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.

- Increase the risk of HIV acquisition.
- Pregnancy complications for newborn such as; preterm birth, low birth weight and death.
- Cause infertility.
- HPV leads to cervical cancer.

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.

The definition of brief sexuality-related communication (BSC): is client-centered approaches facilitated by the providers in which they use counselling skills to address sexuality and related personal and psychological issues, and promoting sexual well-being while taking into account social, biological and psychological dimensions. BCS aims to empower the client and fill the gap between intention and adapting certain behavior through building personalized goals to support the clients in their decisions.

BSC and counselling are similar in using counselling skills as tool, however, counselling requires continuity, which is not required in BSC. Counselling is appropriate for addressing sexual concerns and difficulties in long term relation, on the other hand BSC supports people to find solutions suitable for themselves.

The four components of BSC are; 1) attending, 2) responding, 3) personalizing, and 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.

I think the personal values and attitudes of whom going to conduct the BSC sessions with the clients, are key. In Egypt, for example, the values of providers interfere more often than not in providing the services. This interference starts with the basic assumption that a non-married client does not have sex. Resulting in providers not asking about client's sexual activity, and potentially disregarding testing for STIs. However, there is a massive potential in reaching people and protecting them from potential STIs if BSC is to be carried out appropriately . Based on my experience attending a session with Lebanon-based Marsa before, I foresee a possible shift in quality of service in Egypt by replicating Marsa's model. In that session, I was taken away by how the providers were open and non-judgmental by running regular counselling. A smooth start for BSC application in Egypt could be initially through NGOs and private sector. The key element in BSC is that it considers the preference and choice of the client of what he/she want to do, which goes beyond the biomedical approach where the healthcare provider dictates to the patient what needs to be done. As mentioned in the publications, BSC empowers clients' decision-making and improves their self-efficacy to adapt behavior. And I think this not only respects clients' autonomy, but also

ensures the sustainability of adapting the behavior. Additionally, it will allow to reach more vulnerable social groups in Egypt such as, unmarried adolescents and LGBTI individuals who are excluded from receiving quality sexual health services. Applying BSC could encourage them to have consistent and correct use of condom, help them obtain knowledge of STIs symptoms, encourage them to do test, empower them to tell their partners, and encourage them to receive treatment or vaccination when available.

Question 3.1

Why is it important to provide the HPV vaccination?

HPV vaccinations decrease the risk of having cervical cancer.

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?

As per the WHO's recommendation, HPV vaccine be given to girls aged 9-13 years. The interval between the two doses should be six months. While there is no maximum interval between the doses, however, an interval of no more than 12–15 months is suggested. If the interval between the doses is less than five months, then a third dose should be given at least six months after the first dose.

Question 3.3

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

Around 31 Million women aged between 15 to 44 years in Egypt are at risk for cervical cancer and around 631 death happen annually due to cervical cancer (Bruni et al., 2019). Additionally, Cervical cancer is the 11th most common female cancer in women aged (Bruni et al., 2019). In Egypt providing national vaccination program for HPV requires a lot of efforts policy wise to acknowledge the need to provide for Free giving the lack of community awareness about HPV and the stigma around vaccination.

In rural Egypt, Ministry of Health and Population conducts school visits to provide testing and treatment for Anthelmintic treatment for schistosomiasis, soil-transmitted helminths (STH), and lymphatic filariasis depending on its epidemiological map. Usually, they seek parental consent to provide such treatments, so I think merging those interventions while the lack of knowledge on HPV persists, unlike aforementioned treatments that impose a generational knowledge and familiarity; could deny girls the benefits of other interventions. Additionally, it is concerning to carry out such interventions while seeking parental consent, which might also hinder girls' access to other services. So we need to be attentive to this fine line or alternatively seek a separate consent. Generally, linking HPV to mensural hygiene education, since both targets the same age group (9-13 years), would be potentially successful across country.

Question 4.1

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

- Low level of awareness about HIV and STIs (9 out of 17 were mainly focused on HIV), for example, the majority of women who were able to name an STI mainly mentioned HIV/AIDS and had limited knowledge regarding the nature of the infection, modes of transmission, and prevention. Other STIs such as chlamydia and human papilloma virus were less recognised.
- Low level of knowledge about signs and symptoms: for example, women in nine studies believed that one could identify an HIV-infected individual just by looking at them.
- Low knowledge about mode of transmission, for example, women believed STIs can be transmitted through mosquito bites, with proportions ranging from 18% to 58%. Only two studies reported good knowledge about modes of STI transmission.
- Low knowledge about STI prevention and treatment, for example, nearly 93% of university students in UAE and 77% in Afghanistan believed that vaccinations could protect against HIV/AIDS.

Question 4.2

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

The main two barriers are as follows;

- They thought of themselves as a religiously protected group, and had low risk perception of STIs or HIV; (false sense of security)
- Health providers' negative attitudes towards premarital sex area barrier to access 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 are 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.

Those who attended HIV educational programs know how to use condom correctly and consistently when compared to other students.

Question 5.2

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

- **Knowledge and misconceptions about HIV and condom use**
  All students were aware of HIV to be transmitted sexually, and more than half of them know that condom use can prevent its transmission. The majority of them do not know how to use condom correctly. There are a lot of misconceptions around condom among both sexually active and abstainers.
- **Risk perception** |
  Most of students were aware of being at a higher risk of getting HIV if they had unprotected sex. All of them were aware of the health and social implications of having HIV. Despite this awareness, majority of sexually active students still had unprotected sex.
- **Cues to action**
  Half of the participants were encouraged to use condom as they encountered PLHIV in their life, while few of them were encouraged by having easier access to condom.

References

Bruni L, Albero G, Serrano B, Mena M, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. Human Papillomavirus and Related Diseases in Egypt. Summary Report 17 June 2019. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Available from: https://hpvcentre.net/statistics/reports/EGY.pdf