

The health and wellbeing assignment nursing essay

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Part A: Health Review

Binge drinking concerns particularly related to unwanted sexual practices in adolescents. What can we do as educators to help remedy these issues and improve the health outcomes for these children?

In today's contemporary society through media portrayal we continue to witness adolescents abusing their physical health on a frequent basis through the act of binge drinking. We as educators now more than ever need to address such behaviour in the schooling environment with particular attention to the health issues, both long term and short, that arise from such exorbitant behaviour. Binge drinking, commonly referred to as 'drinking to get drunk', can be defined as drinking an excessive amount of alcohol in a short amount of time, leading to serious health and social consequences (Poncelet, 2009). Australian research shows that in 2010 around 19% of 16-17 year olds drank in a risky or high risk way, monthly. There is the perception that nowadays binge drinking has become pretty much the norm for teenagers. Binge drinking is dangerous and even if there is only the minority who are doing it, they are still obvious and very influential (Drinkwise, 2013). Therefore due to this concerning thought process this essay will delve through the health concern of binge drinking and the health issues that arise from such. It also aims to acknowledge the inequities and social injustices surrounding adolescents engaging in the activity and will endeavor to explore strategies aiding parents, educators and the entire school community address these issues to ensure all students attain the

necessary support to develop as young adults. There are many health related issues, which are encompassed under the banner of binge drinking. Unwanted sexual practice is a frequent result of excessive alcohol consumption throughout adolescents ensuing in unplanned pregnancies, birth defects, human immunodeficiency virus and other sexual transmitted diseases (Powell, 2002). According to a 2007 survey into STDs and unwanted pregnancies conducted by the Royal Society of Medicine, 76% the women questioned had experienced unprotected sex as a result of drinking, and women who binged most heavily experienced significantly more unwanted pregnancies. (Standerwick, 2007). It is acknowledged that the report also found that 32% of women reported a pregnancy and 14%, a termination. In those women reporting a pregnancy, 55% said it was unwanted, and of these 28% reported drinking before unprotected sex (Standerwick, 2007). Within the school environment the main inequitable health outcome arising from binge drinking, which predominantly needs to be addressed, are the unwanted sexual practices that continue to occur. Once parents and teachers form a deep understanding as to why these behaviours occur, they place themselves in greater position to address and possibly assist the child before they become a further statistic. It is vital to clearly evaluate the leading causes for participation in unwanted sexual practices in adolescents. The inequities surrounding appropriate education and access to crucial resources and facilities are two most prominent causes, and will each be outlined here. Appropriate education within sexual health is of great importance as this heavily impacts on ones health behaviour heading into adulthood (AIHW, 2010, p. 80). Developing awareness and shaping attitudes

through education is therefore a key link in the promotion of health throughout today's contemporary society. Yet it is recognised that there are inadequate gaps in adolescent education and knowledge of sexual intercourse and the aftermaths that may occur. (AG-DHA, 2010, p. 21; Chan & Bradford, 2001, p. 198). Notably, the Australian Institute of Health and Welfare (AIHW, 2010, p. 83) underline that appropriate knowledge about Chlamydia, gonorrhoea and other common STIs is lacking in adolescents, while the number of sexually active high school students perceptibly increases (2010, p. 310). The resulting inequity of knowledge contributes greatly to adolescents increased risk of infection (AIHW, 2011, pp. 50, 80). A important example of the inequity of appropriate education can be seen in the lack of condom use whilst under the influence of alcohol. Although rates of contraceptive use in general are high (AIHW, 2011, pp. 61, 81), students lack access to an education that focus on the importance of condom use as well as the aftermath that may follow if deciding not to use a contraception, primarily focusing on pregnancy (AIHW, 2010, p. 83; de Visser, 2005, p. 558; O'Leary, 2011). Thus the lack of education results in misconceptions or a lack of awareness surrounding pregnancies alongside STIs and their popularity (de Visser, 2005, p. 558). Only around half of sexually active students always use a condom (AIHW, 2011, p. 82) - is a leading contributor to increased rates of unwanted pregnancies let alone STIs (AIHW, 2011, p. 50). This low level of regular condom use in adolescents may also develop from a difficulty to access condoms themselves, leading this analysis to shift focus to the second key inequity: access to crucial resources and facilities. Any success in reducing unwanted pregnancy rates relies greatly on access

to effective contraceptive resources like condoms (AIHW, 2011, 81; Bearinger, Sieving, Ferguson, & Sharma, 2007, p. 1221), and access to appropriate medical care and support facilities (AG-DHA, 2010, p. 19; Shone, 2010, p. 591). Unfortunately, these suffer from inequitable barriers that heighten the risk of unwanted pregnancies for adolescents. Queensland schools to this day lack facilities providing professional help to those suffering the aftermath of an unwanted sexual experience. General practitioner access - have obvious costs involved but adolescents usually do not have sufficient funds for access (WHO, 2002, p. 21). Although public funded sexual health clinics are available, knowledge of them is often lacking (Shone, 2010, p. 591; WHO, 2002, p. 21) so they require a more prominent profile. Even when known, other formal barriers exist such as opening hours (AIHW, 2011, p. 163; Braeken, Otoo-Oyortey, & Serour, 2007, p. 173; Shone, 2010, p. 594; Sundby, 2006, p. 365; WHO, 2002, p. 21) and transport to and from facilities (AIHW, 2011, p. 163; Quine, Bernard, Booth, Kang, Usherwood, Alperstein, & Bennett, 2003, p. 6). Personal concerns - such as a lack of confidence, a perceived lack of confidentiality, embarrassment, or a fear of social judgement or punishment are all reasons in which access to relevant facilities are restricted. (AIHW, 2011, p. 163; Bearinger, Sieving, Ferguson, & Sharma, 2007, p. 1226; Braeken, Otoo-Oyortey, & Serour, 2007, p. 173; Quine, Bernard, Booth, Kang, Furthermore a lack of appropriate education and access to crucial resources and facilities leads to increasing rates of unwanted pregnancies throughout Australian adolescents. All adolescents have the right to access comprehensive sexual and reproductive health information and services, and have the ability to make informed decisions

and enjoy a healthy, safe sex life. It is thus imperative that these inequities are acted upon with proactive and intelligent recommendations, generating the goal of Part B.

Part B

Health Report

Extended Written Response. Evaluation and justification.

Recommendations

The second half of this essay aims to construct an extended written response entailing a proactive step forward through recommending how to counter the inequities. The two inequities explored here, being appropriate education amongst schooling, and an enhanced access to sexual health facilities and resources. Evaluation and justification will align with the Ottawa Charter for Health Promotion Framework (OCHP). Accordingly the five action areas – developing personal skills, creating supportive environments, strengthening community action, reorienting health services, and building healthy public policy (WHO, 1986, p. 2) – will be consistently enforced forming a strong structure and plan of attack. Although it is crucial to remember no single response will cover all determinants or all adolescents (de Visser, 2005, p. 565; Shaw, 2009, p 135). The inequity surrounding lack of knowledge and teaching of sexual practice has been established and shown to aggravate the rates of unwanted pregnancies and STIs in Australian adolescents. The educator themselves become a primary source of sexual health information for children when entering their adolescents. 70% of Australia's adolescents have experienced some form of sexual activity by grade 10 (AIHW, 2011, p.

80), half of which have had sexual intercourse by 16 years of age (AG-DHA, 2010, p. 13), meaning the majority of adolescent's first initial sexual encounter occur whilst they are enrolled in schooling. The first distinct recommendation here is for the Australian school curriculum to incorporate a revitalised, up-to-date and nationally researched sex education program primarily focusing on pregnancy in adolescents. The need for a more comprehensive, nationally coordinated and researched, sexual practice aware curriculum can only benefit the Australian adolescent entering adulthood (Bearinger, Sieving, Ferguson, & Sharma, 2007, pp. 1226, 1227; Braeken, Otoo-Oyortey, & Serour, 2007, p. 174; Chan & Bradford, 2004, p. 197; de Visser, 2005, p. 561). For this approach to work however, it is crucial that educators providing the material be sufficiently supported and trained (Skinner & Hickey, 2004, p. 160). To support teacher education in this field funding needs to be provided to the appropriate schools resulting in a recommendation promoting a brighter future in education amongst adolescents. A noteworthy barrier preventing this recommendation from taking full effect is strictly enforced national lesson-plans proving inappropriate across the nation. Any education program must leave space to be adapted to the cultural environment in which it is to be taught (AG-DHA, 2010, p. 22; Bearinger, Sieving, Ferguson, & Sharma, 2007). Another leading barrier to these recommendations develops when parents of adolescents do not wish their children to partake in sexual education, potentially due to a belief that such education will promote earlier sex, despite the lack of - and even contrary - evidence for this (Shaw, 2009, p. 133; Skinner & Hickey, 2004, p. 159; Sundby, 2006, pp. 360-361). Students must be aware death

may be a result of denying such education (Shaw, 2009, p. 132) alongside one must also be aware that this barrier cannot be absolutely countered; however it is vital to realise that adolescents have a right to complete education for their health and wellbeing (Bearinger, Sieving, Ferguson, & Sharma, 2007, p. 1225; Sundby, 2006, p. 360). Desirably, this leading hurdle can be minimised through broader education and awareness in society as a whole, addressed in the following recommendations. The Internet continuously grows as a fundamental point of reference for health related concerns (AIHW, 2010, p. 80). With this in mind, another recommendation towards improved education is generated that being the enhancement of clearly promoted, easy to find and simple to use websites. Keep in mind this idea has been noted and attempted elsewhere, particularly by non-government organisations (Braeken, Otoo-Oyorley, & Serour, 2007, p. 173). However for sexual health websites like this to be effective it becomes imperative they are nationally coordinated (Skinner & Hickey, 2004, p. 160) and all research is sufficiently supported (AG-DHA, 2010, p. 35). Thus it is a recommendation that the Government be the driving force behind these resources. Through this parents and/or guardians of different cultural backgrounds can also be educated. Fourth National Survey of Australian Secondary Students and Sexual Health (Smith et al, as cited in AIHW, 2010, p. 82) found that over 50% of those who sought sexual health information did so from a parent. This will only aid in minimizing the inequity lack of appropriate education as it ensures that the family unit is provided with sufficient skills and understanding. Although as a worrying further barrier, not all family units are dedicated to the wellbeing of their adolescents (WHO,

2002, p. 3), so families cannot be wholly relied upon and more strategies are needed. Furthermore the recommendations made are in clear loyalty to the OCHP framework. Helping develop personal life skills of adolescents through greater education and the skills of sexual health educators and family units through supported training and learning. The recommendations made have the possible potential to generate supportive environments through the advanced knowledge and awareness, alongside the level of sexual health curriculum. Thus also aiding in the strengthening of the community through developing social awareness and understanding. Ultimately, with a government-coordinated education and research into unwanted sexual practices, these recommendations reorient health services to explicitly address the health issue as well as generating a scaffold for the building of a healthy public policy. Moving on this paper will now focus on the second inequity mentioned in Part A, concentrating on the adolescent access to sexual health resources and facilities. Improving access to these services becomes a focal point when aiming to reduce unwanted sexual practices throughout adolescents (Shaw, 2009, pp. 132-133), thus further recommendations are needed. Two key recommendations have been generated to best counteract this health issue, social awareness being the primary focal point. As stated previously an enhanced education does play a significant part in this, although extensive exposure and patent social marketing can help and should be utilised (AG-DHA, 2010, p. 22; de Visser, 2005, p. 561; Rice & Farquhar, 2000, p. 192). Perceptions, awareness and attitudes amongst the community can be improved through effective research based marketing that " presents the issues and consequences of

unsafe sex in Australia" (AG-DHA, 2010, p. 20). Focusing on conventional mediums of portrayal such as television and physical advertising, these campaigns can utilise new electronic social-media, (de Visser, 2005, p. 563) engaging distinct groups, such as men and women (Shone, 2010, p. 592). Early detection and response is crucial in reducing rates of STIs here in Australia, thus forming the second society-focused recommendation (AG-DHA, 2010, p. 26; Quine, Bernard, Booth, Kang, Usherwood, Alperstein, & Bennett, 2003, p. 2). A fundamental goal is then clinical testing amongst adolescents although as put perfectly by Bearinger, Sieving, Ferguson, & Sharma (2007, p. 1226) " clinicians need to develop enhanced methods for reaching larger portions of the adolescent population". In relations to this publicly funded, nation wide mobile services – similar to mobile dental clinics used by Queensland Health (2012) – is recommended. As stated by WHO (2002, p. 19) this then becomes a vital feature of youth-friendly services as students then have access to information, advice, or testing and treatment facilities whilst such mobile services position themselves on school grounds. Personal concerns, travel, time, and cost then become a thing of the past as the importance of this service becomes utilised for beneficial factors. It has even been shown that school-based clinics improve both access and understanding (Skinner & Hickey, 2004, p. 160) furthermore such potential must be utilised. Although as recommendations develop as do obstacles preventing such from occurring. Finding government funding presents itself as an obstacle for the first recommendation, however much emphasis is put on the importance of such funding as it becomes a crucial point in building a sound nation health strategy to resolve such health inequities (Blas et al.,

2008; Chan & Bradford, 2001, p. 197). Although when trying this service in with simulated discussion throughout society alongside an improved education communities will begin to recognise and accept the importance of its incorporation. As for the second recommendation, obstacles lie in not only the costs, but also the numbers of health care professionals and use of resources that such an endeavour will soak up. Intense testing in some areas can be unnecessary and has the potential to block access for higher risk individuals elsewhere (AG-DHA, 2010, p. 26). It is seen that both recommendations significantly tie in with the OCHP framework. Health services are positively reorientated through the promotion of researched marketing and direct action urging health services to effectively respond. Also the recommendations generate and demand political discussion in search of effective and responsive public policy. Personal skills and supported learning are accomplished through the presence of mobile services amongst schools as adolescents may attend such services whenever they choose. Such facilities provide anonymous service providing a more supportive environment for adolescents wishing to partake. Such services aren't limited to adolescents; parents and/or guardian are also welcome to attend thus providing information to people of all ages generating a more aware and stronger community.

Conclusion

At first this essay primarily focused on binge drinking throughout adolescents linking to the health issue of unwanted sexual practice that may follow, before examining the current inequities that form this distressing

health issue. Recommendations to counter act such inequities were then explored. In doing so, this essay has clearly demonstrated that although unwanted sexual practices is inevitable amongst adolescents and aggravated by clear inequities, there are some plausible steps that can be taken.