

# The nurse role in sexual health services

Appropriate training should be undertaken by nurses planning to run a sexual health service, advises **Gina Robinson**

The UK has a high incidence of teenage pregnancy and STIs.<sup>1,2</sup> Nurses are in an ideal position to give sexual health advice to this age group, because they often have contact with teenagers for other reasons, such as chronic disease management and routine vaccination, in particular the new HPV immunisation campaign.

STIs can cause infertility, ectopic pregnancy, pain and anxiety, as well as stigma, while teenage pregnancy and unwanted pregnancy can cause a plethora of social and psychological problems.

In view of such issues, what do nurses need to consider when setting up an effective sexual health clinic?

This article will also review the management of vaginal discharge, chlamydia, gonorrhoea and trichomoniasis.

## Patient history

A discussion of sexual habits can be a daunting experience for a patient – especially a younger person – and practitioner. Nurses need to find their own way of eliciting a patient history without being judgmental or trying to force their own sexual morals onto the patient. Motivational interviewing and counselling skills can be useful tools, particularly when a lot of information and advice needs to be supplied within a short time.<sup>3</sup>

Taking a detailed sexual history is the crux of the consultation because it informs further management. The British Association for Sexual Health and HIV (BASSH) guidelines recommend covering the following:<sup>4</sup>

- Careful assessment of symptoms – use to determine examination and testing.
- Exposure history – to determine site sampling and consider which STIs may be present.
- Contraceptive use and pregnancy risk.
- HIV, hepatitis B and C risk – testing and prevention.
- Risk behaviours – to facilitate health promotion activity, including contact tracing and partner notification.

The DoH advises that a practitioner should have experience and knowledge of the following:<sup>5</sup>

- Particular at-risk groups, for example men who have sex with men, young people, ethnic minorities, sex workers and individuals returning from travel abroad.
- Common presentations of STIs.
- Presentations of psychosexual problems and when to refer for treatment.
- Familiarity with, and application of, Fraser and other national guidelines with regard to consent and confidentiality in relation to under-16s and other vulnerable clients irrespective of age.

As well as the above, the document details other core competencies for practitioners involved in sexual health, including raising the issue of chlamydia screening.

## Service provision

It is important to consider the practical issues of offering a sexual health service. Do you intend to have a separate clinic for sexual health, or will it be incorporated into a general clinic? Do you intend to have appointments or drop-in sessions? Will you have a separate clinic for adolescents? Do you wish to target a specific group of patients? All of the above have pros and cons, so you will have to look at your own practice population to determine the best way to proceed.

Any nurse running a sexual health clinic should ideally have taken a course in family planning and/or sexual health. Because

this may be unlikely in reality, nurses should, as a minimum, be highly experienced in these areas and work closely to agreed protocols. Training should be taken wherever possible, as should opportunities for continuing professional development.

Nurses need specific training if they are undertaking certain procedures, such as cervical cytology, and the insertion or removal of coils and implants.

Protocols and procedures can initially be time consuming to create, but are a necessity when setting up a clinic. Protocols may include: infection control, chaperoning, consent, transport of specimens, management of STIs (including treatment of specific diseases, referral criteria, contact tracing, patient contact and information), cervical cytology, emergency contraception, testing for pregnancy, contraception (protocol for each group given) and management of patients aged under 16 years.

If a non-prescribing nurse is managing the clinic, it is also worth considering whether patient group directions are possible in order for patients to receive medications quickly.

Consider which infections you will be managing and whether it will be beneficial for patients to be diagnosed in general practice, rather than referred to a GUM clinic, which may have a quicker testing time. If the patient potentially has several infections, consider:

- Should treatment be given for one infection if they will need to be referred?
- Is it fair or necessary to put the patient through two examinations instead of one?
- If you refer, is the patient likely to attend? Factors like stigma and time constraints need to be considered.

The mode of testing for STIs can vary geographically and it is a good idea to contact your local laboratory to find out what testing it can provide and how quickly samples need to be sent and will be processed.

It is also important to consider whether a particular medium for storage is advocated and confirm who is responsible for ensuring that stored swabs are sent. If a vaginal swab or endocervical swab needs to be stored, it is recommended that it should not be for longer than 48 hours. A designated fridge should be used, maintained at a temperature of 4°C.<sup>6</sup>

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*Sexual health nurses must receive the appropriate training to be able to treat patients with STIs, such as gonorrhoea*

Contact tracing can be a very sensitive issue to discuss, particularly if infidelity is involved. Responsibility for the contact tracing of sexual partners should also be determined. Many regions have a central area for contact tracing for all patients with an STI. The sexual partners of all people found to have STIs should also be screened and treated.

It is important that the patient knows how they will be contacted with their results and by whom, or who they need to contact. A suitable medium for this should be pre-arranged.

One of the staples of any sexual health service is condoms. Some authorities provide free condoms to GP surgeries. It is important to find out if this is the case and if there is a limit on supply or delivery.

Establish how pregnancy testing will be done. Ideally pregnancy should be excluded immediately to stop the patient continuing to have unprotected sexual intercourse while awaiting results. Assessing when unprotected sex has taken place is very important because some pregnancy tests are ineffective unless used three weeks postcoitus.<sup>7</sup> Always establish whether emergency contraception is required.

Patients with STIs should also be encouraged to undertake screening for HIV and hepatitis B. Hepatitis A and B vaccination should be promoted to those who partake in unsafe sexual practice or misuse drugs.

Provide written information to support any verbal information including treatment, management and follow-up. Self-help groups and website details are also a useful resource, particularly if the patient does not wish to carry written information.

### Under-16s

Young people are becoming sexually active earlier. There is a link between early sexual contact and an increased number of sexual partners, and therefore STIs.<sup>1</sup>

Alcohol and drug misuse also lead to high-risk sexual behaviour and should be assessed. The sexual health clinic can provide an effective, brief intervention for risky alcohol use.<sup>8</sup>

Adolescent development and health is a specialist area and nurses may benefit from additional training in this field.

The legal issues of treating STIs and prescribing contraception to under-16s must be incorporated into practice protocols. Factors such as whether the child/adolescent is Gillick competent (Fraser guidelines) and whether it is felt that consensual sex or sexual assault has taken place must be explored and documented. If necessary, referral to the police or child protection agencies should be undertaken; otherwise patient confidentiality should be maintained.<sup>9</sup>

### Prescribing

As in all prescribing situations, the patient's age, medical history, current medication (including OTC) and allergies must be considered. Differential diagnosis is very important. Remember that many STIs coexist with other STIs or non-STI infections. Pregnancy should always be excluded, particularly when prescribing treatment for STI or contraception.

## BOX 1: BEST PRACTICE

- Take a detailed patient history. Motivational interviewing and counselling skills training may help nurses elicit the necessary patient information.
- Sexual health nurses should be trained in family planning and/or sexual health, or otherwise be highly experienced in this area and familiar with protocols.
- If nurses are treating under-16s, training in adolescent development and health should be considered.
- When prescribing treatment for STIs or contraception, nurses must consider patient age, history, current medication, allergies and differential diagnoses, including coexisting STIs. Pregnancy should always be excluded.

### Contraception

STIs are treated with antibiotics which may reduce or negate contraceptive effectiveness. In general, advise women using oral hormonal contraception that additional protection may be required (for example condoms) while taking the antibiotic and for seven days afterwards. Ideally, they should avoid sexual contact until their partner has been treated.

Where emergency contraception has been given, offer advice about future contraceptive use.

### Vaginal discharge and STIs

Vaginal discharge can have many causes, including non-STI infections, malignancy and foreign bodies.<sup>6</sup> Women need to be advised that it is natural to encounter changes in the colour and consistency of cervical mucus, caused by natural fluctuations in hormonal levels. When examining a woman with vaginal discharge, take a general sexual history and explore the following:<sup>6</sup>

- Why is the woman presenting now?
- What are her concerns?
- Has there been a change in odour, onset, duration, colour or consistency of discharge?
- Ask about associated symptoms – itch, superficial dyspareunia, dysuria and symptoms of upper reproductive tract infection (abdominal pain, deep dyspareunia, abnormal bleeding, dysuria, pyrexia and STIs).
- Consider non-infective causes of discharge, for example foreign body, cervical ectopy or polyps or genital tract malignancy.

Trichomoniasis is the most common STI to cause vaginal discharge. Taking a specimen to test vaginal pH from the lateral vaginal walls can be a useful tool in helping to determine non-STI causes of infection and may influence further investigations (trichomoniasis presents a pH of equal to or greater than 4.5).

Suspected STIs will always require a genital and speculum examination. Nurses must ensure that they gain consent for any investigations and/or examinations that are undertaken, and that they counsel patients as to the implications of a positive result.

If there is a possibility of an STI, a high vaginal swab should ideally be taken from the lateral vaginal walls and posterior fornix. Endocervical swabs or urine sampling should also be taken to exclude gonorrhoea and chlamydia.

If the woman refuses a high vaginal swab, a lower swab taken by the patient may be considered. Swabs from other potentially infected areas (urethra, rectal and oropharyngeal) should also be considered. Swabs and urine samples should be sent for culture and microscopy.<sup>6</sup>

Advise sexual abstinence (including oral sex) or condom use where an STI is suspected, until treatment has been undertaken, for at least one week after treatment, and, ideally, until treatment has been proved effective. Most STIs do not require retesting to ascertain success unless reinfection or compliance is an issue.

### Trichomoniasis

Trichomoniasis is caused by the flagellated protozoan, *Trichomonas vaginalis*. It is associated with a frothy, yellow discharge that smells offensive. Other symptoms may include vulval or penile itch, dysuria and low abdominal pain. Vulvitis may also be present.

In women, *T vaginalis* can be detected by taking a high vaginal swab, or a patient self-administered vulvovaginal swab, and sending for culture or microscopy. In men, either a urethral swab or urine may be cultured – if both are done this increases the diagnostic certainty.<sup>10</sup>

The treatment is a single 2g dose of metronidazole or 400–500mg twice daily for five to seven days. Alternative regimens are available. For pregnant women, metronidazole 400mg twice daily for seven days is recommended.<sup>10</sup>

## Chlamydia

Uncomplicated genital chlamydia infection is asymptomatic in up to 80 per cent of infected women<sup>7</sup> and often found opportunistically. Chlamydia is the most common STI in the UK and is the main cause of pelvic inflammatory disease. Prevalence is highest in patients under 25 years of age.

Screening is recommended for women who have symptoms consistent with chlamydia (see below), have a concurrent STI, are to have an IUD fitted, are aged under 25 years or have changed sexual partners within the past 12 months. Men should be screened if they are symptomatic, are less than 25 years of age and have been sexually active.

Other criteria for screening are also available but are unlikely to be appropriate here.<sup>11</sup> Symptoms may lie dormant for many months. In women, the most common presentations include:

- An unusual or purulent vaginal discharge.
- Pain during sex or when urinating.
- Bleeding during or after sex.
- Lower abdominal pain

Men will suffer similar pain, but may have penile discharge and discomfort and/or swollen testicles.<sup>12</sup>

Testing for chlamydia in women should be undertaken by endocervical or vulvovaginal swab – the patient may self-swab for this. A urine sample may be used and nucleic acid amplification technique (NAAT) testing is generally advocated. Men may undergo a penile swab, but a first-void urine sample is generally used, because this is as effective for diagnostic purposes and less intrusive.<sup>12</sup> For women who are asymptomatic, urine and vulvovaginal swabs are appropriate.<sup>7</sup>

Treatment for uncomplicated chlamydia (not in pregnant or breastfeeding women) consists of a single-dose of azithromycin (1g) or doxycycline (100mg twice daily) for seven days (contraindicated in pregnancy). Erythromycin 500mg twice daily for 10–14 days or ofloxacin 200mg twice daily or 400mg once a day for seven days are alternative treatments if azithromycin or doxycycline are contraindicated.

Follow-up is recommended. Routine test of cure is only required in specific instances including pregnancy and should be performed 5–6 weeks after finishing treatment.

Nurses who are involved in screening for chlamydia should consult the National Chlamydia Screening Programme,<sup>12</sup> which advises on how to target people who are sexually active and aged under 25 years, and the BASHH guideline.<sup>11</sup>

## Gonorrhoea

Gonorrhoea is the second most common STI in the UK. Symptoms are similar to trichomoniasis. The causative organism, *Neisseria gonorrhoea*, can be detected by taking an endocervical swab, vulvovaginal swab or by urine sampling. Culture of endocervical swabs is commonly used, as is microscopy, whereas NAATs and nucleic acid hybridisation tests are used on vulvovaginal swabs and urine samples.<sup>13</sup> It is recommended that anyone with gonorrhoea is screened for chlamydia, and vice versa.

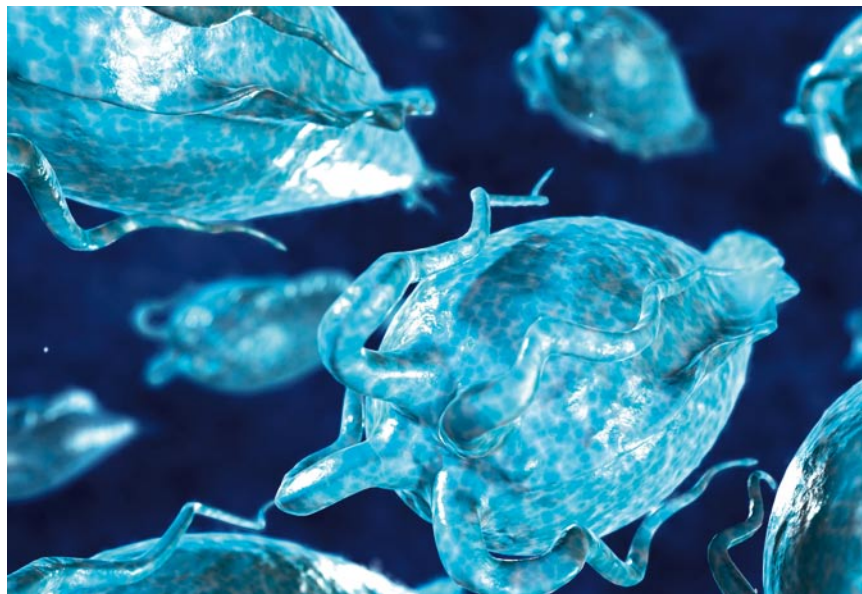
Several treatments can be used for uncomplicated anogenital gonorrhoea, and include the following:

- Ceftriaxone 250mg IM as a single dose.
- Ciprofloxacin 250mg as a single dose.
- Ofloxacin 400mg as a single dose.
- Cefixime 400mg oral as a single dose.

Pregnant women should not be treated with quinolones (ciprofloxacin, ofloxacin) or tetracycline antimicrobials.

Treatments should consider local antibiotic sensitivity and alternative treatments may be used where sensitivity is evident, or where regional resistance to them is less than 5 per cent.<sup>13</sup>

If there is doubt that the patient will return for subsequent treatment, then consider dual treatment for chlamydia and gonorrhoea where needed.



Follow up is recommended. If retesting is required (for example in those with poor compliance with treatment or at risk of re-infection), perform culture tests within 72 hours after completion of treatment and NAAT tests two weeks after treatment has finished.

Providing a sexual health service is a complex issue. Nurses must be appropriately trained to deal with the clinical, physical and psychological requirements that this role requires.

*Trichomoniasis is caused by the flagellated protozoan, Trichomonas vaginalis, and is associated with a frothy, yellow, smelly discharge*

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