Inclusive Sexual Health Services:
Practical Guidelines for Providers & Clinics

NATIONAL COALITION FOR SEXUAL HEALTH

NATIONAL COALITION FOR
SEXUAL HEALTH

Acknowledgments

Many thanks to the members of the National Coalition for Sexual Health's Health Care Action Group (HCAG) for providing their expert opinion and/or reviewing portions of the guide. Special thanks to AllGo and Disabled and Here for use of their free stock photos of people who are plus sized and people with disabilities.

Suggested citation

Altarum Institute. Inclusive Sexual Health Services: Practical Guidelines for Providers & Clinics. Washington, DC: Altarum Institute; 2023.

Inclusive Sexual Health Services: Practical Guidelines for Providers & Clinics was supported by cooperative agreement number 5H25PS003610-05 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of Altarum Institute and do not necessarily represent the official views of CDC.

CONTENTS

NATIONAL COALITION FOR SEXUAL HEALTH

Purpose

This guide was developed by the National Coalition for Sexual Health (NCSH)'s Health Care Action Group to cultivate a clinical environment that supports health care providers and clinical staff in the delivery of inclusive sexual health services to all patients.

Why Is This Important?

To improve sexual health in this country, we must make sure health care services are inclusive. Inclusive services are defined as those that are equitable, accessible, and of high quality for all patient populations. Health care providers serve a range of diverse populations – clients with different genders, sexual orientations, races/ethnicities, languages, abilities, income/education levels, body types or sizes, and ages.

This guide focuses on patients most affected by internal biases and inappropriate treatment including, racism, homophobia, transphobia, classism, ageism, ableism, fatphobia, sexism, general sex stigma, and other forms of oppression. Many health disparities can be better addressed by providing care that is client-centered and meets individual's specific sexual health needs.

How to Use/Implement This Guide

This guide is organized into six sections, starting with workforce and staff training, followed by the overall client flow during a health care visit. It also includes an appendix outlining specific sexually transmitted infection (STI) screening recommendations for specific populations. Some of these practices may not be relevant to all institutions/health centers because of various policies, resources, and/or state laws. This guide was adapted from the American College Health Foundation's *Implementation Guide for Sexual Health Best Practices in College Settings* and also cites the Centers for Disease Control and Prevention's (CDC) *Sexually Transmitted Infections Treatment Guidelines, 2021*.

For each recommendation select the statement that best aligns with your health center's current stage of implementation:

Not Applicable	Your health center is not able to implement due to various factors related to legality and/or resources (e.g., staffing, funding, time investment, policy barriers).
Intend to Implement, Have Not Yet	Your health center is able to implement and intends to do so, but has not yet begun.
Implementation in Progress	Your health center has begun the process of implementing and is actively working to improve/expand it.
Implemented and Maintaining (in Place)	Your health center has implemented the best practice and is actively working to maintain it (e.g., regular staff trainings, budget line item, ongoing evaluation).

Checklist

KEEP IN MIND:

The NCSH recognizes that fully implementing all of these recommendations might not be possible. However, we encourage providers and clinical staff to revisit this list on a regular basis as staffing, funding, time investment, and policy barriers may change. We also encourage providers and clinical staff to use this tool in support of advocacy efforts in your clinics. If you need additional support on how to implement these recommendations, please visit the NCSH's *Compendium of Sexual & Reproductive Health Resources for Healthcare Providers.*

I. Workforce

	N/A	Intend To	In Progress	Maintain
Staff at all levels are diverse and represent the communities that the clinic serves.	○	○	○	○
Job descriptions are inclusive and welcome all candidates.	○	○	○	○
Written policies explicitly state that the clinic does not discriminate on the basis of gender identity/expression, sexual orientation, race, disability, or body size in hiring practices.	○	○	○	○
Interview system is in place to help ensure candidates are evaluated using an equal blend of technical, competency-based, and personality-based questions.	○	○	○	○
Candidates are asked the same set of questions during all interviews.	○	○	○	○
Consider interview panels that represent employees of various roles, race/ethnicities, and ages.	○	○	○	○
Invest in unconscious bias training for hiring managers.	○	○	○	○

II. Staff Training

	N/A	Intend To	In Progress	Maintain
Onboarding training is comprehensive and inclusive to ensure new employees acquire the skills, knowledge, and behaviors to effectively serve all patients.	○	○	○	○
Ongoing education and other professional development opportunities related to inclusive care are available for staff at all levels.	○	○	○	○
Staff receive training on LGBTQIA+ inclusivity. Training should include informing patients of the confidentiality of sexual orientation and gender identity (SOGI) data.	○	○	○	○
Staff are trained on the cultural norms and practices of all populations in the area(s) they serve.	○	○	○	○
Written policies explicitly state that the clinic does not discriminate on the basis of gender identity/expression, sexual orientation, race, disability, or body size in provision of services.	○	○	○	○
Staff have access to training on key topics such as: comprehensive sexual assessment; sexual health across the lifespan; trauma-informed care; and other emerging issues or priorities.	○	○	○	○
Staff are knowledgeable about basic health terms (e.g., body parts, common illnesses, and common symptoms) in relevant languages and know how to work with an interpreter. Please see the NCSH's *Compendium of Sexual & Reproductive Health Resources for Healthcare Providers* for resources on health terms in multiple languages.	○	○	○	○
Interpretation services (including sign language) are available to patients at all times. A written procedure for interpretation services is available to staff at all times.	○	○	○	○
Staff are trained on how to ask patients with disabilities if accommodation is needed.	○	○	○	○
Staff speak directly to patients with disabilities, even if the patient has cognitive disabilities, difficulty with speech, or a support person is involved in their care.	○	○	○	○
Staff repeat back to patients what they understood the patient to say. And have patients repeat directions or explanations back, in their own words.	○	○	○	○

III. Welcoming Environment

	N/A	Intend To	In Progress	Maintain
Websites, posters, brochures, and other materials have sex-positive messages with same- and different-gender partners, as well as people of different races, ethnicities, gender expressions, ages, body sizes, and physical abilities.	○	○	○	○
Brochures, magazines, posters, and other reading materials specific to LGBTQIA+ patients and patients of color are placed in waiting area, exam rooms, bathrooms, and other more visible locations.	○	○	○	○
Clinical spaces are sensitive to trauma experiences by using calming designs and maintaining a comfortable temperature, natural light, plants, multiple options for seating, and considerate noise levels.	○	○	○	○
Physical space displays confidentiality notice and assesses patient flow for privacy issues.	○	○	○	○
Gender-inclusive restrooms are available and accessible.	○	○	○	○
Any office providing safer sex supplies offers a variety of options, styles, and sizes, including lubricant.	○	○	○	○
Patient areas have updated brochures in both plain language and in relevant languages, if available.	○	○	○	○
For those patients with vision loss, large print on forms or audio versions are available.	○	○	○	○
For patients with mobility issues, the clinical space should meet the Americans with Disabilities Act of 1990 (ADA) requirements as required by federal law.	○	○	○	○
Specialized teaching tools and resources are available for patients with disabilities. This includes visuals like models, dolls, and pictures for patients with developmental disabilities. For patients with physical disabilities, use stories and examples of others with similar disabilities who have loving, satisfying intimate relationships.	○	○	○	○

	N/A	Intend To	In Progress	Maintain
Scales for weigh-ins accommodate higher weight patients (minimum of 500lbs).	○	○	○	○
Extra-large cuffs are available for taking blood pressure.	○	○	○	○
Extra-large hospital gowns, exam tables, and seating are available for larger-bodied patients.	○	○	○	○
Staff, community members, and patients serve on paid advisory boards to provide guidance and recommendations on how to better serve the population.	○	○	○	○
Consider having a display of sex toys to foster a sex positive environment and open conversations.	○	○	○	○
IV. Patient Data Collection*				
Patient questionnaires and/or electronic health record (EHR) templates include specific field for name the patient would like to be called (i.e., their lived name), and this field is not referred to as a "preferred name**."	○	○	○	○
Patient questionnaires and/or EHR templates include a specific field for patient's pronouns, and this field is not referred to as "preferred pronouns**." An open-ended "other" option is also available.	○	○	○	○
Names and pronouns are visible on every page of EHRs throughout the entire patient experience. Collecting and storing this information in an area of the EHR that is not easily accessible defeats the purpose of its collection and appropriate use.	○	○	○	○

** Providers are encouraged to use the collected information to assess for disparities in health care. For example, providers can use SOGI data to identify and address gaps in preventive services for LGBTQIA+ persons at their clinics (e.g., cervical screening rates among lesbians versus women who have sex with men only).*

*** Names and pronouns are not "preferred" but instead are required for respectful communication. Preferred assumes that a patient's gender identity is a choice.*

	N/A	Intend To	In Progress	Maintain
Patient questionnaires and/or EHR templates include specific fields for gender identity in a two-step process, where patient is first asked about gender identity and then their sex assigned at birth. Open-ended "other" options are available.	○	○	○	○
Patient questionnaires and/or EHR templates include specific field with options for sexual orientation. An open ended "other" option is available.	○	○	○	○
Patient questionnaires and/or EHR templates include questions about country of origin, spoken language preference, and written language preference on forms.	○	○	○	○
Patient questionnaires and/or EHR templates are available in Spanish and any other relevant languages.	○	○	○	○
Patient questionnaires and/or EHR templates allow patients to mark as many races/ethnicities, genders, and sexual orientations as apply.	○	○	○	○
V. Sexual Health Assessment Clinicians engage patients in conversations about sexual health during preventive visits—not just during problem-focused sexual health visits. See the NCSH's *Sexual Health and Your Patients: A Provider's Guide*. Also see the NCSH's *Compendium of Sexual & Reproductive Health Resources*.	○	○	○	○
EHR templates and/or patient questionnaires use the NCSH's "6 Ps approach" to obtain sexual history (Partners, Practices, Protection from STIs/human immunodeficiency virus (HIV), Past History of STIs, Pregnancy, and PLUS (Pleasure, Problems, and Pride). This is an adapted version of the CDC's 5 Ps approach.	○	○	○	○
EHR templates and/or patient questionnaires used during routine wellness and problem-focused visits include questions about sexual pleasure and satisfaction.	○	○	○	○

	N/A	Intend To	In Progress	Maintain
EHR templates and/or patient questionnaires include field for patient's reproductive goals for the next year.	○	○	○	○
Questions regarding birth control are asked in a manner that does not assume heterosexuality, sexual activity, or desire to not get pregnant. See the Pregnancy section of the NCSH's "6 Ps approach".	○	○	○	○
EHR templates and/or patient questionnaires direct clinicians to counsel patients desiring pregnancy or not using reliable forms of contraception to take a supplement containing 0.4-0.8 mg of folic acid daily for the prevention of neural tube defects.	○	○	○	○
EHR templates and/or patient questionnaires on sexual history use open-ended questions with nonjudgmental tone and demeanor, such as, "Could you tell me about your current relationships (e.g., no partner, one partner, multiple partners)?".	○	○	○	○
EHR templates and/or patient questionnaires ask if patient has preferred language that they like to use to refer to their body parts (e.g., genitals).	○	○	○	○
Clinicians caring for transgender patients have knowledge of their patients' current anatomy and patterns of sexual behavior before counseling or offering them preventive health services including STI and HIV prevention.	○	○	○	○

VI. Clinical Care: General

Providers should remain aware of symptoms consistent with common STIs and screen for asymptomatic infections on the basis of the patient's sexual practices and anatomy. See Appendix for more information.	○	○	○	○
Patients are sent reminders for follow-up appointments and, if they miss their follow-up appointments, are contacted to be rescheduled.	○	○	○	○

	N/A	Intend To	In Progress	Maintain
EHR templates, patient questionnaires, and/or other clinical decision support tools are used to remind clinicians of screening, testing, vaccination, and other preventive care needs.	○	○	○	○
Gender-based screening recommendations should be adapted on the basis of a patient's anatomy as recommended. Clinicians should be aware of how to use the correct and affirming language to relay this to patients. See *CLOSLER's guide to Using Affirming Language With LGBTQIA+ Patients*.	○	○	○	○
Policies and/or procedures are in place for clinicians to screen for STIs at all appropriate anatomical sites, following recommendations published by the CDC and the United States Preventive Services Task Force (USPSTF), regardless of patient's sexual orientation or gender identity.	○	○	○	○
Qualified clinicians provide primary care and gender-affirming hormone therapy for trans and non-binary patients.	○	○	○	○
All patient follow-up visits should be scheduled during their current visit, if possible.	○	○	○	○
VII. Clinical Care: Following the STI Treatment Guidelines				
Clinicians take blood pressure before prescribing certain hormonal birth control methods.	○	○	○	○
EHR templates and/or patient questionnaires for all patients aged 45 years and younger include a question about human papillomavirus (HPV) vaccination status.	○	○	○	○
Fourth generation rapid HIV Ab/Ag testing is available, preferably on-site.	○	○	○	○

	N/A	Intend To	In Progress	Maintain
Policies and/or procedures are in place to permit patients to self-swab rectal, throat, and vaginal specimens when possible.	○	○	○	○
The legal status of Expedited Partner Therapy (EPT) in the state is reviewed with staff.	○	○	○	○
• If legal, policies and/or procedures are in place to offer EPT to patients, especially patients recently diagnosed with an STI.	○	○	○	○
EHR templates and/or patient questionnaires used during routine wellness visits include questions about HIV Pre-Exposure Prophylaxis (PrEP).	○	○	○	○
Policies and/or procedures are in place for clinicians:				
1. To recommend HPV vaccine to all patients aged 45 years and younger who are not fully vaccinated.	○	○	○	○
2. To recommend hepatitis A virus (HAV) vaccine for patients who are men who have sex with men (MSM), who do not have HAV antibodies, or who have not previously been vaccinated.	○	○	○	○
3. To recommend vaccination for hepatitis B virus (HBV) for patients not previously vaccinated, patients at risk for HBV infection (e.g., through sexual exposure), or patients requesting protection from HBV without a specific risk factor.	○	○	○	○
4. To recommend screening for cervical cancer for all patients with a cervix based on current national guidelines, regardless of gender identity or sexual activity.	○	○	○	○
5. To decide, in partnership with the patient, whether to perform a pelvic exam based on medical history or symptoms.	○	○	○	○
6. To offer smaller-sized speculums during pelvic exams if the patient expresses a preference.	○	○	○	○

	N/A	Intend To	In Progress	Maintain
7. To provide routine, opt-out HIV screening following recommendations published by the CDC.	○	○	○	○
8. To ensure HIV testing is offered when STI testing is requested and STI testing is offered when HIV testing is requested.	○	○	○	○
9. Expect clinicians to screen for PrEP eligibility and offer PrEP as appropriate to all patient populations.	○	○	○	○
10. Expect clinicians to offer PEP (post-exposure prophylaxis).	○	○	○	○

VIII. Referrals

Policies and procedures are in place to provide patients who have or are experiencing trauma and trauma symptoms with ongoing support or referred to appropriate agencies and/or mental health professionals.	○	○	○	○
Create and maintain a list of current referral resources. Leave resource list at strategic locations (e.g. nurses' station, front desk, treatment rooms, waiting room.) The referral list should be organized by topic and populations served.	○	○	○	○
Clinicians assist with referrals to surgeons and coordination of care for patients seeking gender-affirming surgery.	○	○	○	○

Glossary of Terms

Ableism	The discrimination of and social prejudice against people with disabilities based on the belief that typical abilities are superior.
Ageism	Prejudice or discrimination against a particular age-group and especially the elderly and young people.
Classism	A belief that a person's social or economic station in society determines their value in that society.
Fatphobia	The implicit and explicit bias of overweight individuals that is rooted in a sense of blame and presumed moral failing.
Gender Expression	External appearance of one's gender identity, usually expressed through behavior, clothing, body characteristics or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.
Gender Identity	One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.
General Sex Stigma	A form of sexism where genders are judged differently for engaging in the same sexual behavior (with feminine genders carrying the stigma).
Homophobia	The fear, hatred, discomfort with, or mistrust of people who are lesbian, gay, or bisexual.
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer/questioning (one's sexual or gender identity), intersex, and asexual/aromantic/agender. The 'plus' is used to signify all of the gender identities and sexual orientations that letters and words cannot yet fully describe.
Oppression	The combination of prejudice and institutional power which creates a system that discriminates against some groups (often called "target groups") and benefits other groups (often called "dominant groups"). Examples of these systems are racism, sexism, heterosexism, ableism, classism, ageism, and anti-Semitism. These systems enable dominant groups to exert control over target groups by limiting their rights, freedom, and access to basic resources such as health care, education, employment, and housing.
PEP	Post-Exposure Prophylaxis is a medicine to prevent HIV after a possible exposure. PEP should be used only in emergency situations and must be started within 72 hours after a recent possible exposure to HIV.

PrEP	Pre-Exposure Prophylaxis, is medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use. PrEP can stop HIV from infection if exposed.
Racism	The process by which systems and policies, actions and attitudes create inequitable opportunities and outcomes for people based on race.
Sexism	Prejudice or discrimination based on sex; especially discrimination against women.
Sexual Orientation	Sexual orientation is about who you are attracted to and want to have relationships with. Sexual orientations include, but are not limited to, gay, lesbian, straight, bisexual, and asexual.
Transphobia	The hate, fear, or disgust for transgender people or anyone who does not fit into the male/female gender binary.
U=U & Treatment as Prevention (TasP)	TasP refers to ways in which we can use HIV drugs, or HIV treatment, to lower the risk of transmitting HIV. TasP should be included to recognize that when a person living with HIV has their virus durably suppressed, or virus is "undetectable" because of adherence to safe, accessible, effective medication therapies, this person can no longer transmit the virus to partners through sex. The virus is "untransmittable" and in this way, treating HIV is prevention as well.

Appendix: STI Detection and Screening Recommendations for Specific Populations

The following clinical STI detection and screening recommendations were taken from the U.S. Centers for Disease Control and Prevention's (CDC) Sexually Transmitted Infections Treatment Guidelines. Text was updated to remove gendered language.

Pregnant People

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

- All pregnant people are tested for HIV at the first prenatal visit, even if they have been previously tested.
- HIV testing is offered as part of the routine panel of prenatal tests (e.g., opt-out testing).
- For those who decline HIV testing, providers address their concerns and, when appropriate, continue to encourage testing.
- Partners of pregnant patients are offered HIV testing, if feasible or referral to where this is possible, if their status is unknown.
- Retesting in the third trimester (preferably before 36 weeks' gestation) is recommended for those at higher risk for acquiring HIV infection.
- Rapid HIV testing is performed for any person in labor who has not been tested for HIV during pregnancy or whose HIV status is unknown, unless they decline. If a rapid HIV test result is positive, Antiretroviral Therapy (ART) is administered without waiting for the results of confirmatory testing.

SYPHILIS

- All pregnant people are screened for syphilis at the first prenatal visit, even if they have been tested previously.
- Pregnant people are retested for syphilis at 28 weeks' gestation and at delivery if the person lives in a community with high syphilis rates or is at risk for syphilis acquisition during pregnancy (e.g., misuses drugs or has an STI during pregnancy, having multiple sex partners, having a new sex partner, or having a sex partner with an STI).
- Any person who delivers a stillborn infant is tested for syphilis.

HEPATITIS B

- All pregnant people are routinely tested for hepatitis B surface antigen (HBsAg) at the first prenatal visit even if they have been previously vaccinated or tested.
- Individuals who are HBsAg-positive are provided with, or referred for, counseling and medical management.
- Individuals who are HBsAg-negative but at risk for HBV infection are vaccinated.
- Individuals who were not screened prenatally,

those who engage in behaviors that put them at high risk for infection (e.g., having had more than one sex partner during the previous six months, having been evaluated or treated for an STI, having had recent or current injection drug use, or having an HBsAg-positive sex partner), and those with clinical hepatitis are tested at the time of admission to the hospital for delivery.

- Pregnant people who are HBsAg-positive are reported to the local or state health department to ensure that they are entered into a case-management system and that timely and age-appropriate prophylaxis is provided to their infants.
- Information concerning the pregnant person's HBsAg status is provided to the hospital where delivery is planned and to the health care provider who will care for the newborn.
- In addition, household and sexual contacts of individuals who are HBsAg-positive should be vaccinated

CHLAMYDIA AND GONORRHEA

- All pregnant people aged <25 years as well as older individuals at increased risk for chlamydia (e.g., those aged ≥25 years who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI) are routinely screened for chlamydia and gonorrhea at the first prenatal visit.
- Pregnant people who remain at increased risk for chlamydial and gonorrhea infection also are retested during the third trimester to prevent postnatal complications and chlamydial and gonorrhea infection in the neonate.
- Pregnant people identified as having chlamydia and gonorrhea are treated immediately and have a test of cure to document chlamydial eradication by a nucleic acid amplification test (NAAT) four weeks after treatment. Gonorrhea test of cures can be done 10-14 days after completion of treatment.
- All persons diagnosed with a chlamydial and/or gonorrhea infection are rescreened three months after treatment.

Persons in Correctional Facilities

CHLAMYDIA AND GONORRHEA

Females aged ≤35 years and males aged <30 years housed in correctional facilities are screened for chlamydia and gonorrhea. This screening is conducted at intake and offered as opt-out screening.

TRICHOMONAS

Females aged ≤35 years housed in correctional facilities are screened for trichomonas. This screening should be conducted at intake and offered as opt-out screening.

SYPHILIS

Opt-out screening for incarcerated persons should be conducted on the basis of the local area and institutional prevalence of early (primary, secondary, or early latent) infectious syphilis. Correctional facilities should stay apprised of local syphilis prevalence. In short-term facilities, screening at entry might be indicated.

VIRAL HEPATITIS

All persons housed in juvenile and adult correctional facilities are screened at entry for viral hepatitis, including hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus (HCV), depending on local prevalence and the person's vaccination status. Vaccination for HAV and HBV are offered if the person is susceptible.

CERVICAL CANCER

Women and transgender men who are housed in correctional facilities are screened for cervical cancer identically to those who are not incarcerated.

HIV

- All persons being housed in juvenile and adult correctional facilities are screened at entry for HIV infection.
- Screening should be offered as opt-out screening.
- For those identified as being at risk for HIV infection and being released into the community, starting HIV Pre-Exposure Prophylaxis (PrEP) for HIV prevention is considered.
- For those identified with HIV infection, treatment is initiated.
- Those persons receiving PrEP or HIV treatment have linkage to care established before release.

Adolescents

CHLAMYDIA

- Routine screening for chlamydia infection on an annual basis is recommended for all sexually active females aged <25 years.
- Screening of sexually active young males is considered in clinical settings serving populations of young men with a high prevalence of chlamydial infections (e.g., adolescent service clinics, correctional facilities, STI clinics).
- Chlamydia and gonorrhea screening, including pharyngeal or rectal testing, is offered to all Young Men Who Have Sex with Men (YMSM) at least annually on the basis of sexual behavior and anatomic site of exposure.

GONORRHEA

- Routine screening for gonorrhea on an annual basis is recommended for all sexually active females aged <25 years.
- Extragenital gonorrhea screening (pharyngeal or rectal) can be considered for females on the basis of reported sexual behaviors and exposure.
- Clinicians consider the communities they serve and consult local public health authorities for guidance regarding identifying groups that are more vulnerable to gonorrhea acquisition on the basis of local disease prevalence.
- Screening for gonorrhea, including pharyngeal or rectal testing, is offered to YMSM at least annually.
- Providers consider opt-out chlamydia and gonorrhea screening (i.e., the patient is notified that testing will be performed unless the patient declines, regardless of reported sexual activity) for adolescent and young adult females during clinical encounters.

HIV

- HIV screening is discussed and offered to all adolescents. Frequency of repeat screenings is based on the patient's sexual behaviors and the local disease prevalence.
- Persons with HIV infection receive prevention counseling and linkage to care before leaving the testing site.

CERVICAL CANCER

- Guidelines from the United States Preventive Services Task Force (USPSTF) and the American College of Obstetricians and Gynecologists (ACOG) recommend that cervical cancer screening begin at age 21 years.

Sexual Assault and Abuse and STIs among Adolescents and Adults

- Examinations of survivors of sexual assault is conducted by an experienced clinician in a way that minimizes further trauma to the person.
- NAATs for chlamydia and gonorrhea at the sites of penetration or attempted penetration is performed.
- Individuals are offered NAAT testing for T. vaginalis from a urine or vaginal specimen. POC or wet mount with measurement of vaginal pH and KOH application for the whiff test from vaginal secretions should be performed for evidence of BV and candidiasis, especially if vaginal discharge, malodor, or itching is present.
- Men who have sex with men (MSM) are offered screening for chlamydia and gonorrhea if they report receptive oral or anal sex during the preceding year, regardless of whether sexual contact occurred at these anatomic sites during the assault.
- Anoscopy is considered in instances of reported anal penetration.
- A serum sample is performed for HIV, HBV, and syphilis infection.
- Emergency contraception is considered when the assault could result in pregnancy.
- A serum sample should be performed for HIV, HBV, chlamydia, gonorrhea, and syphilis infection.