

Training course in adolescent sexual and reproductive
health 2019

Sexually transmitted infections prevention and care

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Background:

World Health Organisation (WHO) defines Sexually Transmitted Infections (STIs) are infections caused by bacteria, viruses and parasites transmitted through sexual contact, including vaginal, anal and oral sex. There are more than 30 different bacteria, viruses and parasites are known to be transmitted through sexual contact. Eight of these pathogens are linked to the greatest incidence of sexually transmitted disease. Of these 8 infections, 4 are currently curable: syphilis, gonorrhoea, chlamydia and trichomoniasis. The other 4 are viral infections which are incurable: hepatitis B, herpes simplex virus (HSV or herpes), HIV, and human papillomavirus (HPV). The burden of morbidity and mortality worldwide resulting from sexually transmitted pathogens compromises quality of life, as well as sexual and reproductive health of all age groups, however, adolescents are more susceptible than adults.

Question 1:

List three serious long-term consequences of STI.

Sexually Transmitted Infections (STIs) have serious long-term consequences on the health and lives of millions of children, adolescents and adults globally. Broadly, following are three major consequences of STIs:

1. **HIV risk:** The presence of a sexually transmitted infection, such as syphilis, gonorrhoea, or herpes simplex virus infection, greatly increases the risk of acquiring or transmitting HIV infection (by two to three times, in some populations)
2. **Fetal and neonatal deaths:** It is estimated that syphilis in pregnancy leads to over 215,000 stillbirths and fetal deaths and 90 000 neonatal deaths each year, and places an additional 215,000 infants at increased risk of early death.
3. **Cervical cancer** – Globally, cervical cancer is the second leading cause of cancer deaths for women worldwide and is one of the leading causes of cancer deaths in some developing countries. It is estimated that the human papillomavirus infection is responsible for an estimated 528,000 cases of cervical cancer and 266,000 cervical cancer deaths in 2012.

Question 2.1:

What is the estimated trend in chlamydia prevalence in men and women aged 15-49 years in your region? How does it compare with the global prevalence?

In South-East Asia region, the prevalence of chlamydia has decreased in women aged 15-49 years from 1.8% in 2012 to 1.5% in 2016. This is in line with the global trends which show a decline from 4.2% to 3.8% in the similar period. It is important to note that this region also has the lowest prevalence of Chlamydia amongst all the regions which needs further study.

Similarly, the estimates also show a decline in men aged 15-49 years from 1.3% in 2012 to 1.2% in 2016. However, at the global level the prevalence of Chlamydia remains static in the same period of time.

Question 2.2:

Give two reasons why the global/regional/national prevalence and incidence estimates of STI are important.

It is very crucial to have global/regional/national prevalence and incidence estimates of STIs for the following reasons:

1. **Advocacy:** The estimates are important to ensure that it remains a priority as a global health issue and an indicator for human development. The information regarding burden of disease also required to advocate for the funding from donors to support programmes related to STIs. It can be also used to promote innovations in diagnostics, path-breaking technologies to cure STIs and affordable vaccines.
2. **Program Planning, Monitoring and Evaluation:** These estimates are vital to design context specific evidence based programs and interventions to tackle STIs. It is important to track trends over time, interpret changes in epidemiology, make contrasts between populations for particular interest and geographies, and obtain a comprehensive picture of causes of death, burden of disease, or risk factors.

Question 3:

Identify one barrier from the perspective of providers and one from the perspective of users to the provision and uptake of STI case management services.

From the perspective of providers, in my experience, there is barrier in terms of their capacity to deal with adolescents. The health care providers are not trained to deal with adolescents, therefore they seem them as patients not clients. The leads to a challenge while communicating with adolescents who seek care.

From the perspective of users, I think availability and accessibility of adolescent friendly services are a barrier. In India, there are more than 7000 adolescent friendly health clinics, however, however, only 20% of the clinics have dedicated counsellors. Thus, on the one hand we have limited no. of clinics who provide services and on the other clinics are not saturated with dedicated counsellors.

Question 4.1:

Provide a brief definition of brief sexuality-related communication (BSC). Name one way in which BSC is similar to and one way in which it is different from counselling. Name its four components.

Brief sexuality-related communication (BSC) is a client-centred approach wherein a provider uses counselling skills “opportunistically with much less certainty about the duration of the encounter” to address sexuality and related personal or psychological problems as well as to promote sexual wellbeing.

BSC is similar to counselling as skills which are desired for counselling are similar to the skills required for BSC. The difference lies in the approach as counselling requires formal,

systematic and continuous approach wherein BSC does not require continuity as it is focused on opportunistic use of counselling.

Following are the components of BSC.

1. **Attending:** One of the important components of BSC is setting and maintaining a relationship with the client by asking socially appropriate context specific questions.
2. **Responding:** Asking questions that open the conversation about sexual health and sexuality
3. **Personalizing:** Identifying the existence of sexual concerns, difficulties, dysfunctions or disorders and the dynamics of any interplay between these
4. **Initiating:** Providing information and, with the client, identifying steps that need or could be taken

Question 4.2:

In the TEDX talk Dr Teodora Wi calls for an open and stigma-free discussion about sex. In your context, describe briefly how BSC could contribute to this.

I think in Indian context, adolescent friendly health clinics can act as a perfect platform to implement BSC for an open and stigma free discussion about sex. I think the Awareness, Skills, Self-efficacy/Self-esteem, and Social Support (ASSESS) Programme can be implemented to increase adolescent awareness about sexual risks, skills to avoid risky sexual situations, self-efficacy and social support. It will be useful as brief interventions are effective in BSC approach.

Question 5.1:

Why is it important to provide the HPV vaccination? Does your country have a national policy and strategy for HPV vaccination? If so, briefly describe it.

Globally, cervical cancer is the 4th most common incident cancer among women, and has the 4th highest mortality rate for cancer among women (1). In 2018, cervical cancer accounted for nearly 570,000 new cases around the world, and nearly 311,000 women died of the disease and its effects (2). Cervical cancer ranks as the second leading cause of overall cancer deaths in Indian women, after breast cancer (3), taking 67,000 lives in a year (2). While Indian women account for about 17% of the global female population – one in six women worldwide (4), the 122,800 new cervical cancer cases that WHO estimates to be diagnosed in the country in a year represent a rate of one in four (2), a disproportionate burden for India to bear. There are more than 100 types of HPV but two types—16 and 18—are responsible for approximately 70% of cervical cancers globally (5) and more than 80% of cervical cancers in India (6).

Since the introduction of HPV Vaccine in 2006, it has emerged as an effective solution to prevent infection from high-risk HPV strains that lead to cervical cancer, especially in resource-constrained regions and countries.

In December 2017, the National Technical Advisory Group on Immunisation recommended inclusion of the HPV vaccine in India's Universal Immunization Programme. An official decision by the Ministry of Health and Family Welfare regarding its national introduction is still pending. However, in India, Health is a State subject and hence States can choose to implement HPV vaccines in the States. In view of this, only four states (Delhi, Punjab, Uttar Pradesh, and Sikkim) had introduced HPV vaccination for girls in the targeted age group of 9 to 13 years. Each of these states has implemented a state-specific strategy for HPV vaccine delivery. The states rolled out the following strategies:

- **Punjab:** The state implemented two rounds of HPV vaccination in the districts of Bhatinda and Manasa. The vaccine was delivered through a health facility-based approach, wherein girls (who were enrolled in government, government-aided and private schools) were brought to the nearest health facility for vaccination.
- **Sikkim:** The state implemented the HPV vaccine across all the districts by following a campaign mode. During one week of the campaign, vaccinations were made available at the schools (state government, central government-aided and private) in the first week; in the following week vaccination was provided at the health facilities to cover out-of-school/drop out girls.
- **Delhi:** The initiative targeted young girls attending school studying in the 6th class between 11-13 years who were enrolled in government schools and were residents of Delhi. The vaccine was delivered through a health facility-based approach wherein girls were brought to the designated health facility for vaccination.
- **Uttar Pradesh:** The HPV vaccination, in the state was offered at '*Sampoorna*' (*Health*) clinics. The clinics offered screening and treatment facilities to women for all major non-communicable diseases including cervical and other cancers. The clinics also offered HPV vaccination to adolescent girls who visited the clinics along with their mothers or other relatives.

Question 5.2:

In your context which is the most important intervention that could be delivered along with HPV vaccine? Explain why.

One of the major learnings I had from my implementation experience of HPV vaccine in Indian states is that rather than integrating the HPV vaccination program in a single intervention, (different) platforms provided by more than one program can be utilized to frame a comprehensive integration strategy. Additionally, since the program plans to reach out to both school going and out-of-school adolescent girls, separate strategies and thus separate platforms must be utilized.

For example, in order to reach school going girls, the HPV vaccination program can possibly be integrated with the National Child Health Program of India called RBSK. In this program, school health teams (each team comprises of 2 doctors, 1 each Staff Nurse, ANM and Pharmacist) visit school once in a year for early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability. This program uses the platform provided by school and provides a range of services to adolescent girls (who are enrolled in schools). Integrating the HPV vaccination program with this program, at the service delivery level, will prove to be cost effective as a mobile health team (consisting of doctors and ANMs) already reaches

out to girls who are enrolled in schools. This team can be trained on delivering the HPV vaccine and can be utilized to implement the service delivery aspect of the program.

I have identified 5 key platforms where we can integrate adolescent related programs with HPV vaccination programs i.e.

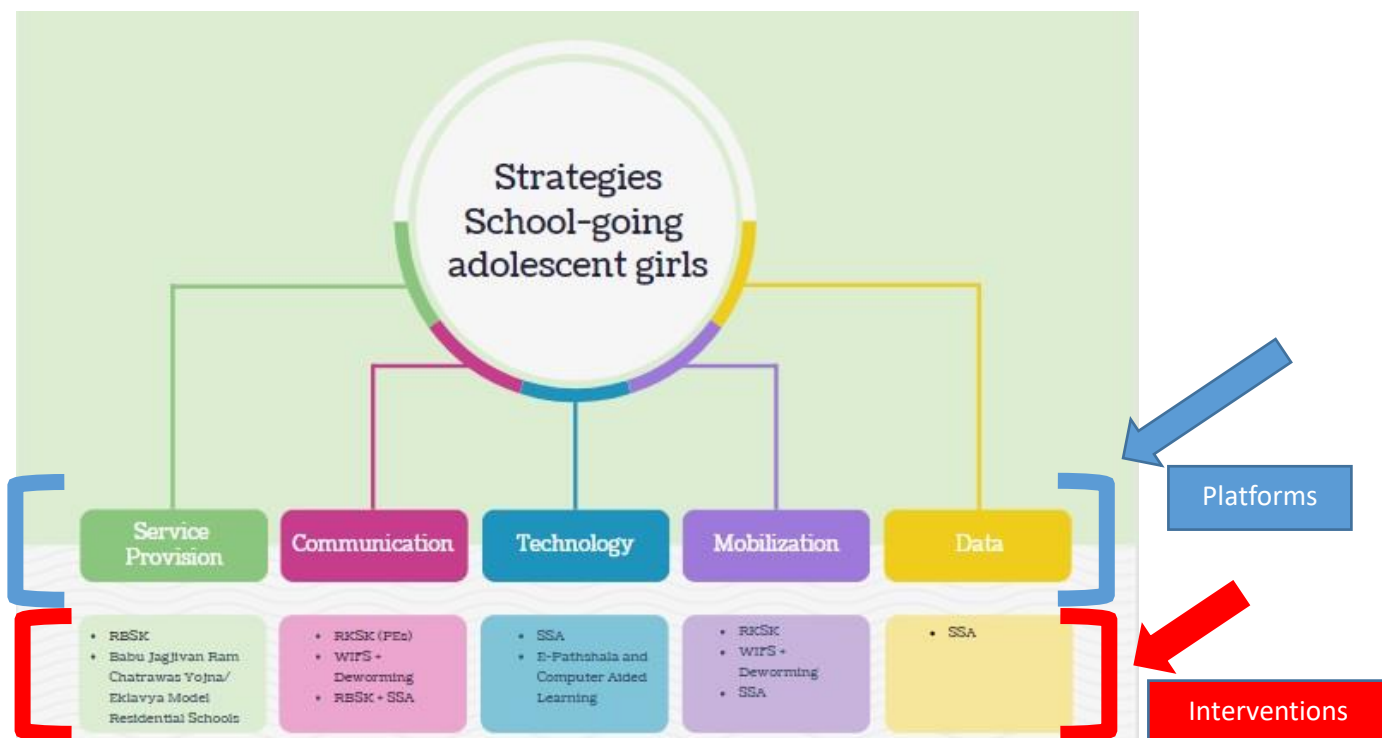
Service Delivery: This aspect explores integration platforms (provided by existing programs) that can be utilized to deliver the HPV vaccine to adolescent girls within the age group of 9-14 years.

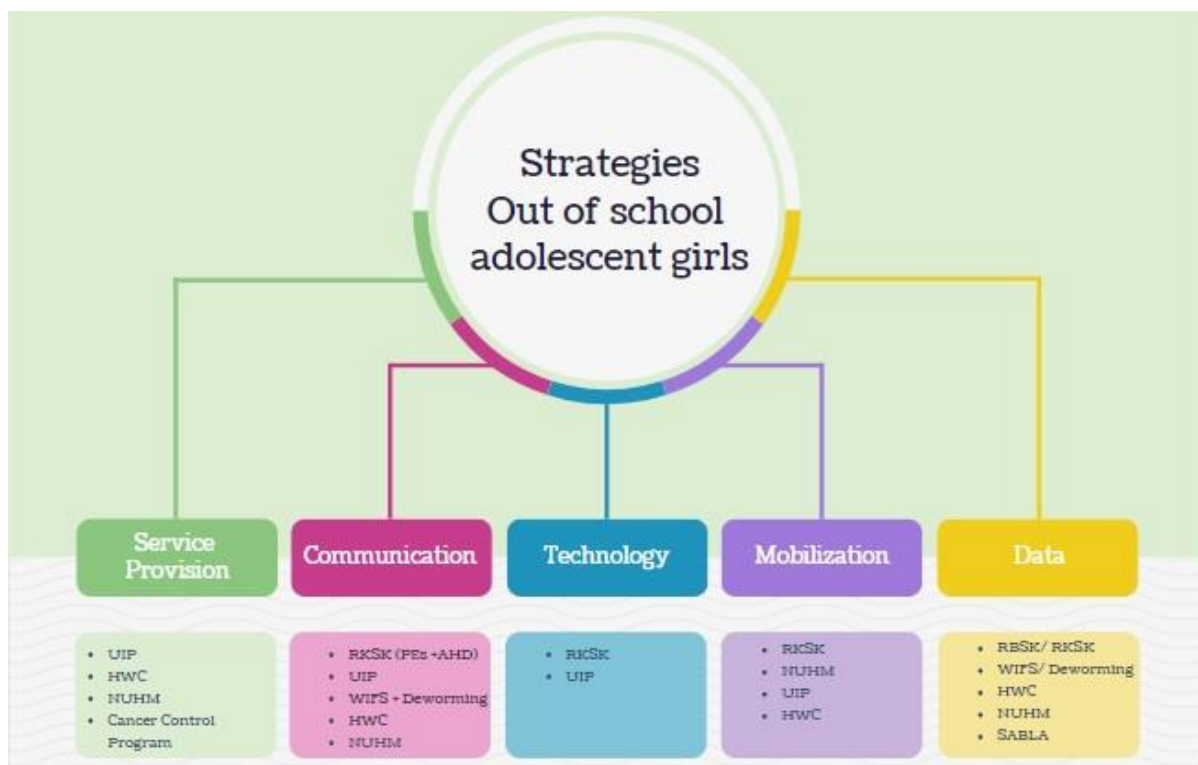
Communication: This aspect explores integration platforms that are provided by existing programs and can be utilized to reach out specifically to adolescent girls and their parents to spread awareness among them about the HPV vaccination program.

Technology: This aspect explores different technological platforms/portals made available under existing programs to spread awareness to adolescent girls, their parents and community members at large. Additionally, it also includes different portals provided by existing programs to enumerate adolescent girls

Mobilization: This aspect explores existing platforms (provided under programs that are currently being implemented) that currently mobilize adolescent girls between the age group of 9-14 years, which can be leveraged by the HPV vaccination program.

Data: This aspect explores existing programs that enumerate adolescent girls between the age group of 9-14 years and also to record data for the purposes of reporting, monitoring and evaluation.





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