Training course in adolescent sexual and reproductive health 2021

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 STI: **(1)** Herpes and ulcerative (syphilis) and inflammatory (chlamydia, gonorrhoea, trichomoniasis) curable STIs are associated with two- to three-fold increased risk of acquiring HIV. **(2)** All the curable STIs have been related to serious pregnancy complications for the newborn, including preterm birth, low birth weight, and death (syphilis in pregnancy leads to around 215 000 stillbirths and fetal deaths and 90 000 neonatal deaths each year). **(3)** STIs such as gonorrhoea and chlamydia are major causes of infertility and Human papillomavirus was responsible for around 528 000 cases of cervical cancer and 266 000 deaths from cervical cancer in 2012.

Question 2.1

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 when the health care provider uses counselling skills "opportunistically" with much less certainty about the duration of the encounter to address sexuality and related personal or psychological problems, also to promote sexual well-being. This approach respects clients' ideas, feelings, expectations, and values. BSC aims to support clients to reframe their emotions then to understand and think about their behaviors and this is through improving their capacity for self-regulation and make them able to exercise their sexuality with autonomy, safety, and satisfaction. BSC also focuses to spend most of the time during the primary health care visit listening to the client's concerns, this is to help clients identify ways to address their concerns. BSC aims to address sexuality and related personal or psychological problems as well as to promote sexual well-being but counselling aims to address emotional, psychological, and social issues that influence a person's health and well-being.

BSC is similar to counselling in their objectives both aim to support clients to reframe their emotions then to understand and think about their behaviors and both provide a service intended to address emotional, psychological, and social issues that influence a person's health and well-being. One essential difference that BSC does not require provider continuity (opportunistically) and these skills are applied during the length of a typical primary health care visit. While counselling is characterized by its continuity (systematic) which means a specific provider builds trust with a client over time.

This approach incorporates the following **four components**: (1) Attending: setting up the relationship with the client by using some typical questions in a socially appropriate manner to initiate the subject of sexual health, (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, those questions should focus on the personal things that client face and (4) initiating: providing information and, with the client, identifying steps that need or could be taken. This process concludes by planning a follow-up or providing a referral for other resources and services when needed. In this way, the client is supported in exploring, understanding, and acting for their sexual health.

Question 2.2

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.

BSC could contribute to an open and stigma-free discussion about sex through the dynamic and interactive communication process between the client and the trained provider which will help the clients to address complex themes and taboos of individual, intimate sexuality in the context of a health care consultation. This interactive way will remove any judgmental attitudes from the provider's side. Besides, the patient-centered approach that is always used in BSC will offer the clients ownership of the situation and makes them aware of various options, empowering them to make an appropriate decision. BSC as well as, help clients by building their self-confidence and skills to take steps to protect their sexual health and well-being. Based on the clue paper, the results showed that the intervention of BSC is feasible within the STI/HIV prevention programmes in low- and middle-income settings, as well as in different cultural contexts which I believe can be applied in Egypt. As I mentioned above BSC is provided by a trained health care provider which is essential to encourage overcoming cultural sensitivities that exist in many contexts around information dissemination and support for adolescents concerning sexuality. Also, when the health care provider is well trained, he can deal with any sexual issues raised by clients in a brief visit to their primary provider and refer to the complex issues. Despite that BSC is one of the important interventions to support adolescents in addressing their sexual health concerns and to reduce STIs and unintended pregnancies, however, it should not be chosen in preference over other effective interventions such as comprehensive sexuality education in schools. So, based on the talk of Dr. Teodora Wi when the clients can express all their concerns and thoughts and subsequently be provided with complete information and education will lead to an open and stigma-free discussion about sex without shame and STI's can be treated like any other infection.

Question 3.1

Why is it important to provide the HPV vaccination?

It is important to provide the HPV vaccination because it is one of the essential elements to prevent and control cervical cancer with regular screening and treatment of cervical pre-cancer. Based on a study about the impact of HPV vaccination and cervical screening on cervical cancer elimination in 78 low-income and lower-middle-income countries (LMICs), it shows that Cervical cancer is the second most frequent cancer among women in LMICs and In 2018, 290 000 (51%) of the 570 000 new cervical cancer cases worldwide occurred in women living in LMICs (500 000 [88%]) when including upper-middle-income countries. Also, based on the comparative modelling analysis done in this study, it provides one consistent result suggesting that 90% of HPV vaccination coverage of girls can lead to cervical cancer elimination in most low-income and lower-middle-income countries (LMICs) within the next century (Brisson et al., 2020).

Question 3.2

As per WHO's recommendation at what age should the first HPV vaccination be given? What is WHO's recommendation on when the second dose could be given?

The HPV vaccine should be provided for girls aged 9–13 years. Based on WHO recommendations, girls receiving a first dose of the vaccine before age 15 years can use a two-dose schedule. The interval between the two doses should be six months. There is no maximum interval between the two doses, but no more than 12–15 months is suggested. If the interval between doses is less than five months, then a third dose should be given at least six months after the first dose. Immunocompromised individuals, including people living with HIV, and females aged 15 years and older should also receive the vaccine; they need three doses (at 0, 1–2, and 6 months) to be protected fully.

Question 3.3

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

HPV vaccines present several unique features that require new delivery approaches. The greatest benefit of HPV vaccines will be achieved by vaccinating young adolescents before the onset of sexual activity. Based on a study done in Egypt to assess women's knowledge about HPV in the faculty of nursing, Zagazig university, only 12.3% of the total studied students who had previous knowledge about HPV and its vaccine (Al-arnous et al., 2020). So, I can imagine that adolescents and young girls have very poor knowledge about HPV vaccines. In this case, I think that ideally, the most important intervention is that HPV vaccines delivered through schools along with sexual and reproductive health programmes, it will have a great protentional in all regions including Egypt because primary school completion rates among older girls (8-11 years) are moderate to high and increasing. Many adolescents in low-income countries face considerable health risks and health systems have difficulty reaching them (WHO, 2008) which makes me think that school-based programs will be adolescents-friendly. Also, including HPV vaccines and information about the prevention of cervical cancer, HIV and other STIs with other sexual and reproductive health topics will lead to spreading the awareness that FTIs are like any other infection and will decrease the stigma. Finally, to ensure equitable access for the most vulnerable populations, school-based delivery of vaccines must be complemented by strategies to reach those not attending school, such as mobile teams, outreach, and provision of vaccines at health facilities (LaMontagne et al., 2017).

Question 4.1

What were the key findings on the knowledge and attitudes of most of the Muslim women in this review?

There are three key findings on the knowledge and attitudes of most of the Muslim women in this review: **(1)** Poor knowledge, myths, and misconceptions about STIs and HIV, in general, Muslim women had poor knowledge regarding STI signs and symptoms, prevention, diagnosis, and treatment, in addition to many misconceptions and myths. **(2)** Sources of sexual health information and information needs, ten studies reported that friends, relatives, magazines, and television were the primary sources of

sexual information for women and girls. Education in schools was a source of STI information for a minority of women (8% to 31%). **(3)** Cultural influences on STI knowledge and attitude, negative attitudes towards people infected with HIV/AIDS were common, and attitudes were highly influenced by misconceptions and insufficient knowledge. Infected women tended to be subjected to more blame and judgment compared to men.

Question 4.2

What were the two main barriers to STI and HIV/AIDS testing and diagnosis as reported in the review?

There are many barriers to STI prevention, diagnosis, and treatment, from personal barriers to cultural and religious barriers. The two main barriers to STI and HIV/AIDS testing and diagnosis are: **(1)** Negative attitudes towards HIV/AIDS and the perceptions that only certain individuals are at risk acted as a barrier to testing and diagnosis. 38% of participants in a Saudi study reported that they would not want to know if they had any kind of STI, although 90% believed that their partners had the right to know if they had an STI, and 55% said that they would ask for a divorce if they found out that their partner had an STI. **(2)** Negative attitudes by healthcare providers towards premarital sex acted as a barrier to young girls' access to sexual health information and services.

Question 4.3

Identify the primary sources of sexual health information for these women.

The primary sources of sexual health information for these women were friends, relatives, magazines, and television.

Question 5.1

Identify one key difference in students who attended HIV educational programs and other students in this paper.

One key difference in students who attended HIV educational programs and other students is that the majority of sexually active participants reported that most of their sexual practices are unprotected but those who attended HIV education program stated that they were more likely to use condoms consistently compared to those who never attended HIV educational program. Also, only the participants who attended HIV educational programs seemed to know how to use condoms correctly compared to other students who only had superficial knowledge.

Question 5.2

Name three pre-motivational determinants among university students to use condoms, as discussed in the paper. Give brief findings.

Three pre-motivational determinants among university students to use condoms: **(1)** Knowledge and Misconceptions About HIV and Condom Use: All of the participants knew that HIV could be transmitted sexually, and more than half of them were aware that condom use could prevent both

HIV transmission and acquisition but the majority had superficial knowledge. However, only those who attended HIV educational programs seemed to know how to use condoms correctly. **(2)** Risk Perception: Most of the study participants perceived the high risk of getting HIV if they practiced condomless sex. Almost all of them also indicated that HIV is a serious disease that not only kills but also destroys the social life of infected people. Besides the risk of having HIV, the majority of participants especially females are concerned about getting pregnant and they also perceived the serious social consequences of illegal pregnancy. **(3)** Cues to Action: half of the consistent condom users reported having previous experience with people living with HIV/AIDS, few participants mentioned the easy access to condoms encouraged them to use condoms consistently.

Reference

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