

## ACHA Guidelines

# Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings

According to The World Health Organization's (WHO) working definition, "sexual health" is: ... a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

The American College Health Association (ACHA) has recently released a number of position statements and guidelines regarding sexual health issues, on topics such as expedited partner therapy (EPT),<sup>1</sup> pre-exposure prophylaxis (PrEP) for HIV prevention,<sup>2</sup> trans-inclusivity,<sup>3</sup> sensitive exams<sup>4</sup> and trauma-informed sexual violence prevention.<sup>5-6</sup> Links to current guidelines, resources, and evidence are provided throughout this document, which are intended to serve as a resource for a broad range of sexual health topics in college health. However, it is not exhaustive.

The intent of this paper is to consolidate this information with guidelines and best practices presented by other national organizations to assist colleges and universities in the provision of sexual health services both in health promotion and clinical care—specifically through the lenses of public health and medicine.

Acknowledging WHO's working definition of sexual health, which emphasizes the need for a holistic approach, we recognize the importance of mental health practitioners' roles in supporting sexual health. This is especially relevant for college health settings as campuses strive to meet their students' increasing mental health needs—which can and does include topics such as sexual dysfunction, healthy communication, dealing with a difficult diagnosis or managing intimate relationships. With that said, the current version of this document does not include comprehensive guidance for clinical mental health professionals such as counselors and therapists. This is both a limitation of this paper and recommendation for a future paper.

**Using this document:** Readers are encouraged to utilize each of the resources and citations provided for more information on a particular issue, choosing which ones may work best for their health center and in what manner. The goal of these recommendations is for them to be utilized by a wide variety of institutions, and the Sexual Health Promotion and Clinical Care Coalition is always available to ACHA members for consultation.

**Structure of the recommendations:** Certain best practices and recommendations will be more clearly relevant for either clinicians or health promotion professionals due to the nature of their roles, though it is of utmost importance to understand that improving sexual health is also a shared responsibility that requires close collaboration among clinical and non-clinical staff. As such, this document is organized into three sections: shared responsibility, health promotion and clinical care.

**A note about language:** We will use "queer" as an umbrella term to describe students whose sexual orientation is not heterosexual/straight, and "trans" as an umbrella term to describe students who are not cisgender.

## Shared Responsibility

### Incorporate Pleasure and Intimacy into Sexual Health Efforts

Sexual health should not only be discussed in relation to sexually transmitted infections (STIs)/human immunodeficiency virus (HIV) and unintended pregnancy, but also how it can promote pleasure and intimacy. The primary reason many people engage in sexual activity is to experience pleasure. To ignore this fact not only prevents us from meeting students where they are and acknowledging the realities of many of their sexual experiences, but also reproduces (and reinforces) stigma and shame around their bodies and sexuality. As such, it is recommended that questions about sexual functioning and satisfaction are included during routine sexual histories.

It is also worth acknowledging that a student's personal views—including faith-based—will affect their decision to engage or not engage in sexual activity, and that those decisions should be validated and respected.

Here are a few practical examples of how to incorporate pleasure and intimacy:

- Discuss fit and feel of external condoms; if condoms fit properly and feel good, then students will be much more likely to use them
- Explain how using external condoms with IUDs, for example, can enhance the sexual experience by lowering anxiety about STIs/HIV and unintended pregnancy
- Emphasize to students with new STI/HIV diagnoses that they still have the right to healthy and pleasurable sexual experiences

More Information:

- [Sexual Pleasure, American Sexual Health Association](#)
- [Publications, International Society for the Study of Women's Sexual Health](#)
- Herbenick, Fu, Arter, Sanders, Dodge. (2018). Women's experiences with genital touching, sexual pleasure, and orgasm: Results from a US probability sample of women ages 18 to 94. *J Sex Marital Ther* Feb 17; 44(2): 201-212.
- Herbenick, Bowling, Fu et al. (2017). Sexual diversity in the United States: Results from a nationally representative probability sample of adult women and men. *PloS ONE* 12(7):e0181198.

### **Create a Welcoming Clinic Environment and Provide Inclusive Resources and Services**

Services start when patients enter your college health center (CHC). Care should be taken to use gender-neutral terms interpersonally and on forms. Posters, brochures and other materials should have sex-positive messages with same- and different-gender couples, as well as people of different ethnicities, gender expressions and physical abilities. Spaces should be sensitive to trauma experiences through using calming designs and providing students with as much control over their experience as possible.

Implementation Resources:

- [Healthcare Equality Index, Human Rights Campaign](#)
- [10 Ways to Make Your Health Center More Welcoming for Diverse Students, ACHA](#)
- [Statement on Cultural Competency, ACHA](#)
- [Creating an Inclusive Environment for LGBT Patients, LGBT Health Education Center](#)

### **Considerations for Trans and Non-binary Students**

College health practitioners should seek professional development opportunities to increase their competencies in caring for transgender and gender-nonconforming individuals. Further, several professional organizations endorse gender-affirming hormone therapy and pre- and post-gender affirming surgical care as being within primary care provider's scope of practice.<sup>7-9</sup> While gender-affirming care is not exclusively related to sexual health, sexual health clinicians often have enhanced training in queer and trans health and provide these important services. As such, we advocate for the provision of these services in CHCs.

Implementation Resources:

- [Gender Dysphoria/Gender Incongruence Guidelines and Resources, Endocrine Society](#)
- [Safer Sex for Trans Bodies, Human Rights Campaign Foundation and Whitman-Walker Health](#)
- [UCSF Center of Excellence for Transgender Health](#)
- [Trans-Inclusive College Health Programs, ACHA](#)
- [World Professional Association for Transgender Health \(WPATH\)](#)

### **Collect Sexual Orientation and Gender Identity (SOGI) Data**

Queer and trans communities experience unique health disparities and are invisible until they are specifically counted in electronic health records (EHR) and other public health systems (i.e., needs assessments, program evaluations, infectious disease reports). As such, CHCs should collect and document these demographic data in order to:

- Provide tailored campus and community resources
- Measure healthcare utilization among queer and trans students
- Identify at-risk student populations when reporting infectious disease data
- Adequately conduct quality improvement activities and patient satisfaction surveys
- Provide a more holistic approach to care

Ideally, explicit fields in the EHR should capture the patient's:

- Sexual orientation
- Gender identity
- Sex assigned at birth
- Pronouns
- Name that they would like to be called (i.e., lived name or chosen name).

The collection of gender identity should be a two-step process, where the patient is first asked their gender identity, followed by their sex assigned at birth; this is to immediately validate a student’s gender identity before determining their medical needs. Additionally, sexual

behaviors do not always correlate with sexual identities, so simply taking a sexual history and asking about partners is not an accurate way to determine a patient’s sexual orientation or gender identity.

**Figure 1. Gathering Sexual Orientation and Gender Identity (SOGI) Data**

*Adapted from the 2017 Recommendations from the University of California LGBTQIA+ Directors' Council*

Lived Name	What name would you like to be called?
Pronouns	What are your pronouns?
Gender Identity	<p>What best describes your gender identity?</p> <ul style="list-style-type: none"> <li>● Woman</li> <li>● Man</li> <li>● Transgender</li> <li>● Trans Woman</li> <li>● Trans Man</li> <li>● Non-Binary</li> <li>● Intersex</li> <li>● Intersex Woman</li> <li>● Intersex Man</li> <li>● Genderqueer</li> <li>● Gender Non-Conforming</li> <li>● Questioning</li> <li>● Two Spirit</li> <li>● Agender</li> <li>● Other (Please specify)</li> <li>● Decline</li> </ul>
Assigned Sex at Birth	<p>What sex were you assigned at birth?</p> <ul style="list-style-type: none"> <li>● Female</li> <li>● Male</li> <li>● Intersex</li> <li>● Non-Binary</li> <li>● X</li> </ul>
Sexual Orientation	<p>What best describes your sexual orientation?</p> <ul style="list-style-type: none"> <li>● Lesbian</li> <li>● Gay</li> <li>● Straight</li> <li>● Bisexual</li> <li>● Pansexual</li> <li>● Queer</li> <li>● Questioning</li> <li>● Asexual</li> <li>● Two Spirit</li> <li>● Same Gender Loving</li> <li>● Other (Please specify)</li> <li>● Decline</li> </ul>

See Figure 1 for a recommended way to ask these questions on pre-visit questionnaires. It is worth noting that the use of “preferred name” or “preferred pronouns” should generally be avoided, as these are not “preferences” and such language is invalidating to trans persons. As language is always changing, it is important to allow students to self-identify by leaving an open-answer option.

It is important to let students know that the information provided will remain confidential in accordance with the law, and that they do not have to answer any questions they do not want to answer. Student confidentiality is discussed in greater detail later in the document.

Implementation Resource:

- [Ready, Set, Go: Guidelines and Tips for Collecting Patient Data on Sexual Orientation and Gender Identity, National LGBT Health Education Center](#)

### ***Staff Training in Collecting SOGI Data***

CHCs should develop policies and procedures that address how to ask these questions, document patient responses and interact with patients accordingly. The patient’s response can not only determine which resources and referrals are most appropriate and relevant to the patient, but also the language used during their visit and the care they receive. Assuring the patient that their responses are confidential is of utmost importance, as many college students have privacy concerns not only around the services they receive, but also around their SOGI data. Patients may have disclosed their sexual orientation and gender identity to their healthcare providers but not to their parents, for example, so they need to know that their information will be protected.

Implementation Resource:

- [Resources for Collecting Sexual Orientation and Gender Identity Data, National LGBT Health Education Center](#)

### **Use a Trauma-Informed Approach to Sexual Health Promotion and Clinical Care**

Many of our students come to campus with various experiences of trauma that they are struggling to deal with every day—and many of these experiences have occurred since becoming college students. Sexual health professionals in the higher education setting must have a fundamental understanding of how trauma impacts our students’ daily lives, especially since our sexual health efforts can have a high potential for re-traumatization.

Students of marginalized identities are particularly vulnerable given the impacts of historical trauma and minority stress, which further highlights the importance of addressing health equity in our work. For example, trans and non-binary students who have a cervix and cisgender women with a history of trauma may experience particular emotional and/or physical discomfort during pelvic examinations. Initiating the visit by establishing rapport and obtaining a history while the patient is clothed, allowing the presence of a support person and using sufficient lubrication with smaller-size speculums may ease some of the stress and anxiety around the exam. Best practices before conducting a medical exam include always asking how they refer to their anatomy and informing the patient that they are in control and are able to stop the process at any time.

ACHA recommends utilizing a clinical chaperone for both clinician and student protection when the breast, genital or rectal areas are involved in any medical examination or procedure.<sup>4</sup> While mandatory policies are supported to mitigate risk, it is recommended that CHCs implement clinical chaperones through an opt-out policy that enhances patient autonomy.<sup>4</sup>

Further, providing trauma-informed sexuality education prioritizes creating a culture of consent and letting the audience members know what to expect so that they can be given the choice whether or not to engage with the material. Consider emphasizing during the establishment of group agreements that audience members are able to leave for any reason at any time so that they know they are in control. It is also important to be mindful that each audience member may describe their bodies in different ways, and to validate each person’s right to call their body parts whatever they want. For example, some transmasculine folks may use “front hole” or “genital opening” instead of “vagina.” Similarly, transfeminine folks may use “strapless” instead of “penis.” This brief listing of examples is not exhaustive by any means but is included to provide visible respect for and validation of how people, especially trans and non-binary students, may refer to their anatomy.

On an organizational level, it is recommended that CHCs conduct an organizational assessment of trauma-informed practice and consider incorporating being trauma-informed into strategic planning processes, building design and policies/procedures. Appropriate training of all staff should follow any assessment. See the [United States Department of Education’s National Center for Safe and Supportive Learning Environments’](#) resources below for a comprehensive implementation guide.

#### Implementation Resources:

- [Safe Place: Trauma-Sensitive Practice for Health Centers Serving Higher Education Students, US Department of Education](#)
- [Trauma and Trauma-Informed Approaches, Substance Abuse and Mental Health Administration](#)
- [Trauma-Informed Care Project](#)
- [Best Practices for Sensitive Exams, ACHA](#)
- [Addressing Sexual and Relationship Violence: A Trauma-Informed Approach, ACHA](#)

### Address Confidentiality Concerns

CHCs should have policies that support confidentiality, as privacy concerns are well-documented barriers to accessing sexual health services. Changes in coverage that allow young adults to remain on their parents' or guardians' health insurance policies until age 26 put students at risk of having an unintended breach of confidentiality when explanations of benefits (EOB) that include tests ordered and medications prescribed are sent to the primary policyholder instead of the patient.<sup>10</sup>

Some strategies that can support confidentiality include:

- Providing STI/HIV screening at low or no cost so that students can pay out-of-pocket and avoid billing their insurance plan
- Educating students on state confidentiality laws and navigating insurance
- Listing any charges on student accounts generically (e.g., "Student Health Center Fee" instead of "Birth Control Visit")
- Encouraging students to have different passwords for their online health portal and other university accounts, and not to share them with anyone

#### Implementation Resources:

- Position Paper: [Confidentiality protections for adolescents and young adults in the health care billing and insurance claims process](#). *Journal of Adolescent Health*. 2016; 58(2016):374–377.
- Guttmacher Institute (2019). [Protecting Confidentiality for individuals insured as dependents](#). (accessed November 19, 2019).

### Make Referrals as Appropriate

A holistic approach to sexual health requires understanding the limits of one's knowledge and role in an effort to ensure each student receives appropriate care. Maintaining up-to-date linkage procedures and lists of referrals—beyond the campus setting—is of utmost importance.

For example, think about the following questions:

- Does your CHC have a procedure for linking students newly-diagnosed with HIV to comprehensive medical and mental health care? How are they referred to Partner Services/Disease Intervention Specialists?
- Do you know how to refer a trans student to gender-affirming care?
- What is your CHC's referral procedure when a student discloses sexual and relationship violence? How is this reported to your Title IX office (if required), and how is the student referred to a mental health professional or academic accommodations?
- Does your CHC maintain a list of campus and community sexuality professionals?
- How does your CHC's clinical staff know when to refer to specialists for complicated STI diagnoses?

Implementation Resource:

- [Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020](#)

### Evaluate Your Efforts

As with any discipline or area of health, evaluation is essential. Understanding current best practices with a mechanism for ongoing evaluation of the adherence to those best practices is important for maintaining quality health promotion and healthcare delivery.

Evidence-based/informed practices come in a variety of forms, and may include:

- Reviewing the literature
- Conducting quality improvement studies
- Adhering to national guidelines and benchmarks
- Focus groups with students and other stakeholders
- Surveys

Quality improvement or evaluation projects could include:

- Adherence to STI/HIV guidelines
- Frequency of capturing demographic data
- Identifying individuals concerned with body integrity, sexual safety, sexual response and pleasure, gender, sexual orientation, emotional attachment and reproduction.<sup>11</sup>

Evaluation should be conducted using a health equity lens and include consideration of utilization rates for sexual health services by different populations.

In considering health equity, one must understand how the Social Determinants of Health<sup>12</sup> affect sexual health. Social determinants of health reflect the social and physical environments (such as neighborhood, school, religious community and workplace) in which the student lived prior to entering college.<sup>13</sup>

Once in a college setting, one may think that social determinants and place are more equalized, but the students' upbringing and experiences they have before college as well as continued experiences with family and others both inside and outside of the collegiate environment will still have an impact on their attitudes, knowledge and behaviors around health, health screenings and accessing health services.

If discrepancies exist between service utilization and the certain populations served in terms of sexual orientation, gender, gender identity, race or ethnicity, then an examination of possible causes and subsequent action should rectify these discrepancies.

One important tool for measuring success is ACHA's National College Health Assessment (NCHA), which asks several questions intended to measure sexual health on a population level. Results of the NCHA can be used in combination with ACHA's Healthy Campus Initiative to see population-level changes and progress (or lack of progress) toward reaching established public health goals among college students.

In addition to quantitative measures such as the NCHA and clinic utilization data, it is important to gather qualitative data from students through focus groups or student interviews. These data can be especially useful in evaluating health communication campaigns or conducting needs assessments among various sub-populations within the campus community.

Implementation Resources:

- [Social Determinants of Health, Office of Disease Prevention and Health Promotion](#)
- [ACHA National College Health Assessment](#)
- [ACHA Healthy Campus](#)
- [Practical Use of Program Evaluation Among STD Programs](#), CDC
- [ACHA Sexual Health Services Survey](#)

## Health Promotion

### Use the Socioecological Model to Improve Sexual Health

Sexual health promotion professionals are trained to improve sexual health and well-being on a population

level. While providing comprehensive, evidence-informed sexuality education directly to students may be a function of college health promotion, the greatest impact is achieved through a data-driven, public health approach that emphasizes primary prevention. Health promotion should "focus on the processes that aim to expand protective factors and campus strengths, and reduce personal, campus, community and environmental health and well-being risk factors."<sup>14</sup>

As such, efforts must be focused on enhancing the many *environments* in which students live, work and play -- by working to ensure that the healthier choice is always the easiest choice for them to make in every setting.

Sexual health professionals on college campuses and universities can use the [Standards of Practice in Health Promotion in Higher Education](#) to support and guide their work. It suggests several strategies, including but not limited to socioecological-based practice, evidence-informed practice and collaboration. Here are some examples of sexual health interventions at each level of the socioecological model:

- Individual Level:
  - Providing skills-building activities that teach students how to properly use safer sex products and engage in effective sexual communication
- Interpersonal Level:
  - Recruiting, training and managing a team of student peer educators who engage in outreach to provide sexuality education across campus
  - Role-modeling consent and effective communication in daily life
- Organizational Level:
  - Implementing mandated training for all CHC staff around best practices in queer and trans care
  - Developing a sexual health clinic to increase access to STI/HIV screening
  - Working with clinical staff to implement STI/HIV testing reminders in the EHR
- Community Level:
  - Working with stakeholders to improve the safety and walkability of campus and enhance the design of social spaces to prevent sexual violence
  - Conducting an environmental scan to create a campus and community map of sexual health resources
  - Collaborating with campus and community partners to install a vending machine that dispenses emergency contraception and safer sex products (where laws allow)

- Developing campus-wide sexual health campaigns
- Societal (Public Policy) Level:
  - Advocating for policies that enhance sexual health and improve sexual health equity
  - Advocating for and/or implementing a mandatory human sexuality course for all incoming students

The needs of each campus community will be unique, and collaboration with campus and community partners is vital to success.

Implementation Resources:

- [Standards of Practice in Health Promotion in Higher Education](#), ACHA
- [Okanagan Charter: An International Charter for Health Promoting Colleges and Universities](#)
- [United States National Prevention Strategy](#)
- [Health, Safety and Well-Being Initiatives of NASPA](#)

### **Implement an Inclusive, Evidence-Based Availability Program for Safer Sex Products**

Condom distribution/availability programs have been proven to increase condom use, prevent STIs/HIV and save money.<sup>15</sup>

Many programs focus on providing external condoms, but not all students engage in sexual activity that involves a penis or insertive sex toy. As such, it is important for a variety of safer sex products to be made widely available to students at no cost. Such safer sex products include dental dams, internal condoms, nitrile gloves, non-latex options, water-based lubrication and silicone-based lubrication.

The Centers for Disease Control and Prevention (CDC) has many resources available for implementing a condom availability program as a structural-level intervention that creates a more health-promoting environment.

Implementation Resources:

- [Condom Distribution, CDC Effective Interventions](#)
- [Condom Distribution as a Structural Level Intervention, CDC](#)
- [Condom Availability Programs, County Health Rankings and Roadmaps](#)

### **Leverage Social Media**

Social media use is common among college students, and it is important that our systems meet students' needs

for accurate and inclusive sexual health information. The ease in which social media and online search engines produce health information on demand are more enticing than potentially experiencing the embarrassment of asking a parent or calling the CHC. There are many social media platforms from which to choose (e.g., Facebook, Snapchat, Instagram, Twitter), and each one would require a unique strategy to build an engaged student audience.

Evidence for the use of social media in promoting sexual health is increasing, particularly for promoting STI/HIV testing and condom use.<sup>16-17</sup> As sexual health can be a stigmatizing topic, it must be noted that students may be less likely to engage with sexuality-related content -- especially when their peers may see their social media activity.<sup>15</sup> However, this does not mean that students will not review and use the information or privately share with their friends.

Ensuring that social media content and messaging is “engaging, has a positive tone, is not too clinical, is focused on building social norms and delivered by trusted organizations” has also been found to be important.<sup>18</sup> Testing content for acceptability with students and developing a social media strategy that considers their unique needs will always be most effective. You may also consider incentivizing student engagement with your social media to grow your student audience. For example, you may offer some free swag when a student “follows” your account or shares your content.

While time-intensive, it is also important to regularly analyze social media metrics (i.e., engagement, reach, impressions, shares) to measure what is working and not working in terms of reaching students and keeping them engaged. If your CHC has a marketing and communication team, it is highly recommended that you consult with them in order to adhere to your institution’s communication guidelines and best practices.

Implementation Resource:

- [Digital Tools from HIV.gov](#)

### **Clinical Care**

#### **Be Proactive about Sexual Health with All Patients and Take an Inclusive, Comprehensive Routine Sexual History**

Clinicians should have conversations about sexual health with students, as appropriate, during preventive visits for all genders—not just during problem-focused sexual health visits. Clinicians might set the stage by letting patients know that the questions are asked of all patients

because of their importance to overall health. If a student reports that they are not sexually active, then that decision should be validated.

These discussions provide important opportunities for risk-reduction counseling, identification of anatomical sites for STI and HIV screening (discussed in greater detail later in this document), promotion of healthy and satisfying sexual functioning as well as diagnosis and treatment of sexuality-related conditions.<sup>19</sup>

Using an “8 Ps” approach when taking a sexual history allows for a comprehensive and inclusive springboard for discussion.<sup>20</sup>

The “8 Ps” approach includes questions about:

1. Preferences
2. Partners
3. Practices
4. Protection from STIs/HIV
5. Past history of STIs
6. Pregnancy
7. Pleasure
8. Partner violence (discussed in greater detail later in this document)

The sexual history is ideally conducted by asking open-ended questions with a nonjudgmental tone and demeanor. If the sexual history is taken during an appointment that includes an examination, the history should be obtained prior to having a patient remove any clothing.

For trans and non-binary patients, it is recommended that providers “maintain an organ inventory to guide screening and management of certain specific complaints.”<sup>21</sup>

Implementation Resources:

- [Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020](#)
- [Sexual History: Talking Sex with Gender Non-Conforming and Trans Patients, Fenway Institute](#)
- [A Guide to Taking a Sexual History, CDC](#)
- [Addressing HIV and Sexually Transmitted Infections Among LGBTQ People: A Primer for Health Centers, LGBT Health Education Center](#)
- [Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers, LGBT Health Education Center](#)
- [TransForming Health: Taking a Sexual History](#)

- Makadon H, Mayer K, Potter J & Golhammer H (2015). *The Fenway guide to lesbian, gay, bisexual, and transgender health* 2<sup>nd</sup> edition. Philadelphia: American College of Physicians.
- Deutsch MB, Green J, Keatley J, et al. Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. *J Am Med Inform Assoc.* 2013;20(4):700–703. doi:10.1136/amiajnl-2012-001472

### **Assess Patients’ Reproductive Goals**

Some college students do want to become pregnant and not all are sexually active. Refrain from making assumptions by using a more inclusive approach to consider a patient’s reproductive goals, with attention to their potential to become pregnant.

Students desiring pregnancy or not using reliable forms of contraception or who are otherwise capable of pregnancy (i.e., transmasculine students having penis-vagina sex) should be counseled to take a supplement containing 0.4-0.8 mg of folic acid daily for the prevention of neural tube defects.<sup>22</sup>

Implementation Resource:

- [Committee Opinion 762: Pre-Pregnancy Counseling](#), American College of Obstetricians and Gynecologists (ACOG)

### **Assess for Trauma and Violence**

Given the prevalence of trauma, it is important to **universally** screen for trauma and trauma symptoms,<sup>6</sup> despite national guidelines using gendered language in their recommendations. People with marginalized identities experience higher rates of violence (and trauma, more broadly), and this must be taken into consideration to provide the best care.

According to the [US Preventive Services Task Force \(USPSTF\)](#), screening for intimate partner violence (IPV) using an instrument should be done for.<sup>23</sup>

- all women of reproductive age
- other vulnerable patients without recognized signs and symptoms of abuse

The following screening instruments accurately detect IPV in the past year among adult women:

- Humiliation, Afraid, Rape, Kick (HARK)
- Hurt, Insult, Threaten, Scream (HITS); Extended–Hurt, Insult, Threaten, Scream (E-HITS)
- Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST)



Screening should be done in private and may be done on an annual basis. Those with positive screens should be provided ongoing support or referred to appropriate agencies.

Implementation Resource:

- US Preventive Services Task Force. Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: US Preventive Services Task Force Final Recommendation Statement. *JAMA*.2018;320(16):1678–1687.

## Orient Clinical Care Toward Prevention

While there is limited evidence to support performing pelvic exams and comprehensive physical exams on asymptomatic young adults, annual “wellness” visits, geared toward prevention, can provide an opportunity to screen for unhealthy or harmful behaviors and provide education regarding health and function of the human body, and counseling regarding healthy lifestyle and risk reduction —such as substance misuse or depression.<sup>24</sup>

### Vaccinations

All patients age 45 years and younger should be asked if they have been vaccinated against human papillomavirus (HPV), with a strong recommendation from the provider to start or complete the series for those not fully vaccinated.<sup>25-29</sup> Provision of the vaccine during the clinic visit may increase uptake with use of a reminder system in EHR to help ensure patients return to complete the series.

Vaccination against hepatitis A virus (HAV) should be encouraged for any patients who are men who have sex with men (MSM), who have not previously been vaccinated.<sup>30</sup>

Routine vaccination for hepatitis B virus (HBV) should be provided for those not previously vaccinated, those at risk for HBV infection (i.e., sexual exposure) or those requesting protection from HBV without a specific risk factor.<sup>31</sup>

Implementation Resources:

- [HPV Vaccine Schedule and Dosing, CDC](#)
- [HPV Vaccine Recommendations, CDC Advisory Committee on Immunization Practices \(ACIP\)](#)
- [Viral Hepatitis and Men Who Have Sex with Men, CDC](#)
- [Hepatitis A Vaccine Recommendations, ACIP](#)
- [Hepatitis B Vaccine Recommendations, ACIP](#)

## Cervical Cancer Screening

For patients with a uterus, screening for cervical cancer (via Pap test) is recommended starting at age 21 regardless of sexual activity.<sup>32-33</sup>

Insufficient evidence exists to recommend for or against performing pelvic examinations as screening in asymptomatic persons for early detection/treatment of gynecologic conditions not related to screening for cervical cancer.<sup>34</sup> The decision to perform a pelvic exam should be based on medical history or symptoms and be a shared decision between patient and provider.<sup>35</sup> Regardless of their sexual partner(s)' body parts, individuals with a uterus are at risk for STIs/HIV and cervical cancer and should follow guidelines addressed above. Shared insertive sex toys and previous partner(s)' body parts may affect the degree of risk, but do not change the recommendations.

In the interest of providing trauma-informed care while acknowledging transmasculine students and students who have never had penetrative vaginal sex, it is recommended to provide patients an option to use a smaller-sized speculum if there is physical or psychological sensitivity.

Implementation Resources:

- [Screening Guidelines, American Society of Colposcopy and Cervical Pathology \(ASCCP\)](#)
- [Screening Recommendation, USPSTF](#)
- [Practice Advisory: Cervical Cancer Screening, ACOG](#)

## STI and HIV Screening

### Implement Routine, Opt-Out HIV Screening

Implementing this best practice will look different for each CHC, depending on staff resources and workflows.

The CDC recommends that everyone ages 13-64 be tested for HIV as part of routine medical care at least once in their lifetime, and more frequently depending on the patient's risk.<sup>36</sup> As such, it is recommended that HIV testing be included as part of routine medical care—and any STI screening—preferably through an “opt-out” option where all patients are informed that they will be tested for HIV unless they decline.<sup>37-38</sup>

CHCs may also consider implementing rapid point-of-care (POC) HIV testing to improve the chances of students receiving their test results.<sup>39</sup> Fourth-generation POC HIV tests, which can detect p24 antigens in addition to antibodies, are able to detect HIV infection earlier than previous testing generations; this is an especially important factor to consider in ensuring all students living with HIV can begin treatment as early as

possible to stay healthy through an undetectable viral load and prevent transmission to their sexual partners.

Implementation Resources:

- [HIV Screening in Clinical Settings, CDC](#)
- Hurt CB, Nelson JAE, Hightow-Weidman LB, et al. [Selecting an HIV test: A narrative review for clinicians and researchers](#). Sexually Transmitted Diseases 2017; 44:739–746.
- [HIV Screening, Standard Care \(campaign\), CDC](#)
- [HIV Screening, Standard Care: A Guide for Primary Care Providers, CDC](#)
- [Ending the Epidemic](#)

*Offer Concurrent Screening for STIs and HIV*

Sexual activity can facilitate transmission of HIV, in addition to STIs such as chlamydia and gonorrhea. As such, HIV should be included as part of any STI screening, preferably through an “opt-out” option.<sup>37-38</sup> Likewise, STI screening should be offered when an HIV test is requested. **All sexually active persons** should be offered an HIV test.

*Screen for STIs at All Appropriate Anatomical Sites* Site-specific screening for STIs should follow recommendations published by the CDC and USPSTF, regardless of sexual orientation or gender identity.<sup>40-41</sup> For most sexually active students, screening should occur at least annually for chlamydia and gonorrhea with more frequent intervals (i.e., every 3-6 months) based on risk. Screening for HIV should be done at least once in a lifetime, with repeat screenings based on risk.<sup>36,42</sup>

Chlamydia and gonorrhea live in mucous membranes, and as such, all mucous membrane sites that have had contact with another person’s mucous membranes should be screened. It is imperative that clinicians know how patients are using their bodies for sexual encounters. See Table 1 for STI/HIV Screening Recommendations Overview, per guidance from the CDC<sup>40</sup> and USPSTF.<sup>41-43</sup>

Referring to a previous recommendation in this document about taking a sexual history and maintaining an organ inventory for trans and non-binary patients, it is important to acknowledge that the current national screening guidelines and recommendations use binary, gendered language (i.e., “men” and “women”). Screenings should always be performed based on the actual organs that patients have. For example, a patient may be a woman and have a penis or may be non-binary and have a cervix.

**Table 1. STI/HIV Screening Recommendations Overview**

	Women	Men	Men who have sex with men (MSM)
Chlamydia	Yearly < 25 y.o. and 25 with risk factors •Retest ~ 3 months after treatment	* Consider yearly in high prevalence settings	At least yearly at all sites of contact (urogenital tract/urine, rectum)
Gonorrhea	Yearly < 25 y.o. and 25 with risk factors •Retest ~ 3 months after treatment	* Consider yearly in high prevalence settings	At least yearly at all sites of contact (urogenital tract/urine, rectum, pharynx) •Every 3 m (increased risk)
Syphilis	*At high risk for infection	*At high risk for infection	At least yearly •Every 3-6 m (increased risk)
Trichomonas	* In high-prevalence settings or at high risk for infection (HIV infection)	*Consider in high prevalence settings	*Consider in high prevalence settings
HIV	All women aged 13-64 years (opt-out) All women seeking STI screen or treatment	All men aged 13-64 (opt-out)	At least annually if HIV status unknown or negative or patient or partner(s) have had > 1 partner since last test

### *Allow Patients to Self-Swab When Possible*

Research studies indicate that self-collected vaginal swabs are patient-preferred and just as reliable as clinician collection for chlamydia and gonorrhea testing.<sup>40</sup> Therefore, self-collection is reasonable at all sites, including oral and rectal samples, for self-motivated patients as indicated. Keep in mind that your CHC's laboratory may need to conduct a validation study before conducting any self-collection.

### **Implement EPT Where Legal**

EPT is the clinical practice of prescribing and dispensing medications to the sexual partner(s) of patients diagnosed with STIs such as chlamydia and gonorrhea without them needing to see a healthcare provider. Although EPT does not replace other strategies for management of partners, the CDC recommends that it be available to clinicians as an option for partner treatment.<sup>44</sup> This has been affirmed by ACHA as an effective means of preventing reinfection<sup>1</sup>. CHCs are encouraged to research the legal status of EPT in their state. Be advised that gonorrhea treatment currently requires combination therapy (an injection as well as an oral antibiotic) due to antibiotic resistance.

Implementation Resources:

- [ACHA Position Statements](#)
- [Expedited Partner Therapy, CDC](#)
- [EPT Gonorrhea Guidance, CDC](#)
- [Legal Status of Expedited Partner Therapy, CDC](#)
- [State Policies: Partner Treatment for STIs, Guttmacher Institute](#)

### **Offer Pre-Exposure Prophylaxis (PrEP) as Appropriate**

In addition to safer sex prevention strategies, ACHA endorses the wide availability of HIV PrEP in CHCs<sup>2</sup>. Clinicians should be proactive about talking about PrEP with students and help to dispel myths about who is a candidate. Any visit for sexual health services provides an opportunity to share information about PrEP and make a significant impact on the health of young adults.

Implementation Resources:

- [ACHA Guidelines: HIV Pre-Exposure Prophylaxis.](#)
- [HIV Nexus Clinician Resources, PrEP, CDC](#)
- [USPSTF Final Recommendation Statement: HIV Pre-exposure Prophylaxis](#)

### **Offer Post-Exposure Prophylaxis (PEP) as Appropriate**

PEP can reduce someone's chances of getting HIV if they may have been exposed to HIV -- such as when a student has experienced a sexual assault or was exposed to HIV during sexual activity (e.g., the condom broke). Clinic visits to access PEP may also be an opportunity to promote PrEP, especially if the student is in a sexual relationship with someone who is living with HIV.

Implementation Resources:

- [Updated Guidelines for Antiretroviral Postexposure Prophylaxis after Sexual, Injection Drug Use, or Other Non-occupational Exposure to HIV \(2016\), CDC](#)
- [Non-Occupational Post-Exposure Prophylaxis \(nPEP\) Toolkit, AIDS Education and Training Center](#)

### **Moving Forward**

Sexual health is a wide-reaching topic that intersects with multiple dimensions of health and wellness. The young adults we serve are at a crucial developmental stage where they are not only learning about themselves and their bodies, but also trying to navigate the healthcare system and develop healthy intimate relationships in a rapidly-changing social and political landscape.

As such, college health practitioners are in a unique position to meet their need for holistic resources and care that consider their experiences and prioritize health equity. The sexual health field is always evolving as new evidence emerges, and it is important to seek out professional development opportunities whenever possible to remain innovative and competent for the students we serve.

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