anal & oral sex can be methods of pregnancy prevention but not effective methods of STD/HIV prevention

II. Biomedical Interventions

- Antibiotics cure bacterial infections
- Convenient diagnostic technologies (urine)
- Early diagnosis and treatment may interrupt transmission
- Male circumcision reduces HIV/STD transmission
- Screening of asymptomatic infection prevents complications
- Effective vaccines for Hepatitis A & B
- New HPV vaccine for girls and young women

III. Health Care Policies

a. Health insurance access
b. HEDIS measures (i.e. yearly screening of sexually active females 25 and under for CT)
c. Culturally competent health care services

IV. Behavioral Interventions

- Community-level (i.e. media campaign)
- Group-level (i.e. educational workshop)
- Individual-level (i.e. counseling)
V. Health Education Messages

- Not having sex is the only sure method
- Talk to your partner about STDs and agree to protect yourselves if and when you have sex
- If you have sex - use condoms properly and consistently
- Have sex with only one partner, who has sex only with you – and who doesn’t have an STD infection
- Avoid sex-under-the-influence (SUI) of alcohol and other drugs.
- If you have sex, ask your doctor about testing for STDs regularly. If you are female – also get Pap tests.

VI. Minor Consent for STD Care in California

- “(a) A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer, or is a related sexually transmitted disease, as may be determined by the State Public Health Officer. (b) A minor who is 12 years of age or older may consent to medical care related to the prevention of a sexually transmitted disease. (c) The minor's parents or guardian are not liable for payment for medical care provided pursuant to this section.
  - Family Code 6926(a)(b) (c)

- There is no law in California requiring providers to notify parents or guardians when minors consent for STD prevention, testing and treatment services & other sexual health services

- Information about testing and/or test results are confidential and cannot be shared with a parent or guardian without the teen’s consent.

- The CA Family PACT program can pay for reproductive and sexual health services for teens and adults who qualify.
VII. Where can I refer people for STD testing and treatment?

See your local referral list, or call the National CDC Hotline in English & Español 24 hours/day, 7 days/week: Toll free: 1-800-CDC-INFO (1-800-232-4636), TTY for the Deaf and Hard of Hearing: 1-888-232-6348.

Or call your county health department (the telephone number will be in the white pages under “County Government”) and ask to speak to someone in the STD clinic or STD program.

Family PACT: Phone: 1-800-942-1054; Online: www.familypact.org

Text the word “hookup” to the number 61827 for STD clinic referrals in California.

VI. Safely Surrendered Baby Law

- Within 3 days of a birth, a person can anonymously turn over a baby to an official safe place – like a hospital or fire department – without being arrested.

- Surrendered babies are given medical treatment and placed in a foster home. A parent or guardian has up to 14 days from the time the baby is dropped off to reclaim the baby.

- For more information go to: www.babysafe.ca.gov
**Framing the Facts**

Behavior Change Theory and Client–Centered Messages

a. **Knowledge of STD Transmission**
   oral, anal, vaginal sex (asymptomatic)

b. **Perception of Susceptibility**
   chance of *exposure* to STD and chance of *infection* if exposed

c. **Perception of Severity**
   consequences and their likelihood and seriousness of consequences

d. **Perception of Self-Efficacy**
   next step and incremental change over time leads to risk reduction methods
How People Change Behavior

⇒ Over time....

⇒ Step...by...step... ⇒...forward...

(...with temporary set-backs) ⇐

⇒...with support... ⇒...

(...and occasional “slips”)... ⇐

⇒...and success experiences

- Knowledge alone is insufficient to achieve behavior change.
- Motivation for behavior change comes from within the individual and is highly influenced by a sense that one is vulnerable to a disease or condition.
- Motivation to change is also influenced by a person’s confidence that she/he can perform a specific behavior (self efficacy).
- Individuals are more likely to change behavior when they choose what, when, where, and how much they will change.
- Individuals are less likely to change behavior when they are “prescribed” only one acceptable behavior by someone else.
- Behavior change is complex. Many internal and external factors can influence an individual’s motivation, commitment, and ability to change behavior. These factors vary from person to person.
Key STD/HIV Facts for Teens

- Not having sex is the only 100% sure method of protecting yourself
- Talk to your partner about STDs and agree to protect yourselves if and when you decide to have sex
- If you have sex use condoms properly and consistently
- “Open sores are open doors” for HIV to enter and exit the body
- STDs are “treatable but repeatable”- you can get some of them again, and some you have for life
- Avoid sex under the influence (SUI) of alcohol and other drugs
- No one should ever force you to have sex
- Abstain from using needles for drug, steroid or tattoos
- STDs are much more common than we think
- STDs are sexually transmitted (vaginal, anal, oral) easily between sex partners.
- Most STDs have no signs or symptoms
- Reinfection by untreated and asymptomatic partners is common. Therefore, sex partners must be treated even if they have no symptoms.
- Serious consequences can occur from STDs
- Many STDs increase chance for HIV infection and transmission.
- If you have sex, ask your doctor to be tested for STDs regularly, if you are female also get a pap smear.
- If a person is concerned with having a STD, advice him/her to go to their doctor, healthcare provider, or STD clinic for help.
- There is no single test for all STDs, so be sure to ask which STDs you are getting tested for.
- Certain STDs can be cured with specific medications prescribed by a clinician. There are no home remedies or over the counter drugs that cure STDs.
Characteristics of Effective Curricula and How To Successfully Implement Them

1. Involve multiple people from varied backgrounds in the development of the curricula
2. Assess the relevant needs & assets of the targeted population
3. Use a logic model approach with specified goals & objectives
4. Design activities consistent with the targeted population’s values & available resources
5. Pilot test the program
6. **Focus** on at least one of three health goals: prevention of HIV, STDs &/or teen pregnancy
7. **Focus** on the behaviors leading to the above health goals
8. **Focus** on psychosocial factors that affect behaviors
9. Create a safe environment for youth to participate
10. Incorporate multiple activities to change targeted behavior
11. Employ teaching methods that are interactive & engaging for youth
12. Employ teaching methods, activities & messages that are culturally and developmentally appropriate
13. Cover topics in a logical way
14. Secure support from “authorities”
15. Select educators that are well trained, monitored, supervised & supported
16. If possible recruit youth and retain them
17. Implement curricula with reasonable fidelity
I. **BASICS OF ADOLESCENT DEVELOPMENT**

Adolescence can be summed up in one word: change. Understanding adolescent development—how children mature between the ages of 9-21, how those changes affect their families and other people around them, and how the surrounding society and culture influence that development—is critical to planning and implementing programs that can give teens the tools and skills they need to make and carry out responsible decisions.

Each adolescent is an individual with a unique personality and special interests, likes, and dislikes. And, although people go through changes at different times and paces, there is a series of developmental tasks that most everyone faces during the adolescent years. The changes generally come in stages depending on their age: early adolescence (9-13 yrs old); middle adolescence (14-16 yrs old); and late adolescence (17-21 yrs old). Some things to consider throughout all of these changes include:

1. **Transition areas for adolescents**
   
   a) **biological changes**: sexual maturation and physical growth
   
   b) **cognitive changes**: qualitative changes in the way adolescents think and gain perspective and quantitative changes in intelligence, brain development and information processing (i.e. critical and abstract thought, impulse control)
   
   c) **psychological changes**: development of identity, emotions, self-concept, experimentation, self-esteem, gender, mental health issues (i.e. depression)
   
   d) **social changes**: social relationships, dating, moral judgment, values, independence, acculturation

2. **Adolescent social and psychological issues**

   a) Identity
   
   b) Autonomy
   
   c) Intimacy
3. Influences on development

a) Families – including values, religion, culture and levels of acculturation
b) Peer groups
c) School
d) Work and leisure
e) Media

4. Social development issues

a) The need to establish caring, meaningful, satisfying relationships with individuals.
b) The need to broaden childhood friendships by getting acquainted with new people of differing backgrounds, experiences, and ideas.
c) The need to find acceptance, belonging, recognition, and status in social groups.
d) The need to pass from the homosocial interests and playmates of middle childhood to heterosocial concerns and friendships.
e) The need to learn about, adopt, and practice dating patterns and skills that contribute to personal and social development as well as romantic partner selection.
f) The need to find an acceptable gender role and to learn sex-appropriate behavior.
II. **GENERAL TIPS FOR WORKING WITH YOUTH**

1. **Things to keep in mind to improve communication and help development:**
   - Be specific in communication (address concrete thinking)
   - Avoid fear tactics (increase threat = increase denial, only short term behavioral reactions to fear, educator loses credibility if they later experience otherwise)
   - Model stress management – relate to emotional and physical response
   - Be cognizant of and help normalize changes like acne, breasts, wet dreams, etc.
   - Model and encourage goal-setting – and being accountable
   - Be friendly, humble and honest – don’t preach to them or try to be someone you’re not, teens will know you’re false and not respect you!
   - Encourage parent-teen communication and other adult mentor relationships
   - Do your homework and keep up on youth culture and media (content & tools)

2. **Logistical ideas that say “teen friendly” and help learning:**
   - Involve youth at all levels of program planning, promotion and delivery
   - Use visuals, multi-media and hands-on activities
   - Have food available
   - Comfortable environment – sit in circle, have couches and/or pillows on the floor
   - Decorations that youth relate to (have them design or add to décor)
Music playing as people gather and at breaks
Hold events in late afternoon, evening and/or on weekends

III. FACILITATION TIPS FOR SEXUAL HEALTH TOPICS

1. General tips for a healthy, helpful, and non-harmful perspective:

   • **Have fun!** Discussing sexuality and sexual health can be challenging and rewarding. You may be influencing very important decisions and life steps for the participants. Take this job seriously, yet have a good time with it.

   • **Be aware of societal attitudes**, media (TV, music, internet), peer norms, gender dynamics, and familial beliefs that play a major role in influencing an adolescent's decisions regarding sexual behaviors.

   • **Consider the participants’ race/ethnicity, cultural, religious, and ethical backgrounds** in the presentation of sexual information and in the preparation of group activities. If appropriate, use specific curricula designed for the cultural groups you work with. Some examples at [www.californiahealthykids.org](http://www.californiahealthykids.org)

   • **Consider the power of gender dynamics** in the classroom when discussing sexual issues. Depending on the topic or age group, it might make sense to separate females and males for certain activities in order to ensure complete and open participation, and then regroup to discuss what each group talked about. However, also be cognizant of transgender and intersex youth when using these facilitation techniques, allowing for individual choice or passing.

   • **Stick to gender neutral terms** when discussing sexual partners or intimate relationships. Avoid pronouns like he or she or the words “boyfriend” or “girlfriend.” Also, when discussing sexual activities, refer to just the body parts (i.e., anus, mouth, penis) versus gendered body parts (i.e., his mouth, her anus) in order to be inclusive of transgender and same sex partners. Also, use terms like “permanent relationship” or “life commitment” vs. marriage, since not everyone can legally
marry. And, use the term “sexual orientation” vs. “sexual preference” in order to not imply that homosexuality is a choice.

- **Listen with respect and see the participants’ viewpoints as imperative.** Their beliefs and points of view can directly impact their decision-making processes. As an educator, you can learn more about youth and sexuality from their beliefs and experiences. Incorporate these perceptions, social norms and experiences into the lessons and present alternative viewpoints.

- **Reserve your own opinions.** Try to listen to the group about what they think and feel. Also, try to avoid sharing your own personal values.

- **Encourage participants to discuss sexuality issues, beliefs, or values regarding human sexuality or STD prevention with their parents, guardians, or other trusted adults.** Research shows that youth fare better when they have at least one trusted adult with whom they can confide. One resource for “how to” is: [www.familycommunication.org](http://www.familycommunication.org)

2. **Practical techniques for safe and enriching sexual health discussions:**

- **Set up group guidelines** with youth to help create a safe space and to use in facilitation. Make sure there is consensus and that the youth create or add to the list. Examples:
  - Respect other people’s opinions, even if you do not agree
  - One person talks at a time (One Diva, One Mic)
  - No making fun of someone else’s questions, in class or outside of class
  - Don’t use real names or tell personal stories – use “a friend…”
  - You have the right to pass (not share verbally)
  - Respect privacy: no talking about personal comments outside of class
  - Step up if you’re more quiet or step back if you’ve been sharing a lot
• **Allow participants to provide responses first** before giving new or additional information. If the educator is the one to always speak first, it may discourage active participation essential to learning.

• **Provide the information in as non-biased a manner as possible.** When issues of morality are raised, bring it back to the science and/or universal principles of respect and acceptance. It is not the position of the educator to debate controversial issues pertaining to human sexuality and STD prevention, but rather to provide a safe place for information sharing.

• **Allow teens to use their own language** to describe a body part or a sexual act, but then respond to them by using medical terms. Recognize some word choices as differences in cultures or comfort levels, rather than differences in education or a lack of respect. However, you may also use this as a teaching opportunity to give participants other options for more widely accepted vocabulary. For example, “jacking off” is another word for masturbation.

• **Avoid the pronoun “you”** when discussing social norms or descriptions of populations in a sexuality discussion. Instead, use phrases like “some people, people your age, or people who share that value, etc.” People are less likely to feel singled out or get defensive.

• **Be humble and admit when you do not know** about the issue being discussed or you do not understand the terms being used. Ask for clarification and/or tell them you’ll get more information and get back to them.

• **Watch out for your own body language** and facial expressions with topics that are uncomfortable for you. The more neutral and supportive you are, the more they will engage and trust you.

• **Use an anonymous questions box.** Participants can write questions down (without their name on the paper) and put them in a box to be read aloud by the educator. This allows participants to ask things they would not say out loud, and to have everyone hear the
answers—since many will have the same questions. Be sure to address all the questions in some way.

- **Use experiential activities** that personalize material to their own lives (i.e. visualization)

- **Use hands-on or interactive activities** (games, demos, line-ups, group work, role plays)

- **Stack questions** – make sure people are recognized and that you’ll get to them

- **Address specific topics and/or behaviors** – concrete and situational examples like bringing up using a condom to protect yourself from HIV and other STDs (including when, how, why, pros and cons, etc.)

- **Focus on assessing perception of risk** (susceptibility and severity) then focus on positive and negative behaviors re: sexual decisions and building skills where needed

- **Address short term, concrete consequences** and how having an STD or getting pregnant may affect them physically and emotionally right now (and ask them what they think the consequences could be for them)

- **Cover age-appropriate topics** (i.e. more abstinence and sexual delay focused with younger teens, additional details on birth control and condom use with older teens)

- Cover topics in a logical sequence emphasizing main points to remember at the end. **Sexuality lessons can sometimes be distracting and can lead into tangents with questions and discussions. Therefore, it always helps to repeat the main take-home messages. This can also encourage participants to share their own personal conclusions.**

- **Clarify comments made by participants through paraphrasing. If clarification is needed, repeat what someone said, changing it**
slightly to make it clearer and then ask, “Is that what you were saying?” Paraphrasing may also be used just to validate or reinforce comments made by participants.

- **Present a comprehensive approach to school health education.** This approach will open communication for parents/guardians, teachers, teens, and community members in support of lifelong responsible decisions and will help reduce the incidence of STDs and other risks among youth.

- **Be cognizant of “challenging participants” need for information.** They could be uncomfortable with the topic, not have the words to ask, or just have other stuff going on:
  - Tired or low-energy – let them pass or involve them in more active work
  - Attention-getter or class clown – address common discomfort and having compassion for others
  - Quiet or shy – let them pass, address common discomfort or involve them
  - Bored or distracted – involve them in interactive methods or as your helper
  - Side-conversations and note-passing – others may benefit from questions or stories, if on topic

**IV. GUIDELINES FOR ANSWERING QUESTIONS ABOUT SEXUALITY**

Accept all questions as valid and legitimate. Some questions may be hard to hear or hard to answer. However, in a sexuality discussion, many times these are valid questions that participants do not get the chance to ask in their daily lives.

Remember confidentiality (ask that people always say “a friend…” when asking a question or telling a story, even when they are talking about themselves…and no names).

Keep in mind the development/maturity level, cultural background, and other visible or invisible diversity characteristics of the group, when answering questions about sexuality. Also, do your best to identify the
kind of question that is being asked and formulate your answer accordingly.

Below are six types of difficult questions you may encounter and some possible ways to for you to respond and address the issues raised:

A. INFORMATION QUESTIONS [Examples: Can you get an STD from a towel?, How long does sperm live in the body?, Where did STDs come from?, Can you get HIV from oral sex?]

1. Be honest. If you don’t know the answer, say so. Tell the group you will find the answer and get back to them or provide them resources so they can find the answer.
2. Answer questions age-appropriately. Pre and early adolescents need simpler, more concrete answers.
3. Don’t give to much unnecessary information. Try to give simple answers that avoid technical jargon.
4. If you aren’t sure what the young person if really asking, you may ask, “What have you heard about that?” or “Can you tell me what you already know about that?”
5. After answering the question, you may ask, “Does that answer you question?” or, if you want to check their understanding, ask them to tell you what they understand.

B. VALUE LADEN QUESTIONS [Examples: How many times should you have sex in one night?, Do you think it is okay to have an abortion?, Isn’t it a sin to have sex before marriage?]

1. Do not impose your own personal values.
2. Enforce universal values (exploitation is wrong, responsibility is good, etc.). For example, you might say: “There are many different forms of sexual expression. The main point is to respect each other and not judge people who are different from you.”
3. Put the value question back out to the participants and trust the group process, but be ready to facilitate! There may be some very
thoughtful responses. Sometimes it can be more powerful for teens to hear another perspective from their own peers. It is also essential in this process to always reinforce universal values (i.e., respect, acceptance, not judging others who are different from you).

4. If participants bring up a value and only discuss one point of view, it is important for you to make sure other points of view are discussed, either by you or the group.

5. Discuss the range of values regarding a specific issue.

6. Use the “for some, for others, for you” technique. For example, If asked, “When should someone have sex?,” you may answer, “That’s a very personal issue. For some people, they might be ready to have sex fairly young, for others, they might want to wait longer or until they are in a committed relationship to have sex, and, for you, that’s something only you can decide.” This technique can also be helpful for personal and sexually explicit questions.

7. Even when participants ask informational questions about value-laden issues, it is appropriate to discuss the value components.

8. Encourage children and teens to discuss values with their parents/guardian.

C. PERSONAL QUESTIONS [Examples: Are you still a virgin?, Do you use condoms?, Have you experienced anal sex?, How old were you when you first had sex?]

1. Feel free not to answer personal questions. You and the participants have the right to privacy. Tell them that these are personal issues and that you are not here to discuss you, rather help them learn more to protect their own sexual health.

2. NEVER discuss your personal sexual behavior.

3. Use your judgment to answer harmless personal questions. Remember, sharing personal information about yourself should always be done for a reason – to model appropriate sharing, to build group cohesion, to demonstrate empathy. It should not be done to meet your own needs.
D. “AM I NORMAL” QUESTIONS [Examples: How often should you masturbate?, How do you know if you are gay?, Is it ok to finger your girlfriend?, When do girls get breasts?]

1. These Questions are typically disguised, so be on the look out for them. Sometimes they are posed as general information questions or as “I have a friend who…” questions.

2. Answer in a reassuring and comforting tone. Be sure to discuss the range of normal and individual differences.

3. Never imply in a group setting that you’ve guessed that you’re answering an “Am I normal” question.

4. Provide appropriate private follow-up and referrals after class or one-on-one (i.e. LGBT or questioning youth, possible sexual abuse or intimate partner violence)

E. SHOCK VALUE QUESTIONS [Examples: What’s it like to get a blow job?, What do you scream when you orgasm?, Does “back door” sex feel like going to the bathroom?, What do you do if your penis is too big?]

1. Sometimes these questions are just to get a reaction or embarrass you and other times they are coming from legitimate curiosity. The best thing to do is to remain as neutral and calm as possible. Try not to react with surprise or rejection to the participants. You don’t want to satisfy the participant who is being disruptive, and you also don’t want to discourage the curious participant from asking questions in the future—especially with issues that may be taboo. Reacting in a calm way may take practice. Be patient with yourself.

2. Feel free to identify shock value questions for what they are, without missing a beat. Then move on. Try to become “un-shockable.”
F. SEXUALLY EXPLICIT QUESTIONS [Examples: What does sperm/vaginal secretions taste like?, How do people use sex toys?, What does your first sexual experience feel like? How do you give oral sex?]

1. Answer explicit questions in a simple, honest and sexually-positive manner. The goal is to be straightforward and clear without being overly descriptive or provocative.

2. Describe sexual behaviors in the context of the program values.

3. Avoid using language that conveys the idea that sex=sexual intercourse.

On-line Resources for Answering sexuality Questions:
These are just two teen-friendly websites that feature archives containing hundreds of questions from teens with credible, accurate answers that have been crafted especially for teens.

Please take note however, all content of answers may not be appropriate for classroom settings. Teachers and educators should carefully review answers and consider their organizational guidelines and rules – and make appropriate adjustments - before repeating answers verbatim.

Sex, etc.: http://www.sexetc.org from Rutgers University.

Scarleteen: http://www.scarleteen.com

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Characteristics of Effective Curricula
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"Making the Connections Between HIV and STDs" Curriculum and the STD 101 Teen Power Point of the STD Community Interventions Program (SCIP) of the Program Support Unit, Disease Prevention Section, STD Control Branch, CA Department of Health Services (CA Department of Public Health) CA STD/HIV Prevention Training Center – course on facilitating youth groups: www.stdhivtraining.org Adolescent Provider Tool Kit from the Adolescent Health Working Group (AHWG), 2003