



in collaboration with



Australian Government
Department of Health and Ageing

Chlamydia: Combating the Epidemic Facilitator's Guide

Chlamydia: Combating the Epidemic

Chlamydia: Combating the Epidemic, produced by the Rural Health Education Foundation, is an educational television program that alerts health practitioners to the high and increasing prevalence of chlamydia and the need to take appropriate measures. It aims to facilitate health professionals in asking sexual health questions, discussing preventative measures, and performing chlamydia screening and treatment.

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Part 1 Introduction - How to use this learning guide

A Guide to Facilitating Adult Learning has been designed with a number of activities that can be used to facilitate group discussion and engage with the material covered in the DVD.

A Guide to Facilitating Adult Learning has been designed to provide a framework for facilitating discussion of the key issues raised in the program Chlamydia: Combating the Epidemic.

A Guide to Facilitating Adult Learning is a booklet developed by the Rural Health Education Foundation (the Foundation) to support the facilitation of discussion with small groups. It covers the basic aspects of how people think and learn, running groups and facilitating learning in face-to-face settings. It is designed to provide some basic instructional information to assist people facilitating face to face learning. We encourage you to read this booklet before you work with groups as a guide to facilitate the learning guide discussion.

Session Planning

The following table overviews the activities within this learning guide. Activity time is based on numbers of 5-6 per group. Larger groups will take up to twice as long.

DVD Chapter	Activity Time	Activity	Page
1 10 minutes	10 minutes	1. Screening from a 15 year old male perspective	6
4 18 minutes	30 minutes	2. Overcoming barriers to screening	8
Case study 1 7 minutes	45 minutes	3. Taking a routine sexual history	12
Case study 2 4 minutes	20 minutes	4. Prevention and community approach	15

The table above gives approximate timings for the activities included in this guide. Session planning should include time for viewing the particular DVD chapter as the prompt to the activity and delivering the background material provided in each section. As a guide each session could be delivered in a 2 – 4 hr workshop.

The activities contained within the Learning Guides are short and not designed to tell a full story. Rather they provide a stimulus for participants to think about the information and the issues arising from it. The case studies and activities provide the opportunity to relate information to real life situations and to use the content to build skills in reflective practice.

Part 2 Chlamydia : Combating the Epidemic

Chlamydia is the most commonly reported notifiable condition in Australia, with an incidence rate of 47,048 in 2006 (National Notifiable Diseases surveillance System, 2007). The incidence of this sexually-transmitted infection has increased six times in ten years.

This program alerts health practitioners to the high and increasing prevalence of Chlamydia and the need to take appropriate measures. It aims to facilitate health professionals in asking sexual health questions, discussing preventative measures, and performing Chlamydia screening and treatment.

The program also discusses efforts that need to be taken to make Chlamydia screening a healthcare routine, particularly among young adults.

Learning outcomes

Following the program, participants will be able to:

- Recognise the need for chlamydia screening and identify how advances in testing may be used in practice.
- Identify strategies to overcome barriers surrounding sexual health screening.
- Recognise the importance of and identify strategies for community engagement.
- Identify specific issues among target groups, including young people, Indigenous communities, men who have sex with men, and pregnant women.

Presenters

Chair: Dr Norman Swan	Presenter of the <i>Health Report</i> on ABC Radio National
Professor Frank Bowden	Professor of Medicine, Australian National University; Chair of the HIV/AIDS & STI Subcommittee of the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH), ACT
Dr Chris Bourne	Senior Specialist & Clinical Services Manager, Sydney Sexual Health Centre, & Chairman of Sexually Transmitted Infections in Gay Men Action Group (STIGMA), Sydney
Dr Miriam Grotowski	Rural GP, Tamworth, NSW & member of NSW Health Ministerial Advisory Committee for HIV, STIs and BBVs
Ms Annette Slater	Aboriginal Sexual Health Worker, Hunter New England Health Northern Sector Area, Tamworth NSW

Session 1

View DVD
Chapter 1

Approx
10 minutes

Introduction and key messages from the panel

- Professor Frank Bowden – Chlamydia is now the number 1 notifiable infectious disease in Australia with a 5 fold increase. It is postulated that this increase could be because of the failing safe sex message of the 1980's, and access to services
- Dr Chris Bourne – we need to control the testing and treatment as a community. We need testing and treatment based on simple technology that GP's can include in assessing young people
- Dr Miriam Grotowski – GP's are well placed to test and treat Chlamydia. GP's have a reason to do it and will definitely make a difference
- Ms Annette Slater – We need to include health checks as part of our wellness checks. The Chlamydia message needs to reinforce that a person can feel OK on the outside and have an infection on the inside.

Why chlamydia is a problem?

In this section we will address:

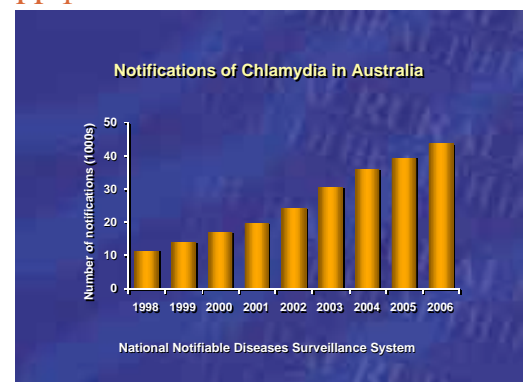
- Epidemiology: common problem “My patient can have it”
- Overall incidence rate
- Incidence rates in particular population groups
- Gravity of potential sequelae: PID, infertility “My patient may suffer because of it”
- Part of National Strategy
- Practical testing and treatment available: “Chlamydia is easy to test and treat”

View PP 1-3

Chlamydia is a significant issue in Australia.

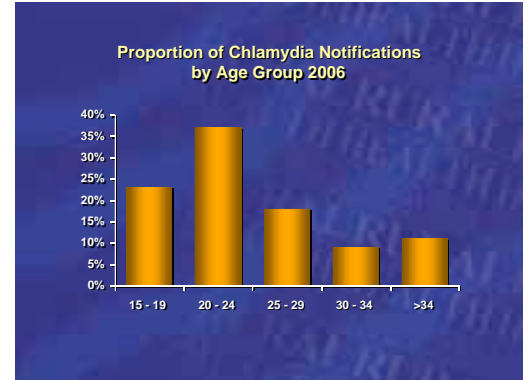
In Australia in 2006 there were 43,600 notifications of the infection.

PP 1



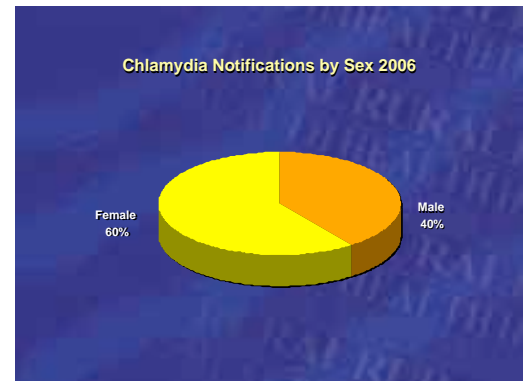
Approximately 80% of the incidence of Chlamydia occurs in 15 – 30 year old age group.

PP 2



Gender prevalence: 60% women and 40% in males. It appears that women are more susceptible to infection. It appears that the best discriminating factor is age.

PP 3



The more sexual partners one has the higher the risk of contracting Chlamydia. Gay men mirror the rise in chlamydia in the general community.

View PP 4-5
(see page 8)

The Royal Adelaide Hospital states that chlamydia often produces no symptoms. Infection of the cervix and fallopian tubes in women, and chlamydia can also cause urethral infection. Symptoms can include dysuria, cystitis, and thin vaginal discharge and or lower abdominal pain. Mucopurulent cervicitis is very common. Eye infections can occur in babies born to infected mothers.
(<http://www.stdservices.on.net/std/chlamydia/details.htm> downloaded 18/04/2007)

In men, chlamydia may produce chlamydia urethritis and may include dysuria and a mucopurulent discharge (ibid).

Chlamydia poses higher risk in females. There is a direct link between untreated Chlamydia and a woman's fertility. There are a range of complications that can result from untreated Chlamydia. These complications in women include:

- heavy periods
- painful periods
- Pelvic Inflammatory Disease
- ectopic pregnancy
- permanent infertility

In Indigenous communities there can be difficulties with access to care and treatment. Particular indigenous communities have set up schools and youth based programs designed for education and early detection.

Testing / Screening

Screening is now part of a National strategy.

The development of more effective tests has made more effective intervention against chlamydia possible. Over the last 10 years the PCR techniques for screening have been introduced. This is based on nucleic acid detection, polymerase chain reaction (PCR) ligase chain reaction (LCR) on either a genital swab or a urine specimen. This tests for DNA of the Chlamydia bacterium and is highly sensitive and very stable. Other tests include fluorescent antibody (FA) examination of a direct smear, the enzyme immunoassay test (EIA) and culture.

Chlamydia is an intracellular organism, existing in the cell, not in the pus. Therefore, it is important that the correct swab technique is used to obtain a positive accurate test result.

There are a number ways to test for chlamydia:

- Urine testing - requires a simple urine test (a first catch, not a midstream specimen) which needs to be stored at 4⁰C,
- Swab Testing – using a swab kit. A swab of the vagina or rectum, can be self inserted, or undertaken by a clinician when a swab is required from cervix. Once the swab has been completed rotate the swab in the transport medium for 20 seconds and then take the swab out, and just send the transport medium to the laboratory.

If testing of the urethra is required it is recommend a urine test be undertaken as the urethra is not ideal to swab (the swab uses a metal brush and may be painful or uncomfortable)

If testing in conjunction with a PAP smear, take a cervical swab and also take a vaginal swab, collecting the extruded cells in the fornix of the vagina.

In Indigenous populations, urine screening is culturally OK, and other methods depend on each individuals comfort level. Women may self collect a vaginal swab.

Screening and diagnosis is based in any symptomatology such as cervicitis, urethritis etc. It is vital to obtain informed consent and let the patient know that a positive result requires the laboratory to notify to the Public Health Unit as part of demographic data collection. It is vital that this aspect is treated “matter of factly” and that no fuss is made of this process.

Activity 1

Activity 1

What might it feel like to be 15 years old?

Imagine you are a 15 year old male who has just become sexually active. Your GP informs you should have a chlamydia test which, if positive will be reported to the Public Health Unit. You have never heard of the Public Health Unit but react with fear to the thought of something so private being made public. In small groups, discuss possible thoughts and feelings based on the scenario.

Session 2

View DVD
Chapter 3

Approx
7 minutes

View PP 4-9

Treatment and Management

For treatment of “simple” cases of chlamydia - a single dose of Azithromycin 1g po stat

For a complicated infection with resistant symptoms, it may require the GP to look for something else, or the person maybe in the process of healing the infection. It may require treatment with doxycyclin.

Patients should not be retested for at least 6 weeks, and they can be retested after 3 months to ensure they are not reinfected. The decision to retest would depend on the patient's behaviour. If their behaviours have not changed, they might be reinfected. Also, we need to consider the patients partner and threat them too.

Chlamydia is generally asymptomatic, particularly in women. It is very common and therefore opportunistic screening needs to be implemented when possible.

Opportunistic times can include:

- 15 – 30 year olds
- Those people having any unprotected sex
- When getting pill scripts
- Antenatal screening
- Emergency contraception – morning after pill (map)
- Pap smear
- Any symptoms in males or females
- Indigenous adult health checks

It is also important that GP's begin to and continue to think chlamydia.

Opportunistic screening can be undertaken when a woman presents with symptoms such as:

- Painful periods
- Irregular periods
- Irregular bleeding
- Abdominal pain
- Urinary symptoms
- Intermenstrual bleeding
- PID symptoms

PP 4

Chlamydia

Asymptomatic

- Very common
- Opportunistic screening
 - 15 - 30 year olds
 - Unprotected sex

PP5

Think Chlamydia

Think Chlamydia if female presents with:

- Irregular bleeding
- Abdominal pain
 - Urinary symptoms
 - Painful periods

PP6

Offer Chlamydia test with

- Pap smear
- Pill script
- MAP
- Antenatal visit
- Symptoms-men and women
- (Indigenous) Adult health check

PP7

Treatment and Management

- Antibiotic -
 - Uncomplicated Chlamydia
AZITHROMYCIN 1g po stat
 - Follow guidelines for complicated infection

PP8

Treatment and Management

- Screen for other STIs
 - Gonorrhoea
 - Syphilis
 - HIV
 - Hepatitis B

PP9

Treatment and Management

- Safe sex counselling
- Support contact tracing
 - SMS, email, letter
- Public health reporting
 - Epidemiology

Overcoming Barriers and Facilitating Contact Tracing

Case question - What advice would you give to a 16 year old female who presents for emergency contraception after an episode of unprotected sex?

Panel Discussion:

- be alert to potential of chlamydia
- to early to detect Chlamydia but will definitely need Chlamydia screening in 2 weeks, unless there have been other episodes of unprotected sex

Barriers to screening

Barriers to screening can come from patients, but it often it is the doctor who has the barriers

Activity 2

Activity 2

Overcoming barriers to screening

In groups identify and discuss possible barriers to opportunistic screening that:

- a) A patient might have, and
- b) That doctors might have

Issues to consider

- Screening, target groups, risk factors and treatment / management
- Issues around screening including making standard sexual health screening a routine part of practice, particularly for young people aged 15 – 30 years
- Handling awkward situations, privacy and confidentiality – making it routine

- Using the issue of Chlamydia as an opportunity to improve health behaviours in young men (i.e. using condoms)
- Appropriate diagnostic testing – ensuring those people who present symptoms are tested
- Conducting opportunistic screening in general practice
- Dealing with the specific needs of Men who have Sex with Men (MSM)
- “Normalising” the process, being non-judgmental
- Developing a routine for sexual history taking (risk assessment)
- Drilling down to determine high risk patients

Debrief

- Opportunistic screening needs to be relevant to the demographics of the patient population – and realise that their intervention does make a difference, albeit small in comparison to other populations 4-6/100 will screen positive. If you screen 50 people the 1-2 cases that are positive is just as important as the 20 cases that may show up in a different demographic
- Chlamydia is often asymptomatic. In general, GP's tend to focus on symptomatology that is presented and may be prompted to opportunistic screening for something that is not presented
- Some GPs may have difficulties, lack of experience or lack of confidence in taking a sexual history
- Behavioural issues need to be considered, with increased incidence of other STI's
- Any discharge infections – people are then more susceptible to chlamydia
- Increased chlamydia in a population could predispose for other infections such as HIV
- A PAP smear is not a full sexual health screening, therefore they need lots of feedback and information to be informed
- Indigenous populations need to be educated that the damage is on the inside, even though they feel OK on the outside
- There are cultural sensitivities with Indigenous communities– men's business and women's business - we need to educate populations towards better sexual health

*View DVD
Chapter 4 as
required or
as a further
stimulus to
discussion*

*Approx 18
minutes*

Discussion based on Case Study

Jane is 16 years old. She is a neighbour whose parents you have known for many years, comes in to request a prescription for the pill contraception. On questioning, she said that she seems to have had her period twice in a month.

Panel Discussion:

- Ask more questions regarding sexual behaviour
- Build and reinforce trust and confidentiality (as long as the patients and the GP's safety are not compromised)
- Develop a good relationship
- Ask if she is using barrier contraception 100% of the time – i.e. all / some / none of the time
- Recommend a chlamydia test
- Explain that it can be transmitted with ANY genital contact
- Be open and honest, confident and non-judgmental

Discussing a positive chlamydia result

- Talk about the infection, transmission, simplicity of treatment

- It is a sexually transmitted infection therefore need to discuss partners, particularly over the past 3 months
- Partners over the past 3 months will need to be contacted and tested and if positive, treated
- Take a gentle and relaxed approach - the patient can often be terrified and anxious as they may be at risk of violence etc
- Discuss ways of letting partner/s know – SMS, phone contact, letter. Can practice role playing telling partner
- Caution with sending a letter to Aboriginal contact as there can sometimes be three generations of family with the same name living in the same home
- Contact tracing – a patient may choose to have a health worker contact the partner/s
- In some demographic populations it can be recommend that al their friends be screened as there is often similarity in behaviours etc
- A positive result can “cross the threshold” to STI therefore need to ascertain sexual history and behaviours. The patient may need a full sexual screening for infections such as:
 - Gonorrhoea
 - Syphilis
 - HIV
 - Hepatitis B
- A patient like 16 year old Jane may need Hepatitis B screening as she may have missed the routine immunization

Session 3

View DVD
Chapter 5

Approx 18
minutes

View PP 11-
20

Taking Sexual History and Dealing with Target Groups

Case Study 2 – DVD

Mat, a young man in his twenties, injured his ankle while training and goes to see his local GP who has known him for many years. After being treated for his foot, Mat is suddenly caught off guard when his doctor begins to ask questions regarding his sexual history and offers a routine chlamydia test.

PP 11

STI Screening

- Developing a routine for
 - Sexual history taking (risk assessment)
 - STI screening
- Acknowledge awkwardness
 - Confidentiality
 - Privacy

PP 12

STI Screening

- Chlamydia diagnosis
 - Opportunity for behaviour change
 - Condoms
- Ensure 'screening' testing accompanies 'diagnostic' testing

PP 13

Target Groups / Risk Factors

- Young people 15-30 years
- Men who have Sex with Men (MSM)
- Aboriginal young people
- Hidden risk - no symptoms, history guide
 - Age is the best indicator

PP 14

Offering Screening

'I offer (STI) testing to all young people'
'Are you / have been sexually active'
'...had sex without condoms'
? Chlamydia test

PP 15

Men who have Sex with Men (MSM)

- Do not assume heterosexuality
- Gender neutral
 - 'Partners' cf 'girlfriend / wife'
- Comprehensive STI check up
 - Rectal and pharyngeal swabs
 - Self collection (rectal, urine) acceptable
 - Proctoscopy for anal symptoms

PP 16

Men who have Sex with Men (MSM)

- Homophobia, stigma and secrecy
- Contact tracing
 - Tricky with anonymous partners

PP 17

Access

- Provide options for accessing appropriate health care
- Support access if needed

PP 18

Choice

- Offer choice in accessing sensitive and confidential health care
- Support choice if needed

PP 19

Informed Consent

- Risk assessment
- Explain reasons for offering test
- Pre and Post considerations

PP 20

Shared Care

- Within the limits of confidentiality and client consent
- Client centred "holistic" care

Activity 3
View DVD
Case Study 1

Approx
7 minutes

Activity 3
Taking a Routine Sexual Health History

In groups of three, take it in turns to role play taking a sexual history from a young patient, and offering them a chlamydia screening test. In turn, one person will have the role of GP (using the template at Appendix 1), one person will be the patient and one person will be the observer and provide feedback on how the role play went (using template at Appendix 2).

GP Questions

Develop rapport, and complete presenting consultation, then move into taking a sexual history.

Contextual framing – I'd like to take a sexual history given your age group, just to make sure there is not some testing we should do...

- So, are you sexually active?
- In the last 3 months how many female partners would you have had sex with?
- Have you had any male partners in the last 3 months?
- In the last 12 months how many female partners have you had?
- Is most of your sex oral, anal or vaginal, or a combination?
- What percentage of the time do you use condoms, say with - your current partner? Other female partners? Male partners?
- Have you experienced any symptoms like burning or stinging when you wee?
- Do you have any discharge that is a bit unusual?

- Has your throat been sore at all?

Then

- Suggest chlamydia testing
- Explain that chlamydia is a common transmitted STD which is easily picked up and easily treated with antibiotics
- Reinforce the safe sex message
- Determine the need for further sexual health testing and use the opportunity of offer further testing
- Consider Hepatitis B immunisation
- Remember informed consent

Target groups / high-risk groups

- Young people 15 – 30 years
- Men who have sex with men (MSM)
- Aboriginal young people
- Hidden risk – no symptoms – seemingly non high-risk population cases should not be overlooked. Patients may not present symptoms / sexual history if not asked. Also, patients may not be initially comfortable to admit their sexual history. Risk assessment may present a potential barrier for testing, therefore, use their history as a guide – age is the best indicator. Ask, “Have you had or are you having sex without condoms? Are you or have you been sexually active?”

Important note on dealing with men who have sex with men (MSM):

- Use the local “lingo” (language) that young people, men who have sex with men (MSM) or gay men use. For example, with MSM it is useful to have some familiarity with the language that men might use and then you can contextually frame a question such as “What have you been up to?”
- Do not assume heterosexuality – ask about sex with both men and women
- Use gender neutral language – partner/s
- MSM – 75% do not identify themselves as gay
- Undertake a comprehensive STI checkup –
 - Recto, pharyngeal swabs
 - Self collection (rectal / urine)
 - Proctoscopy for anal symptoms
- Remain gentle, neutral, relaxed, confident and non-judgmental
- Be alert for any evidence of coercion – psycho-social, legal, medical angles that need to be addressed

Key messages

- Noting sexual health as a standard assessment for certain age groups
- Note intention to ensure health needs are met through service
- Using standard and straightforward sexual health check list questions
- Using sensitive language – implicit vs. explicit
- Same sex health providers or different GP to general GP
- Sexual history taken by relevant non- GP professionals such as aboriginal health worker, nurse, case manager, social worker

**Session
4**

*View DVD
Chapter 6*

13 minutes

**Prevention and Community Approach
DVD Case Study**

Stopping “snakes” from spreading Chlamydia: An Aboriginal approach

This case study presents the *Snake Condom Social Marketing Initiative*, an example of a holistic approach to combat Chlamydia, other sexually-transmitted diseases, and unplanned teenage pregnancies.

Originating in the Aboriginal community in Mildura, Victoria, the SNAKE CONDOMS were first launched through collaboration between Marie Stopes International Australia (MSIA), the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Mildura Aboriginal Health Service.

The *Snake Condom Social Marketing Initiative* encourages safer sex practices (condom use) by packaging it in a way that is more acceptable to the community. This campaign has since spread to Shepparton, Bendigo, Echuca, Bairnsdale and Melbourne Metro (February 9, 2007), and is expected to soon be rolled out across the nation.

This case study presents the importance and benefits of creative communication approaches to bridge cultural barriers between health services and Aboriginal communities. The SNAKE CONDOMS sexual health campaign uses the "snake" as a humorous yet powerful metaphor for the male genitalia. The use of the "snake" metaphor dampens the sense of shame associated with discussing sexuality and sexual health, allowing greater information sharing.

In addition, it provides a familiar close-to-nature allegory that facilitates safe-sex messages. The dangers of sexually-transmitted diseases and the need to use a condom to protect one's self emotionally resonates with the understanding of the dangers of snakes and the need to take safe precaution when snake-handling.

Aside from the use of the snake symbol, the campaign strengthens its identity branding by ensuring that everything from the packaging, posters, caps, visors, T-shirts, key ring condom holders, and even the condoms themselves are made in the colours of the aboriginal flag; red is strawberry, yellow is vanilla and black is chocolate. This enhances community pride and a sense of ownership. A launch of the condom into a community is done through a SNAKEFEST that involves Aboriginal artists and brings the community together.

This case study also illustrates a community framework to support the implementation of this marketing concept. In addition to using traditional retail outlets (supermarkets, chemists, convenience stores, service stations, and local health services), the condoms are also made available at late night eateries, burger vans, pubs and cafes. Most importantly, the initiative also trains and supports a network of peer educators/peer sellers (condom distributors), known as "snake charmers". These peer educators allow the condoms to be discreetly available at parties and places where young people gather and they are also able to make 100% profit of the SNAKE CONDOMS. This network thus increases the community's access to condoms and sexual health information, where and when they are most needed.

The community also decided that in order to ensure that the condoms are well regarded, they are not going to be distributed for free or at a price that would be labelled as "too cheap". Instead, the condoms are subsidised and sold at an affordable \$2 per discreet packet of 3. The "snake charmers" make a profit from selling the condoms, while the rest of the proceeds are used to ensure project sustainability. Aside from enhancing marketing and distribution, this approach provides an opportunity for young people in the community a positive way to earn money and build their self-esteem by promoting sexual health.

The SNAKE CONDOMS have been shown to increase condom use. On evaluation in Mildura, the number of survey respondents who use a condom for every intercourse increased by 18%, and the number of those who used a condom during the last intercourse increased by 20%. The condoms are also extremely popular, with over 15,000 condoms sold since the launch, in a population of 3,000-5,000 people.

Activity 4
View DVD
Case Study 2

Activity 4
Prevention and Community Approach

In small groups discuss how your area health services could utilise and be inspired from the SNAKE CONDOMS approach to combat Chlamydia and enhance sexual health in your community

Key issues to consider:

- People need options and choices
- Close nature and sensitivities of particular communities
- Community involvement
 - Ideas and implementation from young people
- Creative communication to bridge barriers including cultural barriers
 - Snake is a humorous metaphor to reduce sense of shame discussing sexual health and STI's
 - Facilitates safe sex message – beware the snake and caution when snake-handling
 - Branding for pride and ownership
- Community framework to support access to sexual health information
 - Traditional and non-traditional retail outlets / distribution
 - Network of peer educators / peer sellers – increase availability

Appendix

Appendix 1 Sexual History Questions

Name
Age
Gender

Activity 5

View DVD Chapter 5 as required or as a stimulus for discussion

Approx 18 minutes

Taking Sexual History Questions

Contextual framing – I'd like to take a sexual history given your age group, just to make sure there is not some testing we should do...

1. So, are you sexually active?
2. In the last 3 months how many female / male partners would you have had sex with?
3. Have you had any male / female partners in the last 3 months?
4. In the last 12 months how many female / male partners have you had?
5. Is most of your sex oral, anal or vaginal, or a combination?
6. What percentage of the time do you use condoms, say with - your current partner? Other female partners? Male partners?
7. Have you experienced any symptoms like burning or stinging when you do a wee?
8. Do you have any discharge that is a bit unusual?
9. Has your throat been sore at all?

Then

- Suggest chlamydia testing
- Explain that chlamydia is a common transmitted STD which is easily picked up and easily treated with antibiotics
- Reinforce the safe sex message
- Determine the need for further sexual health testing and use the opportunity of offer further testing
- Consider Hepatitis B immunisation
- Remember informed consent

Appendix 2 **Observer Feedback Sheet**

The three strengths of your sexual history taking were:

Some ideas to consider to “stretch” and further develop your sexual history taking might be:

Overall I particularly liked:

This program was endorsed by the RACGP Quality Assurance and Continuing Education Program
and ACRRM as a Professional Development Activity.

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