Taking a sexual history and HIV screening

Marsh Gelbart
More than just form filling…….

<table>
<thead>
<tr>
<th>Last sexual contact</th>
<th>M/F</th>
<th>Reg/Cas/ Known and duration</th>
<th>Country</th>
<th>TYPE OF SEX</th>
<th>Condoms used?</th>
<th>Condom breaks/failure?</th>
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<td>Oral</td>
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<td>Other</td>
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Number of partners in last 3/12
Past history of STDs

Past medical history

Hepatitis A/B vaccination

Medication

Allergies
Recreational drugs (last 3/12)
Injecting drug use
Smoking
Alcohol

HIV TEST
Previous test
Blood donor

Risks
Male partners
HIV positive partner
From high prevalence area
High risk partner

Window period
Expectation of result
PN/support
Taking a Sexual History

A Guide for Practice;

- Gaining an accurate sexual history is vital for the effective treatment of patients and their sexual partners.
- Nurses should emphasise that information is confidential and ask questions in a sensitive and non-judgemental way.
- Patients may ask why certain information is required and the nurse should be able to give a full explanation.
Reassure patients about Confidentiality

- The term confidentiality implies that only the client and the providers involved in direct care have access to clients personal information. Governed by the VD regulations act 1974 & the NHS Trusts and PCT’s Sexually Transmitted Diseases Directions of 2000. 
- If there are any limitations to the boundaries of confidentiality, these should be disclosed clearly at the onset.
Environment is important...

- Sound proof room, preferably away from clinical areas, so that people can talk freely
- Room should be comfortable and not harshly lit
- Arrange comfy chairs, so that interviewer and patient are at an angle facing each other, not face on
- Use same type of chair as the patient
Remember, attending a sexual health clinic can be awkward......
When taking a sexual history, be non-coercive...
Be non judgmental
Use language appropriately, or you may get a bad reaction!

How dare you sir!
I will have you horse-whipped!
History taking needs to be systematic……Part 1

- When did you last have sex?
- Was it with a man or a woman?
- Was it with a regular partner?
- What kind of intercourse was it?
- Were barrier contraceptives (condoms or femidoms) used?
History taking......Part 2

- Do you or your partner/s have any symptoms?
- Have you had any other partner in the past 12 weeks? (If so, double-check partner’s gender).
- Do you have pain during or after intercourse?
- Have you ever had a sexually transmitted infection before?
History taking……Part 3

- Have you ever had a sexual health screen before? (If not explain and reassure).
- Have you ever been screened for hepatitis, syphilis or HIV before. (If not, explain a blood test is involved).
- Have you been vaccinated against hepatitis B? (If not, assess risk and offer vaccination if required)
If symptomatic……

Identify the presenting complaint and ascertain its history.

- How does the patient perceive the problem?
- If there is a discharge, how much is there and what is the colour?
- Any associated bowel or bladder symptoms?
- How long have the symptoms been present?
Other useful information

Ask -
- When was your last period?
- Have any of your sexual partners been from abroad?
- Check if any allergies to medications?
- Past medical history – serious medical conditions & operations?
- Smear history – last cervical cytology & result?
Sensitive questions...

If appropriate, check –
- If there has been a history of a previous sexually transmitted infection -
  - What was diagnosed and when?
  - How was it treated?
  - Did you and your partners comply with treatment?
- Any history of drug usage? What type of drugs etc.
- Ever worked in the sex industry or paid for sex?
Human sexuality is complex......
Presumptions are often wrong...

- Don’t assume the patient is Gay
- Don’t assume the patient is Straight
- Don’t assume, ask….
- Use open, inclusive questions such as – “Do you sleep with men, women, or both?”
Role of Health Adviser

- Partner Notification
- Pre and post test counselling (HIV testing)
- Safer Sex Advice / Health Promotion
Remember partner notification

The cardinal rule of epidemiology –

- If the index patient is found to have a sexual infection, then the source of that infection must be traced and treated before sexual relations resume.
- Otherwise the circle of infection and re-infection may remain unbroken.
Principals of partner notification

- **Health care provider**
  - May give counseling so the patient can notify the partner(s)
  - May notify the partner directly

- **Patient**
  - May notify partner(s) directly following counseling
  - May be involved in provider referral

- **Provider referral**

- **Primary health care**

- **Patient's sexual partner(s)** or those sharing injection equipment are counseled about exposure and offered services

- **Patient referral**
Partner notification at work
If there is a diagnosed infection, refer to the Health Adviser ……

*Health Advisers have the luxury of time*

- Responsible for partner notification
- Provision of safer-sex information
- Making sure client understands treatment, and complies with it.
Why Test for HIV?

• Prior to the introduction of effective antiretroviral therapies, a diagnosis of HIV equated to a progressive, disabling and terminal illness.
• Diagnosis was often compounded by prejudice, stigma and isolation.
• Nowadays, HIV is seen as a long-term chronic illness.
• With knowledge of HIV status, individuals have the opportunity to make informed decisions and choices about lifestyle and treatment options to maintain and improve their health status.
Should testing become routine?

- Should pre-test counselling remain a requirement for informed, consensual testing?
- Before highly active antiretroviral therapy (HAART) was introduced, the advantages of knowing about a positive HIV status were minimal; thus counselling before HIV testing was the recommended practice.
- In the era of HAART, is pre-test counselling unnecessary?
The present approach sees counselling as essential...
Who Should Be Referred for pre-test counselling?

- Anyone requesting to see a Health Adviser
- All gay and bisexual men
- Anyone engaging in high risk sexual activity
- Anyone with a history of IVDU and sharing equipment
- Anyone under 16 years-old
- Anyone with learning difficulties
- Unprotected penetrative sex with someone from high prevalence area / positive partner
- Clinical Symptoms
- Requesting post exposure prophylaxis (PEP)
Risk factors that require assessment

• Sexual behaviour & that of partners
• History of IVDU
• Sexual assault
• Occupational exposure
• Invasive procedures e.g.
• Recipient of blood or blood products 1975-1985 (UK)
• High Prevalence Area
The patient’s perspective

Why does the patient want to have the test?
• Are they concerned they have been at risk?
• Because the test has been offered on attending clinic? (the patient might not have considered testing prior to the offer).
• As part of regular sexual health check-up

Assess patients knowledge base around HIV transmission
Do they know what HIV and AIDS are?
The Window Period

• Any infection within 3 months of taking the test may not be detected

• If patient has had risks within 3 months, advise to test again at a later date to cover window period
ELISA (HIV-1 and HIV-2)

**NEGATIVE**
- Serum samples that do not produce a reaction in the ELISA are considered negative.
- Report absence of HIV antibodies
- The patient is not HIV infected.
  - Retest in 6 months after the most recent risk event.

**POSITIVE**
- Serum samples that produce a reaction are retested twice with the ELISA.
- CONFRIMATORY TESTING (Western blot, immunoblot, radioimmunoprecipitation or immunofluorescence)
- **NEGATIVE**
  - Report test indeterminate
  - When confirmatory testing fails to establish that an ELISA reactive sample is either negative or positive, this result is termed "indeterminate."
  - Retest no sooner than 6 weeks from the date of the first sample.
  - Report indeterminate result is considered negative.

- **INDETERMINATE**
  - Report test indeterminate
  - Staging of infection requires more information such as history, clinical examination and other biological markers.

- **POSITIVE**
  - Report presence of HIV antibodies

*There is a small risk of false positive or false negative results, which should be considered on an individual basis.*
*Where appropriate, rule out false negative or false positive results.*

**POST-TEST COUNSELLING**
Giving a positive result

- Ensure you have the correct patient
- Be prepared for shock/distress from patient
- Keep information to a minimum
- Focus on how patient will cope today and the next few days
- Who knows, who can they tell?
- Arrange follow-up appointment for on-going support and doctors appointment
- Give leaflets and contact numbers
- Discuss safer sex and partner notification
Getting a Positive Result

- Explore what a positive result would mean to the patient
- How might they cope?
- Who could they tell for support?
- Who have they told they are having the test?
If positive- what next?

- Discuss benefits of knowing if positive:
  - Making life decisions
  - Treatment issues
  - Infection control/safer sex issues
  - Reduction in anxiety levels
Knowing Status

- Disadvantages of knowing
  - Stigma
  - Increased anxiety
  - Potential rejection by lovers, family, and friends
  - Occupational implications
Sources