UNIT 11:
STI/HIV AND ADOLESCENTS

INTRODUCTION:

The WHO estimates that over 1 million sexually transmitted infections (STIs) are acquired every day, and that one-third of those infections occur in young people aged 15-24. Over 2 million adolescents (aged 10-19) worldwide are living with HIV, and 26 new infections occur among adolescents every hour. UNAIDS (2016) reports adolescent girls and young women aged 15–24 years as being at particularly high risk of HIV infection, accounting for 20% of new HIV infections among adults globally in 2015, despite accounting for just 11% of the adult population. In regions with higher HIV prevalence, the gender imbalance is even more pronounced: in sub-Saharan Africa, adolescent girls and young women account for 25% of all new HIV infections among adults, and women account for 56% of new HIV infections among adults. Similar HIV global data disaggregated by age and disability are not yet available. UNAIDS, however, highlights that persistent discrimination against and exclusion of persons with disabilities, in particular women and girls with disabilities, increases their vulnerability, including their risk of HIV infection. This is confirmed by the data available on sub-Saharan Africa that highlights an increased risk of HIV infection of 1.48 times in men with disabilities and 2.21 times in women with disabilities compared with men without disabilities. A recent study on Cameroon published by the Lancet, confirms that the higher prevalence of HIV infection in persons with disabilities reflects a higher exposure to HIV infection as well as the presence of disability-associated HIV infection. The susceptibility of people with disabilities to HIV infection seems to be shaped by social and environmental factors. Further research is needed to inform firm recommendations on how to protect this vulnerable population.

An article published in the 2016 Journal of Adolescent Health reported that young people may avoid seeking services for STI symptoms for multiple reasons, ranging from lack of information about STIs and confusion about what services for STIs entail to inability to afford the cost of services or transportation. In some instances, however, easily accessible and free STI testing and treatment services may encourage adolescents and youth, especially boys and young men, to seek SRH services.

In any event, providers working with adolescents and young people **must** promote dual protection approaches, ensuring adolescents and young people understand the importance of taking steps to prevent both unintended pregnancy and STI/HIV infection, and to manage existing infections. Linkages to antiretrovirals (ARVs), the clinical cascade and community-based support is essential, and sexual and reproductive health services must also be available for young people living with HIV to prevent STI co-infection, HIV reinfection and/or unintended pregnancy.

UNIT TRAINING OBJECTIVE:

To familiarize providers with successful HIV and other STI prevention and management strategies for adolescents.

SPECIFIC LEARNING OBJECTIVES:

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

1. Understand the environment in which adolescents obtain information about sexuality, sexual and reproductive health.

2. Identify successful prevention strategies to prevent HIV and other STI transmission in adolescents.

3. Summarize appropriate clinical management of STIs.

TOTAL TIME: 2 HOURS 40 MINUTES

UNIT OVERVIEW:

Session	**Methods**	**Materials**	**Time**
11.1	Bingo game Trainer presentation	Participant Handout 11a Slides 11.1-11.3 *Optional: Local media articles*	1 hour
11.2	Group brainstorm	STI labels Colored candies or slips of paper Post-it notes Participant Handout 11b	30 minutes
11.3	Trainer presentation Group discussion	Slides 11.4-11.11	50 minutes
Unit Summary	Gallery walk	Post-it notes Flipchart	20 minutes

WORK FOR TRAINERS TO PREPARE IN ADVANCE

- Review Slides 11.1-11.11
- SO 11.1: Prepare bingo cards (double sided or two each) for participants. *Trainer's Note: If there is*

time, trainers should look for local media articles about adolescent sexuality, STIs, and HIV for the Media Bingo Game.

- SO 11.2: Prepare slips of paper, STI labels, and participant handouts for the group work.
- SO 11.2: Research national and local laws and policy on age of consent or parental consent/notification for adolescents to obtain sexual and reproductive health services, including HIV and other STI testing.
- Review the content of the UNAIDS publication *Disability and HIV* included in the references list and strengthen the understanding of the link between HIV and disability.

MAJOR REFERENCES AND TRAINING MATERIALS:

All in to #EndAdolescentAIDS Campaign: http://allintoendadolescentaids.org/

Colton, Tayla, Virginia Allread, Elaine Abrams, Anne Schoeneborn, Beatriz Thorne, and Ruby Fayorsey. 2012. *Adolescent HIV Care and Treatment: A Training Curriculum for Health Workers.* New York: Columbia University Mailman School of Public Health.

De Beaudrap P. et al. 2017. Prevalence of HIV infection among people with disabilities: A population-based observational study in Yaoundé, Cameroon (HandiVIH). *Lancet HIV*. April 4(4): e161-e168.

P. De Beaudrap. 2019.VIH & Handicap en Afrique de l'Ouest: Une analyse combinée de 4 études conduites au Burkina Faso, Niger, Guinée Bissau et Cap Vert. Lyon: Humanity & Inclusion.

Newton-Levinson, Anna, Jaime S. Leichliter, and Venkatraman Chandra-Mouli. 2016. "Sexually Transmitted Infection Services for Adolescents and Youth in Low- and Middle-Income Countries: Perceived and Experienced Barriers to Accessing Care." *Journal of Adolescent Health* 59 (2016) 7-16.

United Nations Joint Programme on HIV/AIDS (UNAIDS). 2016. *Global AIDS Update: 2016.* Geneva: UNAIDS.

United Nations Joint Programme on HIV/AIDS (UNAIDS). 2017. Disability and HIV. Geneva: UNAIDS. https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf

World Health Organization. 2015a. *Guideline on When to Start Antiretroviral Therapy and on Pre-Exposure Prophylaxis for HIV.* Geneva: WHO.

World Health Organization. 2015b. *Sexually Transmitted Infection Fact Sheet.* *http://www.who.int/mediacentre/factsheets/fs110/en/*

World Health Organization. 2005. *Sexually Transmitted Infections among Adolescents: The need for adequate health services.* Geneva: WHO.

SPECIFIC OBJECTIVE 11.1: UNDERSTAND THE ENVIRONMENT IN WHICH ADOLESCENTS OBTAIN INFORMATION ABOUT SEXUALITY AND SEXUAL HEALTH

TIME

1 hour

METHODS

- Bingo game
- Trainer presentation

MATERIALS NEEDED

- Local Newspaper/Magazine Articles about STIs including HIV *or* Trainer's Tool: Sample Articles
- Participant Handout 11a: Myths, Misconceptions, and Media Bingo Card
- Slides 11.1-11.3

STEPS

Time: 30 minutes

1. Distribute **Participant Handout 11a: Myths, Misconceptions, and Media Bingo Card** (below) to participants. Tell participants to choose a side to start with and let them know that they will use both sides and it doesn't matter in what order.

2. Introduce the activity. Explain that the trainer will read aloud from sample media articles about adolescent sexuality and sexual health. Participants should cross out squares when they hear examples in the article and yell out "BINGO" when they have a full line crossed out, either vertically, diagonally, or horizontally.

3. Allow time for participants to look over the Bingo card and ask questions about how the terms are defined. Terms on the Bingo card include:

- *Condom Dismissal:* Statements implying or directly stating that condoms are not protective or protective enough.
- *Gender Stereotypes:* General statements about the difference between men and women, or about "all men" or "all women," or statements about traits based on gender.
- *Male Urges*: Specific statements about men's sexual drive or urges.
- *Marriage Bias:* Language promoting marriage as a precondition for sexual activity or about the importance of (heterosexual) marriage to society or about the social dangers of "gay marriage."
- *Medical Inaccuracies:* Factually incorrect or misleading statements about science or medicine.
- *Myths:* Commonly held but false information about gender, disability, sexuality, STIs, and HIV seen as factual.
- "*Normal Sex":* Language implying that there is a correct or "normal" way to have sex, or that certain types of sexual activity and/or orientations are abnormal or incorrect.
- *Overly Scientific Language:* Use of complicated scientific words or phrases to describe sexual health issues.
- "*Purity":* Language or statements promoting chastity or purity, in particular for women and girls.
- *Sex Shaming:* Judgmental or stigmatizing language about sexual activities, sexual orientations, or

particular sexual acts, or implying negative associations with people who are sexually active.
- *Stigma (STIs/HIV):* Judgmental language or statements associating STI or HIV infection with "bad" or "wrong" behavior or personality characteristics.

4. Read **Content: Article 1** below (or from a local media article). When a participant yells "BINGO," have them come to the front of the room and explain to the rest of the group which boxes they've checked off to make a line and why. Ask if other participants disagree or have other examples from their sheets.

Content: Article 1

DISORDERS OF SEX: SEXUALLY TRANSMITTED DISEASES (STDS)

*This article was originally printed in Nigeria's **The Nation** on February 26, 2016, and can be found here: http://thenationonlineng.net/disorders-of-sex-sexually-transmitted-diseases-stds/*

Properly conducted, sex is an enjoyable exercise.

Sex is like everything around us: It too is guided by some natural and man-made rules. When these rules are flouted or when an individual is abused or his/her sex organs are somewhat tampered with or the body is mishandled, then sex becomes a problem and an infection, an unwanted dangerous outside agent may be introduced into the person's system. It's not the intention of the author of this book to write on every sexually transmitted disease.

A general guidance will be enough. Any disease agent can become sexually transmitted so long as it affects the genitals or reproductive organs or the disease affects the entry point used for "sex".

The following are the common sexual disorders or agents of sexual diseases:

Bacteria:

- Gonorrhoea
- Chlamydia trachomatis
- Syphilis
- Lyphogranuloma Inguinale
- Chancroid

Less well recognised but can be considered as sexually transmitted is a bacterium called Staph. Aureus.

Viruses

- Human Immune-Deficiency Virus (HIV)
- Herpes simplex virus (HSV): Type I and Type II
- Human Papilloma Virus (HPV)
- Hepatitis B and C

Parasites

- Trichomonas vaginalis (common in women but can be found in men too).

Fungus

- Candidiasis. Often called yeast, it is a common infection of the warm and moist areas of human body especially vagina. It may also affect other parts of the body such as mouth, gut, anus, and armpit. Untreated, it may be sexually transmitted to the sexual partner. (*Editor's note: Yeast is NOT defined as a sexually transmitted infection*).

Precautions

The probability of getting any of these infections is low provided:

a. You stick to one sexual partner

b. You are honest with your partner

c. You put your sexual organs into the partner's correct and biologically appropriate body entry point for which it was designed.

d. You use barrier a method such as a condom when engaging in sex with non-regular sexual partner. Although herpes type I may be contacted from kissing as are the above hepatitis viruses.

Recent Developments In recent years, there has been a spate of developments in what would otherwise not amount to sexually transmitted diseases.

In the last two years or so, Ebola ravaged West African countries of Liberia, Sierra Leone and Guinea. In recent times, there is a solid scientific proof that 9 months after an individual has

recovered from Ebola infection, he or she can transmit the infection to his or her spouse. We are still not sure if the duration of carrying the virus can be longer than 9 months. Thus, Ebola is effectively a sexually transmissible disease.

The lesson is many folds: When you are in Ebola-infected country, take caution in sexual engagement. Use protective methods such as condom or consider complete abstinence. Similarly, in the last one year, an old viral disease carried by mosquito has emerged. It's called Zika virus.

- ***Trainer's Note****: If one participant finishes quickly, feel free to continue with the first article after they've explained their result. You may continue as long or as short as you feel necessary to make your point*

5. Repeat with **Content: Article 2** below, having participants use the other side of their Bingo Card handout.

Content: Article 2

KENYA: POLICE WARN PARENTS OVER 'SEX' PARTY

This article was originally posted on AllAfrica.com on March 6, 2016, and can be found here: http://allafrica.com/stories/201603060005.html

If you are a parent, especially in Nairobi, you are warned to mark next Saturday on your calendar because it could be the ultimate nightmare for parents raising teenage children.

In what could be an indication of a new level of exploitation by adults luring underage children to house parties that offer alcohol, drugs and sex orgies, promoters of an event have been circulating an invitation on social media that promises to be the "most epic of all time".

The event that is planned to take place at an undisclosed location in Nairobi's upmarket Kileleshwa estate is apparently an imitation of the movie, "Project X", which is described globally as the standard measure of the ultimate home-wrecking hell raiser of a party by unsupervised suburban teenagers.

The 2012 American film is about a teen party filled with alcohol, drugs, topless girls and sex that totally went out of control.

Cases of teenagers emulating the film by staging their own parties have ended disastrously across the world, with some leading to death.

The messages by the supposed organisers of the Kileleshwa event who freely give their contacts, mainly circulated on WhatsApp, appear to advocate a Kenyan version and promise to encourage the teenagers to be involved in debauchery.

A series of games based on new ways to take drugs and alcohol that are popular in Western countries intended to show the revellers how to get high with very little doses are also lined up.

In a show of impunity, the event organisers have even opened social media accounts that have been attracting many followers.

Hundreds of teens have expressed interest to attend the party whose advance tickets cost Sh500.

Some shops on Moi Avenue have been identified for those who want to buy advance tickets. An M-Pesa number has also been provided. Only those who have paid will be given directions to the venue, according to the organisers.

But police told Sunday Nation that they are aware of the said party and said "it won't happen". Police spokesman Charles Owino warned parents to be careful about the behaviour of their children and their whereabouts.

"Rest assured that the organisers will be arrested and charged before it happens," he said.

WORRYING TREND

Nominated MP Isaac Mwaura said the event must be "stopped at all costs." "We cannot allow people to cash in on our vulnerable youth. I have already communicated to Mr (Joel) Kitili (the acting Deputy Inspector General of Police) for them to take action. We must safeguard the morals of our country," Mr Mwaura said.

One parent expressed his worry about the obsession with sex and drugs among the youth.

"Youth should engage in constructive projects like clearing garbage, helping in hospitals, sharpening their debating and fundraising skills. The obsession with sexual orgies is worrying," said Natado Nashon, a parent.

There have been concerns of children involved in underage drinking.

In October last year 550 students, most of them minors were arrested in a basement disco in Eldoret while on a hedonistic rampage of drugs and sex.

In the same month more than 200 boys and girls were arrested at a bar on Dubois Road in Nairobi where they were also drinking alcohol.

And in August, 45 high school students were arrested for smoking bhang, drinking and having sex in a moving bus in Murang'a.

The HIV infection rate among adolescents has also increased.

In its 2015 report on HIV/Aids among children released in December last year the United Nations Children's Fund says almost half of the adolescents with HIV worldwide are in six countries that include Kenya, Tanzania, South Africa, Nigeria, Mozambique and India.

But despite this risk, teenage parties where sex, drugs and alcohol are the main items in the menu have been increasingly becoming common.

6. If there is time and participants are interested, pass out additional Bingo cards and continue with **Supplemental Content: Article 3** below.

- ***Trainer's Note:*** *You can also substitute Article 3 for either Article 1 or 2 above, or use local media articles instead of the articles provided.*

Supplemental Content: Article 3

MORE YOUNG FILIPINOS HIV-POSITIVE

This article was originally posted in the Manila Times on March 25 2014 and can be found here: http://www.manilatimes.net/more-young-filipinos-hiv-positive/85420/

The Philippines is one of nine countries where the number of human immunodeficiency virus-acquired immunodeficiency syndrome (HIV- AIDS) cases is growing. But what is more alarming is that many of the new victims are teenagers, with some as young as 15.

Based on a study conducted by the Department of Health (DOH), more young Filipinos have acquired HIV. Data from the Philippine HIV/AIDS Registry showed that in January of this year alone, 118 of the new HIV patients belong to the 15 to 24 age bracket.

They are among the 448 fresh HIV cases reported for the first month of the year.

Half of the 448 victims, or 224 patients, are from Metro Manila, while 16 percent come from the Calabarzon region, seven percent from Davao region, and four percent from Western Visayas. The rest of the regions recorded less than one to two percent of HIV cases this year.

From 1984 to January 2014, 36 people below 15 years old were infected with HIV. For the same period, 429 people aged 15 to 19 acquired the virus, as well as 3,467 in the 20 to 24 age bracket. The United Nations Children's Fund (Unicef) has also noticed this disturbing trend, saying new HIV infections "now occur at a younger age."

“In some areas, one in three persons most at risk are in the 15-17 age group,” Unicef said. Experts attribute the spike in HIV cases to unprotected sex. The sharp increase in HIV cases started in 2008.

Teresita Bagasao, Country Coordinator for the UN Program in HIV/AIDS (UNAIDS), said there is a decline in infection and death figures worldwide. However, the Philippines is on an upward trend.

“Sad to say, we are included among nine countries with over 25 percent new reported infections. It’s worrisome because the new infections that have been reported have come only in the last three years,” she said.

The other countries where HIV/AIDS is on the rise are Bangladesh, Indonesia, Sri Lanka, Kaszakhstan, Kyrgystan, Republic of Moldova, Georgia, and Guinea-Bissau.

From 2008-2012, there was a 538 percent increase in new cases of HIV in the Philippines, according to the National Epidemiology Center of the Department of Health (DoH).

Bagasao said when the first infection was reported in 1984, HIV/AIDS was considered a slow and hidden disease. But since 2007 when one HIV case was reported every three days, the disease has been on a “fast and furious” rampage. Now, one HIV infection is reported every two hours or 30 cases a day.

According to a 2013 study of the University of the Philippines Population Institute (UPPI), premarital sex among the youth rose to 32 percent from 18 percent in 1994. The study showed that in 2013, 6.2 million Filipino youth had premarital sex, and more than half of this number—4.8 million young people—indulged in unprotected sex.

Of the 6.2 million, 7.3 percent engaged in casual sex (one with no relationship or payment involved, and happened only once or twice), and 5.3 percent of males had sex with other males.

However, only 40 percent of these youth aged 15 to 24 are aware of sexually transmitted diseases. However, 80 percent are aware of HIV/AIDS.

“This means that the youth are not able to connect AIDS with sexually transmitted diseases,” UPPI Dean Joy Natividad said. She described the findings as “shocking” because these are youth who have graduated from high school and college, but they do not understand STDs.

The study noted that unprotected sex could heighten the risk of pregnancy or acquiring sexually-transmitted diseases.

Infections among the youth, which comprise one-fourth of the total number of cases, increased tenfold in 2013, with 995 reported infections from 44 in 2006. The estimates exclude unreported cases.

Natividad said unprotected sex remains to be the main cause of HIV infection.

"There is a heightened, bolder and wider range of sexual behaviors including those that use the new high- speed technology," she pointed out.

She said the study also looked into how many people found sex partners from texting and the Internet and found that ways of interaction can lead to risky behavior among the youth, such as casual, regular, non-romantic same-gender and extramarital sexual experience.

Meanwhile, Jeffrey Acaba, co-convenor of the Network to Stop AIDS-Philippines (NSAP), said migrants, transgenders, homosexuals and other vulnerable sectors are also at high risk.

"The question is, how do we give them access to HIV testing?" he said.

He added that even if condoms are now sold openly, there is still a "social stigma" on the person purchasing them.

7. Discuss with participants the information and media environment in which adolescents live. Sample discussion questions include:
   a. How does the language in the media affect young people's understanding of their sexual health?
   b. How well does mass media/communications that promote healthy sexual and reproductive health behaviors reach adolescents and young people? Why or why not? Are the messages disability inclusive?
   c. What are some of the common misconceptions young people come into services with?
   d. Does disability add any additional layers of misconception? Are there any misconceptions directly or indirectly related to disability?
   e. Where do these misconceptions come from?
   f. How can a service provider counter some of the misinformation young people are exposed to?

8. Close the activity by explaining to participants that adolescents and young people face misinformation about gender, disability, sexuality, sexual health, and HIV/STIs every day. The service provider needs to be equipped not only to provide testing, but to have a compassionate counseling style that helps adolescents identify false information, find accurate information, develop skills to make safe choices and respond to stigma in their environment.

Time: 30 minutes

9. Introduce the trainer presentation **Content: Adolescent-Friendly Language** (Slides 11.1-11.3) below by reminding participants that service providers who work with youth and adolescents frequently find themselves wearing many professional hats, including medical clinician, educator, counselor, social worker, and ally, as well as personal and community hats—father, mother, sister, brother, aunty, uncle, faith leader, community leader.

Begin the presentation.

Content: Adolescent-Friendly Language (Slides 11.X-11.3)

Slide 11.1: Information Environment

Adolescents and young people navigate a complicated world of stereotypes, half-truths, and taboos when it comes to information about gender, sexuality, sexual health, STIs, and HIV. Even well-meaning sources of information for adolescents, such as parents, teachers, religious leaders, and the media, may not have all the latest medical or scientific information, and in any event are often uncomfortable explaining complicated and sensitive issues to young people in a straightforward and non-judgmental way. This is particularly true when it comes to adolescents with disabilities, due to the widespread taboos and myths linked to sexual behavior of persons with disabilities and the limited experience and knowledge of parents, teachers, religious leaders, and the media about sexuality and disability.

Service providers working with adolescents must balance between providing young people with medically accurate, honest assessments of their risk and avoiding language that stigmatizes young people based on their sexual activity or uses fear or shame as a motivator to avoid risk. Service providers should also find ways to praise and reinforce positive behaviors. Remember from Unit 1: adolescents are incredibly sensitive to dishonesty, unfairness, or judgment from adults, and respond more positively to honesty and direct language.

10. Tell participants that you're going to practice using non-judgmental language. Bring up **Slide 11.2: Common Statements about Adolescents** below. Ask participants to try rephrasing the statements in adolescent-friendly, non-judgmental language. Use **Supplemental Content: Rephrased Statements** below for examples as needed.

Slide 11.2: Common Statements about Adolescents

- "Youth lack self-control around sexual decision-making and have irresponsible sex."
- "Adolescents with disabilities can't decide by themselves about their sexual life and need their parents/guardians to take decisions for them".
- "Adolescents know nothing about the symptoms, transmission and treatment of STIs."
- "Adolescents often experiment with drugs and alcohol which leads to irresponsible decisions, and unprotected sex."
- "Young people often confuse sex with love and engage in sex before they are mature."

Supplemental Content: Rephrased Statements

- "Young people have a harder time obtaining contraception and often face social disapproval if they are seen as planning for sexual activity by having condoms."
- Adolescents with disabilities are often denied their sexual and reproductive autonomy as well as full access to SRH information and services. As a result they are more exposed to the risk of HIV, unintended pregnancies, HIV, or violence.
- "Adolescents lack *access* to basic information on the symptoms, transmission, and treatment of STIs."
- "Experimentation with drugs and alcohol may happen as part of adolescence and may have an effect on some young people's decisions about when they have sex and with whom."
- "Young people are experiencing first love and relationships and frequently have questions about sex and how to know if they're 'ready.'"

11. Return to presenting **Content: Social Dynamics and Factors (Slide 11.3)** below.

Content: Social Dynamics and Factors (Slide 11.3)

There are some social dynamics and factors that affect adolescents' risk for STI and HIV infection of which providers should be aware.

➢ ***Trainer's Note****: Ask participants to brainstorm a few factors before citing the following.*

- Unequal gender norms drive power imbalances which can make adolescents more susceptible to sexual violence and sexual coercion.
- Adolescents' need to belong to a social group increases the likelihood of sexual coercion and/or social pressures to have sex.
- Many cultures expect adolescent sexuality to be hidden or non-existent. This is especially true of young people living with HIV, adolescents with disabilities, and LGBTQ youth.
- The intersection of gender, age, and disability often results in additional vulnerabilities, marginalization and exclusion of persons with disabilities from social participation. This limits their access to information and services and makes adolescents with disabilities more susceptible to violence and coercion.
- Taboos often prevent young people from seeking accurate information on sexuality and sexual health. Adolescents with disabilities also face additional physical, communication and attitudinal barriers. These taboos and barriers leave them with unanswered questions and assumptions about the sexual activity and risk behaviors of their friend and peers.
- Young people are frequently disenfranchised and disempowered which can increase their vulnerability to harmful practices, such as early and/or forced marriage, female genital mutilation/cutting, or transactional, coercive, or even violent sexual relationships.
- Adolescents may fear seeking testing or treatment for STIs or HIV because of the social stigma attached to a positive test result. Fear may be even stronger among adolescents with disabilities who are already discriminated against because of their disability.
- Contraception can also be stigmatized, and young people may fear community judgment of their use of contraception.

12. Close the presentation by reminding participants that service providers must always support the adolescent's ability to obtain clear, factual and direct information, while correcting myths and dispelling stigma.

PARTICIPANT HANDOUT 11A: MYTHS, MISCONCEPTIONS, AND MEDIA BINGO

Side 1:

Sex Shaming	Condom Dismissal	Medical Inaccuracies	"Normal" Sex	Stigma (STIs/HIV)
Marriage Bias	"Purity"	Male Urges	Gender Stereotypes	Medical Inaccuracies
Myths	Stigma (STIs/HIV)	FREE SPACE	Overly Scientific Language	"Normal" Sex
Male Urges	Medical Inaccuracies	Sex Shaming	Stigma (STIs/HIV)	Marriage Bias
"Purity"	Gender Stereotypes	Overly Scientific Language	Myths	Sex Shaming

PARTICIPANT HANDOUT 11A: MYTHS, MISCONCEPTIONS, AND MEDIA BINGO

Side 2:

Overly Scientific Language	"Purity"	Sex Shaming	Marriage Bias	Condom Dismissal
Marriage Bias	Stigma (STIs/HIV)	Gender Stereotypes	"Normal" Sex	Medical Inaccuracies
Condom Dismissal	Male Urges	FREE SPACE	"Purity"	Stigma (STIs/HIV)
Myths	Marriage Bias	Medical Inaccuracies	Sex Shaming	Overly Scientific Language
Stigma (STIs/HIV)	Gender Stereotypes	Condom Dismissal	Myths	Male Urges

SPECIFIC OBJECTIVE 11.2: IDENTIFY PREVENTION STRATEGIES USED SUCCESSFULLY IN PREVENTING STI/HIV TRANSMISSION IN ADOLESCENTS

TIME

30 minutes

METHODS

- Group brainstorm

MATERIALS NEEDED

- Colored sweets or small pieces of colored paper in 4-5 different colors and a container to hold them.
- Large and small post-it notes in 3 different colors *or* blank paper/post-it notes and different colored markers.
- Labels for STIs.
- Participant Handout 11b: Common STIs,

STEPS

1. Introduce the activity to the participants. Pass around the container with the colored sweets or colored paper and have participants select a piece of paper or a sweet. Based on the color that they chose, participants can break into smaller groups.

2. Distribute **Participant Handout 11b: Common STIs**. Tell participants to use the handout as a reference for this exercise.

Time: 30 minutes

3. Assign each of the small groups an STI, being sure to include: HIV, herpes (HSV 1 and 2), HPV, syphilis, and gonorrhea or chlamydia.

➢ ***Trainers Note****: other STIs can be added, either for larger training groups or to adjust to local prevalence rates for specific infections. Create labels for each STI used and place them on the walls around the room.*

In some countries, yeast infections are treated as STIs. A yeast infection can be transmitted during sexual intercourse, although this is rare. ***Yeast infections are not considered an STI****. Vaginal yeast infections are caused by an overgrowth of the fungus, Candida, and most women will have at least one yeast infection in their life, which is not related to sexual activity.*

4. Provide each small group with the different color post-its/paper.

5. In the smaller groups, ask participants to discuss and put their responses on post-its to the following questions:

- Why are adolescents at risk for this STI?
- What prevention strategies can adolescents use to protect themselves from this STI?
- How can you as a service provider help an adolescent client implement this prevention

strategy?

6. Ask one of the smaller groups to focus specifically on adolescents with disabilities, to discuss and put on post-its responses to the following questions:
    - Are adolescents with disabilities exposed to different risk factors for this STI? Why?
    - What prevention strategies can adolescents with disabilities use to protect themselves from this STI?
    - How can you as a service provider help adolescent clients with disabilities implement this prevention strategy?

➢ ***Trainers Note****: Have participants use their three different colors to separate their answers to the three questions. For example: Yellow = risks, Green = prevention strategies, and Blue = service support.*

7. Have participants place their post-its on the wall under a label for their STI, and then give all participants time to tour the room and look at other small groups' work.

➢ ***Trainers Note****: Use this time to also wander the room and keep an eye out for judgmental or stigmatizing language, in particular around adolescent risk. Also keep an eye out for prevention strategies which limit the expression of adolescent sexuality, such as total abstinence, or which are gender or disability biased, such as those that cite adolescent women as being responsible for sexual decision-making or adolescents with disabilities as being unable to take autonomous decisions on their sexual and reproductive health. If this language appears, make sure to address it in the group discussion.*

8. Ask the whole group to reconvene in the center of the room to discuss the activity, using the following prompts:
    a. What risks or prevention strategies stood out to you? Were there any listed under different STIs that you thought should also apply to your own?
    b. Did any of the language on risk stand out to you as being judgmental or "sex-negative" around adolescent sexuality? Did any of the language stand out as being particularly youth-friendly or sex-positive?
    c. What were some of the common risks across different STIs?
    d. What were some of the common prevention strategies?

➢ ***Trainers Note****: Ensure that all the prevention strategies listed below under* ***Supplemental Content: Prevention Strategies for Young People*** *have been mentioned.*

    e. Did any of the advice stand out as to how we as service providers can help adolescents implement prevention strategies? Were there any ideas you think you could use in your own work?

Supplemental Content: Prevention Strategies for Young People

Young people should have information about and be encouraged to:

Discuss STI and pregnancy risk and prevention with their partners. Young people should be supported

to develop strategies and skills to discuss risk and prevention with new partners before commencing a sexual relationship.

Find accurate information on risk. Young people should have accurate sources of information to understand how STIs are transmitted and to be able to assess their own level of risk. Mobile apps and online tools are increasingly available for young people to find information and assess their risk. Apps and online tools MUST be vetted to ensure they are evidence-informed.

FHI360 has developed the Mobile for Reproductive Health (m4RH) service, which is an automated, interactive and on-demand SMS system that provides simple, accurate and relevant information on SRH. See: https://m4rh.fhi360.org/

Get vaccinated for HPV. The vaccine for HPV is increasingly available to young people in low- and middle-income countries. The HPV vaccine is recommended by the WHO for adolescent girls as young as age 9. The HPV vaccine is also recommended for adolescent boys, both to protect them and their partners.

Know their condom and protection options. Adolescents should be able to easily obtain both female and male condoms, and know the various benefits, risks, and uses for each.

Learn how to use condoms and use them consistently and correctly. All adolescents should become comfortable with condoms before becoming sexually active. If young people are already sexually active, it is important to make sure they know how to use condoms correctly. This information should also include advice on lubricants which are safe to use with latex or other condoms.

Get tested between partners or with new partners. The importance of regular testing for those at risk of HIV should be emphasized. HIV testing and services can be integrated with other medical services, in particular sexual health and STI assessments. Providers should inform adolescents of relevant national laws affecting age of consent or parental consent/notification for HIV testing and other sexual and reproductive health services.

Frequently national laws only specifically cover age of consent for HIV testing and services, or for general medical services. These laws may not specify an age of consent for other sexual and reproductive health services or STI testing. Providers should clarify the policy or guidelines within their own clinic or organization as well as national and local laws and look for opportunities to improve adolescent access to services. For more information on services for adolescents living with HIV, see Unit 12. For more information on services for adolescents with disabilities see the chapter "Adolescents with Disabilities"

Recognize symptoms of STIs. If there is burning with urination and/or unusual discharge from the penis or vagina, or there are genital sores, young people should come to the clinic for assessment and treatment. Untreated STIs can cause more complex health problems, like pelvic inflammatory disease or infertility. Failure to properly assess and treat STIs can also increase risk of HIV infection.

Discuss sexual issues. Adolescents must feel comfortable communicating with their partners and with service providers about sex, sexual behaviors, and their sexual histories.

Understand their right to autonomy, or to control their bodies. Young people should be supported to know their right to determine if, when, how, how often, and with whom they are sexually active. This includes young persons with disabilities.

Access health and support services in the case of sexual violence. Adolescents should know and understand the role of health services in responding to sexual violence, including their access to Post-

Exposure Prophylaxis (PEP) for HIV, emergency contraception to reduce unintended pregnancy, and other psycho-social support.

Consider Pre-Exposure Prophylaxis (PrEP) for adolescents at high risk of HIV. The latest WHO guidance recommends the use of pre-exposure prophylaxis for people at "substantial risk" of acquiring HIV, including members of key populations such as young gay men, bisexual men, and men who have sex with men; young people who use injectable drugs; young transgender people; young people who sell or trade sex; or young people in sero-discordant couples. PrEP is also recommended for young people engaged in transactional or cross-generational or non-monogamous sexual relationships. The WHO has found no evidence that PrEP increases risk-taking behaviors among those who take the drug. PrEP does not affect the effectiveness of hormonal contraception.

PrEP should not displace or threaten the implementation of effective and well- established HIV prevention interventions, such as condom promotion and harm reduction. Stigma drives HIV infection, and stigma could either decrease or increase depending on the how PrEP is administered. PrEP should be promoted as a positive choice among people for whom it is most suitable and their communities, in conjunction with other appropriate prevention interventions. – WHO Guidance

PARTICIPANT HANDOUT 11B: COMMON STIS

Source: Center for Disease Control and Prevention Fact Sheets (http://www.cdc.gov/std/healthcomm/fact_sheets.htm)

STI	Basics	Symptoms		Transmission
HIV	*Viral *manageable with treatment and care regimen	*flu-like symptoms: fever, body aches, swollen glands *other STIs *tuberculosis		*unprotected vaginal, oral or anal sex *contact with infected blood (shared needles) *mother to child during pregnancy, delivery or breast-feeding
Herpes (HSV1 and HSV2)	*Viral *manageable with treatment and care regimen	*asymptomatic or mild initial symptoms *small, blister-like sores on the genitals, anus or mouth *flu-like symptoms: fever, body aches, swollen glands		*unprotected vaginal, oral or anal sex *contact with an open sore
HPV	*Viral *Vaccine Available *linked to cervical and other cancers *frequently disappears on its own	*frequently asymptomatic *causes genital warts *cervical cell abnormalities		*unprotected vaginal, oral or anal sex
Syphilis	*Bacterial *treatable with antibiotics	Phase 1 *mild symptoms *small, painless sore *non-itchy body rash	Phase 2 *flu-like symptoms: fever, body aches, swollen glands *sore throat	*unprotected vaginal, oral or anal sex *contact with an open sore *mother to child during delivery

			*hair loss *headache *weight loss *fatigue	
Gonorrhoea	*Bacterial *treatable with antibiotics	*frequently asymptomatic *burning during urination *vaginal, anal or penile discharge *testicular swelling *bleeding between periods (spotting) *anal itching, bleeding or soreness *painful bowel movements		*unprotected vaginal, oral or anal sex *mother to child during delivery
Chlamydia	*Bacterial *treatable with antibiotics	*frequently asymptomatic *vaginal or penile discharge *burning during urination *rectal pain, discharge, or bleeding *testicular swelling		*unprotected vaginal, oral or anal sex
Tricho-moniasis	*Parasitic *treatable with antibiotics	*frequently asymptomatic *irritation or inflammation of urethra, vulva, or vagina *itching or irritated penis or vagina *burning during urination *vaginal or penile discharge		*unprotected vaginal sex
Hepatitis	*Viral *vaccine available	*fever *fatigue *loss of appetite *nausea/vomiting		*unprotected vaginal, oral or anal sex *contact with infected blood (sharing needles)

	*manageable with support and care	*abdominal pain *grey bowel movements *joint pain *jaundice	*mother to child during delivery

NOTE: ALTHOUGH YEAST OR CANDIDIASIS CAN BE TRANSMITTED VIA SEX, THIS IS RARE. YEAST/CANDIDIASIS IS NOT A SEXUALLY TRANSMITTED INFECTION

SPECIFIC OBJECTIVE 11.3: SUMMARIZE APPROPRIATE CLINICAL MANAGEMENT OF STIS

TIME

50 minutes

METHODS

- Trainer presentation
- Group discussion

MATERIALS NEEDED

- Slides 11.4-11.11

STEPS

Time: 20 minutes

1. Introduce the presentation. Remind participants that young people are at particular risk for STI transmission, including HIV and that adolescents with disabilities are exposed to even a higher risk. Present **Content: STI Prevalence and Testing** (Slides 11.4-11.11) below.

Content: STI Prevalence and Testing

Slides 11.4-11.11: Prevalence and Testing for STIs

Sexually transmitted infections, or STIs, are increasingly common among all people, including adolescents, worldwide. The WHO and the US-based Center for Disease Control and Prevention estimate that:

- Most sexually active adults will contract some strain of HPV at least once in their lifetime.
- More than 500 million people have a genital infection with HSV.
- There are an estimated 357 million new infections each year with one of four STIs: chlamydia, gonorrhea, syphilis (which are caused by bacteria), and trichomoniasis (which is caused by a parasite).

Many STIs have vague, mild or infrequent symptoms and symptoms may go away on their own. Young women often do not know they have been infected. Due to the limited availability of information and education on STIs, combined with cultural stigmas and taboos, many adolescents, young people, and adults fail to obtain sexual health services, even when they do experience symptoms. Persons with disabilities face even more barriers to accessing services.

Young women may present at clinics with candidiasis or a yeast infection. Although yeast can be transmitted sexually, this is rare. Yeast infections are common in hot, humid climates, and can occur in the absence of sexual activity. Yeast infection is more likely among women who:

- Are using antibiotics
- Are using combined oral contraceptives (due to estrogen content)

- Have a suppressed immune system due to diabetes or HIV
- Are pregnant
- Consume excess sugar
- Have nutritional deficiencies (zinc, B12)
- Wear tight clothing or nylon underwear

STIs are common worldwide, but low- and middle-income countries bear a huge burden of poor health outcomes related to undiagnosed or untreated STIs. While diagnostic tests are widely used to locate and treat asymptomatic STIs in high-income countries, these tests are frequently unavailable in low- and middle-income countries. Most countries use syndromic diagnosis, which is dependent on the presence of recognizable symptoms.

Where testing is available, it is often expensive or limited to select facilities, making it even more inaccessible. Low-cost, rapid tests are increasingly available for HIV and syphilis. The test for syphilis is new and may not be widely available.

2. Pause and ask participants to reflect on what tests if any are available in their clinic and in their nearest district health facility. Return to presentation with **Slide 11.8: Effective STI Treatment** below.

Slide 11.8-11.9: Effective STI Treatment

Source: World Health Organization

Effective treatment is currently available for several STIs.

- Three bacterial STIs (chlamydia, gonorrhea and syphilis) and one parasitic STI (trichomoniasis) are generally curable with existing, effective regimens of antibiotics.
- For HSV and HIV, the most effective medications are antivirals that can moderate the course of the disease. There is no cure for HSV or HIV.
- For hepatitis B, immune system modulators (interferon) and antiviral medications can help to fight the virus and slow damage to the liver.

Safe and highly effective vaccines are available for hepatitis B and HPV. These vaccines represent major advances in STI prevention. The vaccine against hepatitis B is now included in infant immunization programmes in 93% of countries and has already prevented an estimated 1.3 million deaths from chronic liver disease and cancer.

Drug resistance of STIs to antibiotics —in particular gonorrhoea—has increased rapidly in recent years, thus limiting treatment options. New strains of gonorrhoea have emerged that demonstrate decreased sensitivity to the "last line" treatment option (oral and injectable cephalosporins). Gonorrhoea already shows resistance to multiple drugs, including penicillin, sulphonamides, tetracyclines, quinolones and macrolides. Antimicrobial resistance for other STIs, though less common, also exists, making prevention and prompt treatment critical.

Slide 11.10-11.11: STI case management

Low- and middle-income countries rely on identifying consistent, easily recognizable signs and symptoms to guide treatment, without the use of laboratory tests and in accordance with WHO

recommendations. This is called syndromic management. This approach, which relies on clinical algorithms, allows health workers to diagnose a specific infection on the basis of observed symptoms and syndromes (e.g., vaginal discharge, urethral discharge, genital ulcers, abdominal pain).

Syndromic management is simple, assures rapid, same-day treatment, and avoids expensive or unavailable diagnostic tests. However, this approach misses infections that do not demonstrate any symptoms or syndromes, which is true for the majority of STIs globally. Overuse of treatment regimens related to syndromic management contributes to STI drug resistance.

As already mentioned, many STIs present with few or mild symptoms making them difficult to diagnose and treat. Furthermore, many STIs present with symptoms that are identical to or mimic other health issues. For example, vaginal discharge is normal. It can also be related to an infection. In many settings, 40-50% of women will say "yes" when asked if they have discharge, and it is unclear if their discharge is normal or related to an infection. Treating all women who respond yes to the presence of discharge would lead to massive overtreatment of STIs. In fact, studies of the validity of syndromic management have shown that vaginal discharge should not be used as a routine screening question. There is some evidence that syndromic management of vaginal discharge can be strengthened by cervical examination to determine whether there is a cervical discharge or inflammation, but this requires training, tools, time, and supplies.

Time: 30 minutes

3. Ask participants to consider the following case studies in small groups at their tables. Ask them to come up with a diagnosis and treatment plan for each case study based on the resources they have available to them in their clinics.

4. Read **Content: Case Study 1** below and give groups **10 minutes** to discuss and write down a diagnosis and treatment plan.

Content: Case Study 1

A 17-year-old single man with a hearing disability complains of burning on urination and discharge from his penis. He says he has had a new sexual partner in the past month. On examination of the urethra, a thick yellowish discharge is visible.

5. Ask the group to reflect on the following questions:

- *a.* What additional information do you need from this client? What follow-up questions would you ask?
- *b.* How would you build a treatment plan for this client?
- *c.* What additional resources does this client need? How can you talk to this client about future prevention strategies?

Remind participants that accommodations or accessible-format communications may be needed to ensure information is shared in a format that can be understood by the client and that the client is comfortable with. Refer to the communication tips available in the “Adolescents with Disabilities” chapter for all the relevant details on communicating with adolescents with hearing disabilities.

6. Read **Content: Case Study 2** below and repeat the questions from step 5.

Content: Case Study 2

A 19-year-old married woman comes in for routine examination. She reports no vaginal discharge or discomfort, but on visual inspection she appears to have some abnormal lesions on her cervix.

7. Close the activity by asking for examples of similar or challenging cases from the participants' practice. Identify any common challenges and brainstorm solutions among the group. Identify additional resources for participants seeking more information about particular STIs or management strategies.

UNIT 11 SUMMARY

TIME

20 minutes

METHODS

- Gallery walk

MATERIALS NEEDED

- Post-it notes
- Flipchart

STEPS

1. Ask participants to reflect on what they learned today. Give each participant a post-it note and ask them to write down one thing they learned today that they did not know before. Invite participants to walk around the room and look at the information on the walls in order to consider this.

2. Have participants post their notes on a blank flipchart at the front of the room. Gather around the flipchart and identify any trends.