SEXUAL HISTORY-TAKING TOOLKIT:

Focus on Chlamydia, Gonorrhea and HIV in the Family Planning Clinic

I. Introduction

Young women and men bear the greatest burden of adverse health consequences resulting from unprotected sex: unintended pregnancy, sexually transmitted infections (STIs) and HIV infection. The sexual history is the ideal tool to identify interventions which help clients prevent these consequences. Although family planning staff generally acknowledge that a routine sexual history is important, it is frequently overlooked or not adequately completed. Integrating a sexual history into client care requires knowing the content to discuss, using effective communication techniques for interviewing, and accomplishing this in a time-efficient manner.

This Sexual History-Taking Toolkit will provide family planning staff* with the information they need to take a focused sexual history that will identify clients at risk for STIs and HIV. As a routine part of a family planning visit, the sexual history will help staff decide who to test, and who NOT to test, for chlamydia, gonorrhea and HIV. The toolkit focuses on:

- *how* to ask sensitive questions;
- *what* questions to ask in a risk assessment;
- *how* to simply and effectively integrate sexual history-taking into client care.

The Toolkit contains:

1. Information about how to integrate sexual history-taking, focusing on STIs, into client care;
2. *Comfort Scale*: a personal comfort self-assessment exercise for staff (Appendix A);
3. The current national recommendations for chlamydia, gonorrhea and HIV screening;
4. Samples of self-administered history forms that contain essential sexual history questions for females and males (Appendix B);
5. *Questions to Ask*: a pocket guide with the most important, basic questions to ask in a STI-focused sexual history (Appendix C);
6. A demonstration video that presents four dramatizations of sexual history-taking interviews, illustrating situations in which staff assesses whether or not testing for chlamydia, gonorrhea and HIV should be done. You will meet:
   - Alison, a 16 year old adolescent client
   - Anna, a 30 year old woman with a long-time partner
   - Nicole, a 29 year old woman coming for her annual exam
   - Marco, a 27 year old new client.

Each scenario is analyzed by experts from the field to give concrete examples of "do's and don'ts". Recommendations for testing are provided at the end of each scenario. The video is available at www.centerforhealthtraining.org.

* **Note:** Clinicians and all other clinic staff are referred to hereafter as provider or staff.

II. What is a Sexual History?

A sexual history gathers information about an individual's current and past sexual practices that enables the provider to proactively address sexual health issues with the client. A comprehensive sexual health history covers a range of issues, including:

- contraceptive history and pregnancy plans
- menstrual history
- sexual satisfaction and sexual problems, and
- risks for unintended pregnancy, STIs and HIV.

The content of a routine sexual history can be expanded or shortened as determined appropriate for each client. For new clients or at an annual exam, a more complete sexual history is indicated. A review and update of the sexual history should be routinely included at interim visits. In some cases, just a few questions will establish that a client is at very low risk for STIs, in which case a brief history is sufficient. If the questions establish that a client is at moderate or high risk for STIs, a more comprehensive sexual history is indicated.

Taking a sexual history is different from counseling. This Toolkit does not illustrate the individualized health education and risk-reduction messages that could, and should, be integrated throughout the provider-client interaction. Likewise, comprehensive client-centered risk-reduction counseling strategies are not illustrated in these materials.

III. Who Can Conduct a Sexual History?

Any staff person responsible for educating and counseling clients about health issues and risks can incorporate sexual history-taking into their work. These staff may be:

- clinicians
- health educators
- medical assistants
- nurses
- other designated staff who interact with clients in the clinic.

No formal advanced education or certification is required, although training and practice to develop the necessary skills are highly recommended. Specific medical issues, however, may be judged to be only within a clinician's scope of practice. Each clinic should review their history forms, scopes of practice, and policies to determine the type of staff that should be responsible for the various parts of this client interaction.

IV. Consent and Confidentiality

This Toolkit addresses recommendations and requirements that apply for Title X agencies nationally. State and local requirements vary. Be sure to check your state and local laws related to consent and confidentiality, and what information must be provided to clients.

According to the CDC, most states allow a minor to give consent for diagnosis and treatment of pregnancy and STIs. Federally-funded family planning agencies cannot require consent of parents or guardians for the provision of Title X family planning services to minors, neither can the agency notify parents or guardians before or after a minor has requested and received these services. Be sure to check with your state laws to identify exceptions to confidentiality. A state-by-state guide to consent laws for minors is available at: http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf.

Example Statements of Confidentiality Policies:

For adults:
"I want you to know that what we talk about today is completely confidential, meaning that nothing will be shared with anyone outside of the healthcare team without your permission."

For minors:
"Everything we talk about is confidential, or private, meaning that no information will be shared with anyone outside of the clinic staff unless you tell me that someone is hurting you, or that you are planning to hurt yourself. Then I would have to get others involved to help you."

V. Conducting the Sexual History

Sexual history-taking involves a face-to-face interaction with a client by clinic staff. In most clinic settings, a self-administered form is filled out by the client before s/he meets with the staff person. The information is then reviewed and discussed with the client. In some clinics, the self administered history is not used; instead, the history is taken by the staff member.

Introducing the Sexual History

Most clients expect to be asked personal questions about their health and lifestyle during a family planning visit. However, many clients are not accustomed to being asked such specific questions about their sexual practices. In addition to stating the boundaries of confidentiality, it is always important to introduce the interview by explaining its purpose. A respectful explanation given before discussing the sexual history establishes rapport and builds trust.

Begin the discussion with a neutral, normalizing statement which helps the client understand the reason why all clients are asked questions about their sexual history. This type of statement helps the client feel comfortable and understand the importance of the sexual history in the context of their total health care.

Examples of Introductory Statements:

"I talk with all my clients about their sexual history so I can give the best possible care. I'll be asking some personal questions and if you're uncomfortable answering, just let me know and we'll move on to the next question."

"I am going to be more specific about your sexual history, so I understand your risks for sexually transmitted infections."

For a client who has been to the clinic before, familiarize yourself with the client's prior sexual history as recorded in the chart. Begin by finding out what has changed since her/his last visit:

"When I saw you last, you had been with your boyfriend for six months and neither of you were having sex with anyone else – has that changed?"

"Tell me what's going on in your relationship since you were last here…"

How to Ask

A sexual history is best conducted in an interactive manner through the use of both open and closed-ended questions, and active listening, so that the session is responsive to an individual client's needs. Staff's best work will come from maintaining a neutral approach and a non-judgmental attitude.

The *"Comfort Scale"* (Appendix A) is a self-assessment exercise intended to help staff members assess their own level of comfort with some of the issues and sexual behaviors that need to be discussed during a sexual history. In order to elicit accurate and honest answers, staff must feel comfortable discussing these issues. If the exercise helps to determine that there is discomfort with particular topics, staff can increase their comfort by reading about these topics, observing coworkers in action, and talking with their supervisor and others who have experience with these topics.

Avoid Assumptions

Staff's personal values and biases must not be allowed to interfere with the relationship with the client. Staff should never make assumptions about clients' sexual orientation, sexual practices, relationships, or substance use based on appearance, ethnicity, age or other factors.

It is important to begin your conversation using gender-neutral language that does not imply an assumption of heterosexuality. As part of the sexual history, specifically ask every client about the gender of their sex partners. Most patients do not object to answering questions abut whether they have male or female partners, or both, although they may not volunteer this information without being asked.

Some clients understand anatomical and medical language such as vaginal, anal and oral sex, but others do not, so be prepared to explain any terminology the client does not understand. The way in which staff speak to clients should be tailored to clients' age, culture, and educational level.

Ask every client about current and past substance abuse; intravenous drug use in particular is a risk factor for HIV infection.

Communication Skills

Nonverbal communication helps develop rapport and communicate genuine interest. Maintaining eye contact, nodding, and using silence when culturally appropriate can be important ways to communicate without talking.

Questioning A combination of open-ended and closed-ended questions can be used to gather the information of a sexual history.

Open-ended questions are an important tool for effective sexual history-taking. Open-ended questions are ones that cannot be answered with a "yes or no" answer. These questions usually start with Who, What, When, Where or How. Open-ended questions help people to open up, encourage more conversation, and give the client some degree of control over what s/he wants to share. These questions can make the interaction easier by eliciting information without having to ask multiple specific questions to obtain the full story of the client's situation.

Examples:

"What do you think your risks are for HIV?"
"What sexually transmitted infection have you had in the past, if any?"
"How would it be for you to use condoms with your partner?"

Closed-ended questions are effective when all that is needed is a "yes or no" answer, or a specific piece of information, such as a date. These types of questions are also useful with a client who is particularly uncomfortable discussing these issues. Closed-ended questions can obtain the information you need while respecting your client's personal boundaries.

Examples:

"When was your last menstrual period?"
"Have you ever had chlamydia?"
"*Are you having sex with anyone other than your boyfriend?"*

Acknowledge feelings to show an understanding of the how the client feels. Ask questions that help the client explore their feelings in more detail. Many people need to have their feelings acknowledged and discussed before they are able to really *hear* information. Ignoring someone's feelings can damage or disrupt a sexual history-taking session.

Examples:

"I can see this is difficult for you to talk about."
"It seems like this test result was a surprise for you."

Summarize what the client says to clarify information, to allow the client to judge whether you understood them correctly, and at the end of a session to review the client's plan of action.

Examples:

"What you're saying is that you trust that your husband is not having sex with anyone but you."
"So you want to get tested today and then discuss testing with your partners, is that right?"

The 5 **P**'s: What to Ask In A Client Interaction

The content of the sexual history should cover the following areas, summarized as **"The 5 P's"**:

- Pregnancy plans and prevention
- Past STIs
- Partners
- Practices
- Prevention practices

Pregnancy Plans and Prevention

Important issues to assess include current and past contraceptive use, current pregnancy status, and pregnancy goals. Determine first if pregnancy is desired, and proceed with contraceptive options counseling as appropriate.

Examples:

"How would it be for you if you were to get pregnant now?"
"Are you doing anything now to protect yourself from getting pregnant?"
"What birth control methods have you used in the past?"

Past STI

It is important to assess for a history of chlamydia or gonorrhea infection. Reinfection following an initial chlamydia or gonorrhea infection is very common; studies in family planning and other clinical settings show chlamydia reinfection rates that range from 10 to 15% at three to six months post-treatment. Repeat infections confer an increased risk for pelvic infections and other complications when compared with the initial infection. A recent STI also indicates higher risk behavior.

Examples:

"Have you ever had a sexually transmitted infection?"

If yes, follow with more closed-ended questions:
"What kind of infection did you have?"
"What treatment were you given?"
"Did you have symptoms at the time?"
"Did your partner get treated also?"
"Have you had another test since then?"

Partners

This discussion should include:

- number of sexual partners in a specific timeframe (e.g., past six months, past 12 months, lifetime)
- gender of sexual partners (male/female/transgender)
- partner's risk factors (e.g., other partners, injection drug use, history of STIs).

Having a spouse, boyfriend, or girlfriend does not necessarily mean a client has no other partners. Clients should also be asked specifically about the possibility that a partner they had recently may have had other, concurrent sex partners. On the other hand, when a client states that s/he is in a mutually monogamous relationship and there is no evidence of an STI or other risk factors, then STI testing may not be indicated.

Examples:

"Have you had sex with men, women, or both?"
"In the past six months, how many people have you had sex with?"

Ask about partner(s)' risk factors, (e.g., other partners, injection drug use, history of STIs.)
"During the past 12 months, do you think your boy/girlfriend had sex with someone else while s/he was still in a sexual relationship with you?"

"Do you think any of the people you've had sex with in the past year had sex with anyone else while they were with you?"

"Have any of your sexual partners injected drugs?"

The discussion about partners also gives an opportunity to ask about current or past sexual or physical abuse.

Examples:

"Do you feel physically and emotionally safe in your relationship(s)?"
"Have you ever had sex when you didn't want to?"
"Many of our clients have concerns about their relationships and have been threatened or have been emotionally or physically forced to have sex – has that ever happened to you?"

Practices

It is important to ask about specific sexual behaviors, assuring the client that although these are personal questions, the information helps you to provide quality care. Ask about any current or past drug use, and whether the client is exchanging money or drugs for sex.

Examples:

"Do you have: vaginal sex (penis in vagina)?
anal sex (penis in anus/butt)?
oral sex (penis in mouth or mouth on vagina/vulva)?"
"What's your experience been with drugs and alcohol?"
"Have you ever used needles to inject/shoot drugs?"

Prevention Practices:

Important issues to assess include:

- self-perception of risk
- patterns of condom use
- measures such as using clean needles for intravenous drug use
- discussing STI/HIV status with partners
- periodic abstinence as an option

Examples:

"Do you feel you need to do anything to protect yourself from getting a sexually transmitted infection?"
"What do you do to protect yourself from sexually transmitted infections?"
"Many clients have a difficult time talking about birth control and STIs with their partners – is that an issue for you?"
"Have you and your partner(s) discussed using birth control or STI protection?"

See the *"**Questions to Ask**"* Pocket Guide for condensed list of core questions to ask.

VI. Testing Recommendations for Chlamydia, Gonorrhea and HIV for Non-Pregnant Patients

The information obtained by the sexual history helps you decide if screening tests for chlamydia, gonorrhea and/or HIV are indicated.

Your agency's screening recommendations may vary from those suggested below. For further guidance and specific screening requirements applicable to your practice setting, check recommendations from your:

- Regional Infertility Prevention Project
- State and local STD Control or Family Planning programs
- Agency protocol

Screening for Chlamydia and Gonorrhea in Women

Annual screening for chlamydia in all sexually active females 25 years of age and younger is recommended by the CDC[1] and the U.S. Preventive Services Task Force[2], and supported by the Infertility Prevention Project (IPP)[3], with more frequent screening based on sexual risk. When indicated, chlamydia screening should be performed at any visit type, regardless of reason for visit. This includes but is not limited to visits for pelvic exam, contraception, and expedited visits for pregnancy testing or emergency contraception, etc.

Annual screening for gonorrhea in all sexually active females 25 years of age and younger is recommended by the U.S. Preventive Services Task Force,[4] and supported by the CDC. Regional IPP screening recommendations for gonorrhea vary. When practical, gonorrhea screening should be conducted in conjunction with chlamydia screening. Annual screening can be performed at any visit type and regardless of reason for visit. However, screening in very low prevalence populations (<1%) is generally not indicated.

Women older than 25 years of age should not be routinely screened for chlamydia or gonorrhea. Screening should be targeted only to those with risk factors. A variety of demographic and behavioral factors have been identified which may increase risk for chlamydia or gonorrhea, including:

- prior chlamydia or gonorrhea infection, particularly in the recent past
- more than one sex partner
- suspicion that a recent partner may have had concurrent partners
- new sex partner
- exchanging sex for drugs or money
- other population factors identified locally, such as racial disparities in rates of disease

Screening for Chlamydia and Gonorrhea in Heterosexual Men

Annual screening for chlamydia and gonorrhea is not recommended for heterosexual men. Chlamydia screening for men should be considered in clinical settings with a high prevalence of chlamydia (e.g., adolescent clinics, correctional facilities, and STD clinics). Targeted screening for gonorrhea in high prevalence populations should be considered.

Chlamydia and Gonorrhea Testing

Diagnostic Testing

Women and men with symptoms or clinical findings indicative of chlamydial or gonococcal infection, (e.g., cervicitis, pelvic inflammatory disease, urethritis, epididymitis) should be tested for chlamydia and gonorrhea.

Testing of STI Contacts

Women and men who report having contact with someone who has an STI, specifically gonorrhea, chlamydia, nongonococcal urethritis, epididymitis, trichomoniasis, syphilis, or HIV, should be tested for chlamydia and gonorrhea.

Testing Among Clients with a New STI Diagnosis

Women and men with a newly diagnosed STI, including chlamydia, gonorrhea, nongonococcal urethritis, epididymitis, trichomoniasis, syphilis, or HIV, should be tested for other STIs.

Retesting After Treatment

Women and men treated for chlamydia or gonorrhea should be asked to return for a *repeat* test for infection approximately three months after treatment. However because clients do not always return at three months, clinicians should test opportunistically whenever clients next seek medical care any time more than one month following treatment, regardless of whether the client believes that his/her sex partners were treated.

Test of Cure

Except in pregnant women, a test-of-cure (TOC) at three to four weeks is not necessary if the most current CDC recommended treatment regimens are used.

Screening for HIV

The Centers for Disease Control and Prevention (CDC) currently recommends an HIV test for all persons aged 13-64 once, and periodic testing for those with on-going behavioral risks.[5] Persons likely to be at high risk include injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.

Other Testing Considerations

Other conditions or characteristics may warrant screening for chlamydia, gonorrhea, syphilis, HIV, or Hepatitis B.

Factors associated with sexual risk may include:

- Alcohol or substance misuse
- Commercial sex work
- Rape/sexual coercion/sexual abuse

Factors associated with risk of blood-borne illnesses may include:

- History of transfusion of blood or blood products
- Presence of tattoos, especially if performed by an unlicensed artist

Site-specific Recommendations

Check your state, local and agency screening recommendations as these may vary.

Individual risk depends on the local epidemiology of disease. Local public health authorities provide guidance to clinicians to help identify populations who are at increased risk in their communities. In communities with a high prevalence of chlamydia or gonorrhea, broader screening of sexually active people may be warranted, especially in settings serving individuals who are at increased risk. African Americans and men who have sex with men have a higher prevalence of infection in many communities and settings.

Screening Recommendations

	Chlamydia[1,2,3]	**Gonorrhea**[4]	**HIV**[5]
Women 25 and younger	Annually	Annually; not in very low prevalence populations	Once and annually as indicated by risk
Women over 25	Based on risk	Based on risk	Once and annually as indicated by risk
Heterosexual Men	No specific recommendations; consider in high prevalence populations	No specific recommendations; consider in high prevalence populations	Once and annually as indicated by risk

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Footnotes

[1] Centers for Disease Control and Prevention: Sexually Transmitted Diseases Treatment Guidelines, 2006
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5511a1.htm

[2] US Preventive Services Task Force Screening for Chlamydia Infection
http://www.ahrq.gov/clinic/uspstf/uspschlm.htm

[3] Infertility Prevention Project, CDC program website
http://www.cdc.gov/std/infertility/ipp.htm

[4] US Preventive Services Task Force: Screening for Gonorrhea:
http://www.ahrq.gov/clinic/uspstf/uspsgono.htm

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

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