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.

1. Herpes and ulcerative (syphilis), syphilis in pregnancy leads to an estimated stillbirths and fetal deaths and neonatal deaths (1).
2. STIs such as (chlamydia, gonorrhea, trichomoniasis) gonorrhea and chlamydia are major causes of infertility.
3. Curable STIs are associated with a two- to three-fold increased risk of acquiring HIV (1).

Question 2.1

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

"Brief sexuality-related communication (BSC):

It is a guideline document focuses on the opportunistic use of counselling skills, rather than formal – systematic and continuous – counselling (2).

- BSC does not require provider continuity different from counselling which characterized by its continuity.
- BSC is similar counselling which applied during the length of a typical primary health care visit in primary care for addressing emotional, psychological and social issues that influence a person's health and well-being".
- BSC has four components: 1) Attending 2) Responding 3) Personalizing 4) Initiating

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.

The components of BSC, such as asking sexual health questions, providing information, and supporting clients by building their self-confidence and skills to take steps towards protecting their sexual health and well-being. All these components used a client-centered approach, including how to use condoms correctly and how to negotiate condom use both of which are key to STI prevention (2).

Question 3.1

Why is it important to provide the HPV vaccination?

Introduced the HPV vaccination as part of a coordinated comprehensive strategy to prevent cervical cancer and other HPV-related diseases (1).

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?

Provide the HPV vaccine for girls aged 9–13 years. 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 an interval of no more than 12–15 months is suggested. Then a third dose should be given at least six months after the first dose (1).

Question 3.3

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

In Yemen, no HPV vaccines applied (3,4), In MSIY centers they do health education on the importance of VIA test to all woman after marriage to early exclude if there is any abnormal change in the cervical cells which may be converted to cervical cancer if not treatment early (5).

Question 4.1

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

1. Muslim women have poor knowledge regarding signs and symptoms of STIs.
2. Women could not identify correct modes of transmission of STIs.
3. Lack knowledge about STI prevention and treatment.

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 judgement compared to men (6).

Question 4.2

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

Negative attitudes towards STIs make it harder for women to access sexual health information, STI prevention and treatment.

1. **Personal barriers**. Believed that there was no need for sexual education for Muslims, believing that STIs are not an issue among them, or against STIs (6).

2. **Cultural religious barriers.** That religious practices provided them with protection. This is likely because premarital sexual relations are forbidden in Islam, making it difficult for young individuals' access to STI and HIV/AIDS testing and diagnosis openly without being judged or stigmatized (6).

Question 4.3

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

Friends, relatives, magazines, and television were the primary sources of information for women and girls. Education in schools was a source of STI information for a minority of women (6).

Question 5.1

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

The students who had never attended HIV educational most of their sexual practices were unprotected. Compared with those who did stated that they were more likely to use condoms consistently because attended training about HIV held by an organization in which we were told that condom use prevents HIV (7).

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 them 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.
2. **Risk Perception.** Most of the male and female perceived the high risk of getting HIV if they practiced condom less 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.
3. **Cues to Action.** About half of them mentioned having previous experience with people living with HIV/AIDS (7).

References

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