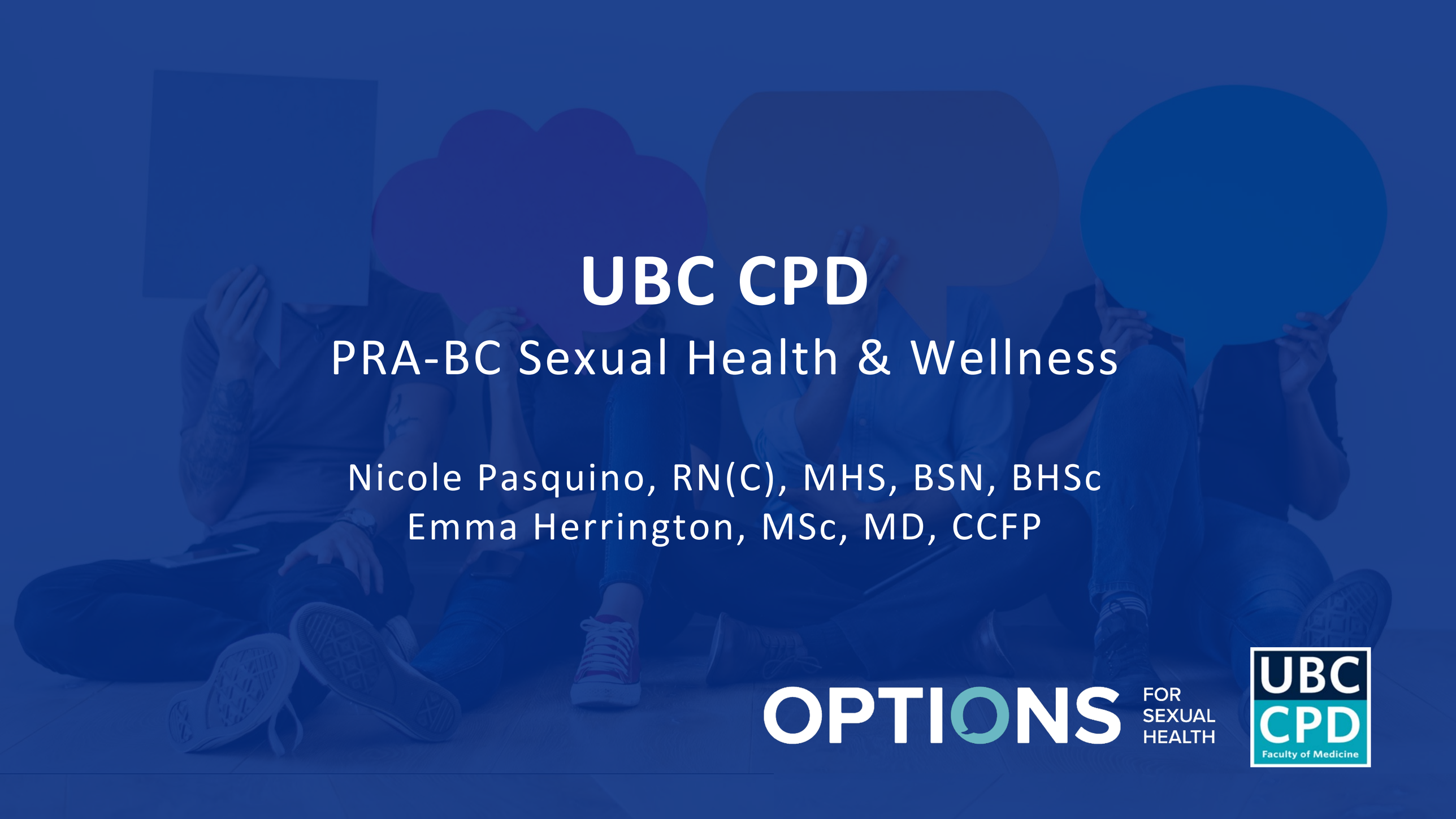

UBC CPD

PRA-BC Sexual Health & Wellness

Nicole Pasquino, RN(C), MHS, BSN, BHSc
Emma Herrington, MSc, MD, CCFP

OPTIONS FOR SEXUAL HEALTH

UBC CPD Faculty of Medicine

We gratefully acknowledge that this work takes place on the unceded ancestral homelands of the xʷməθkʷəy̓əm, Skxwú7mesh and səlilwətaʔɬ peoples.

We stand in solidarity with these Nations and are committed to the decolonization of our practice.

It is the role of all health care providers to ensure that the care they deliver is responsive to the needs of their patients. For Indigenous patients, this includes being considerate of the ways that colonization and racism have shaped their relationship with the health care system.

It’s important to take time to understand and reflect on the ways we may need to evolve and adapt our own practice in order to create a welcoming, inclusive and affirming care experience for Indigenous patients and their families.

Learn more about Indigenous peoples and tools that you can use for effective communication and relationship building through the San’yas Core Indigenous Cultural Safety Health Training - www.sanyas.ca/training/british-columbia/core-ics-health

Disclosures

Affiliations, financial or otherwise, with a pharmaceutical, medical device, or communications organization that may have a direct or indirect connection with the content of this module.	
Nicole Pasquino	**Relationships with commercial interests:** None to declare **Other relationships:** Options for Sexual Health **Disclosure:** Options is a not-for-profit health care organization and contracted service provider to the BC Provincial Health Services Authority (PHSA). Options generates a very small amount of revenue from sales of a limited formulary of contraceptives at affordable prices and without dispensing fees. **Mitigating potential biases:** Modules/presentation/discussions include: • current evidence-based STI treatment guidelines and practices in BC • contraceptive options available in BC, with focus on evidence for effectiveness • evidence-based off label uses will be identified when discussed.

OPTIONS FOR SEXUAL HEALTH

ALL ABOUT CHOICES

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Emma Herrington	**Relationships with commercial interests:** Bayer **Other relationships:** Options for Sexual Health **Disclosure:** Options is a not-for-profit health care organization and contracted service provider to the BC Provincial Health Services Authority (PHSA). Options generates a very small amount of revenue from sales of a limited formulary of contraceptives at affordable prices and without dispensing fees. I have received speaking honoraria for moderating and presenting for events organized by Bayer (World Contraception Day). **Mitigating potential biases:** Modules/presentation/discussions include: • current evidence-based STI treatment guidelines and practices in BC • contraceptive options available in BC, with focus on evidence for effectiveness • evidence-based off label uses will be identified when discussed.

OPTIONS FOR SEXUAL HEALTH

ALL ABOUT CHOICES

Learning Outcomes

By the end of these modules, participants will be able to:

- Discuss legislation, standards and guidelines relevant to patient rights and physician practice in BC
- Differentiate biological sex, sexual orientation and gender identities
- Appraise how language and values influence care provided and received
- Review sexual health history
- Contrast diagnostic vs. screening approaches
- Identify sample collection methods and perform appropriate testing
- Identify contraceptive pharmaceuticals and devices available in BC
- Discuss frequently asked clinical questions

Unit 1: Introduction

General Reminder

To create a safe space, we:

- all retain rights to our own beliefs, values, and opinions; these may differ from others, and that is OK
- acknowledge that we all come from different cultures, backgrounds, experiences – and these inform and influence who we are, our knowledge and believes, and our values.
- presume goodwill; we are, after all, wanting the best for ourselves, our families, our colleagues and our patients.
- are responsible for our own learning

Values

Today is not about changing your personal values regarding sex and sexuality.

Invitation:

- Identify, clarify and evaluate your values
- Assess if they continue to serve you (and your patients) well.

Unit 1 – Self-Reflection

Think about the following:

- How did you learn about sex (and sexuality)?
- Does how you learned serve you well?
- How does it influence you now?
- If there are children in your life, would you want them to learn about sex (and/or sexuality) as you did? If not, how would you like them to learn?

OPTIONS FOR SEXUAL HEALTH

Sex-positivity

"Sex-positivity is the view that the only relevant measure of a sexual act, practice, or experience is the consent, pleasure, and well-being of the people engaged in it or the people affected by it. In my experience, this is a much more useful way of exploring sexuality because it helps us see past our own triggers and squicks, set aside our judgments, and make room for the diversity of human sexuality."

Charlie Glickman, PhD

Unit 2: Legislation, Guidelines & Practice Standards in BC

Unit 2
Case Study Walk Through: Melody

OPTIONS FOR SEXUAL HEALTH

Melody & Dr. Patel

- Melody goes to see Dr. Patel, who has never seen her before without one of her parents accompanying.
- She is late for her appointment, and a little breathless on account of having had to leave soccer practice early for the appointment.
- She recently turned 12 years old, appears physically mature, is soft spoken and seems quite anxious – avoiding all eye contact.
- Melody asks Dr. Patel for birth control.

Which of the following is the most appropriate response by Dr. Patel?

a) Discuss confidentiality, needs, benefits, risks of various contraceptive options and assess Melody's capacity to understand.
b) Explain that a physician in BC is not able to provide a prescription to a young minor without parents' consent.
c) Take a sexual health history
d) A, B & C
e) A & C only

Melody & Dr. Patel

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c) Take a sexual health history
d) A, B & C
e) A & C only

Infants Act

Section 17 of the Infants Act addresses consent for medical treatment of people < 19 years of age.

All people under 19 years are termed “infant”; however, "mature minors" can consent to care.

A *mature minor* is a child under the age of 19 who is considered capable of giving consent, as determined by three criteria:

- ✓The child understands the nature of treatment and possible risks
- ✓The child has the capacity to give consent either verbally or by gesture
- ✓The care is in the child's best interest.

CMA Code of Ethics

If you haven't read this already, add it to your “to do” list.

Melody & Dr. Patel

Dr. Patel takes a sexual health history.

- Melody has had vaginal intercourse with more than one person
- She thinks one of her partners may have had other partners
- She has no symptoms

She seems reluctant to tell Dr. Patel much more. Then, she starts to cry.

It would be reasonable if Dr. Patel:

a) Acknowledges that these are personal questions asked of all patients, regardless of age, gender or sexual orientation. Although they are very personal topics, they are important for her overall health and wellbeing.
b) Defers STI testing because there is no chaperone available today for Melody's examination
c) Puts an arm around Melody to console her until she stops crying
d) A & B only
e) A, B & C

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Physical Examinations & Boundaries

Physical Examinations and Procedures

Always obtain patient consent before proceeding with [any] physical examination or procedure, which includes clearly explaining the rationale for the physical examination or procedure and what it will involve

Offer option for chaperone (irrespective of gender).

Boundary Violations in the Patient-Physician Relationship

Clear professional boundaries ensure the protection of both patients and physicians.

Boundaries include but are not limited to sexual

Melody & Dr. Patel

After Melody has stopped crying, with a little prompting she tells Dr. Patel more:

- Her boyfriend will be 14 years old this week.
- They *always always always* use condoms.
- She isn't totally sure when her last menstrual period (LMP) was. It was "a while ago". But her periods are not regular, and she sometimes only bleeds every few months.

Dr. Patel's care would now best include:

a) Calling a Ministry of Child and Family Services (MCFD) Social Worker because Melody is under 16 years old, Canada's age of consent
b) Recommending a urine pregnancy test and either vaginal self-collected sample or first void urine sample for Chlamydia/Gonorrhea Nucleic Acid Amplification Test (CT/GC NAAT)
c) Discussing contraceptive options
d) B & C only
e) A, B & C

Melody & Dr. Patel

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Age of Consent

Consent implies the ability to understand and agree to an activity.

Bill C-2, Tackling Violent Crime Act, defines age of consent for non-exploitative sexual activity as 16 years. There are exceptions to the age of consent:

- Youth aged 14-15 can consent to sex with people who are no more than 5 years older
- Youth aged 12-13 can consent to sexual activity with people who are no more than 2 years older
- It is illegal for a child < 12 yrs to engage in sexual activity
- For youth under 18 years, consent to sexual activity with someone who is in a position of power such as a teacher, coach or babysitter is never considered consensual.

Melody & Dr. Patel

- The pregnancy test is positive.
- Melody is frantic. “F*ck! What do I do!? I have to get rid of it. How do I do that? You can’t tell my parents. Please!” She starts to sob.
- Dr. Patel is now feeling very uncomfortable, in part because of their own personal values and convictions against abortion. Also, as a parent, Dr.Patel would want to know if their own young daughter was pregnant.

How should Dr. Patel proceed?

a) Say, “I will arrange for another colleague to refer you because termination of a pregnancy conflicts with my own beliefs and convictions.”
b) Offer patient-centred pregnancy information resource that includes all options - parenting, adoption and abortion. For example, Options for Sexual Health website &/or phone advice line (1-800-SEX-SENSE).
c) Explain that in this kind of medical situation where a doctor can no longer maintain confidentiality and her parent(s) will need be informed.
d) B & C only
e) A & B only

Melody & Dr. Patel

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c) Explain that in this kind of medical situation where a doctor can no longer maintain confidentiality and her parent(s) will need be informed.
d) B & C only
e) A & B only

Conscientious objection to providing care

CPSBC defines “Conscientious Objection to Providing Care”

- **if this topic applies to you**, we *strongly* recommend that you have a conversation with the CPSBC Registrar after reviewing relevant Standard

Intentions: to mitigate risk of complaint to the College against you and to provide best care for your patients.

Abortion

- Legal in Canada
- Does not require physician referral in many cases (e.g. patients can self-refer to abortion clinics or FP providers, though referrals are welcome).
- In rural areas, some providers will require referral for reasons of privacy and security.
- If a gynaecologist is the only clinician in town offering abortion services, then referral is usually required.
- Patients will present to any FP for advice relating to abortion, including what kind of abortion (medication or procedural).

Abortion Resources

Finding a Provider	Options Counselling	Support for Patients
1. **SexSense** (https://www.optionsforsexualhealth.org/facts/abortion/abortion-providers/) 2. **Pregnancy Options Line,** 1-888-875-3163 3. Choiceconnect.ca	**Innovating Education abortion counselling resources:** https://www.innovating-education.org/course/the-framework-counseling-for-patient-centered-abortion-care/	1. **Exhale Pro-Voice:** https://exhaleprovoice.org/ 2. **Abortions welcome:** https://abortionswelcome.org/ 3. **MyPostCare:** https://mypostcare.ca/

Melody & Dr. Patel

- Following a more systematic approach to taking a history, the doctor asks about other partners and types of sex.
- Melody has had vaginal, anal and oral sex with the best friend of her 18 year old brother.
- Dr. Patel asks, “Did you want to have sex with him?”
- Melody replies, “No, I totally feel pressured. He’s over at our house all the time… always grabbing at me when no one’s looking. Last night was the third time he’s made me do it.” She starts to cry again.

What are Dr. Patel’s next steps?

a) Explain the law around consent, age of consent, sexual assault, legal duty to report, and who they will report to.
b) Explore Melody’s perceptions of her family’s beliefs and values, and her safety at home.
c) Call Child and Family Services while Melody is in the room and discuss this with the Social Worker.
d) Arrange for an emergent ultrasound to determine dates.
e) A, B, C & D

Melody & Dr. Patel

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e) A, B, C & D

Age of Consent, cont'd

REMEMBER, all sexual activity without consent is a criminal offence… regardless of the victim's age!

Duty to Report & Reporting a Child in Need of Protection

See relevant CPSBC documents

Child, Family and Community Service Act: Child

Ensures the protection of the child. If a physician believes a child has been physically, sexually or emotionally abused or harmed or sexually exploited, then he/she has a duty to report.

Child, Family and Community Service Act defines "child" as a person less than 19 years of age (and "youth" as a person who is 16 years of age or over, but is under 19 years of age).

Balance safety, urgency and trust.

***Remember*: you may be the only person the child trusts and has confided in.**

Melody & Dr. Patel

- A few days later, Melody's self-collected vaginal CT/GC NAAT comes back positive for Chlamydia.

What are Dr. Patel's next steps?

a) Treat Melody with appropriate antibiotics.
b) Discuss partner notification options with Melody.
c) Get public health involved re contacting and treating the alleged abuser.
d) Complete and submit to BCCDC the Confidential Notification of Sexually Transmitted Infection report (Health 208).
e) A, B, C, D

Melody & Dr. Patel

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e) A, B, C, D

Public Health Act

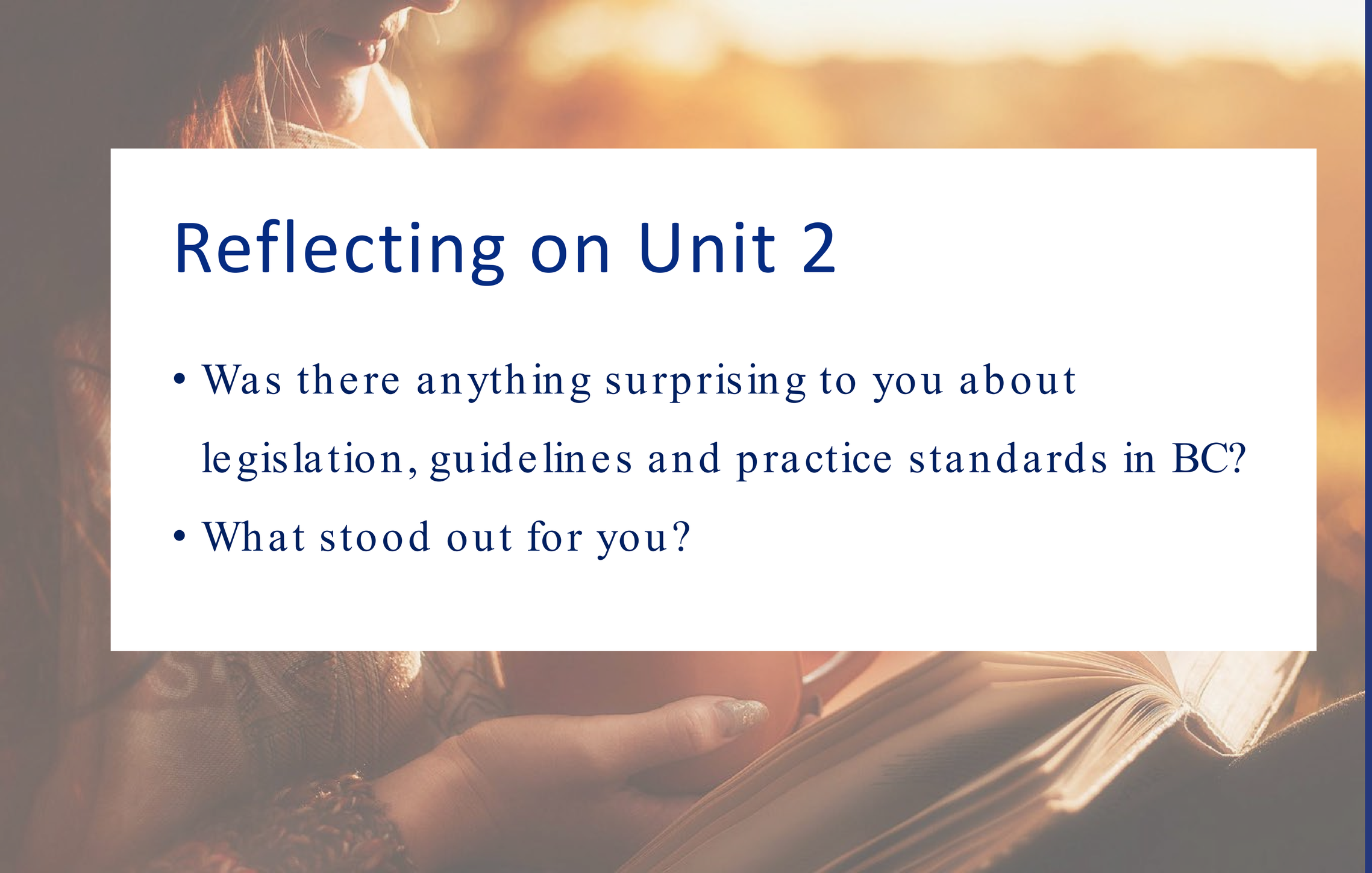
The **Public Health Act** (PHA) identifies specific STI that are reportable by health care providers/laboratories to BC Medical Health Officers (MHO).

The PHA empowers the MHO to ensure there is adequate treatment and follow up

MHO power is used judiciously to protect the rights of an individual and ensure confidentiality

The PHA also stipulates the need for notification, treatment, screening and partner counselling.

In BC, partner notification and treatment may be performed by the physician or public health.



Reflecting on Unit 2

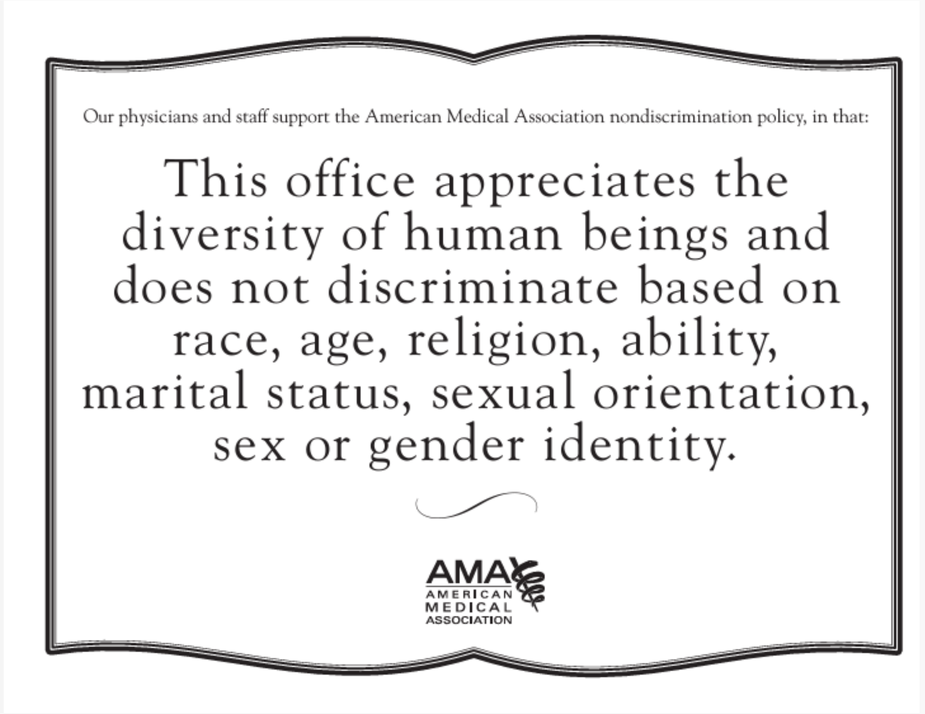
- Was there anything surprising to you about legislation, guidelines and practice standards in BC?
- What stood out for you?

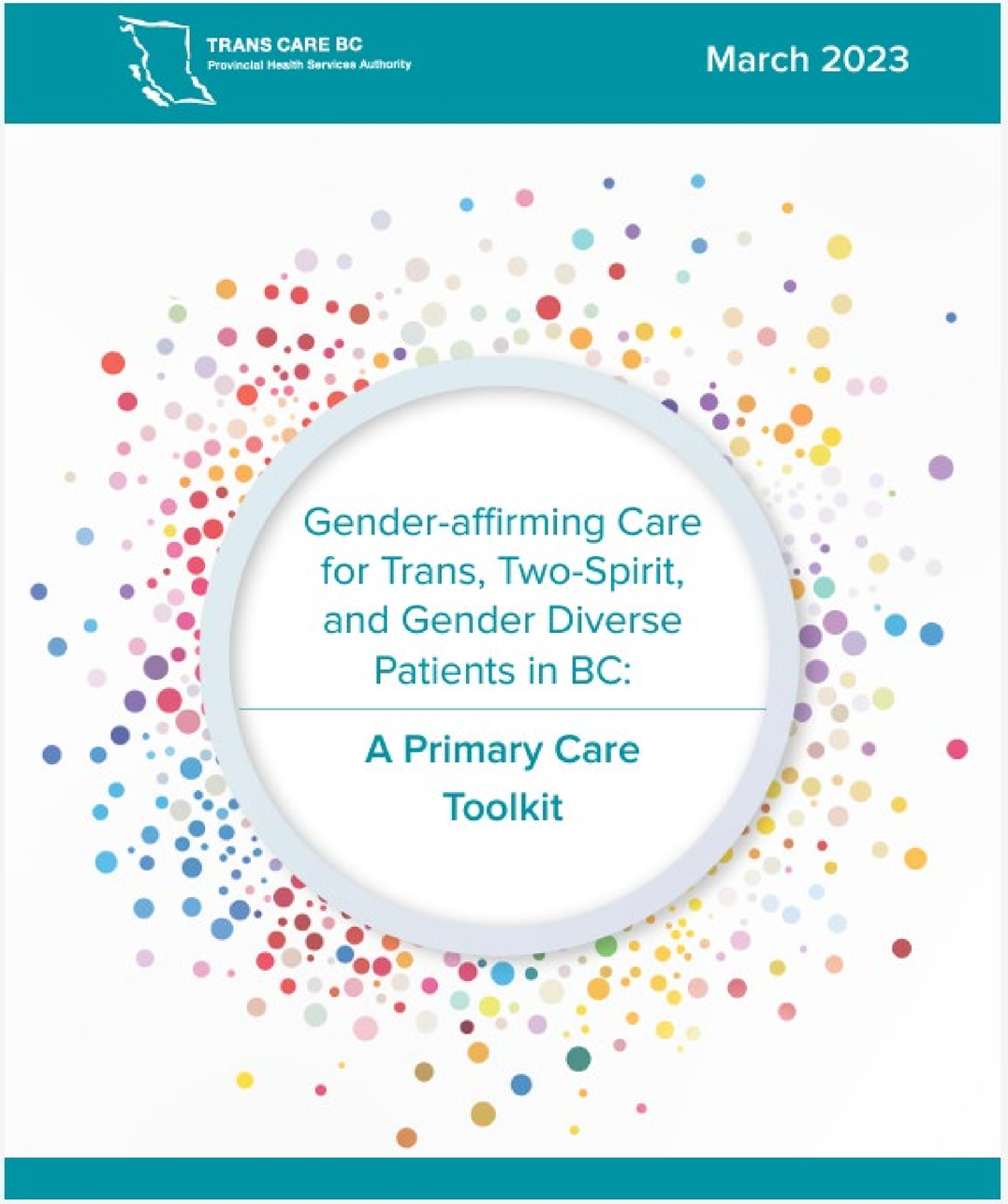
ALL ABOUT CHOICES

Unit 3:
Gender & Sexuality

All Patients are welcome!

- ✓Display brochures and educational materials about LGBTQ2S+ health concerns.
- ✓Visibly post a non-discrimination statement (PDF).
- ✓Display posters from nonprofit LGBTQ2S +organizations.





OPTIONS FOR SEXUAL HEALTH

Suggestions for Primary Care Providers role in gender inclusive care (from TransCare BC)

- ✓ Provide an inclusive clinical environment where patients will feel safe talking about their gender/sexuality
- ✓ Respect your patient's right to self-determine their gender identity and sexual orientation
- ✓ Maintain a gender-affirming approach, including using chosen names and pronouns when interacting with, on behalf of, or when charting on your patient
- ✓ Be prepared to discuss gender and the range of gender-affirming health care options available
- ✓ Discuss current supports and plans for navigating transition in relationships, work or school settings and offer support and resources

Primary Care Providers role in gender inclusive care

- ✓ Assist patients to change their name and identification documents, if desired (see www.transcarebc.ca for more info)
- ✓ Be prepared to work with families, partners and significant others to nurture and sustain supportive relationships, especially when working with youth
- ✓ Work to stabilize any physical or mental health conditions to ensure they do not pose barriers to the patient accessing gender-affirming interventions such as hormones or surgery
- ✓ Seek to restore or build capacity, where it is diminished, to ensure it does not pose a barrier to patient's ability to provide informed consent

- ✓ Assist in facilitating hormone therapy, and with those seeking surgical interventions
- ✓ NEED Help?
  - Trans care BC is there to walk you through

Clinical Handbook

Clinical resources to help learners provide gender-affirming care to trans, Two-Spirit and non-binary people.

Learn more

Education Centre

Professional development courses and educational resources for clinicians and the community. Mainpro+ credits available.

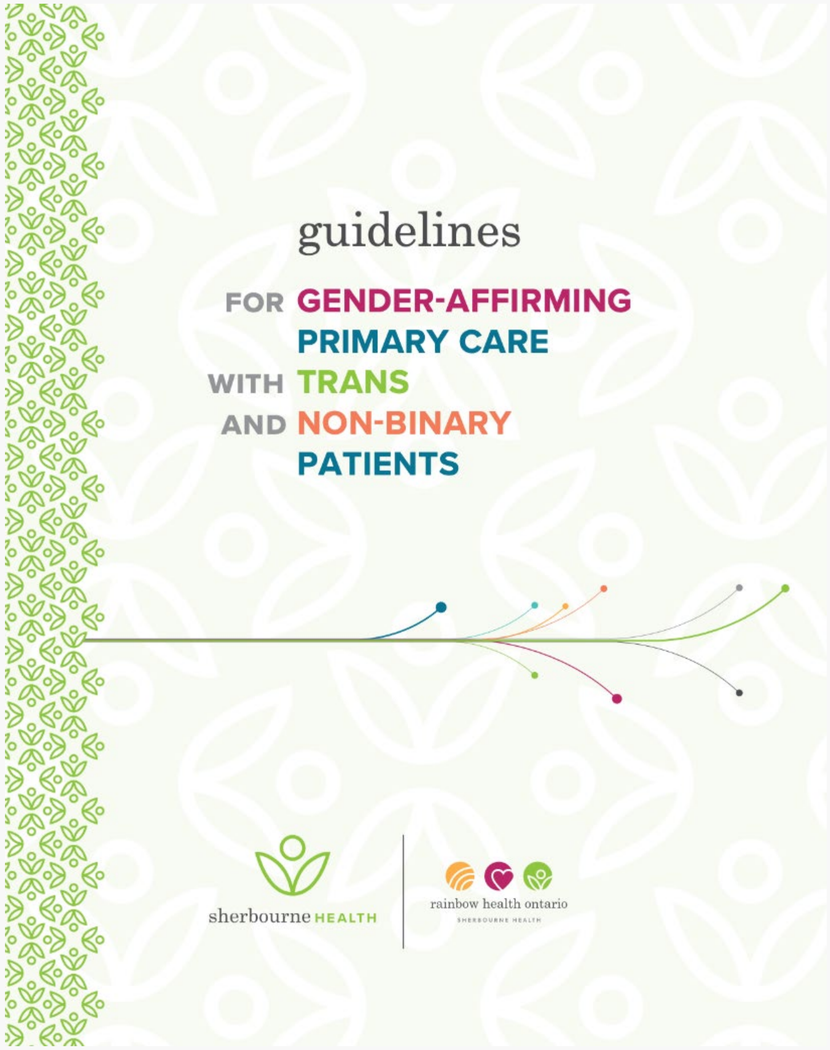
Learn more

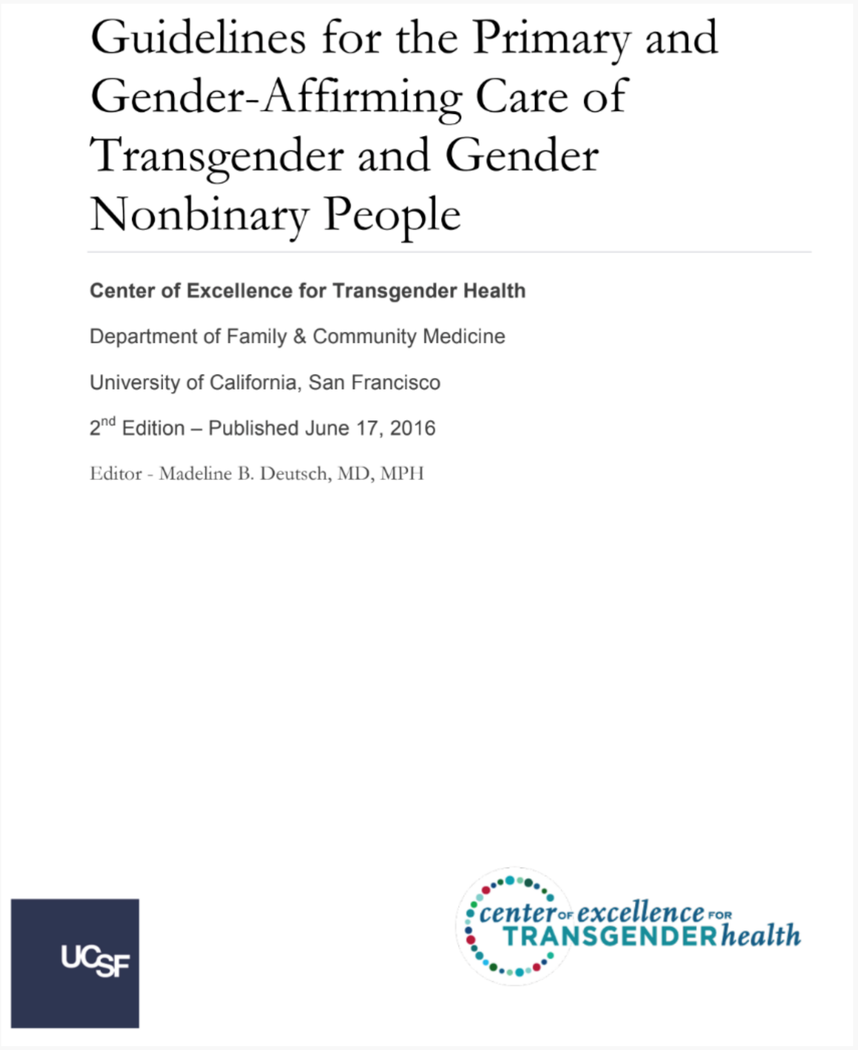
RACE & eCASE

Rapid access to consultative expertise on gender-affirming care.
Local calls: 604-696-2131
Toll-free: 1-877-696-2131

Get RACEapp+

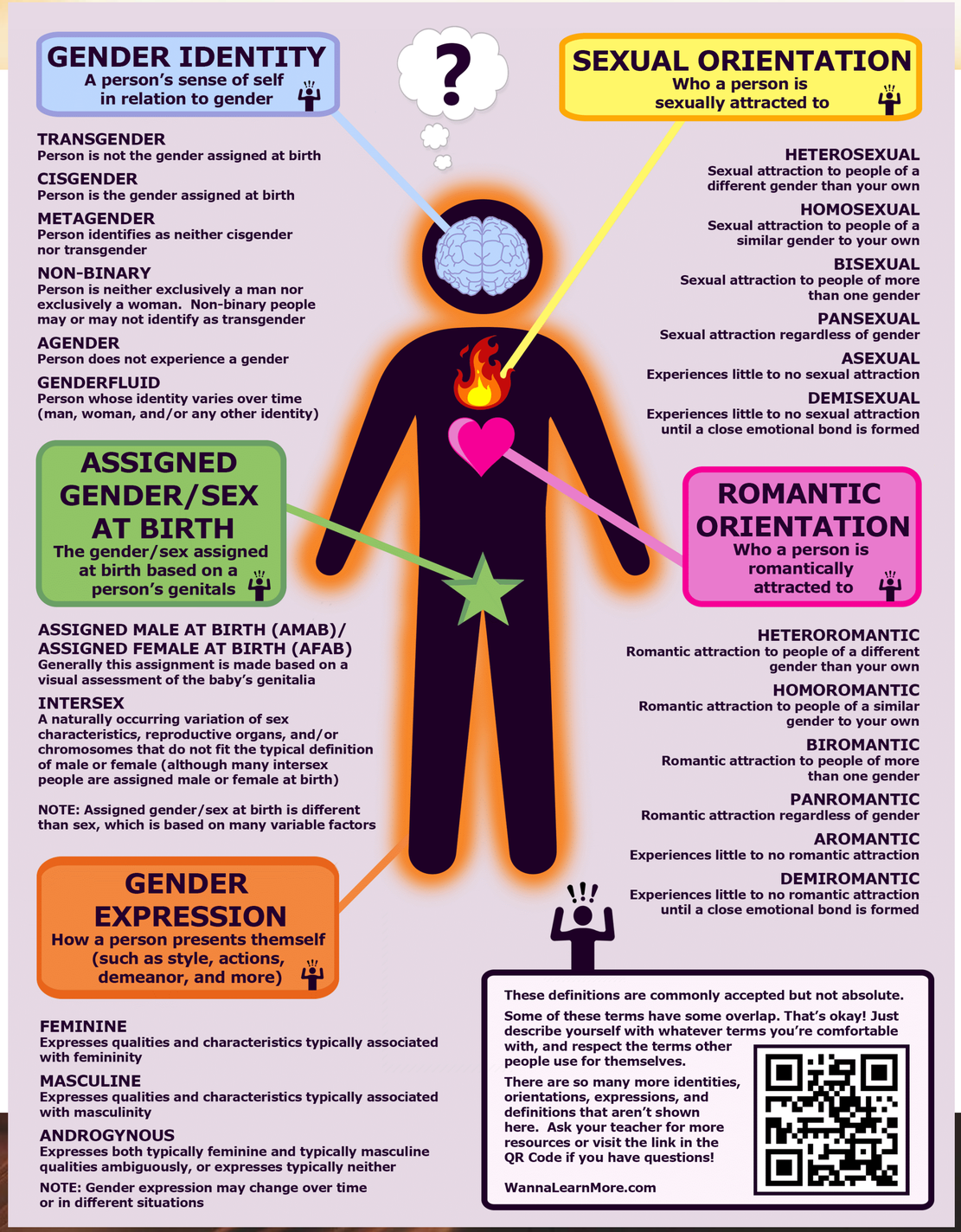
Other helpful resources for providers





Reflecting on Unit 3

What is one thing that you learned that will change your practice?



Unit 4: Trauma & Violence Informed Care

Working toward a trauma-informed practice

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Examples may be

- Experiencing or observing physical, sexual, and emotional abuse;
- Childhood neglect;
- Having a family member with a mental health or substance use disorder;
- Experiencing or witnessing violence in the community or while serving in the military; and/or
- Poverty and systemic discrimination.

TIPS for creating a trauma-informed practice – in the office (organizational) and with your patients (clinical)

Organizational	Clinical
▪ Leading and communicating about the transformation process ▪ Engaging patients in organizational planning ▪ Training clinical as well as non-clinical staff members ▪ Creating a safe environment ▪ Preventing secondary traumatic stress in staff ▪ Hiring a trauma-informed workforce	▪ Involving patients in the treatment process ▪ Screening for trauma ▪ Training staff in trauma-specific treatment approaches ▪ Engaging referral sources and partnering organizations

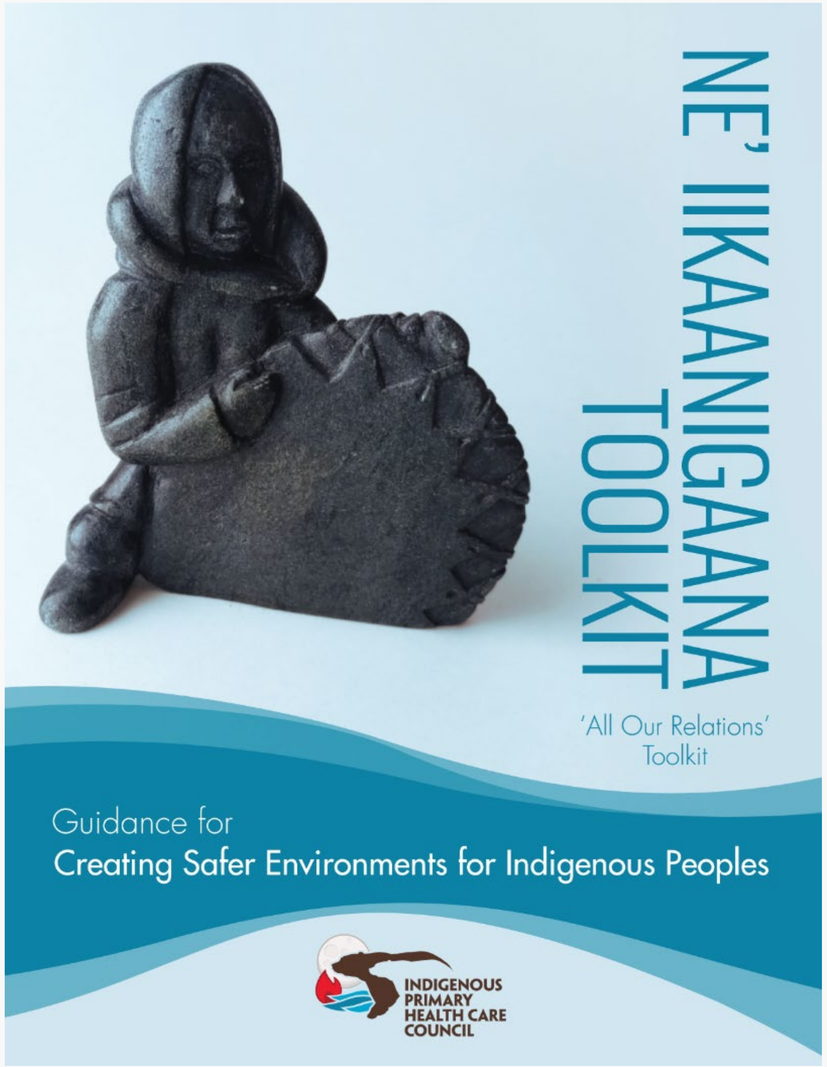
Creating a safe space for Indigenous Patients in Primary Care

San’yas Anti-Indigenous Racism Cultural Safety Training Program

- https://sanyas.ca/courses/british-columbia
- Self-paced course with topics covering colonization in Canada and taking action to strengthen Indigenous Cultural safety

Indigenous Primary Health Care Council Toolkit

- Helpful document covering community building and practical changes for your healthcare space



Language Matters

a brief guide to trauma informed language during sensitive exams

The language we use when we interact with patients/clients may reinforce trauma, such as past experiences of physical assault, or can trigger trauma responses. Consider your setting, your clinical encounter and your approach. Changing just a few words may improve your patients experiences.

INSTEAD OF	TRY..	RATIONALE?
Bed	Table	MAY TRIGGER TRAUMA
STIRRUPS	FOOT REST	MEDICALIZED LINGO
RELAX	TAKE A FEW DEEP BREATHS	MAY TRIGGER TRAUMA
OPEN YOUR LEGS, SPREAD YOUR LEGS	LET YOUR LEGS FALL TO THE SIDE	MAY TRIGGER TRAUMA
ARE YOU COMFORTABLE?	ARE YOU DOING OKAY?	MAY TRIGGER TRAUMA
'SCOOCH' DOWN	MOVE DOWN THE TABLE	COLLOQUIALISM/ INFANTILIZING
COVER/EXPOSE YOURSELF	RAISE/LOWER THE DRAPE	MAY TRIGGER TRAUMA
TOUCH/FEEL (I.E. I AM GOING TO TOUCH YOU HERE...)	EXAMINE, PALPATE	MAY TRIGGER TRAUMA

BCIT Reproductive Health, 2024

INSTEAD OF	TRY..	RATIONALE?
AWESOME, GREAT, PERFECT	OKAY, THANK YOU	VALUE JUDGEMENT
I'M 'JUST' GOING TO	IM GOING TO..	CAN BE MINIMIZING, BE DIRECT
POWER STATEMENTS, SUCH AS "I AM HERE TO GIVE YOU"...	YOU ARE HERE FOR...	DECREASES POWER DYNAMIC
I'M GOING TO GET YOU TO..	WOULD YOU PLEASE	DECREASES POWER DYNAMIC
IM GOING TO 'CLEAN' YOUR CERVIX	I'M GOING TO REMOVE THE MUCUS FROM YOUR CERVIX	VALUE JUDGEMENT
INSPECT/LOOK/INSERT	EXAMINE/ASSESS	MAY TRIGGER TRAUMA
SPREAD I.E. I'M GOING TO SPREAD YOUR LABIA	SEPARATE	MAY TRIGGER TRAUMA

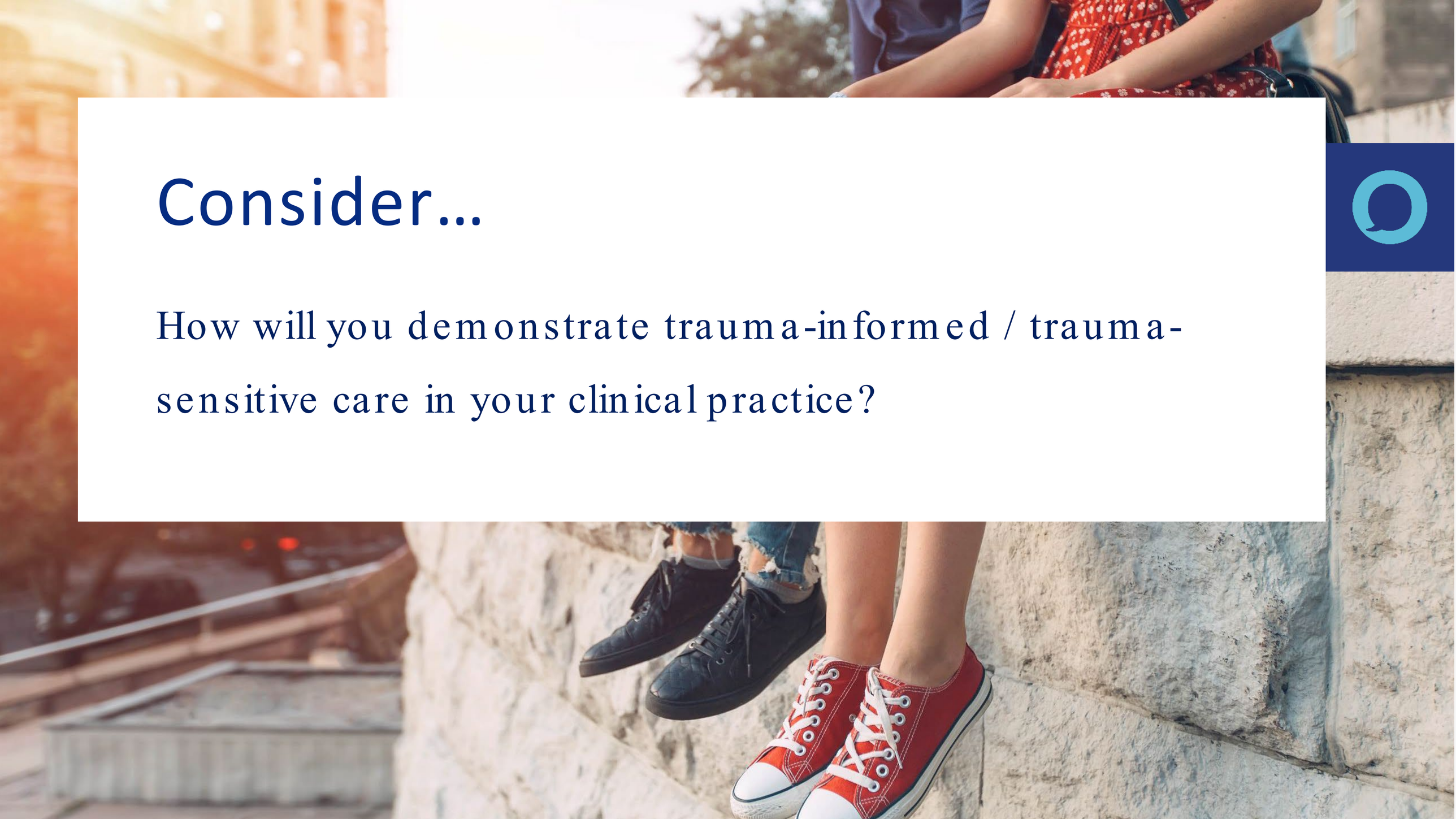
Remember...

WE ARE ONLY HUMAN AND WILL MAKE MISTAKES WITH OUR LANGUAGE, PLEASE AND THANK-YOU GO A LONG WAY!

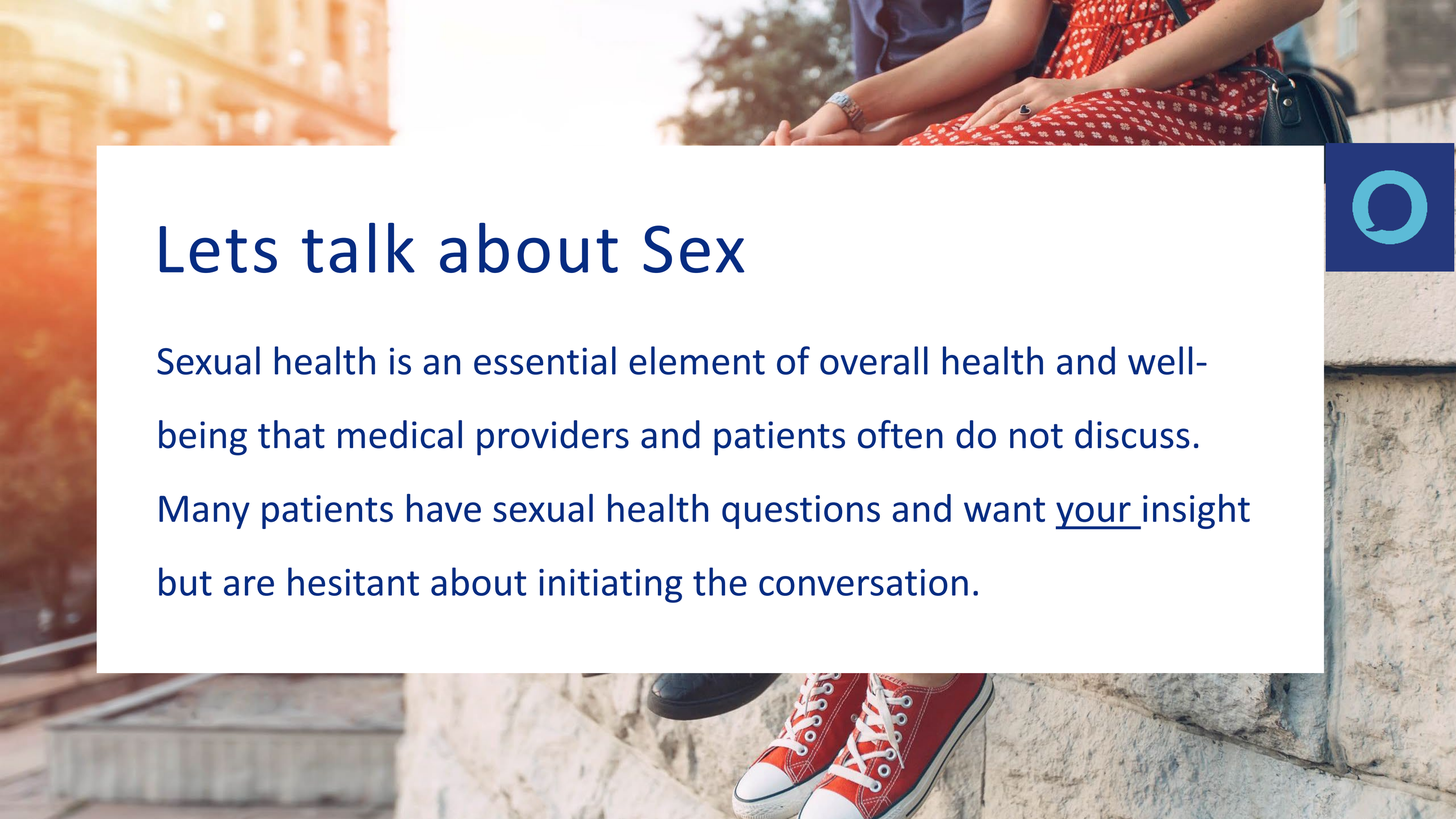
BCIT Reproductive Health, 2024

Consider…

How will you demonstrate trauma-informed / trauma-sensitive care in your clinical practice?



Unit 5: Sexual Health Clinical Encounter



Lets talk about Sex

Sexual health is an essential element of overall health and well-being that medical providers and patients often do not discuss. Many patients have sexual health questions and want your insight but are hesitant about initiating the conversation.

Why?

- Screen for and treat STIs and address other sexual health concerns, commonly contraception.
- Counsel and share information about behaviors that may increase STI/pregnancy risk.
- Gain an overall picture of your patient’s health.

Get the conversation started…

- Use the 5 Ps
  - **P**artners, **P**ractices, **P**rotection from STIs, **P**ast History of STIs, and **P**regnancy Intention.
- Avoid assumptions
- Ask EVERYONE (and let your patients know that you do)
- Pose non-judgemental questions and be willing to defer details

Use open-ended questions

- What brings you in today?
- In order for me to assess what kind of care/testing I should offer you, can you tell me what sex your sexual partners are? vs. “So, you have a girlfriend?”
- Is there anything else about you that would be helpful for me to know today?

Keeping the client informed/transparency and ask permission first

Building on the 5 Ps

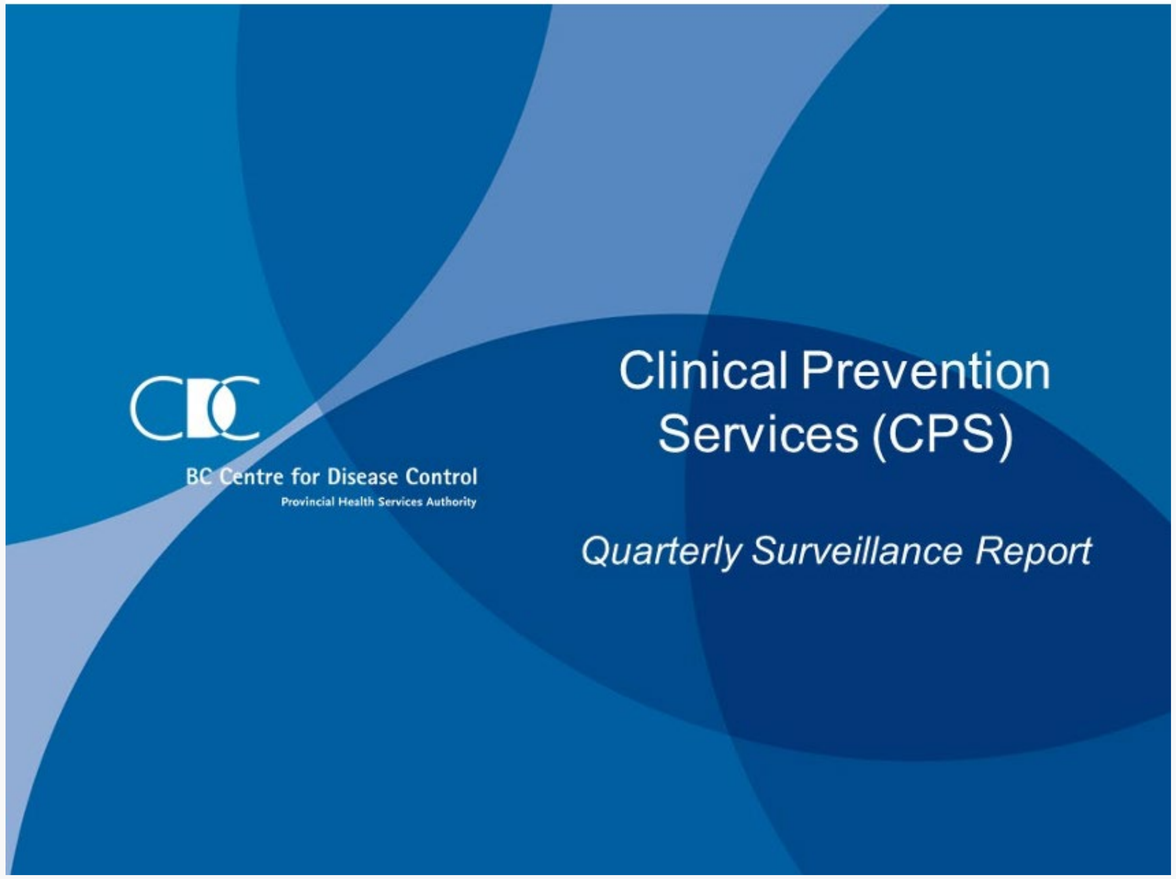
Reflecting on Unit 5

What is one tip that you learned from the material that you can share with your colleagues?

Unit 6: STI Highlights

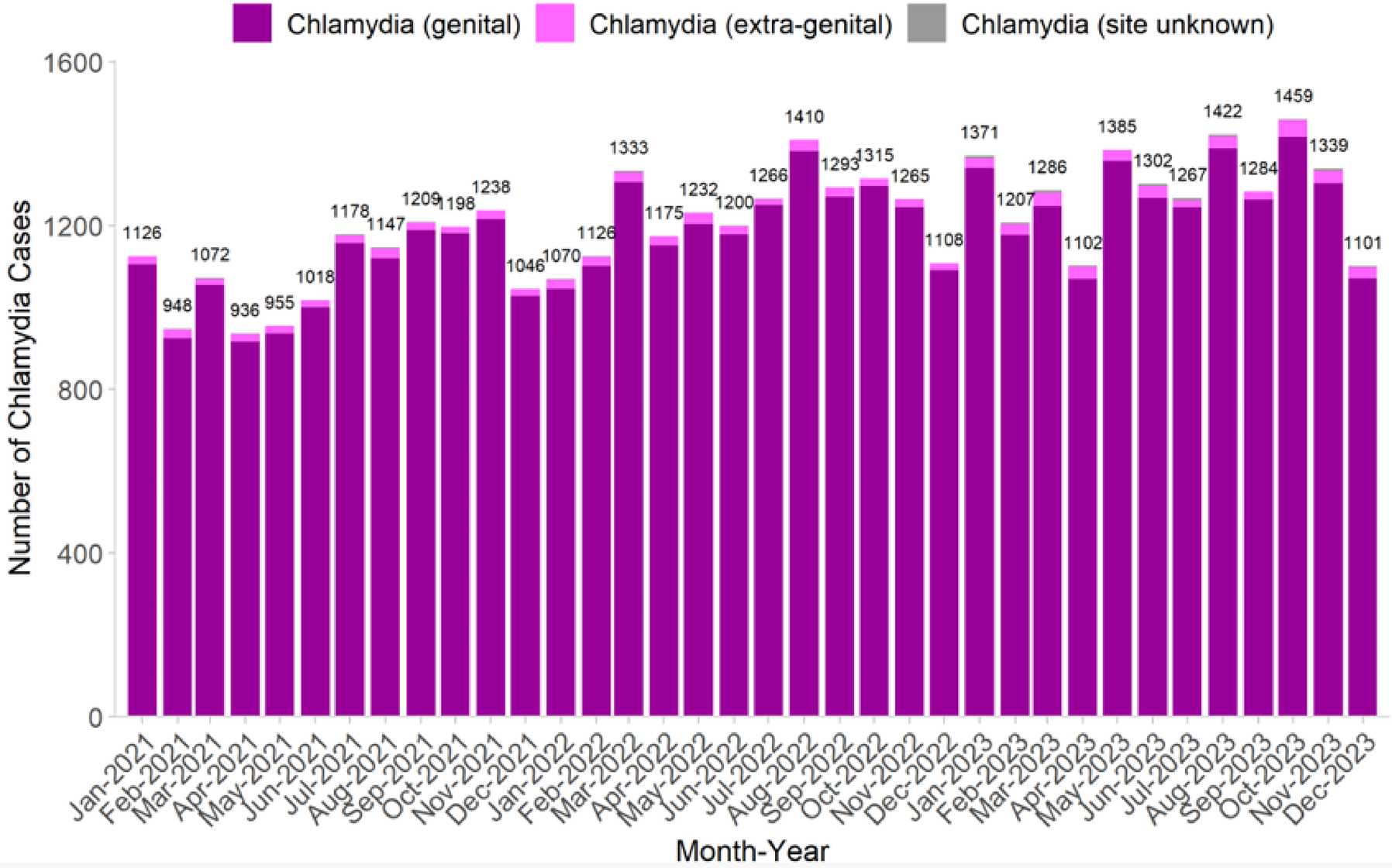
STI Trends in BC – Clinical Prevention Services

Rates of gonorrhea and chlamydia have been increasing over the past decade. Similarly, the incidence of syphilis in BC has been increasing, particularly in men who have sex with men, but also in women aged 15 to 49 years.



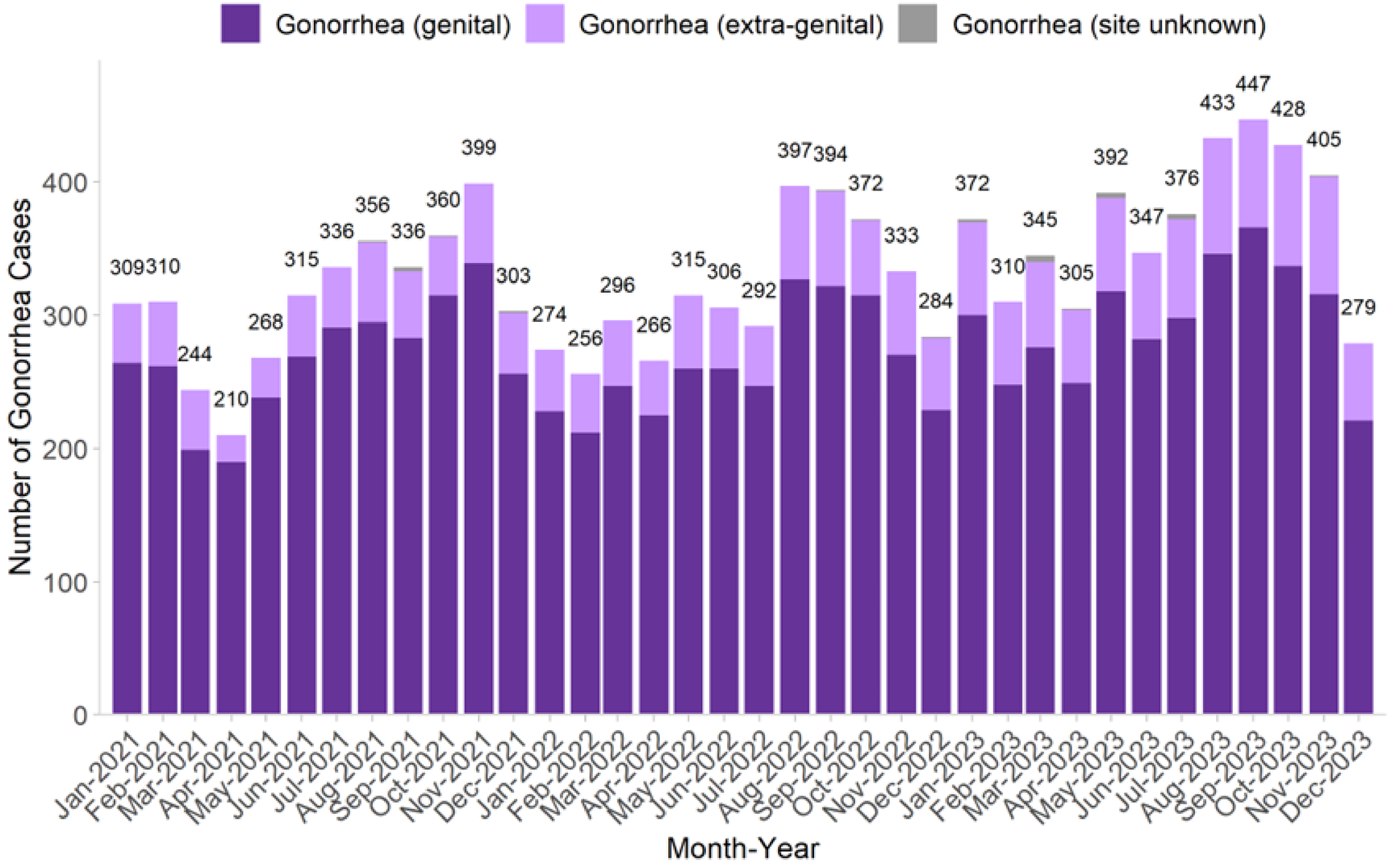
Chlamydia

6. Genital and Extra-genital Chlamydia case reports in BC by month



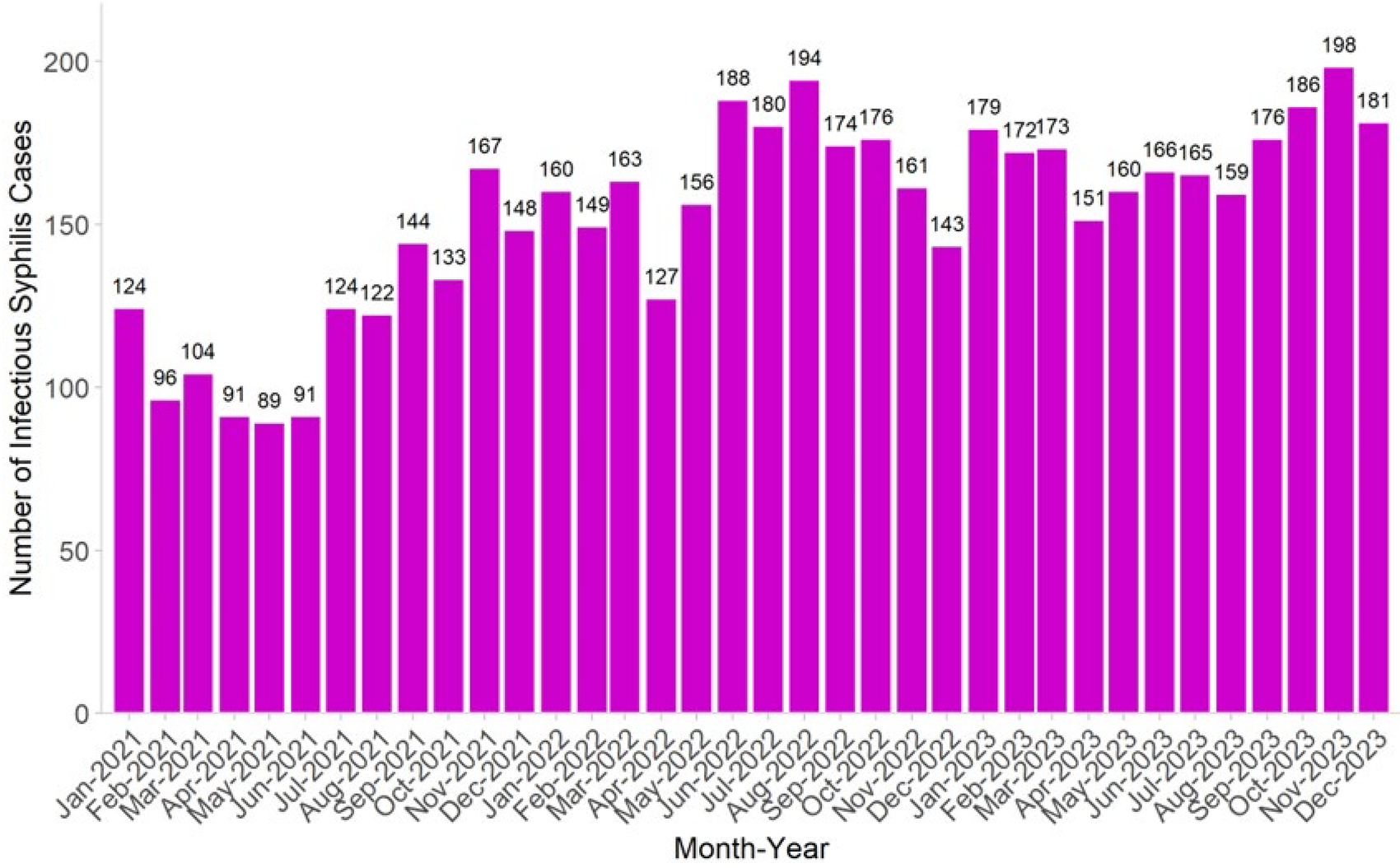
Gonorrhea

11. Genital and Extra-genital Gonorrhea case reports in BC by month



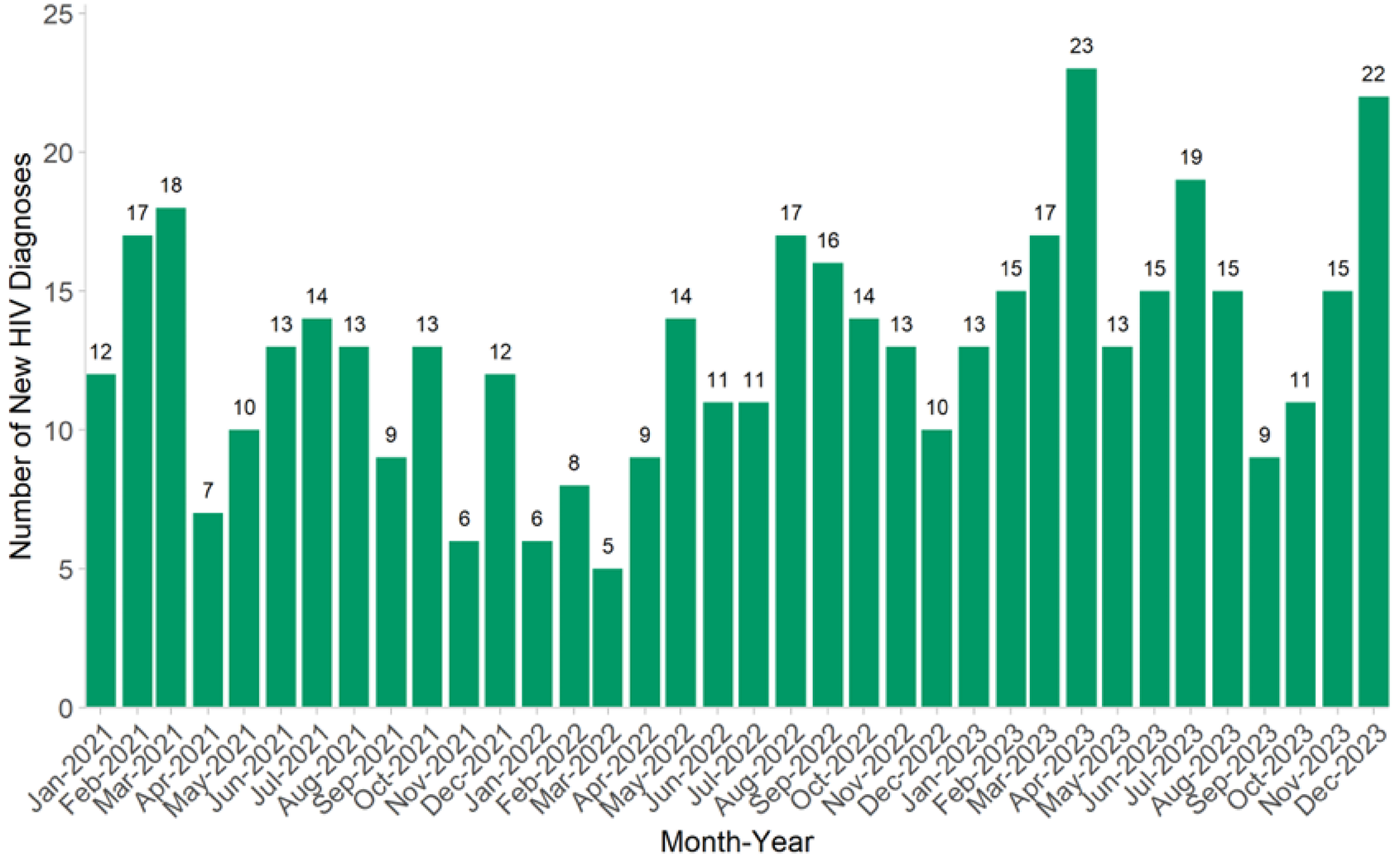
Infectious Syphilis

1. Infectious Syphilis case reports in BC by month



HIV

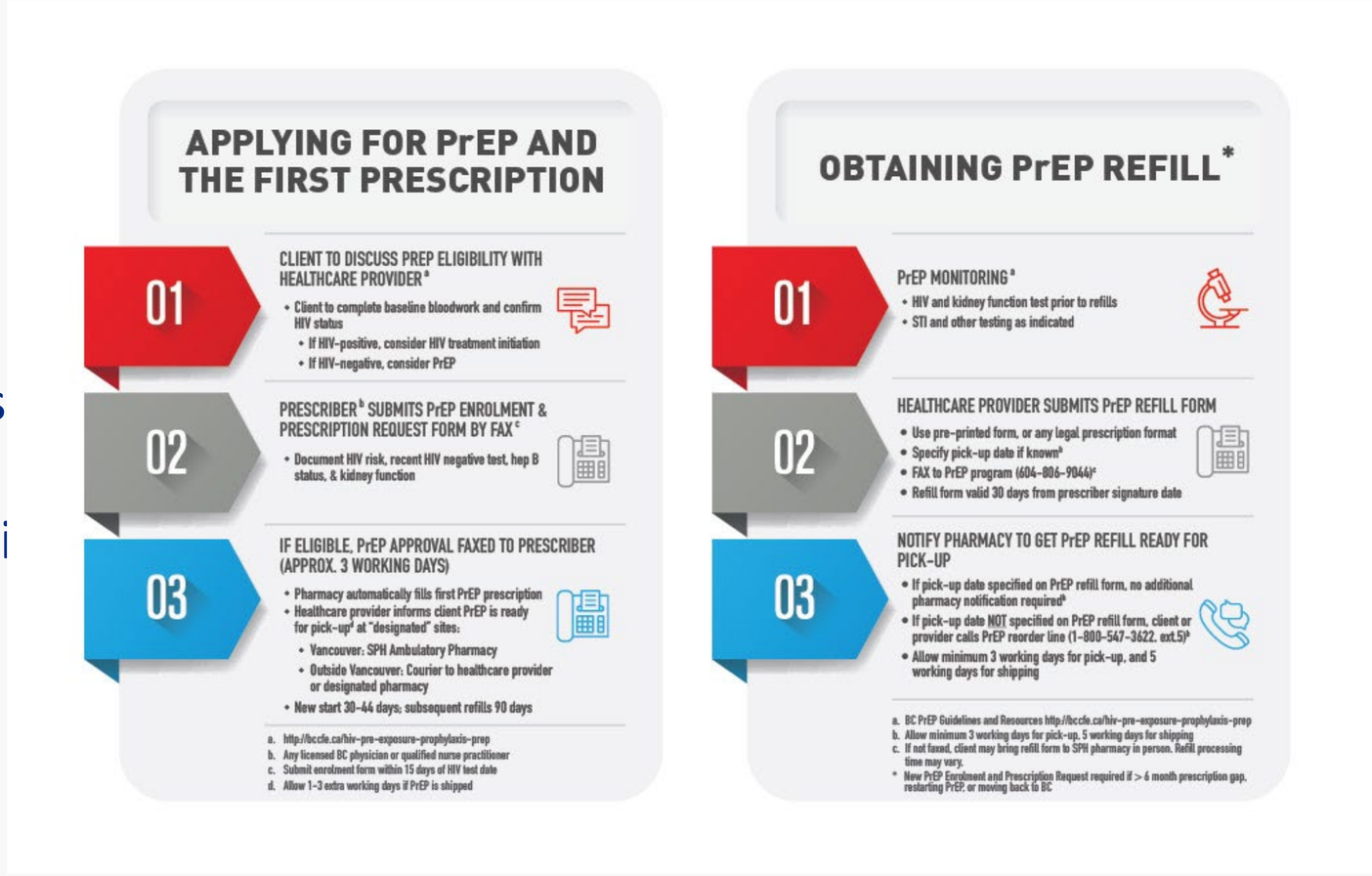
16. New HIV diagnoses in BC by month



STI Trends in BC

But its not all bad news…

- ✓ We have better access to screening then ever before
- ✓ Medications are free and accessible including PREP
  - ✓ (Effective Jan 1, 2018, eligible Britis Columbians have been able to access HIV pre-exposure prophylaxi (HIV PrEP) through the BC Centre for Excellence (BCCfE) Drug Treatment Program at no cost.
- ✓ Online testing services are available



Standard Screening for STIs in asymptomatic patients

- ✓ Urine or multi test swab – GC & CT
- ✓ Serology – HIV & Syphilis

What about Hepatitis?

- Testing indicated only in those who are at risk…
  - ✓ Symptoms of hepatitis
  - ✓ From a HBV endemic country
  - ✓ Contacts of acute or chronic HBV/HCV infection
  - ✓ HBsAg prenatal screening in first trimester (must identify as ‘prenatal’ on the lab requisition)
  - ✓ Injection drug use

Testing Equipment Review - NAAT

Multitest Aptima (orange swab) – vaginal, rectal, throat swab…

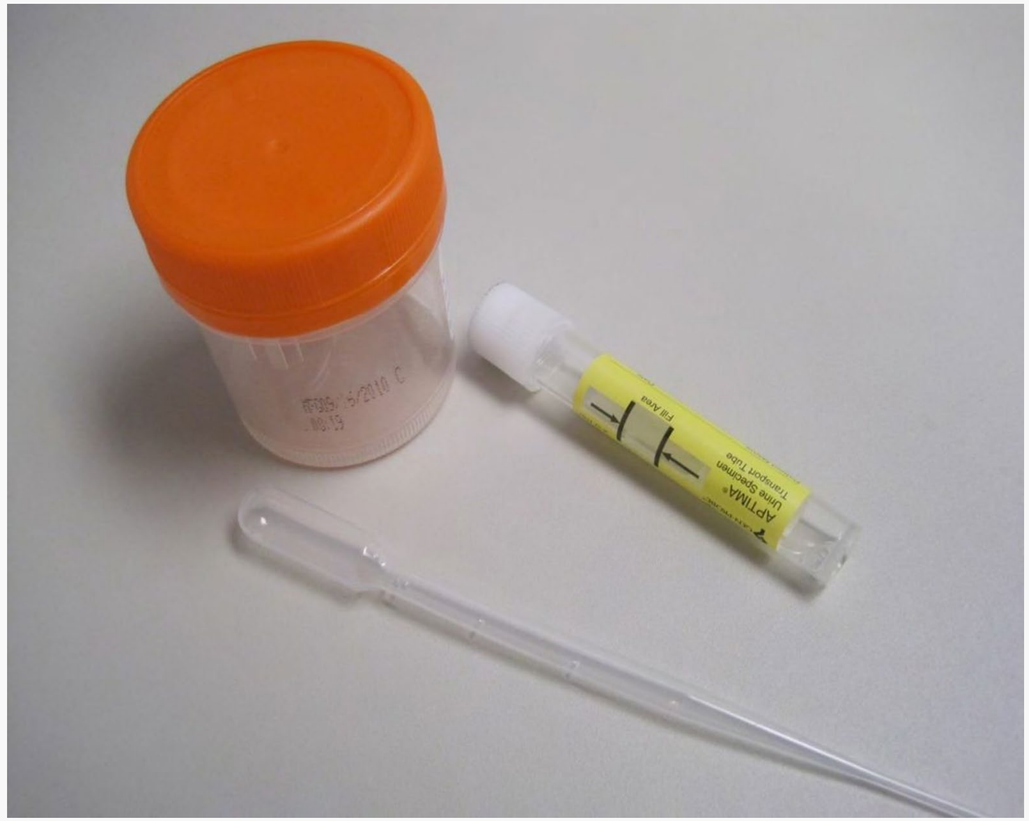
- ✓ GC/CT (vaginal, rectal, throat)
- ✓ LGV – if suspected, write on req, “if positive for CT, check for LGV”
- ✓ Trich – symptomatic only, not on penises
- ✓ Syphilis lesion – if suspected, write on req “syphilis PCR,” send only to BCCDC

Testing Equipment Review - Urine

Urine – container or sample, ensure patient has not urinated in last hour

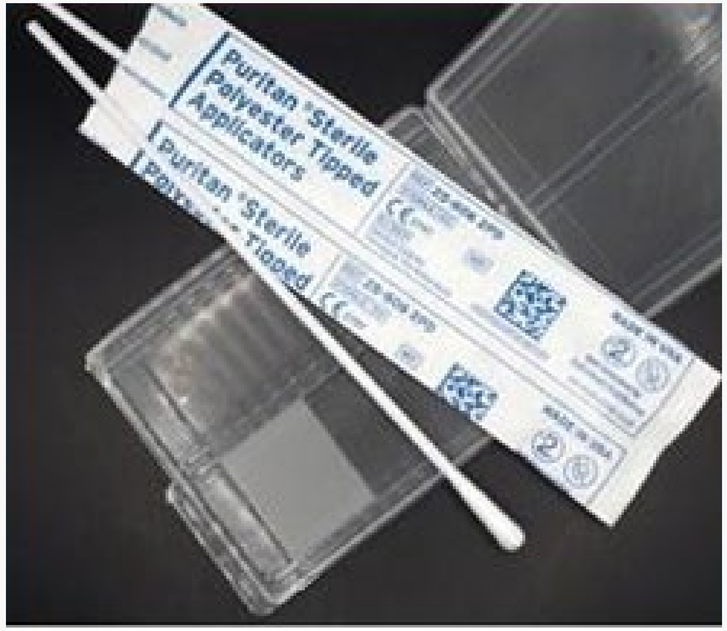
✓ GC/CT

✓ Trich



Testing Equipment Review – Slides

- ✓ Bacterial Vaginosis
- ✓ Vulvovaginal Candidiasis



Vaginal Smear

Testing Equipment Review - Culture

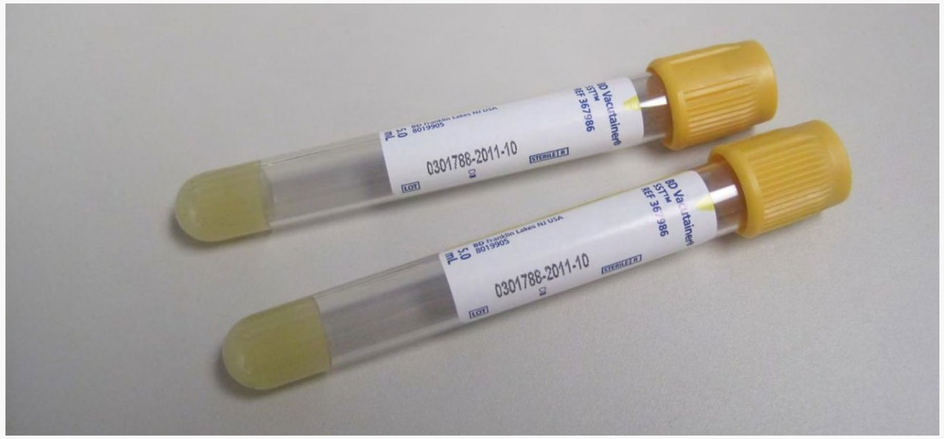
Green Top Collection & Preservation of Aerobic, Anaerobic & Fastidious Bacteria (check with your site)

GC culture

- ✓ Cervix
- ✓ Rectum
- ✓ Penile Urethral
- ✓ Throat

Testing Equipment Review – Serology, lab req

- ✓ HIV (or POC)
- ✓ Syphilis EIA
- ✓ HAV/HBV/HCV



SER BC Centre for Disease Control

Public Health Laboratory

655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

Serology Screening Requisition

SER LM LABS

Section 1 - Patient/Provider Information *(Two matching unique patient identifiers on sample container and requisition are required for sample processing)*

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)
PATIENT SURNAME
PATIENT FIRST AND MIDDLE NAME
DOB (DD/MMM/YYYY)
SEX M F X U (Unk)
PATIENT ADDRESS
CITY
PROVINCE
POSTAL CODE

ORDERING PRACTITIONER
Name and MSC#
Address of report delivery
I do not require a copy of the report
I am a Locum[1]
[1]If Locum, include name of Practitioner you are covering for

ADDITIONAL COPIES TO PRACTITIONER / CLINIC:
(Name, Address / MSC# / PHSA Client#) (Limit of 3 copies available)
1.
2.
3.

DATE RECEIVED
LABORATORY USE ONLY
OUTBREAK ID
SAMPLE REF. NO.
DATE COLLECTED (DD/MMM/YYYY)
TIME COLLECTED (HH:MM)

Section 2 - Clinical Information

Reason for Test
- NEEDLESTICK
- Prenatal
- Outbreak/Cluster/Event
- Other, specify: .....

Clinical Information
- Rash symptoms
- STI contact
- STI symptoms
- Recent Travel History (Date/Location)
- Onset Date (DD/MMM/YYYY)

Section 3 - Test(s) Requested (Note: Codes for PHSA Labs Use Only)

PRENATAL SCREENING (PRENAT)

HIV	HIVCC
HIV Non-Nominal Reporting	HIVCC
HBsAg	HBVP
Rubella IgG	RUBEB
Syphilis Antibody (1st Trimester)	TPE
Other Tests, specify:	

PERINATAL SYPHILIS

Perinatal (>35 weeks/at delivery)	PDSYP

SYPHILIS ANTIBODY

Routine (Non Prenatal)	TPE

HIV (Non Prenatal)

HIV	HIVCC

Note: Patient has the legal right to choose not to have their name reported to public health = non-nominal reporting

Non-Nominal Reporting Requested	HIVCC

HEPATITIS SEROLOGY (Serum)

Acute - undefined etiology HBsAg, Anti-HBc Total, Anti-HBs, Anti-HCV, Anti-HAV IgM	HEPSB
Chronic - undefined etiology HBsAg, Anti-HBc Total Anti-HBs, Anti-HCV	DHEPCH
Hepatitis B Screen Panel HBsAg, Anti-HBs, Anti-HBc Total	HBSAG
Anti-hepatitis A Total (Immune Status)	HAAT
Anti-hepatitis A IgM (Acute Infection)	HAVMB
HBsAg Only	HBVSA
Anti-HBs (Immune Status)	HBSAB
HBeAg (Therapeutic Monitoring)	HBXEA
Anti-HBe (Therapeutic Monitoring)	HBXEB
Anti-HCV	HEPCB

HEPATITIS C PCR (EDTA Plasma)

HCV RNA Quantitative (For diagnosis and monitoring)	HPCRBB
HCV Genotyping (For treatment)	HEPCRB

OTHER SEROLOGY

Immunity		Acute	
CMV IgG	CMVIGB	CMV IgM	CMVSP
EBV IgG	EBGSB	EBV IgM	EBVSP
Measles IgG (Rubeola)	MIGB	Measles IgM (Rubeola)	MEASP
Mumps IgG	MUIGB	Mumps IgM	MUMPS
Parvo B19 IgG	PARVGB	Parvo B19 IgM	PARVP
Rubella IgG	RUBEB	Rubella IgM	RUBP
Toxo IgG	TOXGSB	Toxo IgM	TOXMSB
Varicella IgG	VZIGB		
H.pylori IgG	HELIB	HSV Type Specific IgG	HSVTSS
HTLV I / II	HTLVB		

OTHER TESTS (Specify)

For other available tests and sample collection information, consult the Public Health Laboratory's *eLab Handbook* at www.elabhandbook.info/PHSA/Default.aspx

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.

Form CPSE-100-0001f 1.00 Version 4.1 10/2021

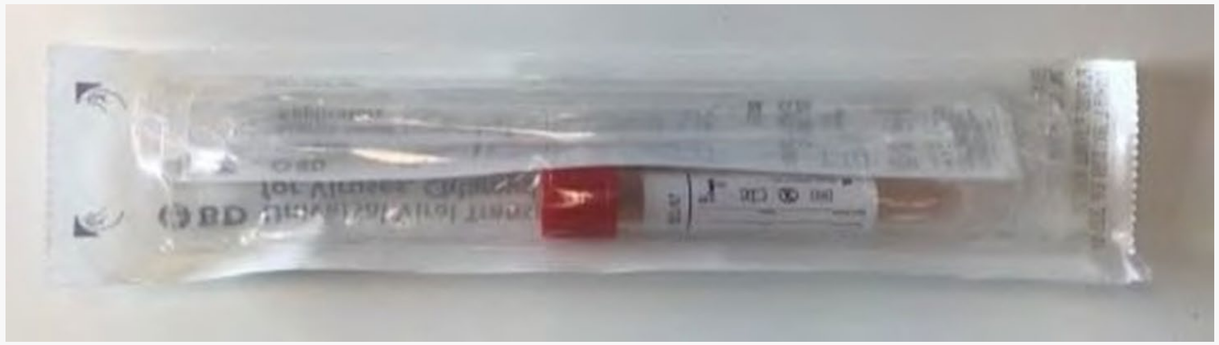
SER SER

OPTIONS FOR SEXUAL HEALTH

Testing Equipment Review – Viral NAAT/PCR

✓ HSV Lesion - (HSV PCR)

✓ Chlamydiae, Mycoplasmas and Ureaplasmas – Viral NAAT

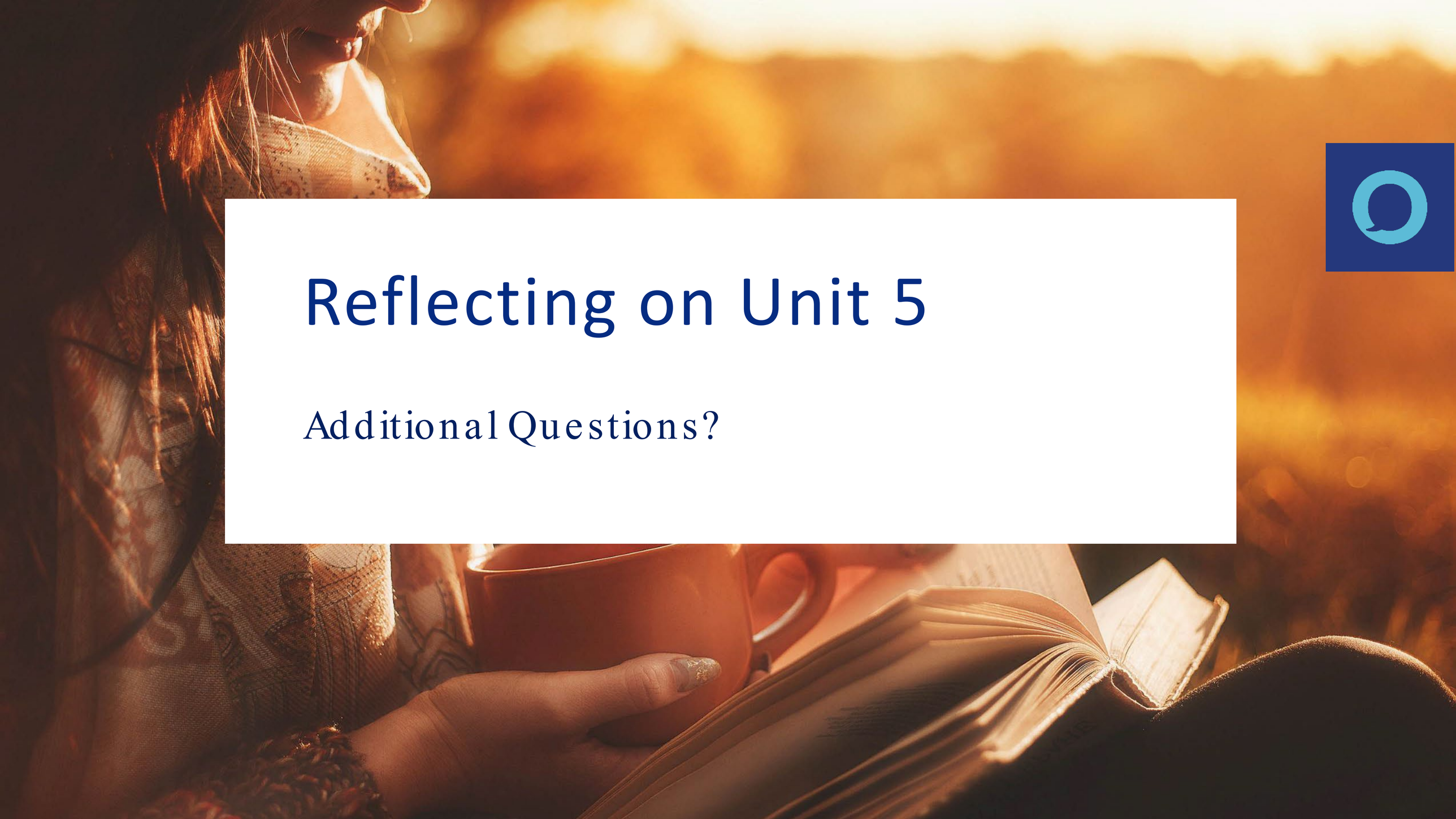


OPTIONS FOR SEXUAL HEALTH

PH Follow up/Reporting & Notification

- ✓ Reportable infections (GC/CT, HIV, Syphilis) are reported to PH (check with your site) using an H208 form.
- ✓ Primary Care clinicians use a patient centered approach to partner notification
  - ✓ Patient notified partners
  - ✓ clinician notify partners anon. on patients behalf
  - ✓ PH may assist if partners are difficult to contact

Support is available via the BCCDC STI team: 604 707 5606

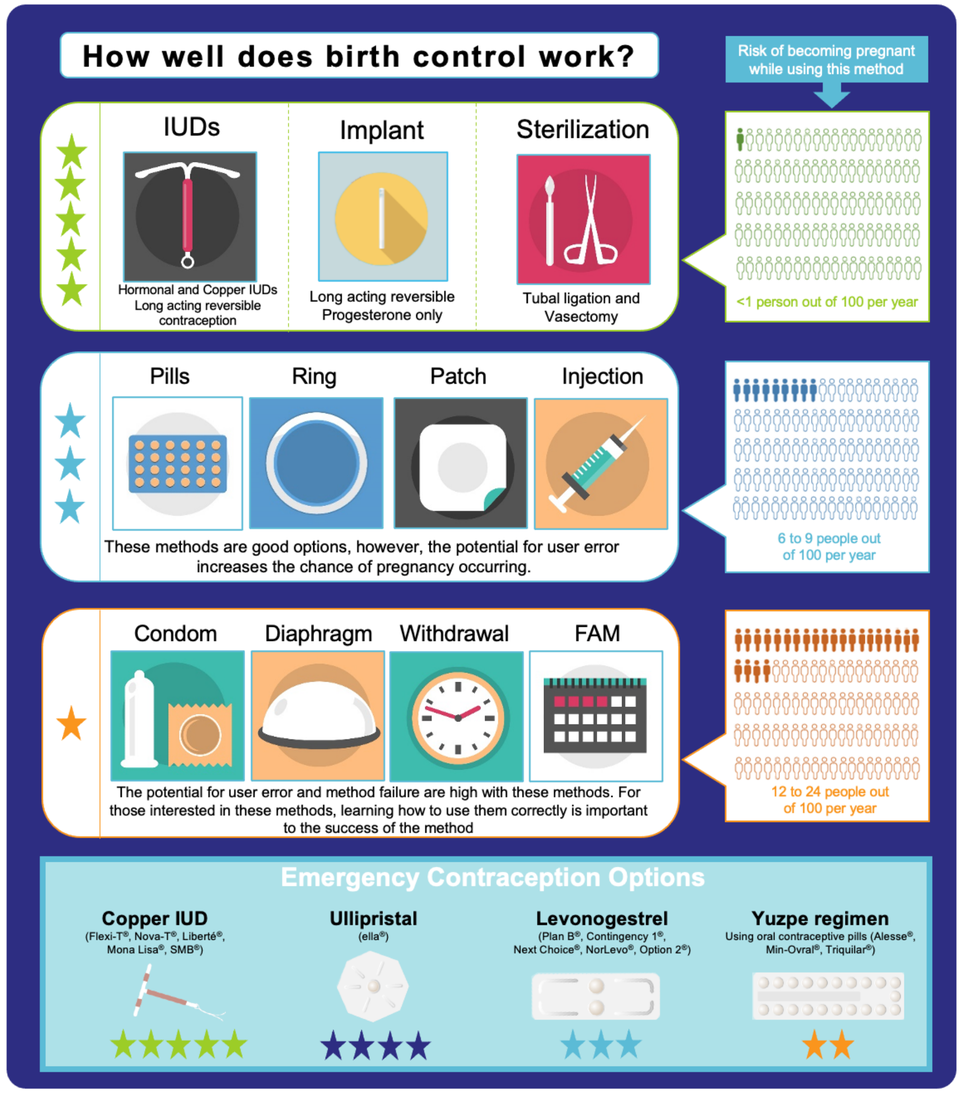


Reflecting on Unit 5

Additional Questions?

Unit 7: Contraception

Contraceptive Availability in Canada



- As of April 2023, most contraception is free to patients who are enrolled in the BC MSP plan (BUT there are still barriers for some patientsά)
- Nurses & Pharmacists also can prescribe/ dispense contraception to patients

Resource: RX FILES

Product	
Combined Hormonal Contraceptives (CHCs)	**Combined Oral Contraceptives**
	Transdermal Patch **EVRA** ethinyl estradiol 35mcg + norelgestromin 200mcg released daily ✗ ▼ **USA:** **XULANE, ZAFEMY** ethinyl estradiol 35mcg + norelgestromin 150mcg released daily **USA: TWIRLA** LNG+EE
	Vaginal Ring **NUVARING** ❄, g=HALOETTE ethinyl estradiol 15mcg + etonogestrel 120mcg released daily **USA: ANNOVERA** ethinyl estradiol + segesterone **reusable ring** (same ring used for up to 1 year)
Progestin-Only Methods	**Injection** **DEPO-PROVERA** medroxyprogesterone acetate 150mg vial for inj. & pre-filled syringe **USA: DEPO-SUBQ PROVERA 104** subcut inj.
	Implant **NEXPLANON** etonogestrel 68mg subdermal rod matchstick-size
	IUD-levonorgestrel **MIRENA** 52mg IUD **KYLEENA** 19.5mg IUD **USA: SKYLA** x3yr, **LILETTA** x8yr
	IUD-copper **FLEXI-T** ✗ ▼ 300, 300+, 380+ **LIBERTE** UT380 short, UT380 ✗ ▼ TT380 short, TT380 ✗ ▼ **MONA *LISA*** ✗ ▼ N, 5-mini, 5, 10

Progestin-Only Pill (POP)

MICRONOR	SLYND ✗ ⊗
g=MOVISSE, JENCYCLA norethindrone 0.35mg	drospirenone 4mg x 24d, then 4 placebo pills

Birth Control: Combined Oral Contraceptives (estrogen + progestin)

Multiphasic pills may have lower hormone exposure per cycle, but lack evidence for less AE or advantage over monophasic.

	ORAL CONTRACEPTIVES BRAND NAME; generic g	COMPONENTS E=estrogen P=Progestin A=Androgen	HORMONAL ACTIVITY E	 P	 A	COST $/30d
1st Generation	**BREVICON 0.5/35**	Ethinyl estradiol 35 mcg Norethindrone 0.5 mg	+++	+	+	$22
	SYNPHASIC (Biphasic)	Ethinyl estradiol 35 mcg Norethindrone 0.5 mg x12; 1mg x 9 tab	+++	++	++	$20
	BREVICON 1/35; g=**SELECT 1/35**	Ethinyl estradiol 35 mcg Norethindrone 1mg	+++	+++	+++	$22 g: $18
	LOLO ✗ ▼	Ethinyl estradiol **10** mcg Norethindrone 1mg	+	+++	+++	$27
		24 x EE/NE; **2** x EE only; **2** x placebo				
2nd Gen	**ALESSE** g=AVIANE, ALYSENA, AUDRINA	Ethinyl estradiol **20** mcg Levonorgestrel 0.1 mg	+	+	++	$22 g: **$10**
	TRIQUILAR (Triphasic)	Ethinyl estradiol 30 - 40 - 30 mcg Levonorgestrel 0.05 - 0.075 - 0.125 mg	+++	+	++	$22
		Sequence: 6-5-10 tabs				
	MIN-OVRAL g=PORTIA, OVIMA	Ethinyl estradiol 30 mcg Levonorgestrel 0.15 mg	++	++	+++	$26 g: **$13**
3rd Gen	**MARVELON** g=APRI, FREYA, MIRVALA	Ethinyl estradiol 30 mcg Desogestrel 0.15 mg	++	+++	+	$25 g: **$14**
	LINESSA (Triphasic)	Ethinyl estradiol **25** mcg Desogestrel: 0.1 Yellow - 0.125 Orange - 0.15 Red mg	++	+++	+	$26
		Sequence: 7-7-7 tabs				
	TRI-CYCLEN (Triphasic) g=TRI-JORDYNA, TRI-CIRA TRI-CYCLEN-LO g=TRI-CIRA LO	Ethinyl estradiol 35mcg (LO: ethinyl estradiol **25**mcg) Norgestimate: 0.18 White - 0.215 Light Blue - 0.25 Blue mg	+++ LO: ++	+	+	g: $21 g: $23
		Sequence: 7-7-7 tabs				
4th Gen	**YASMIN** g=ZAMINE	Ethinyl estradiol 30mcg Drospirenone 3mg	++	++ (?)	–	$19 g: **$12**
	YAZ g=MYA **YAZ PLUS** ✗ ▼	Ethinyl estradiol **20** mcg Drospirenone 3mg (PLUS-0.45mg levomefolate)	+	++ (?)	–	$23 g: **$14** {PLUS $19}
		24 x active; **4** x placebo				
	NEXTSTELLIS ✗ ⊗	Estetrol 15mg (plant source) Drospirenone 3mg	+	++ (?)	–	$25
		24 x active; **4** x placebo				

Note about drospirenone: antiandrogenic; spironolactone derivative may ↑$K^{+\ esp\ with\ 3A4\Theta}$; check K^+ x 1, e.g. @4weeks.

- Advisory: may ↑ VTE risk slightly compared to other COCs.[conflicting data] Also potential DI with sotalol → QT prolongation.

Practice Tools: SOGC Contraception Decision Aid; Sexual and Reproductive Health (U of A); CPhA Contraception Tool

USA only (not in Canada)

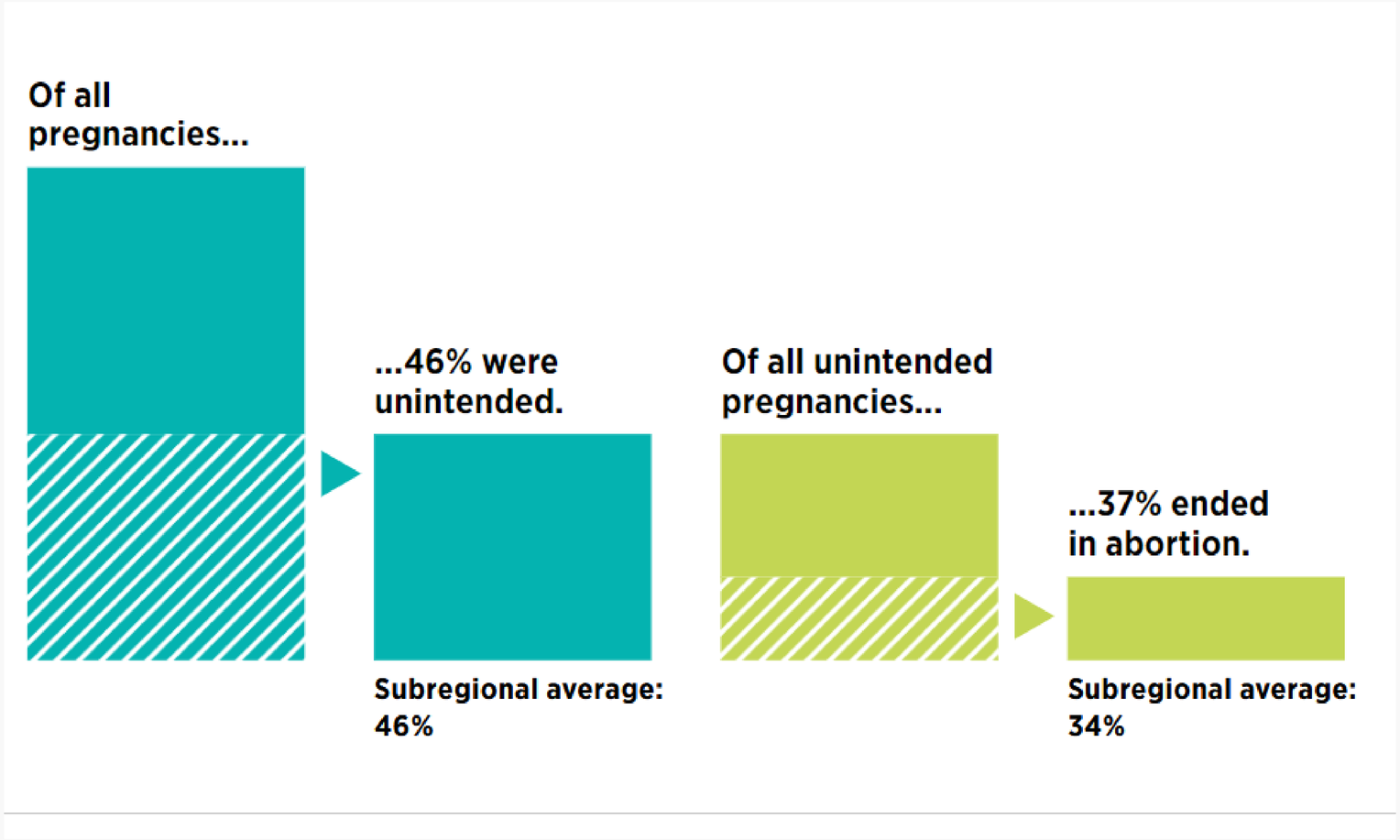
MIRCETTE, g: 20mcg EE + 0.15mg desogestrel x21 days, then placebo x 2 days, then 10mcg EE x 5 days.
NATAZIA: (four-phase) estradiol valerate 3-2-2-1 mg + dienogest 0-2-3-1 mg x26 days, then placebo x 2 days.
BEYAZ, g: EE + drospirenone + levomefolate x24 days, then placebo x 4 days.
LOESTRIN FE, g: 10mcg EE + 1mg norethindrone x24 days, then 10mcg EE x2 days, then 75mg ferrous fumarate x2 days.
LoSEASONIQUE, g: 20mcg EE + 0.1mg levonorgestrel x 84 days, then 10mcg EE x 7 days.
Opill norgestrel 0.075mg tablet at the same time every day (OTC).

OPTIONS FOR SEXUAL HEALTH

Contraception remains a key tool to reproductive health

In Canada in 2015–2019, there were a total of 570,000 pregnancies annually. Of these, 265,000 pregnancies were unintended, and 97,500 ended in abortion

We eagerly anticipate good news on the fore-front of free contraception



Contraceptive Counselling

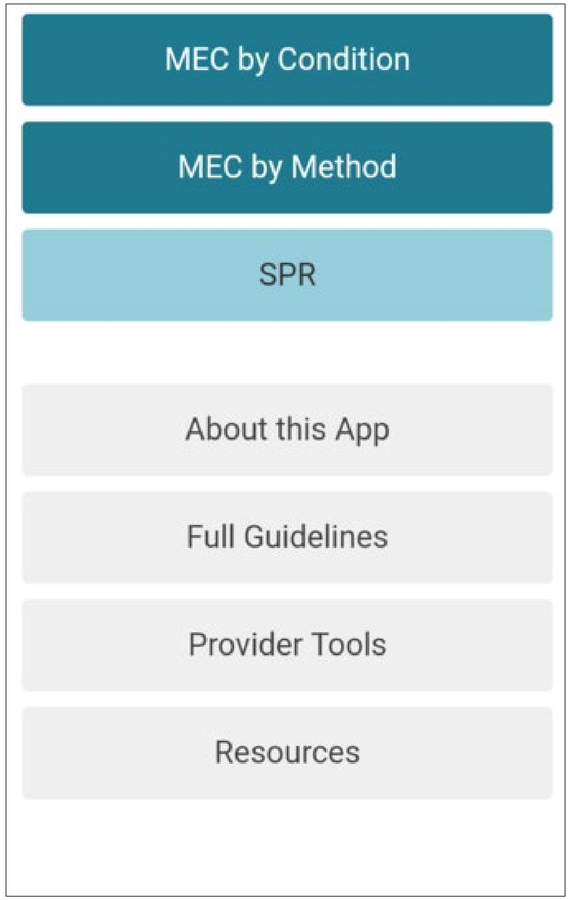
Incorporates:

- ✓ shared decision making
- ✓ patient centred

Use the PATH framework

1. **P**regnancy **A**ttitudes – Do you think you might like to have (more) children at some point?
2. **T**iming – If the patient is considering future parenthood: When do you think that might be?
3. **H**ow important is prevention – How important is it to you to prevent pregnancy (until then)?

US CDC/WHO MEC (medical eligibility criteria)



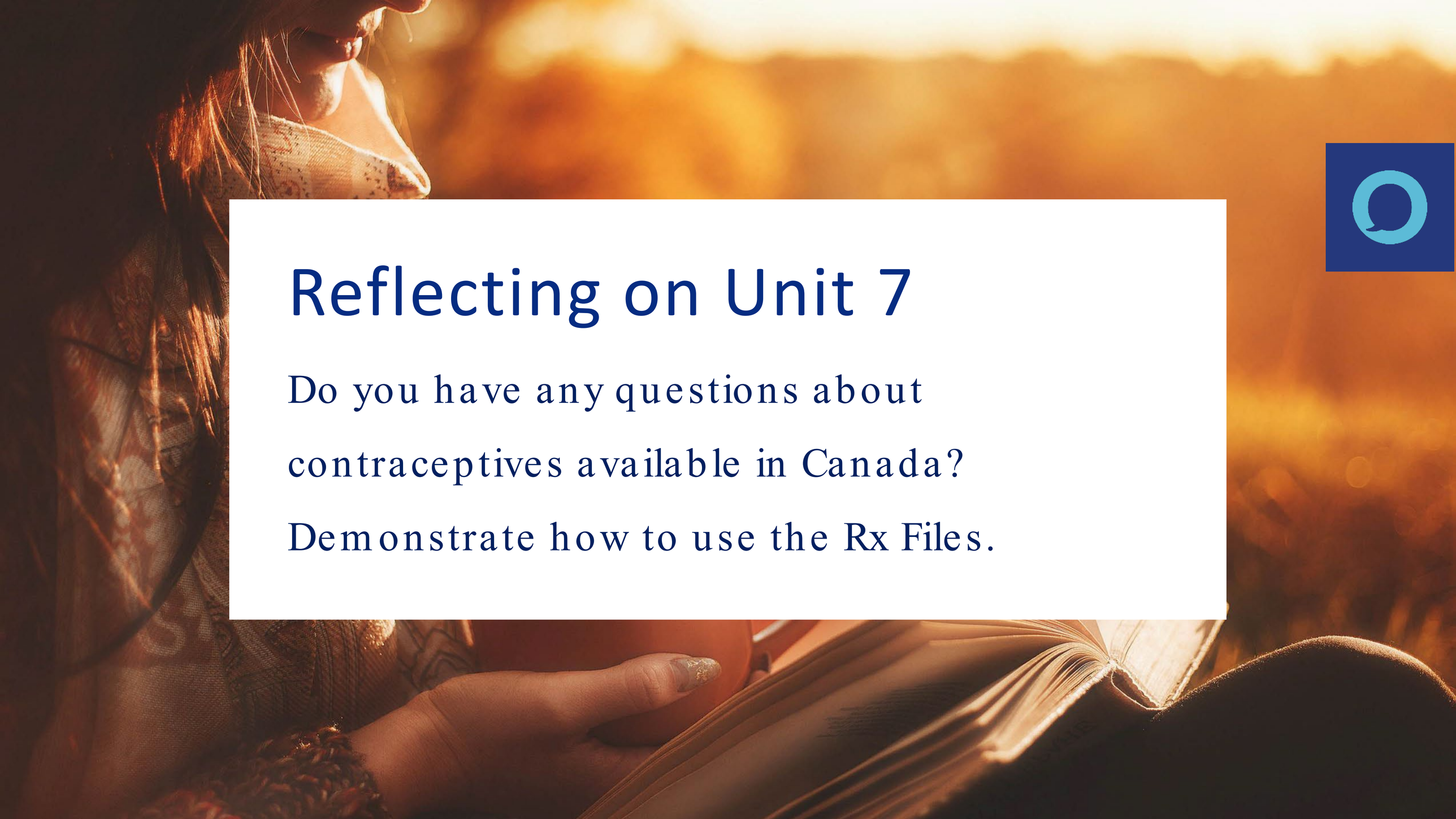
This is a useful tool when deciding if a medical condition precludes the use of certain contraceptive methods. The app can be downloaded https://www.cdc.gov/reproductivehealth/contraception/contraception-app.html

1 = No Contraindication

2 = Benefit generally > Risk

3 = Risk generally > Benefit

4 = Contraindicated



Reflecting on Unit 7

Do you have any questions about contraceptives available in Canada?

Demonstrate how to use the Rx Files.

Thank you!

npasquino@optbc.org
eherrington@optbc.org