Training course in adolescent sexual and reproductive health 2019

Sexually transmitted infections prevention and care

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Question 1:

List three serious long-term consequences of STI.

Three serious long-term consequences of sexually transmitted infections (STIs) are: 1) infertility and pregnancy complications such as low birth weight and preterm birth, 2) increased risk of human immunodeficiency virus (HIV)-infection; for example, chlamydia and gonorrhea are associated with a two- to three-fold increased risk of acquiring HIV and 3) cancers of the cervix, anus and pharyngeal tissue associated with human papilloma virus (HPV) infection [1, 2].

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 the region of the Americas, there is a slightly decreasing prevalence of chlamydia infections in women, from an estimated prevalence of 7.6% in 2012 to an estimated prevalence of 7.0% in 2016 [3]. Globally, the prevalence of chlamydia in women is also decreasing, as evidenced by an estimated prevalence of 4.2% in 2012 and an estimated prevalence of 3.8% in 2016 [3]. The prevalence trends for men in the region of the Americas in the same time period increased by 1.9% from 1.8% in 2012 to 3.7% in 2016 [3]. Globally, the estimated prevalence of chlamydia in men remained unchanged and was 2.7% in both 2012 and 2016 [3].

Question 2.2:

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

Global, regional and national estimates of STI prevalence and incidence impact the design and evaluation of programs and interventions aimed at STIs and HIV epidemiology [3]. In addition, these estimates aid the calculation of disease burden; thereby, endorsing the funding of STI prevention and treatment programs and innovation/research into diagnostics and therapies [3].

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.

In an analysis of adolescent access to STI case management services in low- and middle-income countries, various barriers were identified [4]. From the perspective of providers, lack of confidentiality, staff shortages, lack of physical space, age, sex and providers' attitudes and behaviours towards youth were identified as barriers to accessing sexual health services [4]. From the perspective of service users, the most commonly identified barrier was the acceptability of services including concerns about confidentiality and experiences of shame and stigma [4].

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 an approach used by healthcare providers to address clients' sexuality, sexual concerns or difficulties and to promote sexual well-being [5]. This outcome is achieved by providers via counselling skills integrated opportunistically into their typical client interactions and considers biological, psychological and social dimensions of sexual health and wellbeing [5].

Counselling differs from BSC in its application. Counselling is systematic and continuous in nature, utilizing a therapeutic relationship with a client over a long period of time and may address dysfunctions or disorders that require psychological therapy or physiological medical treatment [5]. Whereas, BSC does not necessitate provider continuity or an interaction of longer duration and it considers the biological dimensions of sexual health [5].

Notably, BSC and counselling are similar as both approaches utilize counselling skills to address sexuality, sexual health and sexual well being while considering the psychological and social dimensions [5].

The 4 components of BSC are: 1) attending, 2) responding, 3) personalizing and 4) initiating [5].

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.

Open and stigma-free discussions about sex are an essential part of my job. As a nurse working exclusively with men who have sex with men in a HIV prevention lab, I engage in BSC daily. For example, I ask clients open-ended questions which allow them to engage in conversations about sexual health topics that often carry shame and stigma. The WHO document on BSC outlines how negative responses to disclosures about sexual orientation can have negative health impacts, including increased vulnerability to STIs [5]. Therefore, by having a positive reaction to these disclosures, I can mitigate these negative outcomes. In addition, the document states that when adolescents talked to their provider about HIV, they were more likely to use condoms and take other precautions to prevent infection [5]. Therefore, simply by engaging clients in open discussions about stigmatized subjects as a form of BSC, providers can have a positive impact.

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.

Cervical cancer is caused by human papilloma virus (HPV) infection [6]. The HPV vaccine is effective [6] and safe [7]- a cohort study in Scotland investigated HPV strains 16 and 18, the ones that cause the majority of cervical cancer cases, and found that prevalence in adolescent females was reduced from 30% prior to vaccination to 4.5% seven years later, after vaccination [6]. In addition, the HPV vaccine has been shown to protect against genital warts through herd immunity [8]. In Australia, five years after the implementation of a nationally funded HPV vaccination program for girls, there was a reduction in the proportion of heterosexual men diagnosed with genital warts [8].

In Canada, the HPV vaccine is offered to all children as a school-based immunization program [9]. In 2018, the vaccination uptake varied between provinces and territories and for school-aged girls ranged from 57.1 to 92% [9]. In school-aged boys the uptake ranged from 67.1 to 89.7% [9]. By the year 2025, the Government of Canada intends to achieve a vaccine coverage goal of 90% in adolescent girls [10].

Question 5.2:

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

The Canadian school-based immunization program allows for the delivery of other health interventions at the same time for an age group that has limited interaction with the healthcare system. The most appropriate intervention would be the provision of sexual and reproductive health education in an age-appropriate manner. This intervention could be delivered by public health nurses with knowledge of sexual health. This would be appropriate as comprehensive sexuality education (CSE) delivery in Canada is limited by the inadequate preparation and support of teachers. For example, in an analysis of Canadian elementary and middle school teachers [11], they were only found to be somewhat willing to teach sexual health education, and this willingness fluctuated between topics.

References

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