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This resource should take approximately 8 hours to complete.

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How to use the learning programme
The programme has been designed specifically to support pharmacists providing the sexual health service in the community pharmacy contract. Some sections may also be relevant and of interest to both general practice and hospital pharmacists.

Aim
The overall aim of the programme is to help you develop your knowledge and skills in the delivery of pharmaceutical care to people with sexual health needs. This programme should equip you to deliver care that is evidence based and up-to-date, while providing you with many additional sources of useful information.

Format
The programme has been divided into 9 sections.

Section 1 starts off by taking a quick look at the definitions of sexual health and sexuality. It focuses on the key policy drivers for the Scottish Government’s Respect and Responsibility strategy for improving sexual health.

Section 2 takes a brief look at the key issues around confidentiality, consent and child protection issues in the provision of sexual health services in the pharmacy contract.

Section 3 looks at some general issues about giving sexual health advice and the key components of taking a sexual health history.

Section 4 looks at the ways you can advise individuals to avoid a sexually transmitted infection. At risk sexual behaviour is outlined and the importance of barrier methods of contraception in preventing STIs is highlighted.

Section 5 takes a brief look at the causes, symptoms, diagnosis and treatment of some of the more common sexually transmitted diseases.

Section 6 highlights the causes, treatment and diagnosis of HIV and other blood borne viruses.

Section 7 looks at your role in the testing and treatment of Chlamydia as part of the sexual health service in the community pharmacy contract.

Section 8 briefly looks at some of the clinical aspects of providing EHC and outlines the main aspects of providing this service in the community pharmacy contract.

Section 9 outlines some of the information resources about sexual health that you may need in your pharmacy.

Sections 1, 2 and 3 form the basis of this programme and ideally should be read and completed before moving on. After that you may complete the programme in any order that you wish.
Special features

Case studies
The case studies are designed to highlight issues that may arise in your everyday practice and allow you to apply your learning in a structured way.

Exercises
In most sections you will come across exercises that require a written response. These are intended to reinforce your learning by giving you an opportunity to reflect on what you have read and understood. You should address each question within the context of your own working practice. If appropriate, answers will be found at the end of the chapter.

Key points

Practice points
Practice points are presented as discrete activities intended to trigger thought and action related to some aspect of the learning.

Reflection points
These are included at the end of each section to get you thinking about what you need to find out or do next.

Summary boxes
There are summary boxes at the end of each section which highlight the key learning points for each section.

Assessment
Multiple choice questions have been designed to test your knowledge of the contents of this learning pack. These questions must be completed on the NES Portal accessible via the NES website on www.nes.scot.nhs.uk/pharmacy

Reference sources and additional reading
You will find reference sources for all the books, articles, reports and websites mentioned in the text, together with a list of further reading to support your learning, at the end of every section.

External websites
NES is not responsible for the content of any non-NES websites mentioned in this programme or for the accuracy of any information found there. The fact that a website or organisation is mentioned in the programme does not mean that NES either approves of it or endorses it.
## Glossary and abbreviations

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<th>Abbreviation</th>
<th>Explanation</th>
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<tr>
<td>Acquired Immune Deficiency Syndrome</td>
<td>AIDS</td>
<td></td>
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<td>British Association of Sexual Health and HIV</td>
<td>BASHH</td>
<td></td>
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<tr>
<td>Chancre</td>
<td></td>
<td>The classic painless ulcer of syphilis. The chancre forms in the first (primary) stage of syphilis. It is highly contagious and can last 1-5 weeks</td>
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<tr>
<td>Community Pharmacy Urgent Supply form</td>
<td>CPUS form</td>
<td></td>
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<tr>
<td>Committee of Safety of Medicines</td>
<td>CSM</td>
<td></td>
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<tr>
<td>Confidentiality and Security Advisory Group for Scotland</td>
<td>CSAGS</td>
<td></td>
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<tr>
<td>Emergency Hormonal Contraception</td>
<td>EHC</td>
<td></td>
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<tr>
<td>General Register Office for Scotland</td>
<td>GRO(s)</td>
<td></td>
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<tr>
<td>Genito-urinary centre</td>
<td>GU centre</td>
<td></td>
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<tr>
<td>Genito-urinary medicine</td>
<td>GUM</td>
<td></td>
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<tr>
<td>Gummatous syphilis</td>
<td></td>
<td>A gumma is a small, rubbery, tumour-like swelling that can develop in almost any part of the body. They are most common in the skin or bone. They develop around three to 15 years after infection.</td>
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<tr>
<td>Health Protection Scotland</td>
<td>HPS</td>
<td></td>
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<tr>
<td>Hepatitis A</td>
<td>HAV or Hep A</td>
<td></td>
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<tr>
<td>Hepatitis B</td>
<td>HBV or Hep B</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>HCV or Hep C</td>
<td></td>
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<tr>
<td>Herpes simplex virus</td>
<td>HSV</td>
<td></td>
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<tr>
<td>Human immunodeficiency virus</td>
<td>HIV</td>
<td></td>
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<tr>
<td>Information Services Division</td>
<td>ISD</td>
<td>ISD is Scotland’s national organisation for health information, statistics and IT services</td>
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<tr>
<td>Term</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>Men having sex with men</td>
<td>MSM</td>
<td></td>
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<tr>
<td>National Sexual Health and HIV Advisory Committee</td>
<td>NSHAC</td>
<td></td>
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<tr>
<td>New variant Chlamydia trachomatis</td>
<td>nvCT</td>
<td></td>
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<tr>
<td>Non-gonococcal urethritis</td>
<td>NGU</td>
<td></td>
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<tr>
<td>Non-specific infection</td>
<td>NSI</td>
<td></td>
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<tr>
<td>Nucleic acid amplification assays</td>
<td>NAATs</td>
<td></td>
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<tr>
<td>Pelvic Inflammatory Disease</td>
<td>PID</td>
<td></td>
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<tr>
<td>Polymerase chain reaction</td>
<td>PCR</td>
<td></td>
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<tr>
<td>Prodrome</td>
<td></td>
<td>An early symptom that may indicate the start of a disease process</td>
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<tr>
<td>Reiter’s syndrome</td>
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<td>Reactive arthritis (ReA) that develops in response to an infection in another part of the body.</td>
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<tr>
<td>Retrovirus</td>
<td></td>
<td>A retrovirus is an RNA virus that is replicated in a host cell via the enzyme reverse transcriptase to produce DNA from its RNA genome</td>
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<td>Scottish Executive Health Department</td>
<td>SEHD</td>
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<td>Scottish Intercollegiate Guidelines Network</td>
<td>SIGN</td>
<td></td>
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<tr>
<td>Serovar</td>
<td></td>
<td>A subdivision of a species or subspecies distinguishable from other strains therein on the basis of antigenic character</td>
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<tr>
<td>Sexually transmitted infection</td>
<td>STI</td>
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<tr>
<td>STI Surveillance Scotland</td>
<td>STISS</td>
<td></td>
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<tr>
<td>BASHH Sexually Transmitted Infection Foundation Course</td>
<td>STIF</td>
<td></td>
</tr>
<tr>
<td>Trachoma</td>
<td></td>
<td>Infectious eye disease which may lead to blindness</td>
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<tr>
<td>Urethritis</td>
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<td>Inflammation of the urethra</td>
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Section 1 Background

This section starts off by taking a quick look at the definitions of sexual health and sexuality. It focuses on the key policy drivers for the Scottish Government’s *Respect and Responsibility* strategy for improving sexual health, looks at some statistics and touches on the published quality standards and key clinical indicators for sexual health services in Scotland. The pharmacist’s role in sexual health is briefly outlined.
Learning Objectives

At the end of this section, you should be able to:
• state a definition of sexual health
• understand the key policy drivers to improve sexual health
• list four of the key sexually transmitted infections in Scotland
• describe the national quality standards applicable to pharmacy practice
• understand the role of pharmacists in providing a sexual health service.

Section Contents

1.1 What is sexual health
1.2 Sexual health in Scotland
1.3 Sexual health strategy in NHSScotland
1.4 Role of pharmacists in sexual health
Section 1

Background

1.1 What is sexual health?

Sexual health in Scotland must be improved - not just for young people, but for people of all ages.

Sexual health is influenced by a complex web of factors ranging from sexual behaviour, attitudes and societal factors, to biological risk and genetic predisposition.

It includes the issues associated with:

- sexually transmitted infections (STIs)
- Human Immunodeficiency Virus (HIV)
- unintended pregnancy and abortion
- infertility from STIs.

Sexual health can also be influenced by mental health, acute and chronic illness and violence.

Addressing sexual health needs at the individual, family, community or health system level requires integrated interventions by healthcare providers and a robust referral system. It also requires a legal policy and regulatory environment where the sexual rights of people are defended.

The Scottish Executive’s strategy and plan for sexual health in Scotland, *Respect and Responsibility*, uses the World Health Organisation’s definition of sexual health as its starting point.

A state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safer sex experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

http://www.who.int/reproductive-health/gender/sexual_health.html#3
Sexuality
Addressing sexual health also needs an understanding and appreciation of sexuality.

Practice Point
What’s your definition of sexuality?

Sexuality refers to an individual’s sexual attitudes, behaviours and practices. It is considered an integral part of our personality and being human. The concept varies widely between individuals and may include physical, psychological, cultural and emotional factors.

1.2 Sexual health in Scotland

Sexual health of young people
The sexual health of young people in Scotland, teenagers and young adults, is a major cause of concern1. Sexually transmitted infections (STIs) are growing at an alarming rate. Workload in the GUM clinic setting has been increasing over the past three years with a 16% increase across Scotland between 2007 and 20082. In primary care, there has been an increase in workload management during the past two years (2006- 2008) for genital Chlamydia, genital herpes and genital warts2.

Between 2004 and 2008, the trends for the four major STIs: genital Chlamydia, gonorrhoea, genital herpes and genital warts indicate a general increase in diagnoses with the exception of gonorrhoea infection in men2.

The data also show that young people (those aged less than 25) continue to bear a disproportionate burden of STI diagnoses in Scotland. In 2008, the under 25s accounted for 13% of the population but 72%, 59% and 61% of all diagnoses of Chlamydia, genital warts and gonorrhoea, respectively3.

In 2008, as seen in previous years, there were more new acute STIs in men, with the number of diagnoses of syphilis, gonorrhoea, genital warts, non specific genital infection, non-Chlamydial, HIV and other STIs being higher in men than women. The number of diagnoses of Chlamydia, genital herpes and trichomoniasis were greater in women4.

Chlamydia is the most frequently diagnosed bacterial STI. The number of Chlamydia diagnoses in Scotland, after increasing rapidly in the first five years of this century, has remained stable over the past three years2.

Teenage pregnancies
Another major cause for concern in Scotland is the number of teenage pregnancies. This is highlighted in the introduction to Respect and Responsibility, the Scottish Executive’s strategy and action plan for improving Scotland’s sexual health1. Reducing teenage pregnancies by 20% between 1995 and 2010 is one of the Scottish Executive’s targets3.
The teenage pregnancy rate in Scotland has been fairly steady for the past decade. In 2007, in the under 16 age group there were 8.1 pregnancies per 1,000, the same rate as 2006. The rates in the older age groups have risen slightly with the under 18s rising from 41.5 per 1,000 in 2006 to 42.4 per 1,000 in 2007 and the under 20s from 57.9 per 1,000 to 58.6 per 1,000. Scotland-wide indicators published by NHS Quality Improvement Scotland show that teenagers in the most deprived areas are three times more likely to become pregnant than their counterparts in the most affluent parts of the country.

**Teenage Pregnancy Rates, 1994-2007 by Age Group at Conception**

- *<16 years*  
- *<18 years*  
- *<20 years*

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p provisional  
*<16 yrs* includes all pregnancies in women aged under 16. the rate is calculated using the female population aged 13-15.  
*<18 yrs* includes all pregnancies in women aged under 18. the rate is calculated using the female population aged 15-17.  
*<20 yrs* includes all pregnancies in women aged under 20. the rate is calculated using the female population aged 15-19.  
Source: GRO(S) registered births and stillbirths & Notifications (to the Chief Medical Officer for Scotland) of abortions performed under the Abortion Act 1967.
1.3 Sexual Health Strategy in NHSScotland

In January 2005, the Scottish Government launched "Respect and Responsibility: a Strategy and Action plan for Improving Sexual Health".

It is firmly based on the principles of respect for self, respect for others and strong relationships. In recognising the diversity of lifestyles in the population in Scotland, the action plan seeks to improve access to information and services whilst enabling flexibility for local services to respond to local needs.

Actions are geared towards:

- improving the quality, range and consistency, accessibility and cohesion of sexual health services
- supporting everyone in Scotland, regardless of faith, ethnicity, gender, age or disability, to acquire and maintain the knowledge, skills and values necessary for good sexual wellbeing and thus avoid sexually transmitted infections and unintended pregnancy
- positively influencing cultural and social factors that impact on sexual health.

To achieve these aims it sets out a range of actions for NHS Boards, local authorities, Health Scotland, Quality Improvement Scotland, Health Protection Scotland as well as for individual departments within the Executive. For the latest information on the implementation of this strategy go to [http://www.scotland.gov.uk/Topics/Health/health/sexualhealth/respect](http://www.scotland.gov.uk/Topics/Health/health/sexualhealth/respect).

NHS Health Scotland, through its Wellbeing in Sexual Health (WISH) programme, works closely with local NHS Boards to implement the national sexual health strategy. The WISH programme supports professionals by:

- producing resources to promote better understanding of sexual health issues
- providing access to important research
- supporting policies so that local practice is evidence based.

One of the programme’s objectives is to share the learning from Healthy Respect, a Lothian-based organisation which has given leadership around engagement with young people.

People can subscribe to monthly WISH updates that are sent electronically.

Quality standards

As part of the programme set out by Respect and Responsibility, NHS Quality Improvement Scotland ([http://www.nhshealthquality.org](http://www.nhshealthquality.org)) published standards for sexual health services in March 2008. These standards promote the up-skilling of the workforce providing sexual health services and set out the expectations for access and equity anticipated for these services. The sexual health standards represent a real step forward in tackling Scotland’s poor sexual health record.

The document that lists the 9 standards can be found at the following web address: [http://www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV_STANF_MAR08.pdf](http://www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV_STANF_MAR08.pdf)
The following standards may have relevance to the services provided by community pharmacy.

**ACCESS TO SERVICES**

**Standard 1: Comprehensive provision of sexual health services**

**Standard Statement 1:**
A comprehensive range of specialist sexual health services are provided locally and individuals with the greatest need are treated as a priority.

**Standard 2: Sexual health information provision**

**Standard Statement 2:**
The public has access to accurate and consistent advice about sexual health relevant to its needs.

**Standard 3: Services for Young People**

**Standard Statement 3:**
NHS Boards ensure the development and delivery of integrated approaches to sexual health improvement, particularly in relation to young people.

**CO-ORDINATION OF APPROACH**

**Standard 4: Partner Notification**

**Standard Statement 4:**
Individuals who are diagnosed with a sexually transmitted infection see an appropriately trained member of staff to organise partner notification (contact tracing).

**EQUITY OF SERVICE PROVISION**

**Standard 7: Hepatitis B vaccination for men who have sex with men**

**Standard Statement 7:**
Men who have sex with men who are at risk of sexually transmitted Hepatitis B are offered vaccination.
Standard 9: Appropriately trained staff providing sexual health services

**Standard Statement 9:**
All staff who deliver sexual health services are adequately and appropriately trained.

The standards are complemented by the development of key clinical indicators and sexual health information by the National Sexual Health Advisory Committee (NSHAC) along with an emphasis on sexual health data analysis by Information Services Division (ISD) and Health Protection Scotland (HPS).

If you want to find out more about this area of work take a look at this document http://www.isdscotland.org/isd/5410.html

1.4 Role of pharmacists in sexual health

Public interest in the availability of advice on contraception and safer sex through pharmacies is high. Pharmacists generally have positive attitudes towards involvement in the prevention of transmission of infection and unplanned pregnancies.

Medicines play a major role in the prevention and treatment of sexual ill health. Pharmacists can provide advice and reinforce key messages as part of the pharmaceutical care delivered when patients receive medicines.

You are in a position to offer support and guidance when problems arise by:
- helping patients deal with sexually transmitted infections or other sexual health problems
- providing appropriate advice on how to reduce the risk of sexually transmitted infections,
- advising on post-coital emergency hormonal contraception.

**Pharmacy contract**

As with all professional groups who have responsibility for the health and well-being of the Scottish population, especially young people, pharmacists are being encouraged to accept a bigger role in this important field. In 2008 a national specification for sexual health as a NHS community pharmacy public health service was adopted. Its aim is to provide extended access through the NHS to advice and specific sexual health services as part of the Public Health Service (PHS) element of the community pharmacy contract.

It formalises the role of community pharmacists in providing a sexual health service and includes four components namely testing, advice, treatment and referral to another healthcare practitioner. The specific services are:
- free provision of Emergency Hormonal Contraception (EHC)
- testing for Chlamydia infection
- treatment of Chlamydia infection where clinically appropriate.

For more detailed information about the service specification go to http://www.communitypharmacyscotland.org.uk/
Summary of learning
You should be aware of the key policy drivers to improve Scotland’s sexual health and the key principles behind Scotland’s sexual health strategy. You should have noted some of the key statistics about the common sexually transmitted infections and be able to describe the role of pharmacists with respect to the sexual health services in the pharmacy contract.

Reflection Points
How could I develop and expand my sexual health services?

What training do I need to be able to do this?

What training would my staff require to help me do this?

How can I address all these training needs?
References


2 Scotland’s Sexual Health Information 2009. Health Protection Scotland and Information Services Division, November 2009

3 Source: Health Protection Agency(HPA). http://www.hps.scot.nhs.uk/ewr/article.aspx, accessed 08/01/10

4 Source: ISD Scotland http://www.isdscotland.org/isd/4907.html, accessed 08/01/10

5 Source: ISD Scotland http://www.isdscotland.org/isd/2071.html, accessed 08/01/10


7 Healthy Respect website for young people in Lothian http://www.healthyrespect.co.uk/Home.htm

8 NHS Health Scotland, Woodburn House, Canaan Lane, Edinburgh EH10 4SG. Telephone: 0131 536 5500. Copyright (C) 2009 NHSHS All rights reserved. Website: http://www.healthscotland.com/wish email: webmaster@health.scot.nhs.uk

wish@health.scot.nhs.uk
Section 2 Confidentiality, consent and child protection

Confidentiality, consent, and child protection issues underpin the provision of the sexual health services in the community pharmacy contract. This section takes a brief look at the key issues and signposts you to further sources of information.
Learning Objectives

At the end of this section, you should be able to:
- explain the difference between explicit and implicit consent
- list the three criteria against which the requirement for consent is considered
- use the set of criteria in the Fraser guidelines to assess the competency of a young person
- be aware of the legal issues governing sexual activity in a younger person
- access all the listed websites for further information on confidentiality, consent and child protection.

Section Contents

2.1  Confidentiality and sexual health
2.2  Consent
2.3  Competency
2.4  Using Information about patients
2.5  Child protection framework and sexual activity
Section 2
Confidentiality, consent and child protection

2.1 Confidentiality and sexual health
Confidentiality is really important for people who want to use a sexual health service or talk about relationships. All people are naturally very sensitive and anxious about discussing details of their sexual activity with strangers. It is vital that all patients, but especially young people, can be sure that you and your staff will respect their confidentiality.

Most pharmacies will have the advantage of confidential areas that can be used, but staff will still have to be as discreet as possible. While all pharmacy staff are conscious of pharmacists’ and technicians’ Code of Ethics, not all members of the public will be aware of this, and reassurance may be needed.

2.2 Consent
Adults, are usually regarded as competent to decide their own treatment. However, there will always be situations where a patient is unable to give consent, e.g. some children, adults with incapacity and the critically ill. In many of these cases, particularly in the case of children, there will be someone, e.g. a parent, who is legally entitled to give consent on their behalf.

Consent for under 16s
A person under 16 years of age may give consent for the supply of a medicine provided he/she understands fully the benefits and risks involved. The individual should be encouraged to involve a parent/guardian, if possible, in the decision. Where there is no parental involvement and the person indicates that he/she wishes to accept the supply, supply should go ahead, if the pharmacist considers the patient to have the legal capacity to consent.

The Age of Legal Capacity (S) Act 1991, s2 (4) states that ‘a person under the age of 16 years shall have legal capacity to consent on his/her own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him/her, he/she is capable of understanding the nature and possible consequences of the procedure or treatment.’

Legal advice from the NHS in Scotland states that if a healthcare professional has been trained and professionally authorised to undertake a clinical procedure which is normally that of a medical practitioner, then that healthcare professional can be considered to have the necessary power to assess the capacity of a child under the 1991 Act, for that procedure.
Implicit or explicit consent
Implied consent means that an individual may voluntarily give personal information for an organisation to collect, use, or disclose for purposes that would be considered obvious at the time. Implied consent is usually inferred from a person’s actions and the situation they are in.

For example, if you give the names of two people in your CV to contact for references and hand it to potential employers, it is implied that you give consent for employers to contact these people. Or if a patient holds out their arm to give blood then consent is implied by their action.

Explicit consent means that an individual is clearly presented with an option to agree or disagree with the collection, use, or disclosure of personal information.

Explicit consent is usually required when clear, verifiable consent is required, and the purposes for which it is being provided may be of a sensitive nature. Explicit consent can be provided verbally or in writing.

Explicit consent is best practice and should become the norm as better informed patients can share in decisions about the use of their information.

Requirements for consent should be considered against each of the following criteria (for further information see http://www.show.scot.nhs.uk/confidentiality):

- **Legal Requirement.** In some circumstances, the law requires clinicians to disclose information irrespective of the views of a patient, e.g. if patients contract certain notifiable diseases. The Data Protection Act requires that the patient be told about the disclosure.

- **To protect patients’ vital interests,** e.g. where a child or vulnerable adult may be in need of protection, at risk of death or serious harm. Professionals who have such concerns should draw them to the attention of the relevant authorities.

- **In the interest of the public.** Examples might be the production of statistics (where the individual is not identified) to assist in the planning of public services; or the disclosure of information to the police to help in the prevention or detection of a serious crime. The Data Protection Act and professional standards specifically allow for information to be disclosed in this way.

2.3 Competency
There is no minimum age in Scotland in terms of legal capacity to consent to medical treatment. But there may still be debate about when a young person might be competent to make their own decisions and seek out services. There should also be concern about whether adequate efforts have been made to encourage under 16s to involve their parent(s) in the issues or decisions which they are facing. However, the Child Protection Team must be contacted for a child aged 12 or under who presents having had sexual intercourse.
When agencies talk about the assessment they make as to whether a young person can be provided with confidential sexual health services without parental consent they often talk about using what has been called the *Fraser Guidelines*. The guidelines arise from the case in the early 1980s when Victoria Gillick attempted to set a legal precedent in England and Wales that would have meant that medical practitioners could not give young people under the age of 16 treatment or contraceptive services without parental permission. Initially successful, the ruling was eventually changed when the House of Lords ruled that people who are under 16, who are fully able to understand what is proposed, and its implications, are competent to consent to medical treatment regardless of age.

In Scotland, the ruling has also been interpreted as meaning that medical practitioners can give contraceptive advice or treatment to young people under 16 without parental knowledge.

**The Fraser Guidelines in detail**

In making his judgement the Law Lord, Lord Fraser, offered a set of criteria that must apply when medical practitioners are offering contraceptive services to under 16’s without parental knowledge or permission. The so-called *Fraser Guidelines* (some people refer to assessing whether the young person is Gillick competent) state that all the following requirements should be fulfilled. The guidelines have proved such a useful tool that most agencies offering information, advice or services to young people about their sexual health have adopted the *Fraser Guidelines* as the basis for best practice. The guidelines suggest that before providing a service to under 16s to which parents have not given consent, the staff member should ensure that the following criteria are met:

- the young person understands the advice being given
- the young person cannot be convinced to involve parents/carers or allow the medical practitioner to do so on their behalf
- it is likely that the young person will begin or continue having intercourse with or without treatment/contraception
- unless he or she receives treatment/contraception their physical or mental health (or both) is likely to suffer
- the young person’s best interests require contraceptive advice, treatment or supplies to be given without parental consent.

In terms of the Law Lords judgement, although a young person or their partner may still be committing an offence if having sex under the age of 16, Lord Fraser also stated that “doctors giving such advice in good faith are not committing a criminal offence of aiding and abetting unlawful intercourse with girls under 16“.
Additional consideration must also be given to the special situations some young people might be in. Being subject to a supervision order does not affect an under 16s capacity or rights to consent to medical treatment. Young people with a physical or learning disability have the same right to appropriate sex education, contraceptive information, confidential advice and treatment as any other young person. They may also have particular individual needs which a professional person may have to consider, but their rights to services remain the same.

Finally, where a professional cannot provide a necessary service, it is within the law to provide information, make an appointment or accompany a young person to an agency that does provide what the young person needs and to do this without parental knowledge. It is worth noting, however, that some individual agency policies, for example in schools, might not permit this.

2.4 Using information about patients

The use of information about patients is governed by:

- statute law, e.g. the Data Protection Act 1998, Adults with Incapacity (Scotland) Act 2000 and many more
- the common law in Scotland on privacy and confidentiality
- professional standards (RPSGB)
- the policies and organisational standards of the Scottish Executive Health Department (SEHD) and NHS Scotland, underpinned by the CSAGS report* (*Confidentiality and Security Advisory Group for Scotland, 2002).

Data Protection Act

The Data Protection Act seeks to strike a balance between the rights of individuals and the competing interests of those with legitimate reasons for using personal information. The Act gives individuals certain rights regarding information held about them. Specific provision is made under the Act for processing sensitive personal information.

Young people under 16 have the right of access to personal information (including medical records) stored on computers and to their written medical records providing that the holder of the records considers them capable of understanding the nature of the request. A parent or guardian will not be given access unless the young person consents or is incapable of understanding the nature of the request and the granting of access would be in their best interests.
2.5 Child protection framework and sexual activity

This section deals with sexual activity within the child protection context; for a fuller training package on child protection issues see the NES distance learning pack on child protection.

This area of practice can be challenging; however by understanding the law surrounding this topic the pharmacist or pharmacy technician can be confident in raising or dealing with this issue.

To establish your level of existing knowledge on this topic try this short exercise.

**Exercise 1**

1. Children and young people have the same right to confidentiality as adults.  TRUE/FALSE
2. The legislation applying to males and females in same-sex relationships is the same.  TRUE/FALSE
3. A young person has the right to request and receive confidential medical advice.  TRUE/FALSE
4. Sexual intercourse under the age of sixteen is unlawful.  TRUE/FALSE
5. The girl and male partner are both guilty of an offence.  TRUE/FALSE
6. Providing contraceptive services to young people under sixteen may constitute aiding and abetting a crime.  TRUE/FALSE
7. The rate of teenage pregnancies in Scotland is on the increase.  TRUE/FALSE
8. A college lecturer who has a sexual relationship with his 17 year old student commits no offence.  TRUE/FALSE

A young person may seek your advice concerning sexual activity, pregnancy or contraception. There is no single standard procedure or protocol to help with this type of situation, each situation should be considered in its own context. However individuals under the age of 16 are protected by law.
The following principles may help you in these situations:

- sexual activity with a girl under the age of 16 years is illegal
- if a female over 16 years has sexual intercourse with a male younger than 14 years, she may be charged with indecent assault
- the legal position is set out in the Heterosexual Sex; Criminal Law (consolidation)(Scotland) Act 1995
- a professional is under no legal obligation to report a young person who is sexually active. However this presents a challenge to distinguish between those who are having consensual sex and those who may have been coerced, exploited or sexually assaulted
- boys and girls can both be subject to sexual abuse
- in any situation of this type an assessment of the young person’s competency to make informed decisions has to be made and balanced with the need to encourage him/her to involve parents or guardians.

The local child protection team must be informed if:

- the young person is 12 years of age or under
- the other person involved is in a position of trust in relation to the young person
- there is a large disparity in age between the elder and younger sexual partners, with the younger person being 16 years or under.

Pharmacists and pharmacy technicians also need to be vigilant to the signs of possible abuse and also be aware of any local protocols dealing with sexual activity in children and young people, for example, Emergency Hormonal Contraception and Chlamydia treatment. You must not deter children from seeking support and advice on sexual health matters.

If referral is necessary, the child’s consent should be sought whenever possible. However, if there is an overriding need to safeguard the child’s welfare, lack of consent could be justified.

Professional judgement should be used to decide when it is appropriate to disclose information and you should record all reasons for your decision.
Case study and ethical dilemma scenario

A 13 year old female comes into your pharmacy requesting the morning after pill. She does not want her parents involved. What points must you consider?

Summary of learning

The importance of confidentiality for people who want to use a sexual health service or talk about relationships was underlined as was the need to be aware of your own professional standards in this area.

The difference between implicit and explicit consent was explained and the set of criteria against which consent is considered was briefly touched on.

The age of legal capacity was noted together with the issue about whether a young person might be competent to make their own decisions. The Fraser Guidelines and how they apply in Scotland were discussed as well as the law governing the use of information on patients and child protection issues in relation to sexual activity.
Reflection Points

How can I ensure that my staff are aware of the issues around consent, confidentiality and child protection?

Do I need to re-read the RPSGB Professional standards and guidance for patient confidentiality?

What type of consent applies to the provision of sexual services in the new community pharmacy contract?

Where can I find out more about the Fraser Guidelines?

Where can I find out about the local policies around child protection?

At what age must I refer an individual to child protection services?
Additional resources

Information Governance


Patient Confidentiality

• How confidentiality works – a booklet for young people http://www.healthyrespect.co.uk accessed 26/09/09

Consent

• Scottish Executive, Health Department, A Good Practice guide on Consent for Health Professionals in NHSScotland (Edinburgh, Scottish Executive, 2006) http://www.sehd.scot.nhs.uk

Child protection

Answers

Exercise

1. Children and young people have the same right to confidentiality as adults.
   TRUE – except where child protection issues are identified e.g. if you believe that a young person is being abused or exploited or is in danger of being so.

2. The legislation applying to males and females in same-sex relationships is the same.
   FALSE – sex between two men is legal providing:
   • both men are consenting and over 16
   • the act is private and not in a public place
   • there are not more than two people present
   • if one man is under 16 and the other is under 24 and he believed his partner to be over 16.
   There is no specific law concerning lesbian sex.

3. A young person has the right to request and receive confidential medical advice.
   TRUE – this right is enshrined in the Age of Legal Capacity (Scotland) Act 2001. For example denying contraceptive services to a young person deemed competent under the Act would be breaching their rights.

4. Sexual intercourse under the age of sixteen is unlawful.
   TRUE – It is unlawful for a male of any age to have sexual intercourse with a female who is under 16.

5. The girl and the male partner are guilty of an offence.
   FALSE – only the male is guilty of an offence.

6. Providing contraceptive services to young people under sixteen years of age may constitute aiding and abetting a crime.
   FALSE – practitioners will be fulfilling their duty of care to the young person but need to consider the child’s right to be protected.

7. The rate of teenage pregnancies in Scotland is on the increase.
   FALSE – the teenage pregnancy rate in Scotland has been fairly steady for the past decade. In 2007, in the under 16 age group there were 8.1 pregnancies per 1000, the same rate as 2006.

8. A college lecturer who has a sexual relationship with his 17 year old student commits no offence.
   FALSE – sexual activity with a young person under 18 by a person in a position of trust is unlawful under Section 4 of the Sexual Offences (Amendment) Act 2000.
Answers

Case study and Ethical dilemma

Points you may wish to consider in this scenario are:

- The age of the child – she is over 12 years of age. The local child protection team must be informed if the young person is 12 years of age or under. A professional is under no legal obligation to report a young person who is sexually active. However, this presents a challenge to distinguish between those who are having consensual sex and those who are not. Are there any signs that this patient is being coerced, exploited or sexually assaulted?

- Consent – As the patient does not want her parents involved; she must give consent for the supply of the medicine. As the qualified healthcare practitioner, do you consider that she is capable of understanding the nature and possible consequences of this treatment?

- Confidentiality – This patient does have a legal right to confidentiality.

- Time of sexual intercourse – Is it appropriate clinically to supply the morning after pill?

- Sexually Transmitted Diseases – The risk of STIs should be explained to the patient.
Section 3 Advising people about sexual health

This section looks at some general issues about giving sexual health advice. The key components of a sexual health history are outlined and its application to the community pharmacy contract considered. Further sources of information are listed.
Learning Objectives

At the end of this section, you should be able to:
• be aware of the type of advice you may need to give
• understand the need for good communication skills
• recognise the key components of a sexual history
• list additional sources of information.

Section Contents

3.1 Providing sexual health advice
3.2 Taking a sexual history

Appendices
Appendix 1: An example of a Chlamydia Testing Screening Form
Appendix 2: The Sexually Transmitted Infections Foundation course (STIF)
Section 3
Advising people about sexual health

3.1 Providing sexual health advice

Everybody, irrespective of race, religion and sexual orientation, has the right to a healthy sex life.

Individuals may seek your help in dealing with unplanned and unintended pregnancies, when asking for emergency hormonal contraception (EHC), problems with their oral contraceptives and in seeking advice and help in preventing and dealing with sexually transmitted infections (STIs).

They may want to know what their symptoms mean, and perhaps how they acquired the infection. They may ask about where they should go for testing and treatment. Some people may be anxious about what the tests involve and the likely success rates of any treatments that may be offered. They may also want to know what records will be kept about them, will they be confidential and what will happen to their partners.

Most people are naturally very sensitive and anxious about discussing details of their sexual activity with strangers. As a result, it is essential that all patients, but particularly young people, must be sure that you and your staff respect their confidentiality. With young people in particular their welfare and safety is paramount. If you have any reason to doubt the welfare and safety of a young person who asks you for sexual health advice, you must refer them to the appropriate local service.

3.2 Taking a sexual history

A discussion of sexual habits can be a daunting experience both for the individual and the healthcare practitioner. Good communication skills are essential particularly on initial contact with the patient. Pharmacists should not be judgemental or try to force their own sexual morals onto the individual. Motivational interviewing and counselling skills may be useful tools to use.

A detailed sexual history is most commonly taken in a sexual health clinic but may be carried out in other health care settings prior to treatment for infection or referral to specialist services. You need to be aware of the kind of questions that may be asked and the rationale for doing so, which may, to some patients, appear intrusive. Your patients may appreciate advance warning of the procedures adopted at the GU clinic.

For community pharmacy-based services it is unlikely that you will need to take a full detailed sexual history. However, you may be asked to carry out a brief sexual history as part of the Chlamydia testing service in order to identify high risk individuals who may require referral to specialist services.

Your roles and responsibilities are clearly defined in the sexual health service of the pharmacy contract. The specific target groups for the service are also identified.
Some local areas have also developed their own detailed proformas to be completed as part of the supply of EHC and also for the supply of azithromycin to Chlamydia positive individuals. SIGN 109 also advises that taking a sexual history is an essential requirement for Chlamydia testing.

**Practice Point**

Find out what documentation needs to be completed in your own area for the provision of the sexual health element of the pharmacy contract.

Taking a detailed sexual history is crucial as it informs further management of the situation.

The aims of taking a sexual history are to:
- facilitate risk assessment
- calculate possible incubation periods for STIs
- provide information to the health care team so that contact tracing and clinical testing may begin.

The BASHH guidelines recommend the following:
- careful assessment of symptoms to guide the examination and testing
- exposure history - to determine site sampling and consider which STIs may be present
- contraceptive use and pregnancy risk
- assessment of other sexual health issues
- HIV, Hepatitis B and C risk - testing and prevention
- risk behaviours – to facilitate health promotion activity, including contact tracing and partner notification.

**BASHH Core sexual history components**

*Symptoms/Reason for attendance*
- Last sexual intercourse (LSI), partner gender, sites of exposure, condom use
- Previous sexual partner details as for LSI
- Previous STIs
- For women: last menses period (LMP), contraceptive and cytology history
- HIV risk history
- Hepatitis B and C risk assessment
- Establish mode of giving results
- Establish competency/ Child protection concerns (if age < 16 years)
The healthcare worker within the GU centre will prepare the patient for the questions and explain their relevance. Information leaflets are usually provided by the GU centre. You may be asked to explain some of the details included in the information leaflets when patients return from the GU centre and realise they have not remembered everything that was discussed.

If you wish to specialise in this area, you should consider enrolling on the foundation course run by the British Association for Sexual Health and HIV (Appendix 2). Alternatively you can undertake self directed learning by reading the references listed.

Details of the NES consultation skills courses can be found at http://www.nes.scot.nhs.uk/pharmacy. From autumn 2010, a NES sexual health e-Learning resource will be available. This will include video clips of sexual health consultations.

**Summary of learning**

You should be aware of the need for good communication skills and the type of questions people may ask when they come into a pharmacy to discuss a sexual health issue. You should understand the relevance of taking a sexual history and its application to the sexual health service in the new contract.

**Reflection Points**

Do I need to practice my consultation skills and access additional learning resources?

Maybe I should arrange to visit a specialist sexual health clinic to see how the process works in my own area?

Should I set aside some time to read the suggested references and complete a CPD record?
Additional resources


- Dealing with difficult discussions: CPPE Open Learning Pack. Contact NES office on 0141 223 1600 if you would like to obtain this pack
Appendix 1: Example of Chlamydia Screening Form

Purpose: take a brief Sexual History, to identify high risk individuals requiring referral to Specialist Sexual Health Services.

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>CHI</th>
</tr>
</thead>
</table>

Symptoms
(Dysuria / lower abdominal pain (females) / Vaginal or Anal Bleeding / Vaginal or Penile Discharge): Refer all pts with possible symptoms of a STI to Specialist Sexual Health Services.

Medication: Current and Recent (last 3 months) and OTC/Herbal medicines

Recent Antibiotic Use:
Avoid testing for Chlamydia within 7 days of antibiotic usage, to prevent false negative results.

Allergies:

Contraception?
Specify type & frequency used

Sometimes Most of the time Always Never

Have you (or any of your sexual partners) ever had a Sexually Transmitted Infection (including HIV) before? If so, specify.

Are you pregnant?
Please refer pregnant patients to their midwife for testing.

High Risk Factors.
If a client answers “Yes” to any of the following questions, they are classified as “High Risk” and should be referred to local NHS Board Specialist Health Services for screening and advice (even if appropriate barrier protection has been used in these encounters).

Recent history of Sexual Abuse or Sexual Assault?

Any history of Intravenous Drug Abuse (IVDA) OR sex with an IVDA?

Have you or any of your sexual partners been diagnosed with HIV Infection?

Have you ever had sex with a person from Africa or Thailand?

For females: Have you ever had sex with a man, who has had sex with another man?

For males: Have you ever had sex with a man?

Have you ever exchanged money in return for sex?

Any current symptoms that maybe associated with a sexually transmitted infection?

Advise on abstinence from future sexual intercourse, until the results of any tests undertaken are known.

Target group for Chlamydia Screening (NHSScotland CP Contract): sexually active, asymptomatic young people, aged 15-24 years.
Appendix 2: BASHH Sexually Transmitted Infections Foundation course (STIF)

This course may be suitable for community and hospital pharmacists wishing to specialise in sexual health.

The British Association for Sexual Health and HIV initially developed a two-day sexually transmitted infection foundation course (STIF). This course has been updated (from August 2010) and is now structured to include approximately 7 hours of e-learning followed by one CORE/Foundation day and one STIF-PLUS contact day. New material has been introduced covering sexual assault, Hepatitis, Genital Dermatology and Syphilis.

This course provides multidisciplinary training in the attitudes, skills and knowledge required for the prevention and management of STIs, using a variety of educational techniques. Core topics include national and local epidemiology of STIs, HIV and Teenage Pregnancies; principles of STI service provision; sexual history taking, HIV testing in non-GU settings; Partner notification and management. Each participant also rotates through small group workshops on common STI presentations.

For further details visit the British Association for Sexual Health and HIV website at http://www.bashh.org/education.asp
Section 4 Promoting safer sex

This section looks at the ways you can advise individuals to avoid a sexually transmitted disease. At risk sexual behaviour is outlined and the importance of barrier methods of contraception in preventing STIs is highlighted. The CSM advice on the use of lubricants is also noted.
Learning Objectives

At the end of this section, you will:

• be familiar with risky sexual behaviour
• be able to identify people most at risk of STIs
• be able to advise people on how to avoid STIs
• be aware of the c-card scheme for the distribution of condoms.

Section Contents

4.1 Introduction

4.2 Promoting safer sex

• sexual behaviour
• at risk individuals
• condoms
• diaphragms
• latex barriers or dental dams
• spermicides
• giving advice
Section 4
Promoting safer sex

4.1 Introduction
The risk of acquiring an STI is significantly decreased by employing safer sexual practices.

Abstinence is the only guaranteed method of avoiding a sexually transmitted infection. Different sexual behaviours have different levels of risk for different STIs. If a sexual activity involves direct contact with blood, semen, or vaginal secretions then it is risky.

The best method of prevention is the use of condoms as these provide a barrier which prevents the mixing of bodily fluids and the transfer of infectious agents. Infection and re-infection can be significantly reduced by always using condoms during sexual activity.

Sexually active people can reduce their risk of STI by reducing their number of sexual partners and by correctly and consistently using condoms during sex. Sharing of sex toys should be avoided. If they are shared they should be washed or covered with a new condom before use.

In a number of NHS Board areas in Scotland there are schemes which involve community pharmacies in distributing condoms free to young people. This is a simple yet effective way for pharmacists to become involved with provision of sexual health services. Condom distribution schemes using the ‘c:card’ approach (see Resources section 9) allow pharmacy staff the opportunity to support young people and direct them to specialist services for young people’s sexual health.
4. 2 Promoting safer sex

Sexual behaviour

The National Surveys of Sexual Attitudes and Lifestyles (NATSAL) have gathered information on sexual behaviour, fertility, contraceptive use and sexually transmitted infections in the UK. The first survey (NATSAL I) was carried out in 1990 and a second study (NATSAL II) was carried out in 2000. The studies provided vital data for scientists, clinicians and policy makers in sexual health and risk taking behaviours. A third study is due to start in 2010.

Key findings of NATSAL II¹:

- the average age at first heterosexual intercourse was 16 for both men and women
- nearly a third of men and a quarter of women aged 16-19 had heterosexual intercourse before they were 16
- about 80% of young people aged 16-24 said that they had used a condom when they first had sex
- less than 1 in 10 individuals had used no contraception at all when they first had sex
- 1 in 5 young men and nearly half of young women aged 16-24 said they wished they had waited longer to start having sex. They were twice as likely to say this if they had been under 15 when they first had sex
- both young men and women aged 16-24 had an average of three heterosexual partners in their lifetime²
- about 1 % of 16-24 year olds had one or more new same sex partners in the previous year³

At risk individuals. Not everyone is at equal risk of acquiring an STI⁴. Different people live different lives, with some people more likely to get a sexually transmitted disease. Some of the main risk factors are listed below:

- sexually active people not using condoms
- young people under 25 years/early age of sexual onset
- women using oral contraception as sole method of contraception
- women undergoing a pregnancy termination
- those people with a new sexual partner
- individuals with more than one sexual partner in the last year
- having an STI makes a person more susceptible to infection by other STIs
- living in an area with a high prevalence of STIs
- alcohol/drug abuse
- commercial sex workers
- men who have sex with men (MSM)
- people travelling to high risk areas such as Africa or Thailand.
You must refer high risk individuals to specialist sexual health services for advice on contraception and safer sex.

**Exercise 1**

Why are young people more likely to be infected with STIs than older people?

*Please write your answer here:*

**Condoms**

Men should always use a condom for all forms of penetrative sex. No condom is licensed for anal sex but a thicker condom should be recommended (Durex™ Ultra Strong or Mates™ Super Strong condoms are examples of these). Lubricants can be used during vaginal or anal sex. Only water-based lubricants should be used during anal sex. Oil based lubricants such as lipstick or baby oil degrade the latex.

Condoms come in a variety of shapes, sizes and flavours to suit everyone’s needs. As providers of condoms, pharmacists should ensure that all of their stock of condoms carries the British Kite Mark or European CE mark, and you should advise your patients to make sure any condoms they use carry either of these two quality marks.
Practice Point

Think about your local population. Is the range of condoms you stock appropriate for your customers’ needs? Would you be able to advise them on how to use condoms?

Condoms should be stored in a cool dry place to prevent deterioration. Additionally you should advise patients to keep condoms in places where sex is likely to occur and to carry them, as the time and place of sexual intercourse may not always be predicted. A condom should be in place from the beginning to end of each sexual activity.

Typical condom use results in an 80 percent reduction in HIV infection incidence, a level of protection only slightly less effective than for pregnancy. In general, condoms are most effective in preventing infections that are transmitted through bodily fluids, such as HIV, gonorrhoea and Chlamydia. They are less effective against infections that are transmitted through skin-to-skin contact, such as genital herpes and warts, because the condom may not cover the entire affected area. Oral sex is cited as a key route of transmission for syphilis as people tend not to use condoms for this sexual activity.

Practice Point

We know that using latex condoms can reduce the transmission of STIs such as chlamydia and gonorrhoea. But how effective are they? Take a little time to do your own research to establish how effective condoms are in reducing the transmission of common STIs.

Hint: Use the keywords ‘Effectiveness of condoms in preventing sexually transmitted infections’ for your search.

Care should be taken to prevent condom failure, which may happen due to the incorrect type being used, incorrect application, or use of substances that degrade the material. Condom packages must be opened carefully to make sure that the condom is not torn by fingernails, teeth or jewellery and used only once.

Some condoms are coated with a spermicide which may cause an allergic reaction, a feeling of pain or discomfort, on the penis, or in the vagina or anus. If this is likely, you should advise patients to use a different brand of condom or one promoted as hypoallergenic. Some people have an allergy to the latex from which condoms are manufactured.

CSM advice (BNF 59, Section 7.3.3 page 487)

Products such as petroleum jelly (Vaseline®), baby oil and oil based vaginal and rectal preparations are likely to damage condoms and contraceptive diaphragms made from latex rubber and may render them less effective as a barrier method of contraception and as a protection from sexually transmitted diseases (including HIV).
Exercise 2
What lubricants are safe to use/do you recommend to use/with latex condoms?

Please write your answer here:

Diaphragms
It is possible that diaphragms offer some limited protection. This is because a diaphragm blocks the entrance to the cervix and gonorrhoea and Chlamydial infection are acquired in the cervix but not the vagina. The cervix is also an entry point for many HIV infections because the endocervical lining is thinner and more fragile than the lining of the vagina, and is therefore more vulnerable to infection.

Latex barriers or dental dams
Latex barriers or ‘dental dams’ are squares of ultra-thin latex that can be put over a partner’s vulva or anal area during oral sex. This creates a barrier which protects against STIs and allows stimulation of these areas without transmission of bodily fluids.
**Spermicides**
Spermicidal contraceptives may be suitable for use with barrier methods such as diaphragms or caps. However they are not generally recommended for use with condoms.

Spermicides containing nonoxynol-9 do not protect against HIV or other sexually transmitted infections and may even increase the risk of transmission in women who use these products frequently. This may be because nonoxynol-9 is an irritant and can disrupt the vaginal epithelium, allowing invasion by an infective organism. Women who have sex several times a day are advised to use alternative contraception which offers better protection from sexually transmitted infections.

**Giving advice**
The advice to give at-risk individuals for preventing the transmission of sexually transmitted infections is summarised below:

- talk to their partner about how they can both protect themselves before they have sex
- a male or female condom can provide protection from most sexually transmitted infections if used correctly every time they have sex
- familiarise themselves with how to use a condom, and have a supply ready
- seek advice straight away from a health professional if they think they have been at risk.

**Case Study**
One of your pharmacy assistants tells you that a young boy, who looks about 15 years old, seems to be about to buy condoms. What should you do?
Summary of learning
The risk of acquiring an STI is significantly decreased by employing safer sexual practices. Not everyone is at equal risk of acquiring an STI. The best method of prevention is the use of condoms and you should ensure that all of your stock of condoms carries the British Kite Mark or European CE mark. Condoms are more effective in preventing infections that are transmitted through bodily fluids, such as HIV and less effective against those which are transmitted through skin-to-skin contact, such as genital herpes and warts. Products such as petroleum jelly (Vaseline®), baby oil and oil based vaginal and rectal preparations are likely to damage condoms and diaphragms made from latex. Spermicides containing nonoxynol-9 do not protect against HIV or other sexually transmitted infections and may increase risk of infection.

Reflection Points
Are there any health promotion leaflets/posters that I can use to promote the safer sex message?

Are there any learning resources that I can use to teach my pharmacy staff about the importance of safer sex?

Do I need to stock a wider or different range of condoms?

What lubricants can I recommend for use during vaginal or anal sex?
Answers

Exercise 1
Less likely to use condoms.
More likely to engage in sexual risk taking, particularly under the influence of alcohol.
More likely to have multiple partners.
Young women are more biologically susceptible – bodies are smaller, maybe more likely to experience tearing during intercourse.
Under the influence of illegal drugs.

Exercise 2
KY jelly. The majority of condom manufacturers produce water based lubricants e.g. Pasante™ or Durex.

Case Study
You should tell the pharmacy assistant that it is OK for the boy to buy the condoms, if he decides to do so. She should not do anything that might discourage him. If your local area has a c: card scheme for young people, you may wish to let the boy know, when he purchases the condoms, that there is a way in which he can get free condoms. What about offering a Chlamydia testing kit to the boy? You could also bring in the aspect of consent if the test is positive and the boy presents for treatment. Consider giving the boy some relevant literature/leaflets and details of local clinics.
This section takes a brief look at the causes, symptoms, diagnosis and treatment of some of the more common sexually transmitted diseases including:

- syphilis
- gonorrhoea
- genital warts
- genital herpes
- non-specific urethritis.

Chlamydia, the most common sexually transmitted infection, will be discussed in depth in Section 7.
Learning Objectives

At the end of this section, you will:

• gain essential knowledge of the common sexually transmitted infections, their presentation, diagnosis and management

• get a basic knowledge of the epidemiology of sexually transmitted infections

• be aware of the consequences of not treating an infection

• know when and how to refer clients to other agencies.

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5.1  Introduction
5.2  Syphilis
5.3  Gonorrhoea
5.4  Genital warts
5.5  Genital herpes
5.6  Non-specific urethritis
Section 5

Common sexually transmitted infections

5.1 Introduction

In Scotland, the incidence of STIs is rising. There was a 16% increase in the overall workload in GUM clinics in Scotland in 2008, compared to 2007. In the last five years, the trends for the four major STIs, genital Chlamydia, gonorrhoea, genital herpes and genital warts show a general increase in diagnoses, with the exception of gonorrhoea infection in men. This is the second successive year that a decrease in gonorrhoea in males has been observed. In women, the largest overall increase, between 2004 and 2008 was observed for diagnoses of gonorrhoea in the GUM clinic setting.1

Exercise 1

How do you explain the upward trend in diagnoses of STIs?

Please write your answer here:
5.2 Syphilis

This bacterial STI, caused by Treponema pallidum, is one of the oldest known STIs. For centuries, known by its street name, ‘the pox’, syphilis was dreaded for the apparent inevitability of its three stages, the last of which could be fatal. Since the advent of mass-produced penicillin in the late 1940s, syphilis can be treated and cured. Syphilis almost disappeared from the UK, but is being reported with greater frequency, especially among men who have sex with other men (MSM).

Syphilis re-emerged in Scotland during 2000/2001 and the number of diagnoses has increased annually since then. The majority of diagnoses were in men. This has mostly been driven by the increasing number of infections in the MSM population; a five-fold increase was observed between 2003 and 2007. However, the numbers in this population have stabilised in recent years with 197 and 212 diagnoses being recorded in 2007 and 2008, respectively. In contrast, there has been an increase in the number of heterosexually acquired syphilis cases due largely to an increase in the number of diagnoses in women.

*Diagnoses of infectious syphilis, made in GUM clinic settings, by gender, 1999 - 2008*

Gum clinic diagnoses include all cases of primary, secondary and early latent syphilis. MSM are a subset of all the cases in men. Data source: STISS
Contact tracing continues to be a challenge, particularly with regard to the multiple anonymous contacts reported by MSM.

**Incubation period**
The initial period, before the first stage symptoms appear, can be as short as two weeks or as long as three months after the infection is acquired.

The second stage occurs several weeks after the first symptoms disappear. The latent period may last several months or many years, and only about one-third of all who have syphilis will experience the final stage of the infection.

**Signs and symptoms**
The signs and symptoms of syphilis are the same in both men and women and can be difficult to recognise. Syphilis has three distinct phases; these have varying symptoms and not all are contagious.

**The primary stage of syphilis**
The first symptom of the primary stage of syphilis is known as a chancre; a firm, round or oval button-like red painless sore, on the site where the skin has been in contact with the bacteria; the penis, the vulva, vagina, cervix or anus. In some cases this may not be seen, or may not even appear. There may also be painless swelling of the lymph nodes in the groin.

This primary stage may occur anything from two weeks to three months after acquiring the infection and is contagious. People seldom feel ill at this stage and the sore, if noticed, heals after a few weeks without treatment. The infection has not gone, it is multiplying in the bloodstream.

**The secondary stage of syphilis**
The second stage is contagious and occurs around six weeks or more after the chancre appears, and generally within two years. People do feel unwell. There are generalised symptoms and specific symptoms.

The generalised symptoms include:
- headaches
- aches and pains
- sickness
- loss of appetite
- a fever, perhaps
- extensive swelling of the lymph nodes.
The specific symptoms of this stage of syphilis include:

- a dark red rash, which may be raised or flat, on the front of arms, backs of legs, including the palms and feet, on the back, and face
- mucous patches (painless silvery ulcers in the mouth and on the genitals)
- condylomata: coalescing tiny wart-like growths which form a grey-white plaque frequently in such folds as the groin, genitals, under the arm, and under the breasts.

This secondary stage may last between three weeks and nine months, but will also disappear without treatment. However, the infection will continue to spread.

The tertiary stage of syphilis
When syphilis is not treated it goes into another phase known as the latent stage (also known as tertiary syphilis), with no symptoms, and can last a few months or many years. The third stage of syphilis is non-contagious.

If left untreated, the disease can cause serious organ damage and even death. The tertiary stage can produce painful permanent ulcers on the skin, lesions on the ligaments, joints and bones (gummatous syphilis), inflammation of the aorta leading to aortitis or aneurysms, and neurosyphilis which affects the meninges, the brain, spinal cord, sight and hearing. Tertiary syphilis is rare in Scotland.

Causes
Syphilis is acquired through unprotected vaginal, anal or oral sex with someone who has the infection. The bacterium is passed through direct contact with syphilitic lesions in the genitals and so penetrative sex is not required. Syphilis can be spread through sharing sex toys if they are not washed or covered with a new condom each time they are used.

Effects on pregnant women and babies
The infection can also be passed by a mother to her baby during any stage of the pregnancy. Babies born with congenital syphilis may suffer from blindness, severe organ damage, and may die.

Diagnosis and treatment
Syphilis testing is essential in order to ensure that proper treatment for the disease is taken. Diagnosis is usually based on a blood test, which looks for the presence of syphilis antibodies in the blood. In some settings, a polymerase chain reaction (PCR) test can be sent to Edinburgh.

Anyone with symptoms of early syphilis should be evaluated urgently in a specialist clinic to allow early diagnosis.

Early diagnosis, and treatment within one year of infection with intramuscular injection of benzathine penicillin can cure the infection. In cases of penicillin allergy, clinics may use doxycycline, azithromycin or erythromycin. The length of treatment depends on the stage and duration of infection.
Common sexually transmitted infections

Practice Point

Go to http://www.bashh.org/guidelines and find the recommended treatment regimes for early syphilis. How do they compare with what is being prescribed locally?

These treatments can cure the infection completely. If the infection is older than a year several treatments will be necessary to effect a complete cure. BASHH guidelines recommend three doses of intramuscular benzathine penicillin over a period of two weeks.

The BNF also recommends the treatment of asymptomatic contacts with a course of doxycycline for 14 days.

It is important all partners are traced, tested and, if infected, are treated. Individuals should be discouraged from sexual activity until their blood tests are negative (or clear).

Effects of syphilis if left untreated

If the infection is permitted to continue through to the tertiary stage, diagnosis may involve a spinal tap to determine whether neurosyphilis is present, and the damage to the heart, joints, bones and ligaments, or the central nervous system may be irreversible.

5.3 Gonorrhoea

A more serious STI compared with genital warts or herpes.

This STI is caused by the gram negative Neisseria gonorrhoeae bacterium. It is one of the oldest sexually transmitted infections and its name, derived from two ancient Greek words, means ‘flow of seed’. A characteristic early male symptom is a milky white discharge, which was once thought to be semen. Its street name is ‘the clap’, but the derivation of this name is unclear. It can occasionally cause serious complications.

In Scotland’s GUM clinics, the number of diagnoses of gonorrhoea decreased in 2008 for the second year running from 864 in 2007 to 829 in 2008. This was due principally to the 19% decrease in infection diagnosed in Men having Sex with Men (MSM). However there was a 13% increase in diagnoses among women.

Signs and symptoms

The early symptoms of gonorrhoea can be mild and most women do not have any noticeable symptoms and so will be unaware that they are infected. Most men, between 80 and 90 per cent, will show symptoms. When young men have symptoms they may include:

- a slimy slight discharge from the penis at first which will become yellowish and purulent inflammation or dull pain in the testes
- burning sensation, which can be severe, during urinating
- irritation or a discharge of bloody pus from the anus, if the infection is the result of unprotected anal sex, fingering the anus, or the result of an unnoticed burst condom.
In women the symptoms of gonorrhoea when present may include:

- pain or a burning sensation on urinating
- a yellowish or bloody vaginal discharge which can have a strong foul smell
- abdominal pain
- irritation or discharge from the anus, again, if the infection is the result of unprotected anal sex.

Anyone who acquires an infection of the throat through oral sex is likely to have no symptoms, or at worst a slight throat infection.

**Causes**
Gonorrhoea, is passed from person to person through unprotected vaginal, anal or oral sex with someone who already has the infection. Gonorrhoea can be spread through sharing sex toys if they are not washed or covered with a new condom each time they are used. However, it is also possible to be infected by contact with the infected areas of another person, without having penetrative sex.

**Effects on pregnant women and babies**

**Gonorrhoea is highly infectious**

Gonorrhoea is highly infectious through genital to genital, oral genital contact and by transmission in the birth canal from an infected mother to a baby. If gonorrhoea infection is noted at or near delivery, then the baby can have some eye cream to prevent any eye infection.

Pregnant women should not be treated with quinolone or tetracycline antibiotics. The common medication usually prescribed to pregnant women is ceftriaxone.

**Practice Point**
Find out your local recommendations for the treatment of gonorrhoea.
Incubation period
In men, the symptoms may appear within two days of the infection being acquired, but it can usually take up to 10 days. As mentioned above, many women will not have any symptoms or it will be mistaken for something else, such as thrush.

Diagnosis and treatment
In the diagnostic process it is necessary to distinguish between gonorrhoea and other STIs. Patients will have a physical examination of the infected area by a doctor or nurse, and if it is thought that there is a gonococcal infection, a swab of the discharge from the infected area i.e. the urethra, the cervix, anus or throat is taken for microscopic examination (if sexual history indicates risk in these areas).

A urine sample may also be taken. Patients may have to wait a few days before the results are available. However, in a specialist clinic, gonorrhoea can be detected by microscopy allowing early blind treatment.

Molecular tests for the detection of Neisseria gonorrhoeae are increasingly being used in laboratories due to their high sensitivity compared to conventional techniques. This has led to an increase in the number of cases detected, particularly in primary care settings and in those who are asymptomatic.

Exercise 2
What do we mean by molecular testing? What are the advantages?

Please write your answer here:
It is often necessary to start treatment before the results are available to prevent unnecessary discomfort to the individual and to reduce the potential for complications. In Scotland, since 2003, cefixime is the first line blind treatment for gonorrhoea due to the drug resistance rate exceeding 30 per cent. Cefixime has a longer duration of action than the other oral cephalosporins and is given as a single oral dose of 400mg (unlicensed indication) for gonorrhoea.

Ciprofloxacin must only be used where there is clear culture confirmation and proof of sensitivity.

**Exercise 3**

What is the treatment of choice for pharyngeal infection in the BNF? What dose do you give?

*Please write your answer here:*
Co-infection with Chlamydia is common. 40% of women and 27% of all men diagnosed with gonorrhoea were also diagnosed with Chlamydia infection. During treatment, and for 7 days after, individuals should be advised not to have any sexual activity, to reduce the possibility of being re-infected or of passing on the infection. As with all STIs, all recent sexual partners should be contacted and treated. After the infection has cleared up, all subsequent sexual activity should be fully protected by use of condoms to prevent any possibility of re-infection. After antibiotic treatment, a follow up appointment will normally only be given to those people being treated for pharyngeal gonorrhoea. Some strains of gonorrhoea, particularly those that do not originate within the United Kingdom, may be resistant to the first-line antibiotic treatment, and use of second-line agents may be necessary. Fortunately, in Scotland there are currently no detectable levels of resistance to the recommended first line antibiotic therapies now in use, i.e. cefixime and ceftriaxone.

Gonorrhoea is such a contagious infection, anyone who is sexually active with multiple partners should have regular tests to ensure that there is no further infection.

Effects of gonorrhoea if left untreated
If gonorrhoea is treated early it is unlikely to lead to any long-term health problems. Without treatment it is possible that the infection may spread to other parts of the body.

As with untreated Chlamydia, untreated gonorrhoea in women can cause
- pelvic inflammatory disease (PID) leading to chronic pelvic pain
- infertility
- ectopic pregnancy
- perinatal transmission to infants.

In men untreated gonorrhoea can cause inflammation of the testicles with reduced fertility.

In a small number of cases, the bacteria can spread throughout the body causing skin rashes and severe pains in the joints. Very rarely the bacteria can infect the blood stream resulting in septicaemia, which in turn can affect the brain and heart valves, and can prove fatal.
5.4 Genital warts

Genital warts are the most common viral STI diagnosed in the GUM setting

Genital warts are a viral infection caused by Human papilloma virus (HPV). This is a very large group of viruses affecting many parts of the body. Most genital warts are caused by the low risk (benign) type 6 and 11. High risk types include types 16 and 18 which cause about 70% of all cervical cancers in the UK.

In 2008, 7360 new cases were diagnosed, this compares with 7258 cases seen in 2007. The annual number of new diagnosis has increased by 37% over the past ten years. This represents a 29% and 44% increase in diagnoses in women and men respectively.

Signs and symptoms
Most people infected with HPV will show no signs while some people may develop visible warts.

Genital warts are skin-coloured or whitish growths or lumps. They can either be flat or raised, and single or in little groups, and sometimes they form a cauliflower-shaped lump. In women they appear on the vulva, vagina and cervix and in men on the penis, scrotum and groin, and in both genders they can occur around the anus.

Genital warts are usually not painful but can cause itching and inflammation and may occasionally bleed.

Causes
Many different HPV types cause genital warts. The types of wart virus causing general skin warts or cervical cancer are different to those causing genital warts. The prevalence of genital HPV types is around 20 to 30 per cent in the population so the majority of those infected show no symptoms.

Genital warts are very infectious – around two thirds of people who have sexual contact with an infected person will become infected. People are most likely to transfer the infection when the warts are present, but even when no symptoms are present an infected person can transfer the virus.

It is possible, but very rare, to develop warts in the mouth or lips from oral sex.

Incubation period
The HPV virus has a long incubation period ranging typically from three weeks to eight months. The average incubation period is estimated to be three months. However, cases have been reported when the HPV virus has emerged some years after exposure. The long incubation period makes it difficult to trace how a person has contracted the infection.

Diagnosis and treatment
You should advise anyone who has noticed unusual lumps around their genitals to consult their GP, or visit a GUM clinic, as soon as possible. As a pharmacist, you should not recommend any treatment for genital warts as you are unable to confirm diagnosis. Additionally, there are no products which are licensed for OTC sale for the treatment of genital warts.
There are a number of treatments to remove genital warts which are chosen according to
the location and size of the wart. All of the available treatments will remove the warts and are
essentially for cosmetic purposes, but they are not curative, the HPV virus remains in the body
and may cause another outbreak.

The treatments involve:
- painting the warts with liquids (podophyllin) or using creams (imiquimod)
- freezing them with liquid nitrogen
- cauterising them with an electric current, or
- destroying them with laser light.

BASHH\(^3\) states that there is no strong evidence to direct first or second line choices and
recommends that healthcare professionals consider a number of factors, such as number and
location of warts and patient preference. All treatments have high failure and relapse rates.
Some discomfort is likely while undergoing treatment and symptomatic relief may be needed.

Some treatment options:
- Soft non keratinised warts respond well to podophyllin and trichloroacetic acid.
- Keratinised lesions are better treated with cryotherapy, excision or
electrocautery.
- Imiquimod may be suitable for both keratinised and non keratinised warts.

The following represent treatments that may be prescribed:

**Imiquimod cream (Aldara\(^\text{®}\))**
should be applied three times a week at night for 16 weeks. The BNF states that: “The cream
should be applied thinly but should be rubbed in and allowed to stay on the treated area for six
to ten hours, then washed off with mild soap”. Imiquimod stimulates the body’s production of
cytokines, chemicals that direct and strengthen the immune system.
Exercise 4

Does imiquimoid cream have any effect on condoms?

*Please write your answer here:*

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Podophyllotoxin cream 0.15% (Warticon®)

This cream is given as a home treatment for patients. The affected area should be thoroughly washed with soap and water, and dried prior to application. The cream is applied twice a day for three consecutive days at weekly intervals. The treatment can be repeated at weekly intervals if necessary for a maximum of four 3 day treatment courses.

Podophyllum

A trained nurse may apply podophyllum paint BP weekly, after screening for other STIs in a GU centre or GP surgery. It should be allowed to stay in contact with the area being treated for a maximum of six hours. After that time the podophyllum should be washed off. The surrounding skin should be protected from ‘splashing’ by covering with soft paraffin. When there are a large number of warts to be treated, only a few should be treated at any one time. Severe toxicity has been reported following absorption of podophyllum.
Cryotherapy
This involves warts being removed by the application of liquid nitrogen. Liquid nitrogen stored in an insulated flask is sprayed onto the warts. Care should be taken to apply the liquid nitrogen only to affected skin as damage may be caused to unaffected areas. On coming into contact with the warts the liquid nitrogen, being considerably colder than body temperature, facilitates the transfer of heat from the wart and surrounding tissue. The resulting decrease in temperature reduces nerve sensitivity and a feeling of numbness results. This means that no pain is felt at this stage. The evaporation of the liquid nitrogen facilitates the desiccation of tissue with which it has contact, thus causing lysis and cell death. This means that host cells of the virus are no longer available. When the anaesthetic effect of the liquid nitrogen diminishes, a dull aching sensation may be present and patients may find this uncomfortable depending on how extensive the warts are. The patient may take appropriate pain relief if necessary.

Generally this treatment is only given when a patient first presents at a Sexual Health Clinic. Any further treatment such as imiquimod or podophyllotoxin cream would be continued at home. Normally patients would only be seen once at the clinic if they present with genital warts.

Prevention
The only way to prevent infection or re-infection is to prevent physical contact with the virus. Ideally, sexual contact should be avoided while the presence of the infection is still visible.

Although data is conflicting, condom use may prove beneficial and their use is advisable particularly in new relationships.

Effects of genital warts if left untreated
About 90% of warts will usually disappear within 12 weeks if left untreated. But in general there are no long-term health risks from not treating the warts.

You should reassure your patients that the types of HPV that cause genital warts do not cause cancer of the cervix.

Most women who have genital warts do not have a high risk of cervical cancer but you should advise women patients that they should continue to have regular cervical smear tests.

Effects on pregnant women and babies
Some warts grow during pregnancy and can cause problems as they can affect the elasticity of the birth canal and cause obstructions during delivery. Rarely, warts can be passed to the baby during the birth.

Human papilloma virus vaccine for cervical cancer
Cervical cancer is also caused by the human papilloma virus, but types 16 and 18 not 6 and 11. Vaccination against types 16 and 18 are now part of the routine childhood immunisation programme; all girls in the second year of secondary school are offered the vaccine. Two HPV vaccines are currently on the market: Gardasil® and Cervarix®; the Cervarix® brand is currently being used in the UK. Both vaccines protect against two of the HPV types (HPV-16 and HPV-18) that can cause cervical cancer, Gardasil also protects against two of the HPV types that cause genital warts.
5.5 Genital herpes

This STI is caused by the herpes simplex virus (HSV). There are two types of herpes simplex; Type 1 and Type 2, both can cause genital herpes. Genital herpes is similar to the herpes that appear on the face (cold sores). The cold sores which affect lips and gums are usually caused by the Type 1 virus. People whose genitals are infected with Type 1 virus are less likely to have recurrences than if they were infected with Type 2 virus.

Both types of herpes simplex are similar and may only be differentiated by laboratory tests. Genital lesions caused by Type 2 herpes simplex virus are usually more severe than those caused by Type 1.

In 2008, 1,644 people attending GUM clinics were diagnosed with genital herpes for the first time. Over the past five years the number of new diagnoses in GUM clinics has risen by almost one third (28%). Most diagnoses of genital herpes were made in women aged 20-24 and in men aged 25-34. HSV type 1 infection was more common in women (57%), while, in men, diagnoses were predominantly due to HSV Type 2 (58%).

Signs and symptoms

Most people who have genital herpes will have no symptoms. When symptoms do occur they are similar to cold sores, but they occur wherever the infection has entered the skin: on the penis, urethra, vulva, vagina, cervix, or around the anus.

The initial symptoms are a tingling or itchy feeling (the prodrome), a reddening and swelling of the skin and then the fluid-filled blisters appear. These can be very painful. Eventually, the blisters burst to form small ulcers, which become crusted, then heal without leaving a scar.

These physical signs at the site of the infection can also be accompanied by:
- flu-like symptoms
- aches and pains in the legs, buttocks and genitals
- a vaginal discharge
- pain or discomfort below the stomach
- pain while urinating
- swollen glands around the genitals.
These symptoms are usually only present with the first outbreak which is often the worst. Second, and subsequent episodes, are normally milder and shorter-lived.

**Causes**

People get genital herpes through sexual contact with someone who already has the virus. It is most likely to be passed on just before, during and straight after an episode where symptoms are present, but it can also be passed by people who have no visible signs of the infection.

Genital herpes can be transmitted by an infected person during vaginal or anal sex. The virus can also be spread by skin to skin contact so it is possible that non-penetrative genital contact can spread the infection. It is possible to get genital herpes from receiving oral sex from someone who has a cold sore. Genital herpes can be spread through sharing sex toys if they are not washed or covered with a new condom each time they are used. It is also possible that the virus can be transmitted by sharing towels with someone who has blisters or ulcers. While the blisters or ulcers are present, and the virus can be shed onto a towel, care should be taken not to share towels. As well as transmission from an infected person, the Herpes simplex virus can be easily transferred between sites on one individual. It is important to ensure infected patients are aware that the virus can be transferred to other sites, and of the need for scrupulous personal hygiene. The trigger factors for recurrent episodes of genital herpes are not well understood. It may be stress, illness, too much sun, or even a menstrual period.

**Incubation period**

Some people will get symptoms one to two weeks after sexual activity with an infected person. In other people the virus may become inactive for months or even years before any signs and symptoms to appear. This means that it is not possible to say when a person has become infected.

**Symptoms**

Patients may complain of discomfort in the genital or anal area. The discomfort may be described as stinging, itching or tingling on passing urine. (Urethritis may also cause pain on passing urine in men, differential diagnosis is therefore necessary.) Flu-like symptoms, including temperature, headache or backache may also be present, plus pain in the groin area and down the thighs and legs. Vesicles may be visible or may be inside the rectum. When vesicles burst, small red ulcers develop and these may cause considerable pain and discomfort. Following ulceration the tissue dries, scabs and eventually heals. The healing process usually takes between two and four weeks.

Following infection, herpes simplex lies dormant in the nerve ganglia. Some individuals are asymptomatic; others experience symptoms when the virus is reactivated.

**Diagnosis and treatment**

As the signs of genital herpes are non-specific in many cases, anyone who has symptoms of HSV should be advised to consult their GP, or visit a GUM clinic. An examination of the sores in the infected area may enable a doctor or nurse to diagnose HSV. But a viral swab may be necessary to confirm the diagnosis as the appearance of herpes sores can vary.

Treatment will be initiated based on clinical examination. This is particularly important for genital and anal herpes where the treatment should ideally be initiated within 72 hours of the onset of symptoms.
Aciclovir, valaciclovir, and famciclovir are licensed for the treatment of genital herpes. BASHH states that any one of the three antiviral drugs can be used to treat genital herpes to reduce the severity and duration of episodes. Treatment may be continued after five days if new lesions are still appearing.

There is no cure for genital herpes, infection is life-long but usually with time the episodes become less frequent and may stop.

**Practice Point**

Which drug and dose regimen is recommended in your local formulary for the treatment of genital herpes?

Consistent condom use during sexual activity may reduce the risk of transmission and acquisition of herpes by about 50 per cent.

As recurrent episodes are usually milder, antiviral treatment is not normally given. Where people with genital herpes have frequent or severe recurrent episodes, continuous treatment with antivirals can be considered. This is usually managed through a specialist clinic. During an outbreak of HSV, patients can take a daily dose of valaciclovir to prevent the spread of the virus to their partners, but it is still possible to transmit the virus despite this precaution.

www.herpes.org.uk

Patients who have symptoms associated with genital herpes will sometimes suffer pain, and you can advise them how best to deal with this. As well as suggesting that patients can contact the Herpes Association, it is possible that a local GUM specialist clinic will be able to provide significant emotional support and information.

You can also give advice on caring for the infected area. The area should be kept clean and dry. Bathing with a salt solution is recommended, using a 5 ml spoonful of salt in 500 ml of warm water. It is important to make sure patients discard the solution with care after bathing to decrease the potential risk of spreading the infection further. It is also advisable to use a separate towel to dry the infected area and not to share towels with anyone else while infected.

Loose clothing is recommended, ideally non-synthetic and preferably cotton or cotton-based fabrics. This improves comfort and provides an environment which may be more favourable for wound healing compared with tight synthetic garments.
Also recommended are:

- avoidance of sun-bathing or sun beds, as this may cause further damage to infected tissue. UV light may also re-activate the herpes virus.
- increasing fluid intake, thus increasing urine flow, which will assist in the removal of infecting organisms both viable and non-viable during treatment.
- using an ice pack for pain relief on the affected area (ensuring that the pack is covered with a clean cloth to protect the skin from any further damage).
- urinating in a bath of water is often recommended for those who experience pain urinating in the usual way. It is believed that this facilitates immediate dilution of the urine which may decrease any irritant effect to the infected area. This process may not, however, be convenient or acceptable to some patients.
- applying vaseline or a topical anaesthetic (e.g. lidocaine 5%) to lesions may help with painful micturition, if needed.

General hygiene advice should include:

- emphasis on importance of hygiene.
- avoidance of sharing face cloths and towels.
- particular care by contact lens users.

In summary, the overall aim is to treat the disease state, make the patient comfortable by reducing the symptoms and also avoiding transmission either between sites on the infected person or between the patient and their partner or contacts.

To prevent infection people should be advised to avoid sex or genital contact when there are genital sores. By always using condoms during sexual activity, an infected person can prevent spreading the infection, although the protection is incomplete.

**Effects on pregnant women, babies and nursing mothers**

Any woman who becomes infected with the herpes virus while pregnant should alert their doctor as the virus can be very dangerous in babies, causing rashes, eye problems and even brain damage. It can also increase the risks of miscarriage and stillbirth. Women with an active herpes infection at term will be offered a caesarean section to reduce the possibility of the baby being infected.

Provided there are no open sores around the aureole and nipple, it is safe to breastfeed while there is an active infection, but all other sores should be covered. If any part of the breast is infected and has open sores, breast milk can be expressed and is safe provided no part of the breast pump comes into contact with the open sores. If this does happen the expressed milk must be discarded.
Case Study

Herpes Infection
A middle-aged woman asks one of your counter assistants if she may speak to you on a personal matter. You take her to your counselling area and she tells you she has been diagnosed as having herpes. Fortunately her partner is clear. She says they’re both very worried that her partner may be infected by her as they enjoy an active sex life. What advice do you give?

*Please write your answer here:*
5.6 Non-specific urethritis (NSU)

Urethritis is inflammation of the urethra. This STI is called non-specific urethritis and the name is used when the cause is not known, or not yet known. It is usually used when gonorrhoea has been ruled out. It is also known as non-specific infection (NSI), or non-gonococcal urethritis (NGU). NSU affects mainly men. There are a number of non-STI causes of NSU.

**Signs and symptoms**

Not all men who have urethritis will have any signs or symptom and where they are present they may be so mild that they are not noticed.

When symptoms are present in men the following may be reported:
- pain or a burning sensation when passing urine
- a white or cloudy discharge from the end of the penis, especially noticeable first thing in the morning
- the need to pass urine more frequently.

If women have NSU they are likely to experience:
- urinary pain
- urinary frequency
- pelvic pain
- thick yellow vaginal discharge
- pain during intercourse

and less commonly:
- deep pelvic pain
- pain between anus and genitals.

**Causes**

There are many possible causes of NSU, some, but not all, are caused by infections passed on during sex. In many cases a cause is never established. About half of all cases of NSU, when identified, are caused by Chlamydia. Herpes and trichomoniasis are less common causes. Infection by tiny organisms called genital mycoplasmas; Mycoplasma genitalium, Mycoplasma hominis, Ureaplasma parvum, Ureaplasma urealyticum and Adenovirus can also cause NSU.

Chlamydia is a common cause of non-specific urethritis.

NSU is usually the result of unprotected sexual activity with someone who already has these infections. Very rarely NSU is caused by an allergic reaction to soap, shampoo, detergents, or even excessive alcohol.

NSU cannot be caught by casual contact such as kissing, hugging, sharing baths or towels, or from swimming pools or toilet seats.
Incubation period
Symptoms, when they do appear, may occur between one week to four weeks after the sexual contact through which the infection was acquired.

Diagnosis and treatment
Diagnosis is made quickly and simply, in a specialist clinic, by microscopic examination of a swab from the infected area. Treatment is based on the appropriate prescribing of antibiotics, and also involves sexual abstinence during the treatment. The patient’s sexual partners also need to be treated to avoid re-infection. Because of its multi-causative nature, initial empirical treatment may involve using a broad range antibiotic that is effective against Chlamydia such as doxycycline or azithromycin.

A second visit to the GP or GUM clinic may be required after treatment to ensure that the infection has gone. There is no acquired immunity from NSU. Unprotected sex with someone who has the infection will almost certainly result in a further infection. The likelihood of re-infection can be reduced by always using condoms during sexual activity.

Effects of NSU if left untreated
While NSU is easily treated with antibiotics, there is no immunity, and it can reoccur. If left untreated in men it can cause inflammation of the testicles, and, as a result, infertility. In some cases, as well as this inflammation of the testicles, it can lead to a group of symptoms similar to arthritis. As well as the inflammation of the urethra, joints become painful, there is an inflammation of the eyes, and sores on the penis and soles of the feet. This is known as Reiter’s syndrome.

Summary of learning
In Scotland, the incidence of STIs is rising. This section looked at the causes, symptoms, diagnosis and treatment of some of the more common sexually transmitted diseases. Basic information about the epidemiology of sexually transmitted infections was outlined. The significance of not treating an infection was discussed as well as when to refer individuals to other local organisations.
Reflection Points

Where can I find out more detailed information about STIs?

What referral pathways operate locally?

Do I need to check local formulary choices and compare them to the national guidelines?
References

1 Scotland’s Sexual Health Information 2009. Health Protection Scotland and Information Services Division, November 2009


5 Home Health UK http://www.homehealth-uk.com/medical/nsu.htm) - accessed 09/10/09

Additional Resources

- Clinical Knowledge Summaries – Sexual Health http://www.cks.nhs.uk/clinical_topics/by_clinical_specialty/sexual_health#

- Clinical Knowledge Summaries – Non specific urethritis http://www.cks.nhs.uk/urethritis_male

Answers

Exercise 1
Increased awareness of STIs.
More reliable diagnostic tests.
Increase in the number of sexual health clinics.
Greater sexual activity in younger people.
Increased screening so more cases are diagnosed than previously.

Exercise 2
Nucleic acid mediated molecular procedures to detect and identify bacteria, mycobacteria and fungi by DNA typing.
• lower risks for contamination
• decreased costs
• faster and more specific than conventional tests.

Exercise 3
Ceftriaxone – a third generation cephalosporin - 1.5 gram as a single dose by IM injection (divided between two sites).

Exercise 4
The BNF advises that if imiquimod cream is being used to treat genital warts, the cream should be washed off prior to sexual contact. Imiquimod cream consists of oils that may damage latex condoms, diaphragms, or cervical caps, inhibiting their ability to prevent unwanted pregnancies or the transmission of sexually transmitted diseases.

Case Study
As she has an active sex life, the following additional advice is recommended to avoid passing on the virus by direct contact. The blisters and sores are highly infectious therefore avoidance of the following is recommended:

• kissing when sores are present around the mouth
• having oral sex when oral or genital sores are present
• Genital or anal contact, even when a condom or dental dam is being used, when genital or anal sores are present.
Section 6  HIV and other blood borne virus infections

This section highlights the causes, treatment and diagnosis of HIV and other blood borne viruses. We briefly mention the implications of these infections if left untreated and touch on the treatment of the chronic phases of these illnesses. Antiretroviral therapies are not discussed.
Learning Objectives

At the end of this section, you will:

• know the signs and symptoms of HIV infection
• be aware of the routes of transmission of the HIV infection
• recognise that effective treatments are available for HIV
• list the routes of transmission of hepatitis A, B and C
• state some of the treatment options for the chronic management of hepatitis B and C.

Section Contents

6.1 Human immunodeficiency virus (HIV)
6.2 Blood borne viruses
Section 6
HIV and other blood borne virus infections

6.1 Human immunodeficiency virus (HIV)

Introduction
Human immunodeficiency virus (HIV) is a virus that can be spread from person to person in a number of ways including sexual transmission. Once infected with HIV the virus progressively destroys vital immune cells, CD4 lymphocytes. Most people with HIV will look and feel healthy and many may not know they are infected. HIV causes Acquired Immune Deficiency Syndrome (AIDS) which is a condition diagnosed when the immune system is damaged to such a degree that it is not able to fight off infections. HIV can be present, without symptoms, for many years before AIDS appears.

Signs and symptoms
The early symptoms of HIV infection, a non specific flu-like condition, are experienced by up to half of newly infected people, but most people mistake them for flu or another viral infection:
- fever
- rash (usually on the face, neck and upper chest, but also on the scalp, arms and legs and the palms and soles)
- ulcers or open sores on the skin or mucous membranes
- sore throat
- headache
- loss of appetite
- swollen glands (enlarged lymph nodes)
- diarrhoea
- nausea and vomiting
- aching muscles and joints.

This stage is known as the acute or primary HIV infection. These symptoms can occur within a few days or weeks of the initial infection. Some people will have some of these symptoms of the infection, but others will have no symptoms at all. During this acute stage, the person with the newly acquired infection is also highly infectious and a serious danger to anyone with whom he, or she, has unprotected sex. These symptoms can last for a week or a month.

Causes
HIV can be transmitted through bodily fluids; blood, semen, vaginal fluids or breast milk of an infected person entering the body of another and allowing the virus to enter the blood.

HIV is passed from person to person through unprotected vaginal, anal or oral sex with someone who already has the infection. HIV can be spread through sharing sex toys if they are not washed or covered with a new condom each time they are used.
Intravenous drug users can also acquire the infection by sharing needles and transferring blood from one to another. HIV can also be passed from an infected mother to a child before or during birth or during breastfeeding.

The primary cause of HIV infection in Scotland is unprotected sexual activity with someone who has the infection. The highest risk groups are men who have sex with men and people from certain countries in Africa.

HIV infection continues to be one of the most important infectious diseases in Scotland. In 2008, 412 new cases of HIV were identified, this represents a 9% decrease on the 452 cases reported in 2007 - the highest annual total since records began in 1984. It is likely that some of these newly identified cases in Scotland will have been diagnosed elsewhere and their care is transferring to Scotland for the first time.

Some of the increase in new reports in recent years reflects an increase in HIV testing. While most (80%) testing is undertaken in the GUM clinic setting, testing in other health care settings is beginning to increase, particularly in the primary care setting.

**Incubation period**
HIV can be present in a body for many years before AIDS appears. During those years HIV is gradually weakening the body’s immunity until the immune system has difficulty resisting certain infections. None of these would necessarily be fatal to a healthy person, but, when the immune system is weakened due to HIV, these infections can be fatal. The early period, during which the immune system of a newly infected person is producing HIV antibodies is usually about three months but can vary from a few weeks at the very earliest, to as much as 6 months.

**Diagnosis and treatment**
Early diagnosis of acute HIV infection can be important as antiretroviral treatment may moderate the symptoms. Current HIV testing includes tests for antigens and antibodies and are often positive within a few weeks. In cases of high suspicion a viral load test may also be taken. Current HIV antibody tests are exceptionally specific and accurate. However, anyone who has had a negative test with recent risk will be advised to have a second test 3 months later.

There is no cure for HIV, or as yet any vaccine to prevent infection, but there are increasingly effective treatments which enable people with HIV to live long, active lives without succumbing to AIDS for up to 30 plus years. It is estimated that half the people with HIV will develop AIDS within ten years of being infected.

HIV is a retrovirus – it multiplies in the immune system by attacking and destroying white blood cells known as helper T lymphocytes, weakening the immune system. Drugs which inhibit this activity are known as antiretrovirals. A combination of these drugs is used to treat HIV. (Helper T lymphocytes are sometimes called CD4-positive (CD4+) T cells.)

People with an HIV infection will have regular tests to measure the level of helper T lymphocytes. A healthy person has more than 600 of these white blood cells per cubic millimetre of blood. A blood count below 300 of these cells per cubic mm is a definition of AIDS, and typically opportunistic infections and malignancy occurs at a count below 200. HIV antiretroviral treatments are recommended when the count falls below 350 towards 200.
Effects of HIV if left untreated
An untreated HIV infection will result in a further series of symptoms 8 to 10 years after the first infection. This stage is likely to be a series of opportunistic infections, as a result of the immune system becoming so weak that it is known as AIDS.

Effects on pregnant women and babies
The risk can be reduced to a minimum by early antiretroviral treatment. If the viral load is undetectable, a vaginal delivery can be attempted usually, but caesarean section is advisable if the virus remains uncontrolled or there are complications in labour.

6.2 Blood-borne viruses
There are a number of other infections which can be sexually transmitted such as the blood-borne viruses hepatitis A, B and C.

Hepatitis A, B and C
Hepatitis is a term for inflammation of the liver. The most common cause is viral infection but it can also be caused by excessive use of alcohol, some medicines and toxins.

The symptoms caused by all three viruses are very similar, but, and this is even more important, most people do not show any symptoms when first infected. When symptoms occur they include a ‘flu-like’ condition (fever), diarrhoea, vomiting and jaundice (skin and whites of the eye are yellowish and urine is dark).

All three hepatitis viruses considered here (A, B and C) cause infection when the blood of an infected person gets into the blood of a non-infected person.

Hepatitis A (known as HAV or Hep A)
HAV is transmitted by the faecal-oral route but can occasionally be transmitted by blood or sexual contact. This virus is very common in parts of the world where sanitation is poor but it is rare in the UK.

It is usually a mild infection, when there are symptoms, but in a small number of cases it can be dangerous. There is a vaccine for hepatitis A.

Hepatitis B (known as HBV or Hep B)
HBV can be spread by sharing contaminated drug-injecting equipment, from infectious mother to unborn baby and can be acquired through unprotected sexual contact with an infected person.

Condoms should be used to reduce the possibility of infection with HBV. Many people will be unaware that they have become infected with HBV as they will have no symptoms. Some people will get a ‘flu-like’ illness.

If the body does not clear the infection after 6 months, chronic infection develops. Many people who become chronic carriers will be unaware that they can transmit the infection to other people and that they themselves are at risk of liver damage.
Diagnosis of hepatitis B is from a blood test
A vaccine is available for hepatitis B which should be offered to all people who are at risk of exposure to HBV. There are antiviral treatments available for chronic hepatitis B.

Practice Point
Go to section 5.3.3 of the current edition of the BNF and note the treatment options for chronic hepatitis B.

Hepatitis C (known as HCV or Hep C)
The most common way to acquire HCV in Scotland is by injecting drugs using shared and contaminated needles and syringes etc.

HCV can be acquired through sexual contact although this is rare. Condoms are an effective way to further reduce the low possibility of infection with HCV.

Some people who get HCV will have no symptoms at all, whilst others will be acutely unwell with fatigue, weight loss, nausea, ‘flu-like’ symptoms, problems concentrating, abdominal pain and jaundice.

Over 80 per cent of people who become infected with HCV will become chronically infected. Only some people with chronic hepatitis C will show signs of the infection due to the ability of the liver to cope with serious infection. Some people will develop serious liver disease such as cirrhosis and liver cancer.

Diagnosis of hepatitis C is from a blood test. Treatment of chronic hepatitis C is with a combination of ribavirin and peginterferon alfa. Peginterferon alfa should be used alone if ribavirin is contra-indicated or not tolerated. There are new treatments for hepatitis C being developed. There is no vaccine for HCV.
Summary of learning
You should be aware of the signs and symptoms of HIV, how the infection is spread, how it is diagnosed and how it can be prevented. You should also have a basic understanding of the difference between HIV and AIDS and know that there are increasingly effective treatments available for HIV. You should be aware of other blood borne viruses such as hepatitis A, B and C infections, how they are acquired, the vaccination choices and treatment options for the chronic phases of the disease.

Reflection Points
What exactly is a retrovirus?

Where can I find out more about HIV and AIDS?

Do I need to find out more about antiretroviral therapy?

What are the treatment options for chronic hepatitis B?
Reflection Points

What are the treatment options for chronic hepatitis C?

What are the immunisation schedules for hepatitis B?

When should immunoglobulin be given to protect against hepatitis A infection?

References

1 UpToDate for Patients- HIV and AIDS http://www.uptodate.com/patients/about/toc.do?full_url_key=true&tocKey=table_of_contents/patient_information/hiv_and_aids
2 NHS National Health Services Scotland – Scotland’s Sexual Health Information – Crown Copyright 2009 available at http://www.isdscotland.org/isd/5717.html, accessed 16/01/10
3 Information supplied privately by The Sandyford Initiative to NES

Additional Resources

- The Hepatitis C Trust http://www.hepctrust.org.uk – accessed 2/10/09
Section 7 Chlamydia, testing and treatment

This section looks at your role in the testing and treatment of Chlamydia as part of the sexual health service in the community pharmacy contract. The signs and symptoms of Chlamydia are described together with the diagnosis, treatment and implications if this infection is left untreated. SIGN guideline109 is highlighted and case studies allow you to put your learning into practice.
Learning Objectives

At the end of this section, you will:

- recognise the symptoms of Chlamydia
- understand the diagnosis and treatment of Chlamydia
- be familiar with the key recommendations in SIGN guideline109
- be aware of your role in the provision of Chlamydia testing and treatment in the pharmacy contract.

Section Contents

7.1 Chlamydia: signs, symptoms and treatment
7.2 Understanding your role in testing and treatment for Chlamydia
   7.2.1 Chlamydia testing service
   7.2.2 Chlamydia treatment service
Section 7
Chlamydia, testing and treatment

7.1 Chlamydia: signs, symptoms and treatment

Currently Chlamydia is the most common and curable sexually transmitted infection in Scotland. Approximately 1 in 10 in the under 25’s have the infection. Rates of infection are highest in young people under the age of 25, and the majority of these are in men and women aged 20-24.

The number of Chlamydia diagnoses in Scotland has remained steady over the past three years; a total of 19,054 diagnoses were recorded in 2008. Consistent with previous years, there were more diagnoses in women than in men. In 2008, 72% of all genital diagnoses were in those aged less than 25. The largest increases in positive diagnoses between 2004 and 2008 were noted in men and women aged 15-19.

Diagnoses of genital chlamydia, made in all and GUM clinic settings, by gender, 1999-2008

GUM clinic diagnoses represent all diagnoses of upper and lower genital tract infection, rectal and other sites of chlamydia infection 2007 data revised since last report.
Data source: STISS and laboratory reports.
Infection with Chlamydia is usually asymptomatic

Many people who are infected with Chlamydia will have no symptoms. At least 70% of all women and half of all men will not experience any symptoms. As a consequence a large number of cases will go undiagnosed. Infected people who have no symptoms can infect a partner without knowing.

Causes
The bacterium, *Chlamydia trachomatis*, is passed from person to person through unprotected vaginal, anal or oral sex with someone who already has the infection. Chlamydia can be spread through sharing sex toys if they are not washed or covered with a new condom each time they are used. It can also be passed from mother to baby during birth. Touching the eyes with fingers which have been in contact with infected genitalia, can result in an eye infection, conjunctivitis. This is different from trachoma, which you may have heard of, which is caused by a different serovar of Chlamydia, not prevalent in the UK.

Exercise 1
What are the common risks factors for becoming infected with Chlamydia?

*Please write your answer here:*
Signs and symptoms
As stated previously, the majority of people with Chlamydia will have no signs or symptoms to indicate infection. The majority of infections will probably clear spontaneously without morbidity.

Symptoms that may be associated with chlamydia infection

<table>
<thead>
<tr>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unusual vaginal discharge</td>
<td>Discharge from the penis</td>
</tr>
<tr>
<td>Pain on urinating</td>
<td>Burning with urination</td>
</tr>
<tr>
<td>Bleeding after intercourse</td>
<td>Swollen and/or painful testicles</td>
</tr>
<tr>
<td>Bleeding between menstrual periods</td>
<td>Reactive arthritis</td>
</tr>
<tr>
<td>Abdominal or pelvic pain</td>
<td></td>
</tr>
<tr>
<td>Reactive arthritis</td>
<td></td>
</tr>
</tbody>
</table>

Where there are signs or symptoms they are mild, non-specific and short-lived. The symptoms of Chlamydia, when they do occur, can take from 7 to 21 days to appear from the time of infection.

Effects of Chlamydia if left untreated
Diagnosis and treatment are important due to the long-term consequences of untreated infection. In a proportion of women, chronic inflammation leads to scarring and damage to the fallopian tubes and surrounding tissues. This may lead to ectopic pregnancy and infertility. In the absence of treatment, 10-40% of infected women will develop pelvic inflammatory disease (PID) and the risk of developing PID increases with each recurrent infection.

There is also the possibility of perinatal transmission to infants.

Of women diagnosed at GUM clinics, 1.3% had ‘complicated Chlamydia’ defined as upper genital tract or pelvic infection: this form of infection was most prevalent among women aged under 25. In men, complications are less common, but Chlamydia can lead to epididymitis; pain and swelling around the testicles which may reduce fertility.

Of men diagnosed at GUM clinics, 6% had rectal Chlamydia infection which is a marker of unsafe anal intercourse and can increase the risk of HIV transmission.

Diagnosis
Recently, new laboratory tests have been developed allowing non-invasive testing for Chlamydia. Chlamydia can now be easily and quickly diagnosed from a urine sample tested by a microbiology laboratory. Previous diagnostic procedures required cervical or urethral swabs and these invasive techniques may have prevented people from being tested.

You should reassure all patients who may be concerned about a Chlamydia infection that the test is simple, painless and reliable.
Choice of test
All Scottish microbiology laboratories use nucleic acid amplification assays (NAATs) to diagnose Chlamydia infection. SIGN 109 guidelines recommend that either single or dual (combined with gonorrhoea) tests can be used to test for Chlamydia infection.

Practice Point
What is the name of the test used locally? Does it also test for gonorrhoea? Why did they choose this test?

Testing
Chlamydia testing is currently carried out across Scotland in a variety of healthcare settings with most being carried out in general practice.

There is no national screening programme in Scotland as there is no evidence that screening for Chlamydia is cost effective with regard to reducing morbidity. However, individuals may suffer intermediate and long term harm. In August 2008, one case of the new variant Chlamydia trachomatis (nvCT) was identified in Scotland and as a result Chlamydia testing laboratories have introduced assays which detect both the normal and new variant strains.

SIGN 109 recommends that testing should be targeted at individuals known to belong to groups with the highest prevalence of infection. A reduction in Chlamydia prevalence should minimise the risk of transmission of infection.

Targeted groups are:
- sexual partners of Chlamydia positive individuals
- women aged 15-19 first and then those aged 20-24
- men aged under 25 years
- people who have had two or more sexual partners in the last 12 months
- people previously diagnosed with Chlamydia
- GUM clinic attendees
- all women undergoing termination of pregnancy
- all MSM attending GUM clinics.

Treating Chlamydia
If caught early, most Chlamydia infections are easily and quickly treated. SIGN 109 recommends treating uncomplicated Chlamydia in men and non-pregnant women with a single dose of azithromycin 1g or doxycycline 100mg twice daily for seven days. Taking compliance into account, treatment with a single dose of azithromycin may be the preferred treatment choice. In symptomatic patients, laboratory confirmation of infection is required before starting treatment.
Exercise 2
What is the treatment of choice for uncomplicated infection in pregnancy?

*Please write your answer here:*

**Partner notification**
Individuals diagnosed with Chlamydia must receive a partner notification interview.

The treatment of sexual contacts prior to continuation of sexual intercourse is the strongest predictor for preventing re-infection².

Individuals should be given a choice of the method of partner notification:
- **patient referral**, when an individual advises their sexual contacts to seek treatment
- **provider referral**, where a healthcare provider advises an individual’s contacts anonymously that they should seek treatment
- **conditional referral**, where a person tries to contact their partner/ex-partner. If unsuccessful, they agree to a health advisor taking on provider referral.
In men with symptomatic Chlamydial infection, all partners from six months prior to onset of symptoms should be contacted. In women and asymptomatic men, all partners from the last six months or the most recent sexual partner (if out with this timeframe) should be contacted.

**Follow up**
A repeat test is usually not required following treatment with azithromycin or doxycycline in individuals who have adhered to therapy and in whom there is no risk of re-infection. A test of cure, however, should be routine in pregnancy.

A test of cure or re-infection should be carried out a minimum of five weeks after the initiation of therapy (six weeks in the case of azithromycin) to avoid false positive results.

Test for re-infection should be recommended at 3-12 months or sooner if there is a change of partner.

### 7.2 Understanding your role in testing and treatment for Chlamydia

The testing and treatment of Chlamydia complements the provision of Emergency Hormonal Contraception (EHC) as part of the sexual health service element of the community pharmacy contract and allows you to offer a more holistic service to this group of individuals.

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**Exercise 1**
What do you feel are the benefits of providing this sexual health service in your pharmacy?

*Please write your answer below:*

**For you**

**For your patient**

**For your local Health Board area**
7.2.1 Chlamydia testing service

The Chlamydia testing service is targeted at asymptomatic sexually active males and females between the ages of 15 to 24 years of age. Pharmacies should provide Chlamydia testing kits to individuals requesting a test or for example when:

- a young person purchases condoms
- you dispense oral contraceptive pills
- you supply EHC.

**Exercise 4**

What are the best predictors of asymptomatic infection?

*Please write your answer here:*

**Risk assessment**

You may be asked to complete a short sexual history screening form to identify high risk individuals requiring referral to Specialist Sexual Health Services.

For more information on taking a sexual history go to Section 3
Consent
Informed consent must be obtained from an individual or their guardian before undertaking any test.

Further information is available in RPSGB ‘Professional Standards and Guidance for Patient Consent’ and Section 2.

Young people less than 16 years of age should be provided with the service if deemed Fraser competent and in line with The Age of Legal Capacity (S) Act 1991, s2 (4) (refer to Section 2).

You should explain the benefits of testing and advise individuals:
- on how to use the kit
- on how to return it for testing
- what will happen following completion of the test (in line with any local arrangements).

In addition, pharmacists (or their staff) should provide support and advice to people accessing the service including:
- advice on safer sex
- condom use
- signpost individuals to c: card registration sites
- advice on the use of regular contraceptive methods
- referral to a local specialist health service (GUM clinic) to seek a full sexual health screen if a person:
  - is showing symptoms
  - may have another sexually transmitted disease
  - is identified as high risk for any blood borne virus.

You and your staff may inform people of their results, undertake contact tracing and/or offer treatment with azithromycin in line with the requirements of the National Patient Group Direction (PGD) and any local modifications. However, in some Health Board areas, partner notification will be done by health advisors as it may be quite complex and extremely time consuming.

Practice Point
Find out about your local arrangements for partner notification/contact tracing.
You need to be aware of, and link, into existing local networks of agencies (including specialist sexual health services) so that there is a robust and rapid referral pathway for people who need access to further treatment and services if needed.

Your local Health Board area will provide up to date details of other services which pharmacy staff can use to signpost people who require further assistance. Some Health Boards have included this information in their local PGD for the supply of azithromycin. Your local Health Board will also coordinate the promotion of the service locally, including the provision of health promotion materials and leaflets on STIs, EHC and contraception.

**Practice Point**

Find out about your local referral pathway for people less than 16 years of age who present for screening and who are not deemed to be Fraser competent.

### 7.2.2 Chlamydia Treatment Service

This service is available in pharmacies for any individual aged 13 years or over with a laboratory confirmed positive Chlamydia diagnosis and any current sexual partners aged 13 or over.

The pharmacist supplies azithromycin treatment as a single 1gram dose. This service is supported by a National Patient Group Direction and must be delivered by the pharmacist in person. For further information on the service specification go to [http://www.communitypharmacyscotland.org.uk](http://www.communitypharmacyscotland.org.uk).

Some local Health Board areas have included additional information about child protection issues and details of local sexual health services and procedures in their local PGDs.

**Practice Point**

Find out if your local Patient Group Direction has any additional information related to local procedures and services. Do you need to update your SOP to incorporate this information?
Exercise 5

The following statements refer to the inclusion criteria for the supply of azithromycin.

Answer true or false.

1. Consent is not needed if an individual is over 16 years of age.

2. You may supply azithromycin to a person who presents in your pharmacy with a positive test result and urinary tract symptoms.

3. You may supply treatment to a person who has previously received treatment for Chlamydia and has had unprotected sex with an untreated partner.

Consent

Prior to supplying azithromycin, consent, preferably in writing, must be obtained either from the individual, parent, guardian or person with parental responsibility.

A person under 16 years of age may give consent for the supply of azithromycin, providing he or she fully understands the benefits and risks involved. Where there is no parental involvement, and they wish to go ahead with the supply, then you should supply the treatment if you think that the young person concerned has the legal capacity to consent. For further details, refer to Section 2.

Assessing suitability for treatment

Pharmacists must assess the suitability of the person to receive azithromycin treatment to ensure that the treatment is safe and appropriate. All individuals regardless of age should be assessed.

You need to ensure that the individual:

- has a positive diagnosis
- is a sexual contact or has had sexual intercourse with an untreated partner
- is not allergic to azithromycin, erythromycin or clarithromycin
- is not pregnant or breastfeeding
- meets the inclusion and exclusion criteria of the local NHS board PGD
- is not taking an interacting medicine.
Pharmacists can then supply azithromycin 1 gram as a single oral dose using the Community Pharmacy Urgent Referral form (CPUS). Ideally the dose should be supervised, but you can supply an individual with azithromycin to take at a later time.

You must ensure that appropriate records are kept for each supply. You should also tell individuals how the information will be stored, who will access the information and how it may be used.

**Practice Point**

Look up Section 7.3.1 in the current edition of the BNF for specific advice on interactions with combined hormonal contraceptives.

You should also advise individuals to:

- contact all recent (within the last 6 months) sexual partners to tell them of the need to be tested (and treated if necessary)
- Practise safer sex and give them verbal and written advice on safer sexual practices, including condom use
- contact local specialist services for further advice and treatment if needed
- be re-tested in 3-12 months although local PGDs may state 6 months.

It is important that any current partner is treated at the same time. If this is not possible, then the individual should be advised to refrain from any sexual activity at all from when he/she is treated until 7 days after their current partner has been treated.

**Referral criteria**

You should refer individuals who:

- seek re-treatment after having vomited the previous dose within 3 hours of taking azithromycin
- present within 3 months of previous treatment
- have symptoms that indicate another sexual infection.

For more detailed referral criteria see Appendix 1, Section 3 - An example of a Chlamydia Testing Screening Form.
Core skills and Training
Pharmacists and staff involved in the provision of the service must have relevant knowledge and be appropriately trained in the operation of the service, including sensitive patient-centred communication skills. You also need to be aware of local and national guidance on safeguarding children.

Practice Point
Find out if your local Health Board or NES are providing any additional training. Your own company may also provide specific training.

Standard Operating Procedures
Pharmacy contractors must have a standard operating procedure in place for both elements of this service. Community Pharmacy Scotland (http://www.communitypharmacyscotland.org.uk) has developed a Chlamydia treatment standard operating procedure which you can modify for your own use.

You must ensure that all pharmacists and staff involved in the provision of this service are aware of, and operate within, national and locally agreed protocols.

Practice Point
Look up Section 8 of Sign Guideline 109 (http://www.sign.ac.uk/pdf/sign109.pdf)

There is a checklist of the key issues that are likely to be of most concern to individuals when discussing Chlamydia. You may wish to adapt this checklist and incorporate some of the points into your Standard Operating Procedure.
Case study 1

A young woman, about 25 years old, asks one of your pharmacy assistants if she can have a confidential chat with you. In the interview area she says that she has a vaginal discharge and has been experiencing some pain when urinating. She tried an OTC treatment for thrush and it made no difference, and she has also tried an OTC treatment for cystitis. What should you do?

Please write your answer here:
Case study 2

A 17-year-old male walks into your pharmacy visibly embarrassed. He confides that three girls with whom he had casual sex have accused him of being the cause of their STI. He says they went to their GPs and were told they had Chlamydia. He states he has no symptoms and is too frightened to go to his GP. He has the additional concern that the examination procedure may cause him pain and discomfort. How would you respond?

*Please write your answer here:*
Case study 3

A young woman presents a prescription for a seven-day course of doxycycline. When you are handing over the medicine she asks for a box of twelve condoms. What should you do?

*Please write your answer here:*
Summary of learning

Genital Chlamydia remains the most common bacterial STI in Scotland. Approximately 1 in 10 in the under 25’s have the infection. Rates of infection are highest in young people under the age of 25, and the majority of these are in men and women aged 20-24. The largest increases in positive diagnoses between 2004 and 2008 were noted in men and women aged 15-19 years.

Most people infected with Chlamydia are asymptomatic and may be unaware of their infection. Chlamydia may have serious long term consequences. It has been implicated in pelvic inflammatory disease which may lead to ectopic pregnancy and reduced fertility in women and has also been associated with fertility problems in men. If caught early, most Chlamydia infections are easily and quickly treated.

The Chlamydia testing service in the community pharmacy contract is targeted at asymptomatic sexually active males and females between the ages of 15 to 24 years of age.

Reflection Points

How can I deliver this service to maximise the uptake of screening and of treatment in my target population?

Will my local Health Board area provide additional training for both myself and my staff?

Are there any additional learning resources available?

Do I need to update my SOP?
References

1  Scotland’s Sexual Health Information 2009. Health Protection Scotland and Information Services Division, November 2009


4  Toth.А (2004) Fertile vs infertile: how infections affect your fertility and your baby’s health, Fenestra Books

Additional Resources

1  RPSGB Practice Guidance: Diagnostic Testing and Screening Services, March 2009 http://www.rpsgb.org/


3  Community Pharmacy Scotland website for details of the National Pharmaceutical Services specification for the Sexual Health Service in the pharmacy contract and the public health service in general http://www.communitypharmacyscotland.org.uk

4  Websites providing information on Chlamydia prevention, testing, treatment and follow up: all accessed (03/09/09)
   • http://www.brook.org.uk
   • http://www.cdc.gov/std/Chlamydia
   • http://www.engenderhealth.org
   • http://www.healthyrespect.co.uk
   • http://www.patient.co.uk
   • http://www.fpa.org.uk/Information/Factsheets
Answers

Exercise 1
Age under 25 years.
New sexual partner in the last year.
Inconsistent use of condoms.

Exercise 2
Taking compliance, tolerability and efficacy into account, azithromycin 1 g as a single oral dose is recommended for uncomplicated genital Chlamydia infection in pregnancy following discussion of the balance of benefits and risks with the patient.

Exercise 3
For you
Increased knowledge about STIs and the risks associated with them.
Develop public health skills.
Multiagency working.
Increased professional satisfaction.

For your patient
Increased knowledge of the risks associated with STIs.
Increased access to treatment of Chlamydia infection with azithromycin.
Increased access to sexual health advice and referral on to specialist services if needed.
Reduction in the long term consequences.

For your local Health Board area
Increased access to screening and treatment.
Increased diagnosis and treatment.
Increased access for young people, to sexual health advice and referral on to specialist services if needed.
To strengthen the network of contraceptive and sexual health services to help provide easy and quick access to advice.
Reduction in the long term consequences.
Achieve NHS QIS targets for Chlamydia testing.

Exercise 4
Age and sexual behaviour are the best predictors of asymptomatic infection.

Exercise 5
False
False
True
Answers

Case Study 1
Given her age it is likely that she has an active sex life. You need to ask her gently and carefully about her social, and then sexual life, and, if it is possible that she may have acquired an STI, you should advise her to go to see her GP or to visit a GUM clinic as soon as possible. You should be able to tell her where and when the local clinic is open. You also need to assure her that the diagnosis and treatment is simple and straightforward, that she will be asked about her sexual partners and that they will need to be contacted so that they can also be treated. This can be done by the clinic. You may also wish to give advice about safer sexual practices.

Case Study 2
You should provide this young man with a Chlamydia testing kit. Reassure him that the test is simple and easy to use and that Chlamydia can now be detected from a urine sample. You should explain the benefits of testing and advise him on how to use the kit, return it for testing and explain what will happen following completion of the test.

You also need to reassure him that treatment is also straightforward. The importance of seeking treatment should be emphasised in order to avoid disease progression, complications and further transmission, as well as to eliminate any presenting symptoms. He should be advised to refrain from all sexual activity until test results are known. It would do no harm to emphasise the importance of safer sex and encourage him to use condoms.

Case Study 3
You should ask her if she has time to have a brief discussion with you about her medicine in a private area of the pharmacy. Ask her if she knows what the doxycycline is for and if she is happy to discuss this with you. You should remind her that she should refrain from all sexual activity during the course of the treatment and for seven days afterwards to prevent re-infection. You should reinforce the messages about safer sex and give her a leaflet about the local sexual health clinics for further advice and treatment if necessary. You may also wish to signpost her to c:card registration sites. You should advise her to be re-tested within 3-12 months or sooner if she has a change of partner.
Section 8 Emergency Hormonal Contraception (EHC)

This section takes a brief look at some of the clinical aspects of providing EHC and outlines the main aspects of providing this service in the community pharmacy contract. It is not designed to train pharmacists on the supply of EHC. A separate NES/CPPE pack is available, which covers this topic in much greater depth.
Learning Objectives

At the end of this section, you should be able to:

• list at least three reasons why emergency contraception is requested
• describe the main side effects of EHC
• be aware of the contraindications and cautions of EHC
• understand the key elements of your role in the provision of EHC in the pharmacy contract.

Section Contents

8.1 Background
8.2 Types of emergency contraception
8.3 Understanding your role in providing emergency hormonal contraception (EHC) within the National Patient Group Direction
Section 8
Emergency Hormonal Contraception (EHC)

8.1 Background
Unplanned pregnancy is an issue for all women of child bearing age. Statistically, most unplanned/unwanted pregnancies and sexually transmitted infections occur in the 18-29 years age group.

The UK has the highest teenage pregnancy rate in Western Europe and successive governments have targeted its reduction. The National Sexual Health Strategy for Scotland\(^1\) includes the target to reduce the under-16 conception rate by 20 percent by 2010. As part of this strategy, the sexual health service of the community pharmacy contract allows pharmacists to supply levonorgestrel (EHC) free of charge to girls aged 13 years or over using a National Patient Group Direction.

Teenage pregnancy
Groups\(^2\) more vulnerable to becoming teenage parents include young people who are:
- in or leaving care
- homeless
- underachieving at school
- children of teenage parents
- members of some ethnic groups
- involved in crime
- living in areas with higher social deprivation.

Teenage mothers are more likely to suffer from complications, for example, pregnancy-induced hypertension and low-birth-weight babies, and are more likely to experience adverse outcomes for themselves and the child – socially, economically, and in terms of their health status. Available figures show the number of teenagers having sex below the age of sixteen is steadily increasing. However, it should be noted that the average age of first intercourse in the UK is not noticeably different from that reported by any other European country, yet these countries have lower rates of teenage pregnancy. A suggested reason for this is the failure of UK teenagers to use contraception\(^3\). There is also a trend for the children of teenage mothers to become teenage mothers themselves.

Contraceptive knowledge was low in this age group, with 39% afraid of using contraceptives. It should be remembered that in relation to adolescent sexual health, young people are more susceptible to some STIs, and this group is also likely to have more sexual partners.
Emergency Hormonal Contraception
Enabling rapid access to EHC offers a method of contraception for women of all ages who might need it. Since EHC became available for sale from pharmacies, research has shown that women believe pharmacies are a suitable place for its supply and are happy with the advice they have been given. The research also demonstrates that pharmacists have not been judgemental.

There are two routes of supply of EHC through community pharmacy. First is the sale as a pharmacy medicine, the second through a National Patient Group Direction. It should be noted that the product licence of the OTC product is for patients over the age of 16 years and it should not be sold to individuals under this age.

Under the direction of the National PGD, the POM pack of EHC can be supplied, and the age group of patients that can receive the EHC is lowered to 13 years. It also allows the supply to be made on the NHS.

8.2 Types of emergency contraception
There are three methods of emergency contraception available in the UK. These are:

1. Non-hormonal releasing intra-uterine device (IUD)
2. Synthetic selective progesterone receptor modulator (ulipristal acetate,EllaOne®)
3. Progesterone-only emergency hormonal contraception.

All methods of emergency contraception exert their effects before implantation takes place; hence the considered clinical opinion is that neither the IUD nor the hormonal method should be considered as abortifacients.

1. **Non-hormonal releasing intra-uterine device (IUD)**
   As the copper IUDs have to be fitted, these are not available at pharmacies. They may be used up to 120 hours (5 days) after unprotected sexual intercourse. It works by stopping sperm from reaching an egg. The IUD has almost a 100% success rate. They can be left in place as a future method of contraception. It is also the preferred option in women taking liver enzyme inducing drugs who require emergency contraception.

2. **Synthetic selective progesterone receptor modulator**
   The treatment consists of one tablet to be taken orally as soon as possible, but no later than 120 hours (5 days) after unprotected intercourse or contraceptive failure. It can be taken at any moment during the menstrual cycle. If vomiting occurs within 3 hours of ulipristal intake another tablet should be taken. Pregnancy should be excluded before ulipristal is administered.

Go to electronic medicines compendium for further information on ulipristal acetate
[http://www.medicines.org.uk/emc](http://www.medicines.org.uk/emc)
3. Progesterone-only emergency hormonal contraception
Levonorgestrel 1.5mg standard dose is available at pharmacies, GP surgeries and Sexual and Reproductive Health Clinics. The opening hours of services may vary considerably between areas, thus collaboration of services will ensure competent and patient-friendly availability of EHC. Enabling rapid access to EHC offers a method of emergency contraception for women of all ages who might need it.

This pill can be taken up to 3 days after sex and prevents up to 95% of pregnancies if taken within 24 hours. However, the later the emergency contraceptive pill is taken the less effective it is. For example, if the pill is taken between 24-48 hours there is an 85% chance of preventing pregnancy. After 72 hours only 58% of pregnancies will be prevented.

Lack of awareness of this time period could lead to women delaying treatment and thus reducing its efficacy, or not starting it at all if they think that they are too late to start. Occasionally levonorgestrel is prescribed after 72 hours have elapsed, this is unlicensed and evidence of efficacy is lacking.

Emergency hormonal contraception is thought to possibly work by several routes. The most likely method currently is that levonorgestrel delays, or possibly inhibits, ovulation.

Indications for emergency hormonal contraception
Progesterone-only EHC is indicated for:
- emergency contraception within 72 hours of unprotected sexual intercourse
- failure of a contraceptive method
- risk of conception while advised to avoid pregnancy.

Assessing the risk of pregnancy from missed oral contraceptive
You should refer to the relevant section in the current BNF. This advice varies and it is essential that you consult the BNF for the most up-to-date guidelines. It is also important that you are aware that the advice is dependent on the type of oral contraceptive used by the patient.

See BNF Section 7.3 for more information.
Contraindications and cautions
There are few situations in which EHC cannot be safely recommended. The only contraindications for women are:
- hypersensitive to levonorgestrel
- suspicion of pregnancy, as it will not work.

It should be used with caution in women who:
- currently have breast cancer
- have severe hepatic dysfunction
- have severe malabsorption syndromes, severe diarrhoea or Crohn’s Disease
- have a lactose intolerance
- take liver enzyme inducing drugs.

Exercise 1
What advice would you give to a mother who was breastfeeding her baby?

Please write your answer here:
**Side effects of EHC**

The most likely side effects of EHC are nausea and/or vomiting and effects on the next period. In trials, 23% of women felt nauseous and between 5-6 % actually vomited. If the woman vomits within three hours of taking levonorgestrel, there will not be full absorption of the drug and the efficacy will be impaired.

**Exercise 2**

What advice would you give to someone who vomits soon after taking the EHC pill?

*Please write your answer here:*

Because levonorgestrel is not 100% effective, the woman should have a pregnancy test if her next menstruation is more than 5–7 days late, if bleeding is lighter than usual, or if she feels that she might be pregnant."
Interactions
Levonorgestrel is metabolised in the liver. Drugs that induce liver enzymes will therefore increase its metabolism and may reduce its effectiveness. Pharmacists need to be aware of these interacting drugs and refer women to their GP or Sexual and Reproductive Health Clinic.

These drugs include:
- anticonvulsants, (carbamazepine, phenytoin, phenobarbitone, primidone)
- rifampicin and rifabutin
- griseofulvin
- ritonavir
- St John’s Wort.

Levonorgestrel may also increase the toxicity of ciclosporin due to possible inhibition of ciclosporin metabolism.

Practice Point
For further information on drug interactions with progestogens, read Appendix 1 in the current edition of the British National Formulary (BNF) or Stockley’s Drug interactions.

Advance supply of EHC
The RPSGB is not against the advance supply of EHC in principle. You need to use your professional judgement to consider whether the supply is appropriate. The licensing conditions do not prohibit supply as a standby in case of unforeseen unprotected sex or condom failure.

Repeated requests for EHC
There is no limit to the number of times a woman can take EHC. No serious side effects have been reported from repeated use of levonorgestrel as EHC and no evidence that women turn to EHC as an alternative to regular contraception. There is no reason for a pharmacist to refuse a repeat supply of EHC simply because it is a repeat request. However repeated requests suggest that you may wish to give advice on conventional methods of contraception and explain that repeated use is also likely to disrupt the menstrual cycle.

Third party requests
Supply to a third party should only be made in exceptional circumstances. In the case of EHC, it is unlikely that another person would be able to provide you with the type and detail of information needed for you to make a supply.
Religious and moral objections to supply
A pharmacist may refuse to provide EHC on grounds of religious and moral beliefs. They should, however, as stipulated in the Medicines Ethics and Practice guide, provide information about where the service is available.

Privacy and confidentiality
A pharmacist’s duty of confidentiality is outlined in Part 2 of the Code of Ethics. People using pharmacies are entitled to a confidential consultation with their pharmacist. A pharmacist should personally deal with all requests for EHC and it is important that women are able to discuss a request for EHC in privacy.

Rape or sexual assault
If, when seeking information to deal with requests for EHC, it appears that risk of pregnancy has arisen from rape or sexual assault, as these are criminal offences, the woman should be encouraged to report such matters to the police without delay. However, if she is a “competent adult” then her wishes to keep the matter confidential should be respected.

If the patient is under 16, then there are expectations in the Children Act 2004 that all health professionals will develop local procedures that will guide the action needed in the event that a suspect rape or sexual assault has been identified. It is important that you check with your local Health Board for the local policy and contact numbers should this situation arise.

8.3 Understanding your role in providing Emergency Hormonal Contraception (EHC) within the National Patient Group Direction
In October 2008, NHS Scotland produced a National Patient Group Direction (PGD) for the provision of Emergency Hormonal Contraception by pharmacists.

The PGD covers the supply of levonorgestrel 1500 micrograms (Levonelle® 1500) for use by females who are aged 13 years or over within 72 hours of unprotected sex. This service must be provided by the pharmacist in person and follow the procedure set out in Section 3 of Appendix A in the service specification.

Further information can be found at http://www.communitypharmacyscotland.org.uk
Assessing suitability for treatment

Every female must be assessed to find out the need for EHC. You must ensure that:

- unprotected sexual intercourse has occurred within the last 72 hours and has not previously occurred within this menstrual cycle
- she is not already pregnant
- she meets the inclusion and exclusion criteria of the PGD
- she is not taking an interacting medicine.

The pharmacist can then prescribe levonorgestrel 1.5mg tablet on the CPUS form and counsel her as described in the PGD. Details of each supply should be recorded in your Patient Medication Record (PMR).

You must provide support and advice to all individuals using the service, including advice on sexually transmitted infections and future contraceptive needs. It is important to link into existing local networks so you can direct women to services that provide long term contraceptive methods and diagnoses and management of STIs.

All females excluded from the PGD criteria should be referred to a local Sexual and Reproductive Health Clinic or GP practice that will help them as soon as possible.

You must contact your local Child Protection Team for girls of 12 years and under, who come into your pharmacy having had sexual intercourse.

An example of a detailed proforma outlining all the data that must be recorded with each supply is provided as part of the National PGD. Many Health Boards have modified this form for their own use. Community pharmacy Scotland have also developed an Aide Memoire to help you provide this service.

Further information can be found at [http://www.communitypharmacyscotland.org.uk](http://www.communitypharmacyscotland.org.uk)

**Standard Operating Procedures**

Pharmacy contractors must have a standard operating procedure in place for both elements of this service. Community Pharmacy Scotland ([http://www.communitypharmacyscotland.org.uk](http://www.communitypharmacyscotland.org.uk)) has developed an EHC standard operating procedure which you can modify for your own use.

You must ensure that all pharmacists and staff involved in the provision of this service are aware of, and operate within, national and locally agreed protocols.

**Consent**

Informed consent, preferably in writing, must be obtained from the individual, her parent, guardian or person with parental responsibility before supplying levonorgestrel.

Further information is available in RPSGB ‘Professional Standards and Guidance for Patient Consent’ and Section 2.
Females less than 16 years of age should be provided with the service if deemed Fraser competent and in line with The Age of Legal Capacity (S) Act 1991, s2.

You should also inform individuals on how the data on the supply will be stored, who will access that information and how it may be used.

**Advice**

You should discuss the mode of action, failure rate and possible effects on the foetus with levonorgestrel. Pregnancy should be excluded before a supply is made. Additional advice on the following should be given:

- the use of a barrier method of contraception until her next period
- highlight that her next period may be early or late but most women have a normal period at the expected time
- if she vomits or has serious diarrhoea within three hours of taking the medication, she should seek advice immediately
- suggest that she makes an appointment with either her GP or Sexual Health and Reproductive Clinic to discuss her ongoing contraceptive needs
- encourage women with diabetes to monitor blood glucose levels closely
- promote the use of condoms in the prevention of STIs
- she can be tested and treated for Chlamydia at a subsequent consultation (see below)
- give her details of local agencies that can provide access to further treatment and services if needed.

**Testing for Chlamydia** should not be done until two weeks after unprotected intercourse since the test will not detect infection acquired until that point.

**Core skills and Training**

Pharmacists and staff involved in the provision of the service must have relevant knowledge and be appropriately trained in the operation of the service, including delicate, patient-centred communication skills. You also need to be aware of local and national guidance on safeguarding children.

Staff need to be aware that all requests for EHC should be referred to the pharmacist early on in the consultation.
Practice Point
Find out if your local Health Board or NES are providing any additional training. Your own company may also provide specific training.

Summary of learning
Unplanned pregnancy is a particular issue for women in the 18-29 years age group.

Levonorgestrel is a highly effective emergency contraceptive with an acceptable side effect profile. Levonorgestrel 1.5 mg is licensed as a P medicine for women over 16 years old but can be supplied to females aged 13 years and over using the National Patient Group Direction. It should be taken within 72 hours of unprotected intercourse. There are few situations in which EHC cannot be safely recommended. The drug increases the toxicity of ciclosporin while drugs that induce liver enzymes such as carbamazepine may reduce the efficacy of levonorgestrel.

There is an alternative to EHC in the form of an intra-uterine device (IUD) which needs to be fitted. Pharmacies need to know where this service is provided locally.

Reflection Points
Will my local Health Board provide additional training for both myself and my staff?

Are there any further learning resources available?

Do I need to update my SOP?
References


Additional resources


- RPSGB practice guidance for pharmacists on the supply of EHC as a P medicine is available at [http://www.rpsgb.org/pdfs/ehcguid.pdf](http://www.rpsgb.org/pdfs/ehcguid.pdf) – accessed 19/09/09

- Updated advice on supply in advance of need is available at [www.rpsgb.org/pdfs/pr061218.pdf](http://www.rpsgb.org/pdfs/pr061218.pdf) – accessed 19/09/09

- fpa (Scotland) for information on any aspect of contraception [http://www.fpa.org.uk](http://www.fpa.org.uk)

Answers

Exercise 1
Only small amounts of levonorgestrel appear in breast milk. Any potential problem can be overcome by advising the mother to take a dose immediately after feeding and not feeding the baby for at least three hours after taking a dose.

Exercise 2
Advise the individual that a replacement dose should be taken as soon as possible or a copper IUD may be fitted instead.
Section 9 Resources
Learning Objectives

At the end of this section, you should be able to:

• access the National Sexual Health Website
• download your local health service strategy
• list at least five of the key organisations and agencies with an interest in sexual health and wellbeing in Scotland
• signpost people to sexual health services in their locality.
Introduction
The information resources about sexual health that you may need in your pharmacy will depend on the community you serve. Take two extreme cases: some pharmacists will require information for all ages if they work in an urban community, such as: Nicholson Street, Edinburgh; Byres Road, Glasgow; Perth Road, Dundee, with a mix of families with young children, teenagers, students, young adults and older people, while other pharmacists will require much less information and be asked for it much less often, especially if they serve small settled communities with few young people, a large number of households with two adults and an ageing population.

The resources you can find to support your local community are dependent on what the local Health Board provides.

Depending on where you are working and whether your NHS Board has implemented its sexual health strategy, you can obtain a supply of advice leaflets and information on services and clinic times. Some web sites not only give addresses, phone numbers and days and times of opening but also give good advice and provide links to other sources of advice and information.

Printed Information
All NHS boards will produce leaflets covering health promotion with sexual health topics. The procedures for ordering and locations of storage will vary depending upon the local NHS Board policy. It is important that each pharmacy is aware of the local ordering procedures and uses them accordingly.

C:card scheme (free condom distribution scheme)
This scheme distributes free condoms to young people (in some areas it operates for under 25s only, but Glasgow has no upper limit) once they have registered by giving their age and the first part of their postcode. There are two parts to the scheme enabling distribution to over 16s, and distribution to under 16s. With the younger age group distribution only takes place at the same time as an advice and counselling session.

You should take the opportunity to find out as much as possible about your local condom distribution scheme and consider joining it as part of the local sexual health service.
National Sexual Health Website

The National Sexual Health website has a range of resources and advice to help members of the public and the healthcare professional. The contact details of local services can be found by pressing the ‘Get Help’ icon from the home page of this website http://www.sexualhealthscotland.co.uk This website also has details about the WISH programme which supports professionals by producing resources to encourage better knowledge and understanding of sexual health issues.

Scottish Government

The government is responsible both for NHS Scotland and for the development and implementation of health and community care policy in Scotland (including the National Sexual Health Strategy, Respect and Responsibility). The department is also responsible for social work policy, community care and voluntary issues.

http://www.scotland.gov.uk/Topics/Health/health/sexualhealth

This is a very useful website which links into all the local Health Board strategies, key policy documents and provides details and links to some of the key organisations and agencies with an interest in sexual health and wellbeing in Scotland.

The Royal Pharmaceutical Society of Great Britain (RPSGB)

RPSGB Sexual Health toolkit looks at pharmacy contributions to sexual health and supports the integration of pharmacy into care pathways for sexual health. Section 6 deals specifically with policies and standards in Scotland while Section 9 has a summary of key resources that you might find useful. It is available at http://www.rpharms.com

Summary

The resources you can draw together to provide information about sexual health are partly dependent on the provision by your local area Health Board, and your own imagination. You need to find out what is provided locally in terms of services: Sexual Health and Reproductive clinics, GUM clinics, drop-in centres for young people, the availability of condom distribution points, and what sources of information are available: leaflets, help lines, websites.

Research on the internet about what is provided locally will enable you to identify up-to-date sources of information that young people especially will often prefer to access, as this type of information is not only more accessible and but also more private than leaflets.

You may also decide to develop links with the other professional services in your own area; GPs, health visitors, police, social work, local GUM and sexual health and reproductive clinics. It may be possible to develop a team approach which will enable advice, services and other resources involving sexual health to be offered directly to communities and young people, rather than waiting for them to make the first step.
Multiple choice questionnaire
Congratulations

You have now made it to the end of the pack.

However, we require one more task of you – to complete the attached self-assessment questionnaire. This allows you to test your understanding of the package and to receive feedback on the answers.
Multiple choice questionnaire

- Please answer the following questions by ticking the appropriate box.

1. Sexually transmitted infections (STIs) in Scotland:
   a) About 25% of all acute STI diagnoses are in people less than 20 years old
   b) Chlamydia is the most frequently diagnosed bacterial STI
   c) There has been an increase in the number of diagnoses of gonorrhea in men in the last few years
   d) The number of Chlamydia diagnoses in Scotland has increased rapidly in the last three years

2. Teenage pregnancies:
   a) Reducing teenage pregnancies by 20% between 1995 and 2010 is one of the Scottish Executive’s targets.
   b) The teenage pregnancy rate in Scotland has been increasing steadily over the past decade.
   c) Teenagers in the least deprived parts of the country are more likely to become pregnant than their counterparts in the most deprived areas.
   d) Most unplanned pregnancies occur in the 18-29 years age group.
3. **Respect and Responsibility: a Strategy and Action plan for Improving Sexual Health in Scotland:**

a) Scotland’s sexual health strategy is loosely based on the principles of respect.  
   - **true**  
   - **false**

b) The strategy aims to encourage a more positive view of relationships and sexual health.  
   - **true**  
   - **false**

c) The Wellbeing in Sexual Health (WISH) programme, works closely with local NHS Boards to implement the national sexual health strategy.  
   - **true**  
   - **false**

d) NHS Quality Improvement Scotland (NQIS) published eight standards for sexual health services in 2008.  
   - **true**  
   - **false**

4. **Competency and Consent:**

a) An individual must be approached for consent for it to be considered explicit.  
   - **true**  
   - **false**

b) Implied consent is usually clear from a person’s actions.  
   - **true**  
   - **false**

c) A person under 16 does not have the legal capacity to consent to the supply of Emergency Hormonal Contraception (EHC).  
   - **true**  
   - **false**

d) Explicit consent must be given in writing.  
   - **true**  
   - **false**

5. **HIV infection:**

a) HIV retrovirus progressively destroys CD4 –positive lymphocytes.  
   - **true**  
   - **false**

b) During the acute stage of HIV infection, the person is not infectious.  
   - **true**  
   - **false**

c) HIV may be present in a body for many years before AIDS appears.  
   - **true**  
   - **false**

d) 75 percent of people with HIV will develop AIDS within 5 years of being infected.  
   - **true**  
   - **false**

6. **Confidentiality and using information:**

a) Children and young people have the same right to confidentiality as adults.  
   - **true**  
   - **false**

b) The use of information about patients is solely governed by statute law.  
   - **true**  
   - **false**

c) A parent will be given access to personal information about their child if he or she is under 16 years of age.  
   - **true**  
   - **false**

d) A young person does have the right to request and receive confidential information.  
   - **true**  
   - **false**
1. Multiple choice questionnaire

7. Gonorrhoea:
   a) Gonorrhoea can be asymptomatic in most men.  
      true □   false □
   b) A single oral dose of cefixime 400mg is used to treat gonorrhoea.  
      true □   false □
   c) Around 50% of men with gonorrhoea will also have Chlamydia.  
      true □   false □
   d) Pregnant women should usually be treated with a quinolone antibiotic.  
      true □   false □

8. Child protection and sexual activity:
   a) A professional is under a legal obligation to report a young person under 16 who is having consensual sex.  
      true □   false □
   b) The child protection team must be informed if the young person is 12 years of age or under.  
      true □   false □
   c) Sexual intercourse with a girl under 16 years of age is illegal.  
      true □   false □
   d) Providing contraceptive services to young people under 16 may constitute a criminal offence.  
      true □   false □

9. Chlamydia trachomatis:
   a) The number of Chlamydia diagnoses in Scotland has increased rapidly over the past three years.  
      true □   false □
   b) Most people infected with Chlamydia will have no signs or symptoms.  
      true □   false □
   c) Chlamydia is the most curable sexually transmitted infection.  
      true □   false □
   d) Almost three quarters of all diagnoses were in those aged over 25 years.  
      true □   false □

10. HIV infection:
    a) The primary cause in Scotland is sharing needles by intravenous drug users.  
       true □   false □
    b) HIV is one of the most important infectious diseases in Scotland.  
       true □   false □
    c) Antiretroviral treatment may aggravate symptoms.  
       true □   false □
    d) HIV antiretroviral treatments are given when the CD4+ count fall below 600.  
       true □   false □
11. Hepatitis:

a) There are vaccines to help prevent hepatitis infections A, B and C.  
   - true  
   - false

b) Hepatitis A virus is common in the UK.  
   - true  
   - false

c) Hepatitis C is usually acquired through sexual contact.  
   - true  
   - false

d) Condoms should be used to reduce the possibility of infection with Hepatitis B.  
   - true  
   - false

12. Treatment of Chlamydia:

a) Uncomplicated Chlamydia infection can be treated with doxycyline 100mg twice daily for seven days.  
   - true  
   - false

b) People being treated for Chlamydia should abstain from sexual activity for at least two weeks after finishing treatment.  
   - true  
   - false

c) Azithromycin 1 gram as a single oral dose can be given to pregnant women with uncomplicated infection.  
   - true  
   - false

d) In men with symptomatic Chlamydia infection, all partners from three months prior to onset of symptoms should be contacted.  
   - true  
   - false

13. Levonorgestrel - Emergency Hormonal Contraception (EHC):

a) EHC can be sold OTC to individuals under 16 years of age.  
   - true  
   - false

b) The licensing conditions of levonorgestrol prohibit advance supply.  
   - true  
   - false

c) There is no limit to the number of times a women may request EHC.  
   - true  
   - false

d) The National PGD allows the supply of levonorgestrel 1.5 mg to females who are under 16 years.  
   - true  
   - false

14. Genital herpes:

a) Herpes simplex virus (HSV) type 1 infection is more common in men.  
   - true  
   - false

b) People infected with Type 1 virus are more likely to have severe recurrences.  
   - true  
   - false

c) Most people who have genital herpes will have no symptoms.  
   - true  
   - false

d) Infection is life long as there is no cure for genital herpes.  
   - true  
   - false
15. Levonorgestrel - Emergency Hormonal Contraception (EHC):

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Women taking anti-epileptic medication may need a higher dose of levonorgestrel.</td>
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<tr>
<td>b) Levonorgestrel should not be taken by breastfeeding mothers.</td>
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<tr>
<td>c) Pregnancy must be excluded before a supply of EHC can be made.</td>
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<tr>
<td>d) Levonorgestrel 1.5 mg must be taken within 120 hours of unprotected sex.</td>
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</tbody>
</table>

16. Syphilis:

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) In recent years there has been an increase in diagnoses in women.</td>
<td></td>
<td></td>
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<tr>
<td>b) All three stages of syphilis are contagious.</td>
<td></td>
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<tr>
<td>c) About two-thirds of all people who have syphilis will go through the final stage of the infection.</td>
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<tr>
<td>d) The second stage of syphilis may cause a rash and ‘flu-like’ symptoms.</td>
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</tbody>
</table>

17. Genital warts:

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Most genital warts are caused by type 6 and 11 Human Papilloma Virus (HPV).</td>
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<tr>
<td>b) The short incubation period makes it easy to trace how a person has contracted the infection.</td>
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<tr>
<td>c) There is strong evidence to support imiquimod cream (Aldara®) as first line choice of treatment.</td>
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<tr>
<td>d) Most warts will disappear within 3 months is left untreated.</td>
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</tbody>
</table>

18. Genital herpes:

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) The HSV virus can be transmitted by sharing towels with someone who has blisters or ulcers.</td>
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</tr>
<tr>
<td>b) The HSV virus can be transferred between sites on one individual.</td>
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<tr>
<td>c) Wearing a condom should protect fully against passing on the virus when symptoms are present.</td>
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<tr>
<td>d) There is an increased risk of miscarriage if a pregnant woman becomes infected with the HSV virus.</td>
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</tr>
</tbody>
</table>
19. Screening and testing for Chlamydia:

a) There is evidence that screening for Chlamydia is cost effective with regard to reducing morbidity.  
   
   true □ false □

b) Testing should be targeted at individuals known to belong to groups with the highest prevalence of infection.  
   
   true □ false □

c) Complicated Chlamydia infection is most prevalent in women aged 25 or under.  
   
   true □ false □

d) The pharmacy Chlamydia testing service is targeted at asymptomatic individuals between the ages of 13 to 24.  
   
   true □ false □

20. Syphilis:

a) The infection is only acquired through penetrative sex.  
   
   true □ false □

b) If left untreated, the disease can cause serious organ damage and even death.  
   
   true □ false □

c) Babies born with congenital syphilis may suffer from blindness.  
   
   true □ false □

d) An older infection requires three treatments with intramuscular benzathine penicillin.  
   
   true □ false □
The Pharmaceutical Care of Sexual Health

We would appreciate your feedback on this pack, both positive and negative. Please complete the following:

Name: ___________________________  Registration No: ________________

Comments

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