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 are infections that are transmitted through sexual intercourse. It can be caused by bacteria, viruses or parasites and transmitted through vaginal, anal and oral routes. Nonetheless, some STIs can be transmitted through skin-skin sexual contact or through non-sexual means such as mother to child transmission that happens during pregnancy and childbirth.

In the context of community perception, STIs are believed to be diseases of prostitutes especially among adolescent girls. This definition does not consider other routes of transmission but perceive that all STIs, if one contracts, is through sexual intercourse. It is also a definition that stigmatizes young people since it is believed that they are innocent about sexual activity

STIs, when not treated or when not treated appropriately, are likely to cause serious long-term consequences as below:

- ***Infertility:*** STIs are capable of destroying fertile ova and or block fallopian tubes causing permanent infertility among adolescent girls and women.
- ***Complications related to pregnancy:*** This could be among new born babies and mothers, for example, ectopic pregnancy, preterm delivery, intra-uterine fetal growth retardation resulting into low birth weight, intra-uterine fetal deaths, neonatal deaths and still births.
- ***Cancer especially cancer of the cervix:*** This is mostly caused by Human papillomavirus (HPV). HPV was responsible for an estimated 528,000 cervical cancer cases and 266,000 deaths from cervical cancer in 2012 (WHO, 2018).

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?

In 2012, the estimated chlamydia prevalence among women aged 15 – 49 years in *African Region* was 3.7% (2.7 – 5.2) and 5.0% (3.8 – 6.6) in 2016. This represented an increase of 1.3%. While the estimated prevalence of chlamydia among men was 2.5% (1.7 – 3.6) in 2012 and 4.0% (2.4 – 6.1) in 2016, representing an increase of 1.5%. The increase is slightly higher among men. This could be because men sometimes are open and can easily seek for treatment compared to women who are often times oppressed and keep off.

Estimated trend in chlamydia prevalence among men and women aged 15 – 49 years in African region and globally

	2012		2016	
	Women	**Men**	**Women**	**Men**
African Region	3.7 (2.7 – 5.2)	2.5 (1.7 – 3.6)	5.0 (3.8 – 6.6)	4.0 (2.4 – 6.1)
Global	4.2 (3.7 – 4.7)	2.7 (2.0 – 3.6)	3.8 (3.3 – 4.5)	2.7 (1.9 - 3.7)

How it compares with the global prevalence

Globally, estimated prevalence among women in 2012 was 4.2% (3.7 – 4.7) and 3.8% (3.3 – 4.5 in 2016. This represent a decrease of 0.4% among women. While in 2012, the global estimated prevalence of chlamydia among men was 2.7% (2.0 – 3.6) and 2.7% (1.9 – 3.7) in 2016. This suggest that the global chlamydia prevalence among men remained the same.

Comparative to African region, the global trend in chlamydia prevalence decreased while in African region, it increased. As observed among women, though the global estimate was higher (4.2% compared to African region (3.7%) in 2012, the global prevalence decreased by 0.4% yet in the African region, prevalence among women increased by 1.3%. On the other hand, prevalence among men globally remained the same i.e. in 2012 and 2016, indicating no significant change. However, in the African region, there was a significant increase of chlamydia prevalence of 1.5% among men. This still explains that globally, there was not significant change compared to African region where a significant increase was noted among men. This could be because of health seeking behaviour, good control measures and treatment in some countries as compared to African region that is characterised by poor health seeking behaviour. Overall, the trend indicates that chlamydia is persistently endemic worldwide.

<u>Question 2.2:</u>

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

- ***Estimate burden of disease due to STIs:*** Global, regional and national prevalence and incidence helps in calculating the burden of disease due to sexually transmitted infections (STIs). This provides statistics that can be used for advocacy for funding for STI programs and promote innovation for point-of-care diagnostics, new therapeutics, vaccines and microbicides.
- ***Monitoring resistance to antimicrobials:*** There is a global threat of antimicrobial resistance, particularly the emergence of Neisseria gonorrhoeae resistance to the few remaining

antimicrobials recommended for treatment. Prevalence and incidence estimates can therefore help monitor such phenomenon.

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.

Barriers are obstacles young people face in utilisation of STI related services. The barriers can be related to availability, accessibility or acceptability of services and can be from the service providers or users.

One barrier from the perspective of providers

Inadequate knowledge, attitude and negative behaviours among service providers:
Overwhelmingly, it has been noted that service providers do not have enough knowledge on the content and how to provide adolescent friendly sexual and reproductive health services. In many public health facilities, service providers offer general services to everyone regardless of age. In some cases, service providers act in accordance to societal culture, norms and taboos that hinder discussions around sexuality among adolescents especially girls. This then escalate their behaviours and consequently become rude to the young people and release information about their sexuality life to the public. They also blame the young girls for contracting STIs. This has a bearing on adolescent health seeking behaviour. It is worse with young people with different sexual orientation (LGBTI) that I regarded a *"no go area".* Health care providers do not attempt to discuss such as they are bound to loose their jobs if identified. They will be perceived to be promoting un tolerated culture. Comprehensive sexuality education in its full state with the 8 key components would offer a solution but, in my country,, this is not taken in its state and hence deny health care providers opportunity to acquire comprehensive knowledge on sexuality to be able to offer adolescent friendly sexual and reproductive health services.

One barrier from the perspective of the users

Inadequate knowledge and information on sexual and reproductive health (SRH) and availability of services among adolescent girls and boys limit their access and use of STI case management services. It is important to note that adolescents especially those from rural areas and more so the girls do not have the right information on sexual and reproductive health. The cultural norms, behaviours and perception bars them from accessing information. Sexuality conversations with or among adolescent girls is not tolerated. It is perceived to be one way of preserving their virginity up to the time of marriage. To prove innocence, young people tend to fall back in case of STI and do not seek for medical treatment. They fear to be identified to have had sexual act and therefore to remain *"sexually innocent"* in the eyes of the public, they hide their health problems. Many adolescents resort to self-medication; seek for traditional medicines (herbs), buy drugs from drug shops without telling service providers their health problems and some keep silent until they realize some complications. The situation is worse for adolescent with different sexual orientation as mentioned above.

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.

A brief definition of brief sexuality-related communication (BSC)

Brief Sexuality-Related Communication (BSC) is an approach that uses counselling skills opportunistically with far less aware on the duration, to address sexuality and related personal and psychological problems as well as to promote sexual well-being of the client.

One way in which BSC is similar to counselling

Counselling is systematic consultations in primary care for addressing emotional, psychological and social issues that influence a person's health and well-being. BSC on the hand uses counselling skills to address psychological and social dimensions of sexual health and well-being and helps an individual to work through their problems. Therefore, BSC and counselling are similar in a way that they both use similar skills and address psychological and social issues of individuals and help them work through their challenges.

One way in which BSC is different from counselling

Counselling is characterized by its continuity, i.e. a specific provider builds trust with a client over time to ensure continued consultations but BSC does not require provider continuity.

Its four components

Attending: This involves establishing relationship with the client. The service provider may use some questions in an acceptable and appropriate manner to provoke discussions with the client. The questions should be those that can enable the client reveal subject of attention, for example, *"would you like to share any concerns about sexuality"?*

Responding: This involves asking questions that open the conversation about sexual health and sexuality, for example *"what is your personal experience on sexual relationships"?*

Personalising: This involves identifying existence of sexual concerns or difficulties or dysfunctions or disorders and the forces of interaction between them. Questions that may enable the client speak out about previous experience or concerns on sexuality could be used, for example *"what is your experience in using contraceptives"?*

Initiating: This involves providing information and, with the client, identifying steps that need or could be taken.

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, in her discussion advocated for open sex discussions. She rightly points out conversations about sex to take the same direction as one would discuss about other subjects, for example food - what to eat and how to prepare or driving where a lot of information is being discussed openly about road safety including acquiring licenses for one to qualify to drive. "What about taking similar approach on sexuality", where we could openly share basics about sex. She then calls for media houses, parents/guardians, health workers and policy makers to promote open sex discussions and services in the same manner other subjects are given attention without stigmatization or shock.

In my context, BSC focus is to help clients identify ways to address their concerns. It helps clients to freely discuss concerns/issues about their sexual life, supports them to unearth issues of concern and respects clients' ideas, feelings, expectations and values. In the process, clients are able to reformulate their emotions, their thinking and understanding, and subsequently, their behaviour. In that way, they will be able to develop their capacity for self-regulation, such clients will be able to exercise their sexuality with autonomy, satisfaction and safety and will be encouraged to openly and freely converse about sex.

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.

According to WHO 2018, HPV was responsible for an estimated 528,000 cervical cancer cases and 266,000 deaths from cervical cancer in 2012. Promoting preventive measures against HPV infection has far reaching benefits in the reduction of cervical cancers and associated deaths. HPV vaccination is therefore important because it protects against cervical cancer.

Does your country have a national policy and strategy for HPV vaccination?

Uganda does not have separate policy on HPV vaccination per say, but rather incorporated in the national immunisation policy. We also have Uganda National Expanded Program on Immunisation (UNEPI) that guides immunisation services in the country.

Is so, briefly describe it.

National immunisation policy focuses on strengthening planning, management and organisation of immunisation services. It has the following priority areas:

vaccine supply and quality, service delivery, surveillance, logistics advocacy and communication, strengthening management, strengthening human and institutional resources, financial sustainability, community involvement and research. Its objectives are

Question 5.2:

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

As mentioned in the paper, the current practice in Uganda is that HPV vaccination is combined with deworming treatment and is also linked with Child Health Days plus.

Nonetheless, the most important intervention to combine with HPV vaccination is information and life skills among young people. This includes menstrual hygiene education, Sexual and reproductive health education, HIV prevention and condom promotion, promotion of physical activity and prevention of mosquito-borne diseases.

Explain why.

The selection of information and life skills as detailed above is premised on the fact that access to sexual reproductive health information is inadequate among adolescents especially girls. Since there is positive response to up take of HPV vaccination among girls and services are taken to within their access, it could be an opportunity for them to get the missing yet important information especially on menstruation, sexual reproductive health, HIV prevention and condom use at the same point. This also reduces beneficiary fatigue as the young people will benefit from the same at one point of service. The services mentioned can fit into the six months duration for the HPV vaccination schedule.