Sexual and reproductive health fundamentals

Figure 1.1 Range of services offered in SRH clinics

Box 1.1 Confidentiality: disclosure

Confidentiality is an important duty; however, it is not absolute. Disclosure of personal information can occur if:

- it is required by law
- the patient consents
- it is justified in the public interest, e.g. child abuse, the spread of a serious communicable disease

Before disclosing information expert advice should be sought

Box 1.2 Requirements for valid consent

In order for consent to be valid:

1. The individual must be competent
2. The individual must be able to give their consent freely (without coercion)
3. The individual must be fully informed

Further information:
GMC. Consent: Patients and doctors making decisions together. 2008
FSRH. Service Standards on obtaining valid consent in sexual health services. 2011

Box 1.3 Information provision for valid consent in SRH

Clients should be informed of:

- The purpose of the intervention, investigation or treatment, e.g. why and how a test will be taken
- The details and implications of a positive result (both to self and any partners)
- The risks (such as possible side effects or complications) and benefits of undertaking the treatment or investigation
- The implications of not carrying out the treatment or investigation
- The risks and benefits of carrying out an alternative intervention if applicable

Box 1.4 Laws governing sexual activity in the UK

England and Wales
- Sexual Offences Act 2003

Scotland
- Sexual Offences (Scotland) Act 2009

Northern Ireland
- The Sexual Offences (Northern Ireland) Order 2008
Background
Sexual and reproductive health (SRH) is a holistic specialty providing a broad range of client-centred clinical care. The cornerstones of SRH services are:
- provision of contraception
- diagnosis and management of sexually transmitted infections (STIs)

Most specialist centres however offer a wide range of services (Figure 1.1).

Historically provision of SRH was fragmented in the UK with most aspects of care being provided by either 'Family Planning' clinics (often community based and mainly offering contraception) or Genitourinary Medicine clinics (GUM; primarily hospital based and offering diagnosis and management of STIs). In the mid- to late 1990s the process of integration of services began and this accelerated following the publication of Sexual Health Strategies in England, Wales and Scotland.

Both GUM and reproductive health providers are concerned with preventing the potential adverse consequences of sex – namely STI acquisition and unplanned pregnancy; therefore, integration of the specialties is advantageous both in terms of efficient use of resources (including clinical expertise) and more importantly to enable delivery of client-focused care. Modern SRH services are often community based and offer a variety of choices for client access such as drop-in clinics, telephone advice lines and services for minority and vulnerable groups. In the UK, the specialty has close reciprocal links with many specialties including primary care, gynaecology, dermatology, infectious diseases and urology. Certain aspects of SRH care can be provided in non-specialist settings such as primary care and this is commonplace in the UK.

Globally there is wide variation in the nature and extent of SRH provision. Sexual healthcare is provided by dermatovenerologists in some areas of Europe and elsewhere by primary care physicians, gynaecologists or infectious disease specialists.

Confidentiality
Codes of confidentiality are paramount to SRH services given the sensitive nature of information that clients share with healthcare professionals. There are three areas of law which are relevant to protect personal health information:
- The Human Rights Act 1998: a right to 'respect for private and family life'
- The Common Law of Confidentiality: general health confidentiality in the UK is a common law duty
- The Data Protection Act 1998: regulates processing of identifiable data

The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) offer guidance on confidentiality including advice on situations when personal information can be disclosed (Box 1.1). The Department of Health's 'Confidentiality: NHS code of practice' sets out standards to ensure that patient information is handled as fairly, lawfully and transparently as possible.

Additional statutory regulations exist specifically for services managing STIs. Clients attending these services should be assured that their information will not be shared with anyone outside the service unless specific concerns arise (e.g. child protection issues).

Record keeping
Many SRH clinics use unique clinic numbers in place of the clients name to preserve anonymity. This unique number (usually accompanied by date of birth) is used throughout the patient’s written or electronic patient record (EPR) and for any specimens or forms. Concise record keeping is vital for client management, to facilitate audit and to record obtaining informed consent. Standard history pro formas are used in many services. They support more complete and timely history taking and facilitate audit. They can also be helpful in documenting minimum data sets which are mandatory in some regions.

Consent
Before any examination or investigation can take place consent must be obtained in keeping with General Medical Council (GMC) guidance. Consent may be given orally or in writing or it may be implied, e.g. by rolling a sleeve up to have a blood test taken.
- Minor investigations: as long as the client understands the nature and purpose of the proposed investigation verbal consent is usually satisfactory, e.g. chlamydia testing
- Complex procedures or those with significant consequences: written consent should be obtained, e.g. vasectomy, abortion

In practice, most of the investigations or procedures undertaken in SRH settings require implied or verbal consent only. Consent should be clearly documented in the client’s record along with evidence that the patient was fully counselled and informed before giving consent. Generally, for consent to be valid three requirements must be met (Box 1.2). Information: client must have received appropriate information on the procedure, its risks and benefits (Box 1.3). It is good practice to support any discussion with written information leaflets. Capacity: any person over 16 years of age is assumed to be competent to consent unless a lack of capacity can be established. Capacity is the ability to make a specific decision at that particular time. It is not based on an individual’s general ability to make decisions. Lack of capacity may be permanent, e.g. a disability, or temporary, e.g. due to alcohol or sedation. For further information on contraception, capacity and consent see Chapter 9.

Sexual activity in under 16s
- The age of consent to sexual activity in the UK is 16 years for men and women regardless of gender of partner
- Approximately one-third of young people have had sexual intercourse by this age
- Different legislation governs sexual activity in England and Wales, Scotland and Northern Ireland (Box 1.4)
- Although unlawful, mutually agreed sexual activity between children of a similar age would rarely be prosecuted
- Under 13 year olds (male or female) cannot give consent to any form of sexual activity and are protected by specific laws

Background
Sexual and reproductive health (SRH) is a holistic specialty providing a broad range of client-centred clinical care. The cornerstones of SRH services are:
- provision of contraception
- diagnosis and management of sexually transmitted infections (STIs)

Most specialist centres however offer a wide range of services (Figure 1.1).

Historically provision of SRH was fragmented in the UK with most aspects of care being provided by either 'Family Planning' clinics (often community based and mainly offering contraception) or Genitourinary Medicine clinics (GUM; primarily hospital based and offering diagnosis and management of STIs). In the mid- to late 1990s the process of integration of services began and this accelerated following the publication of Sexual Health Strategies in England, Wales and Scotland.

Both GUM and reproductive health providers are concerned with preventing the potential adverse consequences of sex – namely STI acquisition and unplanned pregnancy; therefore, integration of the specialties is advantageous both in terms of efficient use of resources (including clinical expertise) and more importantly to enable delivery of client-focused care. Modern SRH services are often community based and offer a variety of choices for client access such as drop-in clinics, telephone advice lines and services for minority and vulnerable groups. In the UK, the specialty has close reciprocal links with many specialties including primary care, gynaecology, dermatology, infectious diseases and urology. Certain aspects of SRH care can be provided in non-specialist settings such as primary care and this is commonplace in the UK.

Globally there is wide variation in the nature and extent of SRH provision. Sexual healthcare is provided by dermatovenerologists in some areas of Europe and elsewhere by primary care physicians, gynaecologists or infectious disease specialists.

Confidentiality
Codes of confidentiality are paramount to SRH services given the sensitive nature of information that clients share with healthcare professionals. There are three areas of law which are relevant to protect personal health information:
- The Human Rights Act 1998: a right to 'respect for private and family life'
- The Common Law of Confidentiality: general health confidentiality in the UK is a common law duty
- The Data Protection Act 1998: regulates processing of identifiable data

The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) offer guidance on confidentiality including advice on situations when personal information can be disclosed (Box 1.1). The Department of Health’s 'Confidentiality: NHS code of practice' sets out standards to ensure that patient information is handled as fairly, lawfully and transparently as possible.

Additional statutory regulations exist specifically for services managing STIs. Clients attending these services should be assured that their information will not be shared with anyone outside the service unless specific concerns arise (e.g. child protection issues).

Record keeping
Many SRH clinics use unique clinic numbers in place of the clients name to preserve anonymity. This unique number (usually accompanied by date of birth) is used throughout the patient’s written or electronic patient record (EPR) and for any specimens or forms. Concise record keeping is vital for client management, to facilitate audit and to record obtaining informed consent. Standard history pro formas are used in many services. They support more complete and timely history taking and facilitate audit. They can also be helpful in documenting minimum data sets which are mandatory in some regions.

Consent
Before any examination or investigation can take place consent must be obtained in keeping with General Medical Council (GMC) guidance. Consent may be given orally or in writing or it may be implied, e.g. by rolling a sleeve up to have a blood test taken.
- Minor investigations: as long as the client understands the nature and purpose of the proposed investigation verbal consent is usually satisfactory, e.g. chlamydia testing
- Complex procedures or those with significant consequences: written consent should be obtained, e.g. vasectomy, abortion

In practice, most of the investigations or procedures undertaken in SRH settings require implied or verbal consent only. Consent should be clearly documented in the client’s record along with evidence that the patient was fully counselled and informed before giving consent. Generally, for consent to be valid three requirements must be met (Box 1.2). Information: client must have received appropriate information on the procedure, its risks and benefits (Box 1.3). It is good practice to support any discussion with written information leaflets. Capacity: any person over 16 years of age is assumed to be competent to consent unless a lack of capacity can be established. Capacity is the ability to make a specific decision at that particular time. It is not based on an individual’s general ability to make decisions. Lack of capacity may be permanent, e.g. a disability, or temporary, e.g. due to alcohol or sedation. For further information on contraception, capacity and consent see Chapter 9.

Sexual activity in under 16s
- The age of consent to sexual activity in the UK is 16 years for men and women regardless of gender of partner
- Approximately one-third of young people have had sexual intercourse by this age
- Different legislation governs sexual activity in England and Wales, Scotland and Northern Ireland (Box 1.4)
- Although unlawful, mutually agreed sexual activity between children of a similar age would rarely be prosecuted
- Under 13 year olds (male or female) cannot give consent to any form of sexual activity and are protected by specific laws
Table 1.1 UKMEC categories

<table>
<thead>
<tr>
<th>UKMEC</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A condition for which there is no restriction for the use of the method</td>
</tr>
<tr>
<td>2</td>
<td>A condition where the advantages of using the method generally outweigh the risks</td>
</tr>
<tr>
<td>3</td>
<td>A condition where the risks of using the method usually outweigh the advantages (see text for further explanation)</td>
</tr>
<tr>
<td>4</td>
<td>A condition which represents an unacceptable health risk if the method is used</td>
</tr>
</tbody>
</table>

Table 1.2 LARC methods

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>Duration of action for contraception</th>
<th>Pregnancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cu-IUD</td>
<td>5 – 10 years</td>
<td>&lt; 20 in 1000 over 5 years*</td>
</tr>
<tr>
<td>LNG-IUS</td>
<td>5 years</td>
<td>&lt; 10 in 1000 over 5 years</td>
</tr>
<tr>
<td>Progestogen-only implant e.g. Nexplanon</td>
<td>3 years</td>
<td>&lt; 4 in 1000 over 2 years</td>
</tr>
<tr>
<td>Progestogen-only injection e.g. DMPA</td>
<td>12 weeks for IM-DMPA, 13 weeks for SC-DMPA (8 weeks for NET-EN)</td>
<td>&lt; 1 in 1000 over 3 years</td>
</tr>
</tbody>
</table>

* for devices containing 380 mm² copper

Figure 1.3 Female reproductive cycle

- Follicular phase
  - Anterior pituitary hormones
  - Ovarian activity
  - Ovarian hormones
  - Endometrium

- Luteal phase
  - The LH surge
  - Ovulation

Hypothalamus → GnRH → Anterior pituitary → LH, FSH → Ovaries → Estrogen and progesterone → Corpus luteum → Progesterone → Secretory endometrium → Menstrual cycle
UKMEC
The UK Medical Eligibility Criteria (UKMEC) for Contraceptive Use were adapted from the World Health Organization Medical Eligibility Criteria (WHO-MEC) to provide evidence-based guidance for the safe use of contraceptives in the presence of specific characteristics or medical conditions. UKMEC has four categories. The definitions are given in Table 1.1.
In practical terms, a UKMEC category of 1 or 2 would allow safe use of the contraceptive method; conditions given a category 3 would only allow the method to be used if other methods are unacceptable or unavailable and on the advice of a specialist contraceptive provider, and category 4 indicates that the method is contraindicated with this condition.
Additionally, some methods are awarded different categories to distinguish between initiation of the method (I) and continuation of the method (C). For example, if a client requests insertion of a copper intrauterine device (Cu-IUD) (initiation) but has an untreated chlamydia infection, this would be awarded a UKMEC category 4 (until the condition has been treated); if however a client is diagnosed with chlamydia infection and has a Cu-IUD already in situ then continuation of this method is a UKMEC 2.
UKMEC also provides categories for fertility based awareness methods and for male and female sterilization (see individual chapters for details).

Long-acting reversible methods (LARC) (Table 1.2)
- LARC methods are contraceptive methods which are administered less than once per cycle or month
- These methods do not depend on daily adherence and therefore offer higher efficacy than methods such as the combined oral contraceptive pill (COC) or progestogen-only pill (POP)
- Increasing the uptake of LARC can reduce the number of unintended pregnancies
- Despite the initial higher outlay (in terms of cost of method and staff time), the LARC methods are more cost-effective even at 1 year than the COC
- The very-long-acting methods (vLARC), namely the intransuterine methods and the progestogen only implant are more cost-effective than the progestogen-only injectable
- Service providers should offer women a choice of contraceptive methods including LARC

Partner notification
Partner notification (PN) is an essential component of care, which should be provided by all services managing sexually transmitted infections (STIs). PN (also called contact tracing) is a mechanism whereby the sexual contacts (past and/or present) of a person with a diagnosed STI (the index case) are informed in order that they can access appropriate advice, testing and treatment. Each STI has a look-back interval in which infection of sexual contacts may have occurred. The aims of PN are:
- to prevent reinfection of the index case
- to prevent the sequelae of undiagnosed infection in sexual contacts
- to prevent the onward transmission of STIs in the community (a Public Health issue)

Partners can be informed by the patient themselves (index referral) or by health professionals (provider referral). Newer strategies aimed at improving PN rates are being studied, e.g. using patient-delivered testing kits or patient-delivered partner therapy (PDPT). In the UK PN is voluntary; however, in other countries such as Norway and Sweden it is compulsory (a legal requirement).

Staff in SRH services
SRH services are consultant led, but the role of nurses has evolved, and experienced nurse practitioners staff many clinics independently or alongside medical colleagues. Additionally, healthcare assistants often provide sexual health screening to ‘low risk’ asymptomatic patients.

Sexual health advisors have an important role within an SRH service. They provide information, advice and counselling to patients diagnosed with an STI. They facilitate PN and support patients in managing their condition. They provide sexual health education and health promotion and a range of counselling interventions. In some services, this role will be undertaken by a practitioner with sexual health advising competencies.

Notifiable diseases
The Health Protection (Notification) Regulations 2010 (Department of Health, England) outline the responsibilities to notify the proper officer of a local authority of individual cases of specified infectious diseases. In Northern Ireland, England and Wales, acute hepatitis A, B and C are notifiable diseases. In Scotland, under the Public Health etc. (Scotland) Act 2008, hepatitis is not notifiable by clinicians; however, hepatitis A, B and C are notifiable organisms and diagnostic laboratories must report identification of these viruses to Health Protection Scotland (HPS).

‘Off-label’ prescribing
Practical prescribing of contraceptives and other drugs in SRH, may be at odds with the product licence. The GMC offers guidance for such ‘off-label’ prescribing in ‘Good Practice in Prescribing Medicines’ (2008). ‘Off-label’ use in these situations is sanctioned as long as there is sufficient evidence base for such use. Furthermore, if such use is deemed ‘common practice’ then documentation regarding non-licensed use, may not be required on every occasion. Evidence based guidance from National Institute for Health and Care Excellence (NICE) and the FSRH are examples of accepted ‘common practice’.

The female reproductive cycle (Figures 1.2, 1.3)
- The female reproductive (menstrual) cycle is controlled by the anterior pituitary hormones luteinizing hormone (LH) and follicular stimulating hormone (FSH), which are regulated via the hypothalamic secretion of gonadotrophin-releasing hormone (GnRH)
- LH and FSH stimulate the release of the ovarian hormones estrogen and progesterone
- The average reproductive cycle length is 28 days but it can vary from 21 to 35 days
- Day 1 is the first day of menstruation
- The follicular phase is from day 1 of the cycle until ovulation and is of variable length
- The luteal phase is from ovulation until the next menses and its duration is fairly constant at 14 days ± 2 days. To calculate the approximate day of ovulation, 14 days should be subtracted from the total cycle length
Box 1.5  Risk factors for STIs

- Non-use of barrier method
- Multiple partners (≥ 2 partners in last year) or recent change in partner
- Age < 25 years
- Sexuality: men who have sex with men (MSM)
- Previous STI

Box 1.6  Assessing pregnancy risk

- Date of LMP
- Was it a normal period?
- Date of last sexual intercourse
- Contraception used reliably for last sexual intercourse (SI)?
- Emergency contraception used?

Box 1.7  Reliably excluding pregnancy

You can be ‘reasonably certain’ that pregnancy is excluded if ≥ 1 of the following criteria are met (and there are no signs or symptoms of pregnancy):

- No SI has occurred since the last normal menstrual period
- There has been correct and consistent use of a reliable contraceptive method
- The woman is:
  within the first 7 days of the onset of a normal menstrual period
  or < 4 weeks postpartum (not breastfeeding)
  or < 7 days post-abortion or miscarriage
- Fully or nearly fully breastfeeding, amenorrhoeic and < 6 months postpartum

N.B. A pregnancy test can help exclude pregnancy but only if ≥ 3 weeks since last UPSI

**History taking**

Taking a concise history is a fundamental element of the SRH consultation. Many of the history taking skills overlap with those used in general consultations; however, there are specific aspects unique to SRH which must be included. As the sexual history necessitates enquiring about very personal issues, it is vital that the consultation takes place in a private environment with no interruptions. It is essential that the patient deems this a safe and confidential setting in which they can disclose intimate information.

**Communication**

Good communication skills and a non-judgemental approach are vital when working in an SRH setting. Clients can be extremely anxious or embarrassed. Explaining the rational for some of the questions you are asking may be helpful, e.g. “Some of the questions I’m going to ask you today are quite personal but they are important to see how we can help you.” Open questions should be asked and non-verbal cues – particularly signs of distress – should be recognized.

**Components of the SRH history**

**Reason for attendance**
- **Presenting complaint and history of presenting complaint:** enquire specifically about symptoms, their onset and any treatments the patient may have already tried
- **Past medical, surgical and family history**
- **Drug history:** including allergies

**Reproductive history**
- **Menstrual history:** LMP, menstrual problems (current or past), changes in bleeding pattern
- **Contraceptive history:** current contraceptive method (if any) and any problems with this? Barrier method used? Past contraceptive methods
- **Gynaecological and obstetric history:** number and outcome of previous pregnancies; cervical cytology screening and whether any previous colposcopy

**Sexual history**
- **Recent sexual history:** when did they last have sexual intercourse? What was the gender of that person? Was it a casual or regular partner? What kind of sexual contact did they have (oral, vagina, anal)? Did they use a barrier method of contraception and was it effective? How many partners have they had in the last 3 and 12 months, and how many of these were new partners?
- **Lifetime sexual history:** how many previous sexual partners have they had? Have their previous partners been male, female or both and how do they identify their sexuality. Have they had sex with someone from another country and if so which country? Have they ever had sex involving payment? Any history of STIs? Do they use barrier methods?
- **Blood-borne viruses (BBV):** have they ever injected drugs or share needles or had sex with someone who has? Have they had blood transfusions at home or abroad or tattoos in an ‘unsafe’ environment? Have they ever been tested for HIV or hepatitis B or C (when and what was the result?). Have they been vaccinated for hepatitis B?

**Social history**
- **Smoking history:** important for contraception prescribing
- **Alcohol and recreational drug consumption:** identifies risk taking behaviours and gives an opportunity for brief interventions
- **Gender based violence (GBV):** enquire about a history of domestic violence or bullying and any previous non-consensual sexual activity including childhood sexual abuse. Routine enquiry about current and historic GBV is mandatory in SH services in Scotland.

Finally, it is useful to ask the patient what their concerns are. There may have been suspected infidelity in a relationship or they may be anxious about a (often inaccurate) self-diagnosis they have made. Enabling the client to express these concerns can be helpful. It is also useful to ask what treatments the patient has tried and what effect (if any) these have had.

**Risk assessment (Boxes 1.5–1.7)**

It is useful to gather your thoughts after taking the history and make a risk assessment from the information you have obtained. You should assess the risk of pregnancy, STIs and BBVs. Based on the history you should also be able to decide which tests should be offered to the patient (although sometimes your examination findings will alter this), and whether they will need to return for further tests in a set period of time (e.g. too early for accurate pregnancy testing, or within the window period for HIV testing). You should also be able to reliably exclude pregnancy.

**Examination**

**Intimate examinations**

A chaperone should be offered for all intimate examinations regardless of the gender of health care professional (HCP) or client. The presence of a chaperone and their identity should be documented in the client’s case record. Permission for the examination should also be sought and documented.

**Male and female reproductive anatomy (Figures 1.4–1.7)**

Anatomical drawings are often used in history-taking pro formas to identify the site of lesions. Otherwise, any examination findings should be described as accurately as possible in relation to anatomical landmarks.
Box 1.8 Bimanual pelvic examination
- **Uterus**: direction (anteverted, retroverted or axial), size and mobility, tenderness
- **Adnexae**: normal or enlarged, any tenderness
- **Presence of pelvic masses**
- **Discomfort or pain**: does the examination elicit any tenderness, e.g. cervical motion pain?

Box 1.9 Routine STI screen (asymptomatic patients)

<table>
<thead>
<tr>
<th>Clinical situation</th>
<th>Specimen type</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic female</td>
<td>Self-taken vulvo-vaginal swab</td>
<td>NAAT for chlamydia and gonorrhoea</td>
</tr>
<tr>
<td></td>
<td>Venous blood sample</td>
<td>Syphilis and HIV</td>
</tr>
<tr>
<td>Asymptomatic male</td>
<td>First void urine*</td>
<td>NAAT for chlamydia and gonorrhoea</td>
</tr>
<tr>
<td></td>
<td>Venous blood sample</td>
<td>Syphilis and HIV</td>
</tr>
<tr>
<td>Asymptomatic MSM</td>
<td>First void urine*</td>
<td>NAAT for chlamydia and gonorrhoea</td>
</tr>
<tr>
<td></td>
<td>Pharyngeal swab†</td>
<td>NAA† for chlamydia and gonorrhoea</td>
</tr>
<tr>
<td></td>
<td>Rectal swab†</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Venous blood sample</td>
<td>Syphilis, HIV and hepatitis B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hepatitis C†</td>
</tr>
</tbody>
</table>

* Urine should be held for at least 1 hour before voiding
† If indicated by history/examination

Table 1.3 Recommended tests and investigations

Figure 1.8 On-site microscopy

Figure 1.9 Self-taken vulvo-vaginal swab method

Insert the tip of the swab about 2 cm inside your vagina and turn the swab around once. Count to ten whilst holding the swab just inside the vagina.

Figure 1.10 Equipment required for an asymptomatic STI screen
General examination
Measurement of BP, weight and height (for body mass index – BMI) is essential in contraceptive consultations. Other systems should be examined depending on the patient’s history and the primary purpose of the consultation, for example examining the skin for features of a dermatological disease in a patient complaining of a rash.

Genital examination
The clinical history should indicate the extent of the required examination. For example, a bimanual pelvic examination is not usually indicated unless an aspect of the history raises concerns regarding pelvic pathology. If the patient has symptoms, then a genital examination should be undertaken as follows:

**Female examination**
- **Inspection of the vulva**: look for discharge, ulcers, blisters, excoriation and inflammation, changes in skin colour or texture and lumps such as genital warts. Noting down negative as well as positive findings will be helpful for future examinations
- Palpate the inguinal region for lymphadenopathy
- **Pass a speculum**: only use a small amount of lubricant such as KY jelly as this can interfere with cervical cytology and measuring the vaginal pH. The speculum can be lubricated with warm water as an alternative
- **Inspect the vagina and cervix**: look for inflammation, a retained foreign body, and assess the amount, colour consistency and odour of any discharge. Document the appearance of the cervix (e.g. healthy, cervical ectropion) and the presence of IUD threads if applicable
- **Bimanual examination**: this should be undertaken only if indicated by the history. Although positive findings such as a mass are helpful, a negative bimanual examination does not exclude pathology (Box 1.8)

**Male examination**
- Inspection of the anogenital area: look for discharge, skin lesions
- Palpate the inguinal region for lymphadenopathy
- Palpate the scrotal contents for masses and tenderness
- Examine the urethral meatus for discharge and skin lesions

**Rectal and oropharyngeal examination**
- Should be undertaken in those with symptoms at these sites

Investigations
Specialized SRH services have facilities for on-site microscopy (Figure 1.8). This allows immediate examination and reporting of specimens from patients with symptoms, expediting diagnosis and treatment. Point-of-care tests (POCTs) are also available in some specialist services. It is increasingly common for diagnosis and management of sexually transmitted infections (STIs) to take place in non-specialist settings such as primary care. New technologies allow less intrusive sampling and facilitate this.

**Asymptomatic men and women**
- Men and women attending an SRH consultation are often asymptomatic. The development of highly accurate laboratory tests which identify minute amounts of organism DNA and RNA – nucleic acid amplification tests (NAATs) – has enabled the development of self-taken sampling (Figure 1.9)
- These tests do not require viable organisms so are less affected by transport issues, allowing testing to be undertaken in a variety of settings
- The minimum investigations constituting an ‘STI screen’ in an asymptomatic individual and the method of sampling are listed in Box 1.9, Table 1.3 and Figure 1.10
- An STI screen in an asymptomatic MSM who has had receptive oral sex should include a pharyngeal sample for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* NAATs
- An STI screen in an asymptomatic MSM who has had unprotected receptive anal sex should include a blind rectal sample for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* NAATs

**Investigations in symptomatic females**
- **Vaginal pH**: using narrow range pH paper (4–7) (Chapter 12)
- **Wet mount and Gram stain**: Material from the vaginal walls and posterior vagina can be used to prepare a suspension in normal saline (wet mount) and a Gram-stained smear for immediate microscopy
- **High vaginal swab**: can be taken in settings without access to cervical cytology and measuring the vaginal pH. The speculum can be lubricated with warm water as an alternative
- **Bimanual examination**: this should be undertaken only if indicated by the history. Although positive findings such as a mass are helpful, a negative bimanual examination does not exclude pathology (Box 1.8)
- **Endocervical swab**: for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* NAAT if the woman is being examined. An additional swab can be taken for microscopy, culture and sensitivity if gonorrhoea is suspected
- **Viral swab**: for herpes simplex virus and syphilis polymerase chain reaction (PCR) if presenting with anogenital ulcers
- **Oropharyngeal and rectal samples**: for chlamydia and gonorrhoea should be taken in symptomatic patients or high risk situations (e.g. sexual assault)

**Investigations in symptomatic males**
- **Urethral smear**: on slide for Gram stain (microscopy) and for culture and sensitivity for gonorrhoea
- **First void urine**: for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* NAAT
- **Viral swab**: for herpes simplex virus and syphilis polymerase chain reaction (PCR) if presenting with anogenital ulcers
- **Oropharyngeal and rectal samples**: for chlamydia and gonorrhoea NAAT should be taken in symptomatic patients or high risk situations. Additionally, a rectal swab for microscopy (gram stain), culture and sensitivity for gonorrhoea should be taken in men with symptoms of proctitis or anal discharge