manual of sexually transmitted infections

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Manual of Sexually Transmitted Infections

by

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This book is dedicated to the memory of my brother,
Kevin Michael Peate.

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Introduction

The topics discussed in this text are relevant to all nurses, midwives, specialist community public health nurses and other health care workers, working in the primary, secondary, intermediate and tertiary sectors of health care, the independent sector and the National Health Service. Sexual health matters for everyone; however, sexual health needs vary from one person to another, from one community to another as well as evolving throughout life (Medical Foundation for Sexual Health, 2004).

Some key facts related to sexual health

- There has been an increase across the population related to sexual risk-taking behaviour.
- HIV prevalence in adults has increased by 20 per cent. It is estimated that on average 31 per cent of people who are HIV positive in the UK are unaware of it.
- The most common STI is chlamydia which affects one in ten sexually active young women. If left untreated chlamydia can lead to pelvic inflammatory disease, ectopic pregnancy, infertility, psychological and emotional distress.
- Genital warts have increased by 2 per cent and syphilis by 28 per cent.
- Delays in accessing treatment for STIs can lead to an increase in the number of people infected.

There are inequalities associated with sexual health and the provision of services. Women, young people, gay men, black and ethnic minority groups and people living in London are disproportionately affected (DoH, 2004b). Discrimination is a real threat to persons with STIs; discrimination on the basis of infection (direct or indirect) with an STI is unlawful.

The national perspective

The most influential government report produced to improve the sexual health of the nation was published by the Department of Health in 2001 – the Strategy for Sexual Health and HIV in England (DoH, 2001c). Scotland has a five-tier model of sexual health service provision (Scottish Executive, 2003). The Welsh Assembly has produced their own strategic document (National Assembly for Wales, 2000) and Northern Ireland is currently preparing their own strategy (Department of Health Social Services and Public Safety, 2003). The strategy for sexual health together with the Implementation Action Plan (DoH, 2002d) have been produced to improve sexual health and reduce health inequalities. England is currently experiencing a rapid decline in its sexual health (House of Commons Health Committee, 2003). There is also recognition of the direct links between health inequalities and sexual ill health:

- poverty;
- poor housing;
- unemployment;
- discrimination;
- other forms of social exclusion.

The main aims of the strategy are to:

- reduce the transmission of HIV and STIs;
- reduce unintended pregnancy rates;
- improve health and social care for people living with HIV;
- reduce the stigma associated with HIV and STIs.

Plans are outlined in the strategy that propose a modern, efficient and user-centred sexual health service. There are proposals to abolish the unfair and unjustified variations in access, quality and provision of sexual health services (Medical Foundation for Sexual Health, 2004).

The Sexual Health Strategy (DoH 2001c) states that there should be a new model of working, with three levels of service provision (see Table I.1).

The recommendations made in the Sexual Health Strategy (DoH, 2001c) are to be translated into practice by the provision of Sexual Health Leads at each Primary Care Trust (PCT). For nurses this will have implications: the role of the nurse will be further extended and autonomous practice will be enhanced.

The Royal College of Nursing has produced their own sexual health strategy (RCN, 2001) providing further guidance for nurses. The strategy provides guidance that will help the nurse work more effectively in the field of sexuality and sexual health.

Table I.1 The three levels of sexual health service provision

Level 1
A basic level of sexual health provision, this is likely to be carried out in a GP surgery or walk-in centre; both of these venues will not provide an enhanced or specialist service. Some of the services offered at level 1 may include:

- The provision of emergency contraception
- Hormonal contraception
- Opportunistic screening for STIs
- Treatment for STIs
- Cervical cytology

Level 2
This level provides care that is offered at an enhanced level; it will include all services offered at level 1 and a degree of specialist provision. Services at this level may include:

- Fitting of intrauterine devices/intrauterine systems
- Advanced genitourinary care that may include the treatment of complicated STIs and contact tracing
- HIV counselling, testing and treatment
- Training for nurses and doctors who may wish to undertake family planning or genitourinary courses

Level 3
Specialist provision of sexual health services that provide most of or all of the above; this level will also provide expertise in research, education and training

Source: adapted from Royal College of Nursing, 2004a.

Nurses caring for patients in the primary care sector, i.e. GP surgeries, might find that their work practices may change with the implementation of the new General Medical Services contract, as some surgeries may opt to deliver sexual health services. These changes can provide the practice nurse with new ways of providing a service with a sexual health focus in some PCTs.

A toolkit has been produced to help those in the PCTs and others who work in the field of promoting good sexual health and HIV services (DoH, 2003a). The aim of the toolkit is to help implement the sexual health strategy at a local level. The Royal College of General Practitioners (2003) provide guidelines for the appointment of general practitioners with special interests in the delivery of clinical services associated with sexual health; the guidance details the core activities of a GP surgery considering offering special sexual health services.

The context and association with other national initiatives

The strategies associated with sexual health are planned and implemented in the context of other programmes and strategies produced by the government; they should not therefore be seen as strategies in isolation. The following provides details of some documents, in addition to those discussed above, that have been produced by the government. They will impinge upon and inform the implementation of the sexual health strategy.

The government's teenage pregnancy strategy (Social Exclusion Unit, 1999) is complemented by the national strategy for sexual health. The aim of this strategy is to address teenage pregnancy and consider some of the reasons behind the high rate of unintended pregnancies in the UK and to set out an action plan, including better campaigning and joined-up, coordinated prevention and support services.

The NHS Plan (DoH, 2001d), a vision for providing a better quality service, was produced in 2001. In this proposal the aim was to provide better quality services, designed around the needs of patients and delivered by a sustained programme of investment and reform.

A radical restructuring of the NHS was undertaken in response to Shifting the Balance of Power produced in 2002 (DoH, 2002e). Decentralization of power and resources occurred and this was devolved to PCTs with the aim of providing better delivery of health care to patients.

Choosing Health: Making Healthy Choices was published in 2004 (DoH, 2004b). The focal point of this publication is to ensure that the most marginalized and disadvantaged groups in our society have the opportunity to see faster improvements in their health.

An international perspective

The above discussion is concerned primarily with a local/national approach to enhancing sexual health services. From an international perspective the WHO (2000) consider sexual health problems as syndromes: they identify eight clinical syndromes (see Table I.2).

The Royal College of Nursing (2004c) has developed a competency framework to enhance the delivery of sexual health care in response to:

- a need for a clear pathway for nurses working in the sexual health and reproductive fields;
- the rapid increase in acute STIs;
- the increase in HIV diagnoses;
- the high rates of teenage pregnancy.

The framework recognizes the further extended role the nurse is likely to

Table I.2 Sexual health problems as identified by the WHO

Clinical syndromes that impair sexual functioning (sexual dysfunction):

- Hypoactive sexual desire
- Sexual aversion
- Female sexual arousal dysfunction
- Male erectile dysfunction
- Female orgasm dysfunction
- Male orgasm dysfunction
- Premature ejaculation
- Vaginismus
- Sexual pain syndromes (including dyspareunia and other pain conditions)

Clinical syndromes related to impairment of emotional attachment/love (also known as paraphilias):

- Exhibitionism
- Fetishism
- Frotteurism
- Paedophilia
- Sexual masochism
- Sexual sadism
- Fetish transvestism
- Voyeurism
- Unspecified paraphilia

Clinical syndromes related to compulsive sexual behaviours:

- Compulsive cruising and multiple partners
- Compulsive fixation on an unattainable partner
- Compulsive autoeroticism
- Compulsive love affairs
- Compulsive sexual behaviour in a relationship

Clinical syndromes involving gender identity conflict:

- Childhood gender dysphoria
- Adolescent gender dysphoria
- Adult gender dysphoria
- Intersex syndromes
- Unspecified gender identity syndrome

Clinical syndromes related to violence and victimization:

- Clinical syndromes following being sexually abused as a child/minor (including but not limited to post-traumatic stress disorder)
- Clinical syndromes following being sexually harassed
- Clinical syndromes following being sexually violated or raped
- Clinical phobia focused on sexuality (e.g. homophobia, erotophobia)
- Clinical syndromes related to engaging in threat or acts of violence focused upon sex or sexuality (e.g. raping another person)
- Patterns of unsafe sexual behaviour placing self and/or others at risk for HIV infection or/and other sexually transmitted infections

Table I.2 continued

Clinical syndromes related to reproduction:

- Sterility
- Infertility
- Unwanted pregnancy
- Abortion complications

Clinical syndromes related to sexually transmitted infections:

- Genital ulcer
  - Non-vesicular
  - Vesicular
- Oral ulcer
  - Non-vesicular
  - Vesicular
- Rectal ulcer
  - Non-vesicular
  - Vesicular
- Discharge
  - Urethral
  - Vaginal
  - Rectal
- Lower abdominal pain in women
- Asymptomatic STIs and infestations (including HIV)
- Acquired Immunodeficiency Syndrome (secondary to HIV)

Clinical syndromes related to other conditions:

- Clinical syndromes secondary to disability or infirmity
- Clinical syndromes secondary to physical or mental illness
- Clinical syndromes secondary to medication or other medical and surgical interventions
- Colo·ectal conditions
- Clinical syndromes secondary to other conditions

Source: WHO, 2000.

develop in the future and the potential nurses have to improve the outcomes for the patient with respect to their sexual health.

The DoH in conjunction with the Royal College of Nursing (2003b) has stated that what is important to the patient is that they are seen by the right person, with the right skills and competence regardless of whether they are a nurse or doctor. In many situations regarding sexual health and STIs the nurse may well have the right level of competence and skills and s/he may well be the right person to be seen by the patient.

One example of the extension of the nurse's role may be with the use of patient group directions. These directions (previously known as group protocols) are written instructions for the supply or the administration of

medicines for groups of patients who may be individually identified before presenting for treatment (RCN, 2001). Patients with STIs may be considered in this respect and as such, the nurse may be involved in patient group directions for managing the patient with an STI.

The competency framework focuses on the patient's experience related to sexual and reproductive health services. There are five competencies addressed by the framework, which are seen as specific to sexual and reproductive health. They are:

- clinical assessment;
- clinical examination and specimen collection;
- interpretation and provision of findings;
- provision of treatments and therapies;
- health promotion.

The competencies are ordered in a way that reflects the patient journey through the sexual and reproductive health services; they are also described across three levels of practitioner:

- registered practitioner;
- senior registered practitioner;
- consultant practitioner.

The need for professional education

In order to provide high quality sexual health services nurses must acknowledge the need to enhance their knowledge, skills and attitudes to do this. Lifelong learning is one way in which the nurse can build upon current skills and enhance the care provided to the patient; professional ongoing education is also needed.

Skilled nurses have pivotal roles to play in HIV and STI prevention, raising awareness of sexual health and helping people to get the services and information they need. Better education of health care professionals and building upon the evidence that is available are central to the success of the sexual health strategies of all four countries in the UK. Staff should have access to flexible, multiple professional education in order to deliver successful health promotion activities. One example of a flexible approach is the Royal College of Nursing's sexual health skills distance learning pack (RCN, 2003b). This initiative aims to improve the levels of sexual health knowledge and skills of Registered Nurses in an attempt to help them contribute towards the sexual health needs of society.

Quality education can help the nurse develop his/her interpersonal and communication skills, as well as their clinical and technical abilities (DoH, 2001a). Section 6 of the Sexual Health Strategy (DoH, 2001c) details issues

related to the development of professional education and training for health care staff.

The chapters

Chapter 1 concentrates on health promotion. Health promotion plays a major part in helping the population maximize their health, and this is also true with respect to sexual health promotion which is crucial if the incidence of STIs is to be reduced.

Understanding the key concepts associated with health promotion (the theoretical concepts and theories) will enable the nurse to apply the theories and principles to practise in order to provide high quality sexual health promotion. This chapter provides definitions of complex terms, i.e. health, sexual health and sexual health promotion.

The five strategies associated with the Ottawa Charter are provided for the nurse to use in order to provide a framework for successful sexual health care delivery. The chapter suggests that there are three main categories in which health promotion models can be placed:

- behavioural change;
- self-empowerment;
- collective models.

It is noted that all three models and the elements associated with these models are not mutually exclusive; often all three are used together and interchangeably.

Practical advice and guidance are offered to the reader in relation to the preparation of written patient information. The nurse is encouraged to provide quality information, as any information presented to patients can influence each experience they have with health care provision and providers.

In Chapter 2 emphasis is placed on the importance of obtaining a detailed sexual health history. Taking a sexual health history can be carried out as part of general history taking. This is not the exclusive province of the sexual health nurse: all nurses should develop the skill needed to do this with confidence and competence. The outcomes of the sexual health history can also allow people to receive appropriately targeted advice and information on prevention of STIs, HIV or unintended pregnancies within many clinical settings.

There are practical hints and tips that can ease the novice nurse into the taking of a comprehensive sexual health history. Emphasis is placed on the importance of documentation and the nurse's responsibilities related to documentation and record-keeping.

Chapter 3 provides the reader with much detail relating to the management of STIs. Nine STIs have been chosen and discussed in order to care for patients and their partner(s) with STIs. The nurse needs to have an in-depth understanding of the range of conditions with which they may come into contact. Understanding the fundamental facts about the various STIs, and how they may be transmitted, can be the first steps towards preventing them.

Each section related to the STIs deals with a particular infection and specifically addresses – the epidemiology, the causative organism, transmission, the incubation period, clinical manifestations, potential complications, diagnosis, management and subsequent care and any special considerations that may need to be noted. In order to detect an STI the nurse needs to employ practices that are commensurate with high quality nursing and this will include obtaining an adequate specimen from the patient in accordance with local policy; failure to obtain an adequate specimen may be detrimental to a patient's care.

Counselling skills and the skills the nurse needs to communicate effectively with patients who have an STI are highlighted in Chapter 4. The nurse is encouraged to beware of his/her limitations associated with the complexities of counselling. Key terms are defined and discussed in an endeavour to define what is meant by counselling and to differentiate between counselling, using counselling skills and using communication skills.

While it is acknowledged that nurses offer support and give advice to patients in many ways in their everyday work, it is also noted that nurses are not counsellors and as such they need to refer patients to the most appropriate health care professional when they have recognized their limits. The issue of pre- and post-test HIV counselling is also addressed in this chapter.

Chapter 5 centres on the complexities associated with partner/contact notification; these terms are discussed in an attempt to ensure that they are used in the correct and most appropriate way when working with patients, contacts and partners. The processes related to partner/contact notification are described; the advantages and disadvantages associated with the various approaches are outlined. This chapter concludes by suggesting that further research is needed in order to determine the true effectiveness of the various approaches used so as to determine best practice with the best evidence available to support such practices.

There are few areas of health care that are untouched by the law and involvement with the legal process may occur during the course of a nurse's career. Chapter 6 considers the legal, ethical and professional issues which nurses need to consider when working with patients. This chapter draws on professional standards, legislation and ethical/moral theory. A brief overview of the legal system is provided.

It is acknowledged that within the legal/ethical framework conflict can and does occur, so an understanding of the legal and ethical burden placed on the nurse may assist him/her in coming to terms with the potential incompatibility. As a registered nurse, midwife or specialist community public health nurse, the reader is reminded that you are personally accountable for your practice. Adherence to the standards laid down by the profession and acting within the realms of the law are required by the nurse when working with patients and their partners with STIs.

The final chapter, Chapter 7, considers those groups of people in society who are deemed vulnerable when the issue of STIs is being considered. Some groups are considered particularly vulnerable, for example, young people, men who have sex with men, some black and minority ethnic groups and those who have been raped or sexually assaulted. These groups are discussed in this chapter; however, it is acknowledged that there are other groups who may also be deemed vulnerable, i.e. those with learning disabilities, prisoners and intravenous drug users.

Each group is considered individually and the discussion includes insights into their specific needs related to the provision of an effective sexual health service. The discussion regarding young people, for example, provides various definitions of the term 'child'.

Sexual abuse can occur in any society. In this chapter it is addressed specifically in relation to young people and there is a section regarding those adults who have been raped or sexually abused. Practical advice concerning the examination and the forensic examination that may take place after the attack is discussed.

Ubiquitous and insidious, STIs are accountable for much morbidity and mortality locally, nationally and internationally; they are also important cofactors in the sexual transmission of HIV. STIs have a direct and indirect economic impact for society; they are a major cause of productive years lost (Edwards et al., 2001).

While this text focuses upon STIs it must be noted that sexual health is central to our health and well-being. Positive sexual heath has long-term implications for our self-esteem, socio-economic status and livelihood. These implications are influenced by policies related to education, welfare and regeneration. The sexual health 'agenda' now takes up a major role with respect to public health and has been identified by the government in several key documents.

Sexual health must be underpinned by a holistic philosophy, positively endorsing human sexuality and accepting sexual activity as normal and life-enhancing. An integrated approach to the contributing factors surrounding STIs should be considered and the range of influencing dynamics at play addressed.

If the rising numbers of STIs are to be tackled then access to services must be improved and a creative and innovative approach is required to promote an open and healthy environment for sex and sexual relations to take place and flourish in, for all members of our society. An integrated service is advocated; for example, one that embraces local communities and educational programmes. The nurse, in a knowledgeable and informed manner, can contribute to these aspirations in a variety of ways with the patient at the centre.