Training course in adolescent sexual and reproductive health 2019

Sexually transmitted infections prevention and care

Aisling Corr

Plan International, London, United Kingdom

aisling.corr@plan-international.org

Question 1:

List three serious long-term consequences of STI.

Three serious long-term consequences of Sexually Transmitted Infections (STI) are pregnancy complications (e.g. stillbirths, preterm birth, complications for new-borns), infertility, and some curable STI's are also associated with an increased likelihood by two-to-three times of acquiring HIV.

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?

There is an increased trend estimated in the prevalence of Chlamydia in the European Region for women between 2012 to 2016 of 45.45% (2.2 to 3.2), similarly for men in the European Region during this time there was an increase of 46.67% (1.5 to 2.2). This conflicts with the global estimated trends where for women the prevalence is estimated to have decreased between 2012 and 2016 by 9.52% (4.2 to 3.8), whilst there is no change in the global trend for men (2.7 and 2.7).

Question 2.2:

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

Two reasons why the global/ regional/national prevalence and incidence estimates of STI's are important are that they can help in the design and evaluation of programmes and interventions for STI and in monitoring and interpreting changed in HIV epidemiology. The second reason is that they are essential for calculations of the burden of disease due to STI, which are needed to advocate for funding to support STI programmes and promote innovation for point-of-care diagnostics, new therapeutics, vaccines and microbicides.

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.

One barrier from the perspective of providers to the provision of STI case management services is a lack of confidence and comfortability in communicating particularly with adolescents about the topic, including being able to break the social stigma around the subject when they themselves may adopt a faux-parental role, with respective judgement, when approached by an adolescent service user. One barrier from the perspective of the service user to utilising STI case management services is fears over confidentiality, particularly in circumstances where there is no visual or audio privacy to discuss symptoms or needs. Both problems can be linked, in part, to the wider issue of continued social stigma.

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) refers to where a provider (nurse, doctor or healthcare 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 wellbeing. BSC is similar to counselling through providing a service intended to address emotional, psychological and social issues that influence a person's health and well-being, the difference between BSC and counselling is that the service is provided in a less systematic and continuous way, which doesn't require provider continuity. The four components of BSC are named; attending, responding, personalizing and initiating.

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.

BSC could contribute to open and stigma-free discussion about sex through encouraging brief and more accessible engagement with healthcare providers around the subject of sexual wellbeing. Within the UK there is a tendency to avoid talking about sex, or related subjects, with estimates suggesting that 60% of parents find it difficult or even avoid speaking to their children about such subjects (Winter, 2014). As such, despite the UK having what some perceive as particularly liberal sex laws (Strimpel, 2016), sex and sexual health remains a stigmatised and largely undiscussed topic within society. BSC could help address this by offering brief, open and confidential spaces to seek advise from healthcare providers around all aspects of sexual wellbeing, including, sexuality and related personal or psychological problems as well as to promote sexual health. For those who find it difficult to discuss the topic, it offers a more informal, commitment free opportunity to gain accurate information around questions they may previously not have been able or felt comfortable in asking e.g. within the home or their family. By increasing knowledge, communication skills and comfort around the topic will in turn help normalise sex within society and contribute towards open and stigma-free discussions.

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.

The human papillomavirus (HPV) vaccine is important as it helps protect against cervical cancer, some other cancers including of the anal, genital areas, mouth and throat, as well as protecting against genital warts. It is estimated that 99.7% of cervical cancers are cause by infection with a high-risk type of HPV. HPV infections generally do not present with symptoms and as such those who are infected are often unaware, making the vaccine an important preventative measure. The UK has a national policy for HPV vaccines which is that all girls and boys aged between 12 to 13 years will be offered the first HPV vaccine

when they are in year 8 during secondary school education. The second dose is generally provided 6 to 12 months after the first vaccination. Those who miss the vaccination in this time frame may arrange to have the vaccines up until the age of 25 (NHS, 2017).

Question 5.2:

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

The most important intervention that could be delivered along with the HPV vaccine in the UK is information and life skills. Whilst the UK has progressive laws and resources for vaccinations there remains a cultural stigma around discussions of sexual practice, health and wellbeing. Accordingly, if sexual and reproductive health education was provided alongside the vaccine there may be far greater awareness of why the vaccine is required, broader sexual wellbeing topics and consistent uptake in girls and boys receiving both doses of the vaccine to optimise its effect. This is an important issue as it is estimated that between 2017-2018 1 in 3 girls in the UK did not get both doses of the vaccine, linked to fears or misunderstandings e.g. misconceptions that the vaccine encourages sexual activity among adolescents which limits parents consent for their children to receive the vaccine (England, 2019).

References

England, R. (2019) 'HPV Vaccine: Thousands of girls did not get full dose' https://www.bbc.co.uk/news/uk-england-46953452 Accessed 10/10/2019.

NHS (2017) 'HPV Vaccine Overview' https://www.nhs.uk/conditions/vaccinations/hpv-human-papillomavirus-vaccine/ Accessed 10/10/2019.

Strimple, Z. (2016) 'The infamous British reluctance to talk openly about sex is one of our greatest assets' https://www.telegraph.co.uk/news/2016/12/02/infamous-british-reluctance-talk-openly-sex-one-greatest-assets/ Accessed 10/10/2019.

Winter, K. (2014), 'No sex please we're British! Parents are too embarrassed to talk to their own children about relationships and puberty' https://www.dailymail.co.uk/femail/article-2750906/No-sex-British-Parents-embarrassed-talk-children-relationships-puberty.html Accessed 10/10/2019.