

Education and Counseling Protocols

The following protocols are meant to be used as guidelines for clinics to develop counseling protocols appropriate to their particular agency's needs, services, and resources. This information should be provided in verbal communication with the client, and reinforced and supplemented with written client education materials.

Each clinic should provide clients with general information regarding sexually transmitted diseases. Each clinic participating in the Region VIII Infertility Prevention (Chlamydia) Project should provide chlamydia-specific information, education, counseling and referral services based on client needs.

A. GENERAL STD INFORMATION

Clients should be provided with the following information as needed/appropriate to assist them in (1) assessing their risk for contracting a sexually transmitted infection, (2) assessing their knowledge about STDs, and (3) modifying their behavior, if necessary, to reduce their risk:

1. A brief overview of STDs to all clients includes:
 - common infections/diseases
 - that diseases are sexually transmitted
 - that STDs have various symptoms such as sores, discharge, pain, skin rashes, lumps and/or swollen glands
 - that many people, especially women, may have no noticeable symptoms
 - that STDs can have serious complications including infertility if untreated
 - that STDs can potentially be passed from a mother to her newborn
2. To reduce the risk of contracting a sexually transmitted infection, those who are sexually active should:
 - avoid multiple sex partners, anonymous sex partners, and persons with multiple sex partners such as prostitutes

- know the personal history of your sex partner(s), including sexual behavior such as having multiple sex partners, drug use, and physical signs and symptoms (genital discharge, warts and pain; lesions)
- examine own and sex partner(s)' genitals for evidence of infection (sores, discharge, rash, etc.)
- have a periodic examination (at least annually) for sexually transmitted agents and syndromes if at high risk for STD
- use condoms correctly
 1. Use a new condom with each act of sexual intercourse (e.g. oral, vaginal, and anal).
 2. Carefully handle the condom to avoid damaging it with fingernails, teeth, or other sharp objects. Put the condom on after the penis is erect and before any genital contact with the partner.
 1. Use only water-based lubricants (e.g. K-Y Jelly™, Astroglide™, AquaLube™, and glycerin) with latex condoms. Oil-based lubricants (e.g. petroleum jelly, shortening, mineral oil, massage oils, body lotions, and cooking oil) can weaken latex. For persons who have allergies to latex, suggest the use alternatives such as polyurethane condoms.
 2. Hold the condom firmly against the base of the penis during withdrawal, and withdraw while the penis is still erect to prevent spillage.
- know where to go for evaluation and treatment

B. BASIC CHLAMYDIA INFORMATION FOR ALL CLIENTS RECEIVING TESTS

For a client who is being screened for CT, the following points should be made verbally or with written materials:

- Chlamydia is a sexually transmitted disease
- Chlamydia infections are frequently asymptomatic, especially in women
- A laboratory test is necessary to be certain if a person is infected
- Chlamydia is easily cured with antibiotics
- If chlamydia is not treated with antibiotics, several complications may result such as PID, epididymitis, and proctitis

C. EDUCATION/COUNSELING FOR CHLAMYDIA-POSITIVE CLIENTS AND THEIR SEX PARTNERS

Clients with a presumptive diagnosis of chlamydia or a positive chlamydia test should be provided with the information listed below to assist them in understanding chlamydia, especially its treatment and prevention. It is recommended that the clinician assess the client's knowledge about chlamydia and STDs before conducting the counseling session. A behavioral risk assessment as well as education and counseling should be documented in the patient's chart. It is also recommended that Chlamydia patients should be screened or recommended for screening of HIV.

1. A brief overview of chlamydia

- name of disease
- signs and symptoms of the disease
- high probability of asymptomatic state for long periods of time
- complications of untreated chlamydia for women, men and babies
- how disease is transmitted

2. A discussion of chlamydia treatment

- the name of the drug(s) being used
- quantity and frequency of drug usage
- probable efficacy of treatment
- potential side effects and precautions, e.g., yeast infections in women
- the necessity of abstinence until all sex partners have completed treatment

3. Partner management

a. The importance of treating sex partners

- all sex partners need to be treated to prevent reinfection (examination of partners is encouraged)

- consequences to client from re-infection if sex partners are not treated before further sexual contact
- meaning of negative test results, sensitivity of tests, likelihood of infection, need for treatment

Please refer to the Region VIII Introduction to Expedited Partner Therapy and Toolkit, recommended as another potentially effective means of partner management

b. Referral of sex partners

A partner referral system, preferably a written plan, for the examination and/or treatment of sex partners must be in place. This is especially important for a chlamydia program because most males and females infected with chlamydia are asymptomatic. Notification and referral can be initiated by the client, by the health care provider, or by health department staff. The process begins by counseling the client.

Patient Referral

- Assess the client's plan for telling sex partner(s) about the positive test result, e.g.:
 - When do you plan to tell them?
 - What do you plan to say?
- Assess the client's willingness to refer sex partner(s). The following questions can help this assessment:
 - How much does your sex partner(s) know about your exposure?
 - What do you feel their response will be if you tell them you are positive?
 - How will you respond to their reaction?
- Recommend to the client to refer all sex partners exposed within the critical period.
 - Patients should be instructed to refer all of their sex partners within the last 60 days for evaluation, testing, and treatment.
 - The following recommendations on exposure intervals are based on limited evaluation.
 - Sex partners should be evaluated, tested, and treated if they had sexual contact with the patient during the 60 days preceding onset of symptoms in the patient or diagnosis of chlamydia.

- The most recent sex partner should be evaluated and treated even if the time of the last sexual contact was >60 days before symptom onset or diagnosis.
- Coach the client on what to say and how to say it. Important points to cover with the client during the coaching process are:
 - Need to inform a sex partner(s) in a private setting
 - Do not accuse the partner of infecting you
 - Anticipate that your partner(s) may be upset or hostile
 - Partner(s) need to be counseled and tested as soon as possible
- Discuss possible reactions and effects upon relationship
 - denial
 - depression (anger at self)
 - anger at person perceived as source of infection
 - problems of relationship - blame, suspicion, increased stress

If client is reluctant to inform sex partner(s), the counselor can use the following motivations:

Partner Positive - If your partner(s) is positive, you will want to avoid repeated exposures.

Partner Consideration - Partner(s) have a right to know they have been exposed to the infection and to be given a chance to seek medical evaluation. Only the client knows who these people are and about their exposures; denying them this important knowledge about their health may result in serious consequences.

Partner(s) Spread - Any partner(s) who are positive or have been exposed, may unknowingly spread chlamydia.

Pregnancy - If a partner is female, positive, and pregnant, she needs an immediate referral for evaluation.

If the client is still reluctant to inform sex partner(s), a referral card or letter can be used to facilitate the treatment of partners if appropriate in your clinic.

The counselor should:

- Provide referral cards or referral letters
- Offer Expedited Partner Therapy, if appropriate
- Coordinate further follow-up with the state or local STD department
- Emphasize discretion, confidentiality, and the fact that the client is not and will not be involved in any way

If the client is unwilling to inform sex partner(s), the counselor should refer to local protocols, which may include the measures listed above.

4. Risk reduction and prevention recommendations:

- Learn to communicate and learn/know as much as possible about sex partner(s).
- Reduce the number of sex partner(s).
- Avoid "unsafe" or unprotected sex.
- Review with the client other ways of mutually expressing sexual intimacy and emphasize use of latex condoms with each episode of sexual intercourse.
- Refer clients to resources to support them in a risk reduction plan.

**GIVE APPROPRIATE LITERATURE TO EMPHASIZE RISK REDUCTION/
PREVENTION MESSAGES**

Summary

- ✓ Assess client's knowledge about chlamydia and provide key information about chlamydia and STDs
- ✓ Address any questions the client has
- ✓ Emphasize confidentiality
- ✓ Make sure the client knows when to call back or return for test results if treated presumptively
- ✓ Advise the client that a positive chlamydia test or presumptive treatment for chlamydia means that partner(s) should be notified and also treated for the infection

Introduction to Region VIII Expedited Partner Therapy (EPT) Toolkit

INTRODUCTION

In light of the recommendations and barriers related to use of EPT, the Region VIII Infertility Prevention Project has prepared this EPT toolkit to assist participating sites and clinician in exploring whether, how, and when to implement EPT as a partner management strategy.

BACKGROUND

In 2005, the Centers for Disease Control and Prevention received reports of 976,445 chlamydia cases and 339,593 gonorrhea cases that occurred in the U.S.¹ As an important component of reducing the prevalence and impact of these and other STD, public and private providers have implemented various strategies for managing the partners of patients diagnosed with STD. Types of partner management include provider referral in which the health department or provider notifies a partner of an STD exposure with or without the assistance of the original patient and patient referral in which the original patient attempts to assure his/her partner receives appropriate medical follow-up without assistance from the health department or provider. A limited number of studies suggest that provider referral is more successful in ensuring that exposed partners receive appropriate medical follow-up compared to patient referral. However, the high number of cases and the costs of provider referral make use of this partner management strategy an impractical tool for controlling GC and CT in many regions of the U.S.

EVIDENCE

As a means to assure that exposed partners are adequately treated, providers in many areas are practicing expedited partner therapy (EPT) by which partners of STD patients are treated without an examination and without counseling messages. Among EPT practices, some providers are utilizing patient-delivered partner therapy (PDPT) in which patients diagnosed with STD deliver medications to their partners. To encourage more widespread consideration of these partner management options, the CDC published its 2006 guidance report, *Expedited partner management in the treatment of sexually transmitted diseases*.² The guidance summarized evidence based on the results of four randomized controlled trials (RCT) for the efficacy of EPT in preventing recurrent chlamydia and gonorrhea infections after initial treatment and in assuring that partners are notified and receive treatment. Additionally, the RCT demonstrated that EPT was associated with a decreased likelihood that a patient would have sex with an untreated partner. The following salient findings related to EPT are found within the CDC guidance:

1 Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2005*. Atlanta, GA: US Department of Health and Human Services, November 2006.

2 Centers for Disease Control and Prevention. *Expedited partner therapy in the management of sexually transmitted diseases*. Atlanta, GA: US Department of Health and Human Services, 2006.

- In one six-city multicenter study, female patients diagnosed with chlamydia that were provided azithromycin to give to their partners were statistically no more likely to have persistent or recurrent chlamydia infections at one month and four month follow-up than were women who were provided a list of clinics where their partners could be examined.
- In Seattle-King County, persistent or recurrent gonorrhea and chlamydia infections were found less often among male and female patients assigned to deliver medications to their partners than among patients assigned to patient referral or provider referral arms of the study. EPT was shown to be more effective at preventing recurrent gonorrhea infections than chlamydia infections.
- In New Orleans, among a subset of 977 men with symptomatic urethritis who were diagnosed with gonorrhea, chlamydia, or both, those assigned to the PDPT arm of the study were significantly less likely to experience a recurrent infection upon follow-up testing.
- PDPT was slightly more costly than patient referral when considering only program costs. However, when the costs from preventing infection sequelae such as PID are considered, EPT was shown to be more cost effective.

The CDC has been joined by the American Medical Association in recommending that EPT be considered and implemented as a partner management strategy.

OPERATIONAL BARRIERS

A number of barriers remain to be addressed in assuring more widespread and consistent use of EPT. A 2005 survey of various clinical sites in the Region VIII IPP3 identified a number of these barriers including:

- Information regarding the partner is secondhand. The original patient may have no knowledge of a partner's allergy history or if the partner is currently taking other medications.
- Partner treatment cannot be tied to a specific person. One clinic that was in the process of implementing an electronic system for generating prescriptions noted that there would be no tie to a patient record number when the partner was not also a patient at the clinic. In another clinic, EPT was deemed problematic because no social security number or other identifier would be available to link the treated partner with the prescribed treatment.

³ The 2005 EPT survey obtained data from IPP sites located in Colorado, Montana, and South Dakota. The survey was designed to identify how often EPT was being practice, the circumstances when EPT was practiced, barriers to implementing EPT, and what clinics would need to implement EPT as a more standard practice. One community health center, five STD clinics, and over twenty-four family planning clinics provided survey information.

- Clinicians were unsure whether EPT is good medical practice and feared that practicing EPT might result in losing their license to practice.
- EPT was so rarely practiced that clinicians had little experience with its use.
- Clinic directors were described as often being resistant to EPT and in need of information about why EPT is desirable and how it should be implemented.
- Clinics did not know whether EPT was a practice that was recommended by their state health department.

Additional barriers to EPT have also been cited. Similar to situations involving more traditional DIS mediated partner notification, a diagnosed patient may refuse to deliver medications or a prescription to a partner because s/he: 1) does not know or has no locating information for the partner; 2) does not like the partner; or 3) is afraid of the partner. EPT may also be resisted because it is seen as a missed opportunity to test for other STD and to provide counseling messages to an exposed partner. Although the risk of adverse reactions to therapy has been shown to be low, providers may be reluctant to tolerate even a low risk given possible legal and medical ramifications of an adverse event. Additionally, EPT is not feasible in many setting because of operational barriers, including the lack of clarity regarding the legality of practicing EPT in many states.

TOOLKIT CONTENTS (currently in draft form)

In order to support the efforts of states interested in practicing EPT, this toolkit contains the following resources:

- ❖ Supporting documentation and research
- ❖ Current Rules and Regulations regarding EPT
- ❖ Sample policies and protocols
- ❖ Operational barriers and successful strategies