Training course in adolescent sexual and reproductive health 2019

Sexually transmitted infections prevention and care

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Question 1:

List three serious long-term consequences of STI.

Sexually transmitted infections among adolescents have major long-term consequences, beyond the immediate impact of the infection itself. Firstly, herpes and ulcerative (syphilis) and in inflammatory (chlamydia, gonorrhoea, trichomoniasis), which are all curable STI's are associated with a two to three-fold increased risk of acquiring HIV. Secondly, all curable STIs have been linked with serious pregnancy complications for the newborn, including preterm birth, low birth weight and, death. For example, syphilis in pregnancy leads to an estimated 215,000 stillbirths and fetal deaths and 90,000 neonatal deaths each year. Lastly, STIs such as gonorrhoea 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.

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?

The global estimates for the year 2016 indicate that there were 127.2 million (95% UI: 95.1-165.9) new chlamydia cases, in men and women age 15-49 years, out of a total of 376.4 million curable STIs. These incident rates translate to 34 cases per 1000 women (95% UI: 25-45) and 33 per 1000 men (95% UI: 21-48). Based on prevalence data from 2009 to 2016, the estimated pooled global prevalence of chlamydia in 15-49 year old women was 3.8% (95% UI: 3.3-4.5) and in men 2.7% (95% UI: 1.9-3.7).

The chlamydia prevalence for women age 15-49 years in the Eastern Mediterranean region, in 2012, was 3.5% (IU: 2.4-5.0), with a rise in prevalence in 2016, of 3.8% (IU: 2.6-5.4). Chlamydia prevalence in women, in 2012 (24 per 1000) started lower than global estimates in 2016 (35 per 1000), however, by 2016, Eastern Mediterranean estimates (38 per 1000) had exceeded the global estimate (34 per 1000). Between the 7-years of 2009 – 2016, the global trend for women, had increased by 38 per 1000, compared to the Eastern Mediterranean between 2012-2016 with an increase of 3 per 1000 over 5-years. Therefore, the global estimates for chlamydia in women are increasing globally at a faster rate than that of the Eastern Mediterranean.

The chlamydia prevalence for men age 14-49 years in the Eastern Mediterranean region, in 2012, was 2.7% (1.6-4.4), with a rise in prevalence in 2016, of 3.0% (IU: 1.7-4.8). Chlamydia prevalence in men, in 2012 (27 per 1000) was the same as global estimates in 2016 (27 per 1000), however, by 2016, Eastern Mediterranean estimates (30 per 1000) had exceeded the global estimate (27 per 1000). Between the 7-years of, 2009 – 2016, the global trend for men, had increased by 27 per 1000, compared to the Eastern Mediterranean period between 2012-2016 with an increase of 3 per 1000

over 5-years. Therefore, the global estimates for chlamydia in men are increasing globally at a faster rate than that of the Eastern Mediterranean.

Question 2.2:

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

The global, regional and national prevalence and incidence estimates of STI are important for two following reasons. Firstly, the global estimates of prevalence and incidence of four curable sexually transmitted infections are important in the broader global context, highlighting a continuing public health challenge. Prevalence and incidence data play an important role in the design and evaluation of programmes and interventions for sexually transmitted infections and in interpreting change in HIV epidemiology. The global treat of antimicrobial resistance particularly the emergence of N. gonorrhoea resistance to the few remaining antimicrobials recommended for treatment further highlights the importance of investing in monitoring prevalence and incidence. Secondly, estimates of prevalence and incidence are essential for calculations of the burden of the disease due to sexually transmitted infections, which are needed to advocate for funding to support sexually transmitted infection programs These burden estimates, can also be used to promote innovation for point-of-care diagnostic, 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.

There are three barriers from the perspective of users to the provision and uptake of STI case management services; these are availability; accessibility and acceptability. Accessibility is when services are available, accessible in the sense that adolescents can use them, but they don't want. A reason for this is due to the perception of negative provider behaviour. Young people constantly report that the provider is rude and offers unfriendly treatment through blaming, lecturing, and scolding or yelling. However, NGO's or specific youth services are noted to be friendlier than public services. Even providers, acknowledge that their attitudes and behaviours could be a barrier. They are aware of societal taboos regarding adolescents seeking sexuality services, in turn experience challenges in communications with youth due to lack of skills and often adopting a parental figure role. The key to overcoming these barriers is to provide high-quality training and ongoing, supportive supervision for health workers to ensure that they provide effective STI care, with sensitivity. In this way, young people services will become friendlier and more responsive and most importantly, accessible.

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.

The definition of brief sexuality-related communication (BSC) is when the provider – 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 promoting sexual well-being. This approach respects clients' ideas, feelings, expectations, and values.

BSC uses the theoretical dimensions of 'information, motivation and behavior' model. This model in cooperates the following four components, which are *attending, responding, personalising and initiating.* Attending involves setting up a relationship with the client by initiating the subject of sexual health in a social acceptable manner through the question - 'Do you have any questions or concerns about sexual matters?'. Responding involves starting a conversation by asking the client; open-ended questions about sexual health and sexuality – 'Are you satisfied with your sexual life?'; 'Is your sexual life going as you wish?'; or 'How do you feel in your sexual relationships with others?'. Personalising involves identifying the existing sexual concerns, difficulties, dysfunctions or disorders of the client and the dynamics of interplay between these. These questions are more specific relating to an issue that the client is facing – 'What difficulties are you facing?'; 'How is it for you?' Lastly, initiating involves providing information and with the client, identifying steps that need or could be taken. The process concludes by planning a follow up or providing referral to other resources and services when needed. In this way the client is supported in exploring, understanding and acting for their sexual health.

Counselling is defined as 'systematic consultations in primary care for addressing emotional, psychological and social issues that influence a person's health and well-being'. While, BSC takes into account the psychological and social dimensions of sexual health and well-being as well as the biological ones. Both counselling and BSC aim to support the client in reformulating their emotions, thinking and understanding, and subsequently, their behaviour. However, one main difference is that counselling is characterized by its formal, systematic and continuity of trust over time, whereas, BSC focuses on an opportunistic use of counselling and does not require provider continuity, instead counselling skills are applied during the length of a typical care visit.

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.

Dr Teodora Wi advocates normalizing sex by an open and stigma-free discussion, to have effective prevention, diagnosis and treatment facilities. This must start by facing the fact that sex is a natural part of life – whereby STIs do exist. They must be treated

like any other infection - without shame from patients, which stop them from seeking appropriate care and - without shame from health care providers who, can sometimes be the cause of stigma by not openly talking about STIs or healthy sexual practices. In this way, adolescents can have a fulfilling sex life by knowing the basics, being comfortable with their sexuality and knowing how to be safe, rational and responsible. This can create better health and better relationships and overall prevent adverse health consequences.

Given the prevalence of taboo and stigma associated with sexual norms and practices in many parts of the world, as well as the existing barriers to the inclusion of some populations in accessing health services, BSC is but one of the interventions necessary to support adolescents in addressing their sexual health concerns to reduce STIs. Although BSC is primarily applied to primary health care settings, it is also recommended as an integral component of an STI/HIV combination prevention strategy. Therefore, in the context of education institutes, it can run concurrently with comprehensive sexuality education. Readily available BSC in education institutes can overcome barriers of 'accessibility'. Whereby, reaching a larger population, in which adolescents have knowledge of where to seek helpful and trustworthy advice. It can also overcome barriers of costs of services and transportation, operating hours and systems, and services that are not catered to young people. As a result, adolescents can be well informed about their bodies and health and prepared for the changes and challenges they will be experiencing.

BSC can help to overcome the barrier of 'acceptability'. Whereby sexual health care services are readily available but adolescents chose not to use them for several reasons. Fear about confidentiality prevents many young people from using services. Therefore, health policy markers and decision makers in health care professional training institutes need to ensure that, where BSC is introduced, it respects, protects and fulfills clients' human rights. Besides, BSC is patient-centered, by adopting the patients' perspective and respecting the patient ideas, feelings, expectations and values; it supports them in expressing their emotions, thinking, understanding and subsequently their behaviour. This two-way conversation leaves no space for judgemental attitudes of many health professions, who often discourage married and unmarried adolescents from seeking advice and treatment. Rather, patients are encouraged to take ownership of the situation and feel empowered to make appropriate decisions and develop their capacity for self-regulation and autonomy. Furthermore, it is necessary that training of health care providers have knowledge in sexual health and skills of brief sexuality-related communication. This enables providers to feel comfortable addressing issues with adolescents, relate to young people, and provide a positive and none judgemental behaviour. Improving adolescent knowledge and understanding of sexual and reproductive health, along with building life-skills to take charge of their health, is a crucial step in meeting their health needs and fulfilling their rights.

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.

Cervical cancer is caused by sexually acquired infection with certain types of HPV, subtypes 16 and 18. In 2018, globally there were 569,847 cases of cervical cancer with 311,369, over half of those cases resulting in mortality. Globally, Southern Africa had the highest incidence of cervical cancer with 43.1 ASR per 100,000, while Western Asia, experienced the lowered incidences of cervical cancer, with 4.1 ASR per 100,000. However, Eastern Africa, had the highest mortality rates of cervical cancer with 30.0 ASR per 100,000, while, Australia/New Zealand, experienced the lowest morality rates, with 1.7 ASR per 100,000. In 2012, there were 1,035,000 cases of cancers associated with HPV infections, globally. Cervix uteri was the most common cause of cancer associated with HPV infection, with nearly half the cases, followed by eight other cancers, with oral cavity at second place with 200,000 cases. Of those 530,00 cervix uteri cases, 75% of cases were attributed to high risk HPV subtypes 16 and 18.

Unlike many other cancers, cervical cancer can be prevented by HPV vaccination or when identified early, through regular cervical cancer screening. HPV for girls is highest at the age population prevalence of 15 years and gradually decreases by the age of 30. Therefore, the WHOs recommendations HPV vaccine targets girls, ages 9-14 years, requiring 2 doses, between 6 – 15 month intervals. To maximize the impact of the vaccine, it can be given to all girls, ages 9-14 years and 15-18 years if feasible or affordable. Secondary preventions are needed for all women around 30 years old and older. This is because age population prevalence of pre-cancer is most likely to occur during this period; therefore screenings and treatment are required, especially testing for high-risk subtypes. Lastly, tertiary prevention is required when needed for women with the age population prevalence of 45 and upward, since it is a time when cancer is most likely to occur. This can range from treatment of invasive cancer (ablative surgery, radiotherapy, chemotherapy) to palliative care. Although HPV vaccine can be administered at a later age, results for HPV vaccine have been proven to be more effective during primary prevention when women are vaccinated at a younger age. Since 1988, the prevalence of cervical cancer due to subtype 16/18, administered to 20 years old females, pre and post HPV immunization, reduced from 30.0% (IU: 26.9-33.1) to 4.5% (IU: 3.5-5.7) in 1995. The HPV vaccine has also reduced subtypes 31/33/45 in women, reducing prevalence from 14.2 in 1988 to 2.6, in 1995. Likewise, the HPV vaccine has shown to be effective for reducing genital warts in males. Early intervention is key, although post vaccination in males aged 21-30 years showed a steep decline of 51.1%, post vaccination for males aged <21 years showed a greater decline of 81.8%.

According to the WHO National Immunization Programme, Egypt is one of 94 out of 194 countries that has not introduced or has no plans to introduce the HPV vaccination.

Question 5.2:

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

HPV vaccination should be seen as integral parts of, rather than separate from or instead of a wider health promotions programme, to adequately reach young adolescents. In this way, population groups, which are often not reached through traditional approaches, can be overcome. Therefore, in the context of educational institutes, the most important intervention that could be delivered along with the HPV vaccine is sexual and reproductive health education; HIV prevention and condom promotion, whereby, cervical cancer prevention can be viewed in a similar way to any other sexually transmitted infection. In addition partnerships between schools and health departments to provide vaccine should be sought after. Adolescents, especially junior middle school students, are the primary candidates for HPV vaccination. However, adolescents have poor knowledge about HPV and its vaccine, which may pose potential barriers to the promotion of the HPV vaccination. It is crucial to understand how this population thinks about cervical cancer, HPV and vaccines as well as how to educate this population to ensure a successful vaccination program that aims to decrease cervical cancer and HPV related disease burden in the future. Education aiming to improve knowledge of HPV and its vaccines among this population has become extraordinarily important as it plays a key role in improving vaccination compliance among adolescents. The WHO has reviewed the potential interventions that can be delivered in combination with the HPV vaccine. One criterion used included the duration of the intervention, which should be shorter than 6 months, in order to fit within the appropriate 6 months HPV vaccination schedule. Therefore, regular health education on HPV and cervical cancer prevention at a shorter interval, during the interval before and between doses should be guaranteed to ensure continuous effectiveness.