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.

Herpes and ulcerative (syphilis) and inflammatory (chlamydia, gonorrhea, trichomonas) curable STIs are associated with a two- to three-fold increased risk of acquiring HIV. All of the curable STIs have been linked with serious pregnancy complications for the newborn, including preterm birth, low birth weight and death. Furthermore, STIs such as gonorrhea and chlamydia are major causes of infertility. Human papillomavirus was responsible for an estimated 528 000 cases of cervical cancer and 266,000 deaths from cervical cancer in 2012. (1)

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.

In brief sexuality-related communication, the provider – whether a nurse, doctor or health educator – 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 well-being.

While counselling requires continuity, BSC does not require provider continuity. In addition, these skills are applied during the length of a typical primary health care visit. Both counselling and BSC are used to address sexuality and related personal or psychological problems as well as to promote sexual well-being.

The four components of BSC are 1) Attending 2) Responding 3) Personalizing 4) Initiating. (2)

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 study shows that BSC improves sexual health knowledge, attitudes towards and intentions to engage in safer sex, and STI prevention skills; these improvements were sustained over a 12-month period. Evidence and recommendations 34 Studies described the effects of these improvements in different ways and on different populations, including particularly vulnerable groups. Studies found BSC resulted in: fewer sexual risk behaviors; an increased reported consistency of male condom use, especially in high-risk populations; and decreases in STI incidence. Four studies found fewer sexual partners and fewer episodes of unprotected sexual events with BSC. One article found a significant increase in glove use during digital-vaginal sex post-treatment for bacterial vaginosis (BV) among same-sex female partners. So, in a culturally sensitive country like Afghanistan, BSC could play a very important role in promoting stigma-free discussion about sex. (2)

Question 3.1

Why is it important to provide the HPV vaccination?

HPV vaccination is important in cervical cancer prevention and control. (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. 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. (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 our country context, a combination of school-based delivery, campaign-style delivery and community-based outreach could be the most important intervention for delivery of HPV vaccines. Afghanistan is a conflict prone country with most of its population living in rural areas making it difficult for them to access information and health services. Through the above strategies we will be reaching people living in hard-to-reach areas and along with providing vaccines, increase the awareness of the communities on the importance of HPV Vaccine. (3)

Question 4.1

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

Muslim women had poor knowledge regarding signs and symptoms of STIs, in addition to many misconceptions Women in nine studies believed that you could identify an HIV-infected individual just by looking at them. In a study from Saudi Arabia, only 5% of university students knew that HIV can be asymptomatic. Similarly, a study in Iran conducted on soon to be married women showed that only 4.5% knew that a person with an STI does not necessarily look ill, and 78% did not know that painful urination could be a sign of an STI. A further 51% did not know that the presence of sores in the genital area is an STI symptom in both men and women. Poor knowledge of STIs was found among university students as well as women who were unemployed and illiterate.

Women in ten of the studies had negative attitudes towards people infected with STIs and HIV/AIDS and were highly influenced by misconceptions and poor knowledge. Negative attitudes were reported across studies from a range of different countries. For example, 32% of participants in a study from UAE said that "I do not feel sorry for people who caught HIV/AIDS because it is their own fault", 81% believed that those who transmit the infection should be punished, and 53% thought that people with HIV/ AIDS should be made to live apart from the general Public. (4)

Question 4.2

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

In a study among people with hemoglobin disorders in Saudi Arabia of *attitudes*: negative attitudes towards HIV/AIDS and, regarding perception - a *perception* that only certain individuals are at risk acted as a barrier to testing and diagnosis. For example, 38% of participants in a Saudi study said that they would not want to know if they had any kind of STI,30 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. (4)

Question 4.3

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

According to the study 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 (8% to 31%). (4)

Question 5.1

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

Compared to the students who had never attended HIV educational programs, those who did stated that they were more likely to use condoms consistently. (5)

Question 5.2

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

1. Knowledge and Misconceptions About HIV and Condom Use:

To explore their knowledge about HIV and condom use, the participants were asked what they knew about HIV and its transmission and prevention. They were also asked what they knew about condoms and whether they knew how to use condoms correctly. No knowledge difference was observed between male and female students. 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. However, the majority had the only superficial knowledge, if any, about how to use condoms and only those participants who attended HIV education programs seemed to know how to use condoms correctly. The majority of the sexually active participants gained detailed knowledge about condom use several years after they had started practicing sex.

2. Risk Perception:

The participants were initially asked about any risks they will be exposed to if they practiced sex without condoms. To explore their perception of susceptibility to HIV, they were asked how likely they believed they would contract HIV if they practiced condom less sex. They were

also asked how serious HIV is to explore their perception of severity. Most of the male and female participants 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:

When asked about the cues that encouraged them to use condoms consistently, consistent condom users reported different cues. About half of them mentioned having previous experience with people living with HIV/AIDS. A few participants also explained how having easy access to condoms encouraged them to use condoms consistently. (5)

References

1. WHO. WHO recommendations on adolescent sexual and reproductive health and rights. WHO, 2018.
2. Brief sexuality-related communication: recommendations for a public health approach. WHO, 2015. p 69.
3. WHO. Options for linking health interventions for adolescents with HPV vaccination. WHO, 2014.
4. Alomair N, Alageel S, Davies N, Bailey JV. Sexually transmitted infection knowledge and attitudes among Muslim women worldwide: a systematic review. Sexual and reproductive health matters. 2020 Jan 1;28(1):1731296.
5. Elshiekh HF, Hoving C, de Vries H. Exploring Determinants of Condom Use among University Students in Sudan. Archives of Sexual Behavior. 2020 May 1;49(4):1379–91.