

Health promotion strategies: sexual health and chlamydia



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Sexual Health Chlamydia

This essay seeks to discuss a topical health promotion issue in the United Kingdom and to explore the topic in terms of current research findings, support mechanisms currently on offer and the role of the nurse in promoting health and well being. Relevant health promotion models, terms relating to health and health promotion will also be analysed. Primarily the focus will be on sexual health promotion of sexually transmitted infections such as chlamydia, its effect on young people including barriers that are inhibiting sexual health promotion.

Rationale for choosing sexual health and targeting young people has been the increased concern by the government to promote sexual health in young people necessitated by the rise in figures of sexually transmitted infections. The Department of Health (DoH, 2008c) acknowledges that due to new evidence from research, sexual transmitted infections (STIs) and Human immunodeficiency virus (HIV) are causing a wide range of illnesses and are a significant cause of long term and serious disability in the United Kingdom.

It goes on to mention about the arrival of HIV epidemic in the 1980's, high infection rates and risky sexual behaviours as the reasons for increased concern among health professionals, the government and the public (DoH, 2008c).

Chlamydia is the most common STI diagnosed in genitourinary medicine clinics in England with high prevalence among young men and women under 25 years old. The highest rates are among the 20-24 year age group in men and 16-19 years in women (DoH, 2008c).

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Because of these reasons the government has targeted chlamydia for sexual health promotion through published reports and implementing educational programmes with the help of different public bodies and organisations. Prior to that, 'pilot studies of opportunistic screening for genital chlamydia' were carried out in Portsmouth and Wirral between 1999 and 2001, and they revealed high figures of chlamydia infection (DoH, 2008b).

DoH (2003) reiterated that another reason why chlamydia had been targeted was because of serious health problems associated with it since it is asymptomatic and at least three quarters of women and half of men with the infection have not been treated. Furthermore, one in ten young people are unaware of the infection.

Chlamydia is known to cause pelvic inflammatory disease, ectopic pregnancy and infertility in women and in men it can cause arthritis, epididymitis and Reiter's Syndrome (DoH, 2008c).

The anticipated change in the National Health Service (NHS) in dealing with sexual health matters was facilitated by the government through programmes such as the National Strategy for Sexual Health and HIV which was implemented in 2001 in conjunction with the DoH and the NHS.

It outlined among other issues the need for a National Chlamydia Screening Programme which was subsequently established in 2003 with the aim of controlling chlamydia in young adults, detecting and treating the infections thereby preventing further infections and complications associated with it (DoH, 2008b).

In 2005 there was a re-launch of the National Chlamydia Screening Programme in collaboration with the Health Protection Agency to raise awareness of Chlamydia amongst young people by offering free confidential screening, a website with factual information on chlamydia which also addresses some commonly asked questions (DoH, 2008c).

This in itself indicates some failings in the programme between the time it was first established in 2001 until the re-launch in 2005. Nevertheless, this also shows the commitment of the government in promoting sexual health by aiming to improve the services and continuing to try different ways of reaching out to the public.

It is interesting to note that the idea of health promotion was initiated as early as 1977 with targets and legislative policy and guidance being put in place but little seems to have been done practically. Kart (2000 p. 6) mentioned that ' In 1977 Health for All by the year 2000 was launched at the 30th World Health Assembly.

This policy initiative formulated a range of performance indicators by which progress towards better health might be judged, such as reduction in rates of disease, increased levels of nutrition and improved primary healthcare.' One can certainly conclude that the battle is still ongoing and much more practical interventions to facilitate sexual health promotion calls for serious consideration. However, Johnson et al, (2001) agrees that HIV and STI transmission is a major public health challenge.

Davey et al (2001) sought to obtain views from the public on the definition of health. Their definitions included health as the absence of disease, as physical fitness, as energy, as a social relationship, as function and as psycho-social well-being. Davey et al (2001) concluded that the differences in definitions were influenced by sex differences and age groups.

The World Health Organisation (1986) emphasised health as a two-way process of critical consciousness raising, clarifying values, exploring attitudes, educating policy makers and taking control over one's own health. This definition seeks to empower the individual who is in need of assistance by giving them the opportunity to identify and learn from their experience alongside professional support.

Evidence has proved the ambiguity of the term health promotion. Many authors have defined health promotion in various ways. Terms such as health education and public health have been used in place of health promotion but conflicts still arise in terms of what is to be included in the definition and what has to be excluded.

Tones (1994 p. 14) defined health promotion as 'health promotion = health education x health public.' While French (1990) questioned the exclusion of disease management as a way of promoting health. Most authors agree that health promotion cannot be discussed without mentioning health education in the process. Perhaps, it should be acknowledged that the two work effectively when used concurrently.

Health education also emphasizes the large part of health promotion offered by nurses, as their intervention seeks to empower the patient with <https://assignbuster.com/health-promotion-strategies-sexual-health-and-chlamydia/>

knowledge. Kartz et al (2000) described health education as a form of communication that offers knowledge and skills essential in making healthier choices through behavioural changes that will benefit the wider community.

The Department of Health asked the National Institute for Health and Clinical Excellence (NICE, 2007) to produce public health guidance on interventions to reduce the transmission of chlamydia, including screening and other STI's including HIV reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups. This guidance focuses on one to one interventions to prevent STIs and under 18 conceptions.

In 2004 the DoH on behalf of the government published a report by Tony Blair titled ' Choosing Health: Making healthy choices easier.' This white paper explained how the government intended to support the public in making informed healthy choices and tackling the causes of ill health without discrimination. It also aimed to set realistic goals and offer ongoing health support into the 21st century.

The government also initiated the accessible services provided by adults who feel confident working with young people through youth services such as Young People's Development Programme and outreach services with a particular focus on those who are experiencing or are at risk of experiencing, poor outcomes because of mental health problems or substance misuse (DoH, 2004). Furthermore, the government provided £300 million in support of the White Paper: Choosing Health as a constructive measure to sexual health promotion and introduced a reduction in value added tax for condoms if one has to buy them (DoH, 2004).

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Due to inadequate access of specialist sexual health, the DoH (2008a) introduced the Evaluation of One-Stop Shop (OSS) model of sexual health provision for different specialist care under one roof for easy accessibility and effectiveness of services. However, there was much debate on the issue with some professionals welcoming the idea while others did not think that this would make much difference after considering costs and opening times of different clinics.

Measor et al (2000) points out the discrepancies in policies or lack of consideration when it comes to making policies that involve young adults such as the lack of a clear national policy. This has had a number of negative effects on sexual health promotion. The result has been a confused mix of messages for adolescents about sexuality. A research done by Blenkinsop et al (2004) on adolescents highlighted that young people were not in agreement with the government's view of the rights of parents over children. They challenged this view of the balance of power between the generations.

However, the children acknowledged the need for adults to be involved in sexual health promotion but the vast majority preferred to discuss sexual concerns with teachers, nurses and other health professionals. On the other hand, the children expressed their right to withdraw if they suspected that information was going to be shared with their parents, which is a breach of confidentiality. Confidentiality and trust should be guaranteed and where possible maintained at all times and this is in accordance with the NMC code of professional conduct (2008).

Some cultures need to depart from traditional health communications and beliefs that do not permit sexual health issues to be discussed with a parent as the DoH (2003) highlighted cultural differences, stigma, discrimination, inequalities and poverty as barriers to sexual health promotion. An important aspect that parents have to keep in mind is to refrain from the blame culture, being judgemental or dominating conversations when their children seek advice on sexual matters.

The government through the document ' Choosing Health' intend to develop new ways of supporting the parents of teenagers so that they feel equipped to help their children make informed choices, particularly on sensitive issues such as sex and relationships (DoH, 2004).

Some Primary Care Trusts have begun to implement the government's plan by involving young people in projects that offer communication on sexual health through magazines.

In Manchester Your Life magazine which covered sexual health issues has published and distributed over 7, 000 copies of the magazine through Manchester Secondary schools, attracting a positive response from both pupils and education professionals. The response of young people towards the magazine was exceptionally overwhelming (DoH, 2004).

There seem to be more need to change behaviour now than ever before. Dines et al (1995) points out that there is research evidence of increased risky sexual behaviour mostly amongst young people and also across the population. NICE (2007) elaborates on behaviours that increase the risk of

STIs as including drug and alcohol abuse, early onset of sexual activity, <https://assignbuster.com/health-promotion-strategies-sexual-health-and-chlamydia/>

engaging in unprotected sex and frequently changing sexual partners.

Therefore NICE (2007) recommends health professionals working in general practice, genito-urinary medicine (GUM), community health services (including community contraceptive services), voluntary and community organisations, school clinics to actively facilitate health promotion programmes .

Benzeval et al (1995) also highlighted the interconnections of lifestyle and environmental factors, suggesting that action was required to combat inequalities at various levels. Assumptions, different beliefs and values also play an important role in how people react to health promotion as well as prioritising it. However, evidence from research has to be embraced to avoid conflicting ideas and approaches in analysing and implementing the health models individually and in the society.

Ewles et al (1999) defined five approaches to health promotion as medical which promotes health by providing medical intervention, behaviour change which encourages attitude and behaviour change by adopting healthier lifestyles, educational which empowers individuals with knowledge and understanding to make informed decisions, client centred which facilitates choice of health actions as identified by the client, last but not the least is the societal approach which seeks to change the physical and social environment to enable choice of healthier lifestyle. One can conclude that these theories are direct input to health promotion which is provided by facilitators of health promotion such as nurses, other health care professionals and teachers.

Young people need to learn about behaviour change. Changing behaviour can be challenging, stressful and bring uncertainty in one's life but support from friends, families and professionals is of paramount importance in convincing the individual that they are doing the right thing. Ewles (1999) further suggests that the individual should implement and adopt behaviour that promotes health.

Maslow's hierarchy of needs as cited by Wagner (2008) identified basic needs such as self actualisation, esteem, social, safety and physiological needs. Young people should be encouraged to realise these needs, have a sense of belonging and fulfil love needs through working with families and groups. Self actualisation assists in having a deeper understanding of self through realising personal potential, growth, peak and self fulfilment.

Nurses play an important role in facilitating awareness of sexually transmitted infections in young people at an early stage through school nursing. The nurses work closely with children, teenagers, their parents, carers and teachers providing advice and support about health issues such as puberty and sexual health.

As Murphy (2004) suggests that nursing intervention aims to control genital chlamydia infections through early detection and treatment. This reduces the chance of onward transmission and prevents the development of complications.

NICE (2007) recommend action from health professional to identify individuals at high risk of STIs using their sexual history. Opportunities for risk assessment may arise during consultations on contraception, pregnancy
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or abortion, and when carrying out a cervical smear test, offering an STI test or providing travel immunisation. Risk assessment could also be carried out during routine care or during registration of new patients.

One to one structured discussions with individuals at high risk of contracting STIs offer more privacy, is assuring to the individual and encourages good rapport. The discussions should be structured on the basis of behavioural change theories. They should address factors that can help reduce risk-taking and improve self-efficacy and motivation. Ideally, each session should last at least 15-20 minutes. The number of sessions one can receive depends on individual need.

As difficult and embarrassing as it may be for young people, the acceptance of behavioural change should prepare them to take action and ensure their sexual partners also seek help. NICE (2007) remind facilitators of health promotion to ensure that sexual health services, including contraceptive and abortion services, are in place to meet local needs. Services should include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI.

The government also highlighted the need to combat health inequalities by targeting young people from poor and disadvantaged backgrounds who are socially excluded such as those who are in care, disabled, from black and minority groups, with low educational attainment or those who are or have experienced homelessness (DoH, 2004 & NICE, 2007).

GPs, nurses and other clinicians working in healthcare settings such as

primary care, community contraceptive services, antenatal and postnatal
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care, abortion and GUM services, drug/alcohol misuse and youth clinics, and pharmacies other clinicians working in non-healthcare settings such as schools and other education and outreach centres should take responsibility of health promotion (DoH, 2006).

Nurses also have a responsibility whenever possible, to provide one to one sexual health advice on, preventing and getting tested for STIs and preventing unwanted pregnancies by introducing methods of reversible contraception, including long-acting reversible contraception, how to get and use emergency contraception and other reproductive issues and concerns. Another group that seem to be forgotten is the vulnerable young women aged under 18 who are pregnant or are already mothers (NICE, 2007).

The unique function of the nurse is to assist the individual who has ill health to perform activities that contribute to health or its recovery that he would perform unaided if he had the necessary strength, will or knowledge (McBean, 1992). Nurses must not be judgemental or make assumptions of situations. Young people would benefit from being given time to explore their feelings uninterrupted and the nurse must seek to consider health promotion activities that best suit the individual and offer flexible alternatives as well.

Watterson (2003) suggested that affected young people should have influence over the outcome of their health as young people often feel powerless because of the way issues are addressed as nurses at times unconsciously exclude them in decision making. He goes on to say that it is more effective to empower young people by involving them in decision

making processes, giving them a voice and valuing what they know and believe about matters that affect their health.

This encourages behavioural change by using the patient centred approach model of health promotion. The role of the nurse is to encourage the youths to discuss issues of sexual health with their parents, approach teachers and to provide them with information about services available such as Young People's Development Programme and National Chlamydia Screening Programme. Nevertheless, parents need to realise the need for open dialogue and creating relationships built on trust.

The DoH in 2006 launched a campaign through the website known as the 'Condom Essential Wear' to raise awareness of sexual health by encouraging the use of condoms. It encourages safe sex and communication about condoms as means of minimising the risk of sexually transmitted infections and unwanted pregnancy among young people.

However, an independent advisory group (IAG) as cited by the DoH (2008c) found out that of the original £50 million budget for sexual health awareness campaign only £4 million had been released. IAG raised concern as to whether enough free condoms were being distributed to recommended places such as GUM clinics, GP surgeries, schools, community contraceptive clinics and youth centres. Consequently, it is arguable that the issue of funding jeopardizes sexual health promotion services to prosper. Nurses need to educate young people on the correct use of condoms. Posters can also be placed in private and public toilets for young people to read and condoms can also be distributed via this channel.

In view of GUM clinics, the government mentioned about the prioritisation of the 48 hour GUM access target as one of the NHS top six targets and the access to specialist sexual health services. However, these clinics are not as wide spread as they should be to accommodate and provide services to youth. The recommended quality service is not consistent at both national and local level as stipulated in the 2005/2006 annual report (DoH, 2008c).

Opening hours are about an hour and a half for two times a week which is not sufficient or beneficial at all to young adults. This does not encourage young people to come forward because they would have to wait long in the queue and being seen by other people is quite embarrassing for them. This further complicates the problem and better services need to be put in place to encourage increased uptake of sexual health services.

To conclude this essay, it can be said that nurses must provide supporting information in an appropriate format to encourage young people to take responsibility for their own actions as far as sexual health promotion is concerned. Cultural differences, age and gender differences can be barriers for health promotion.

Nurses should therefore acknowledge these facts and seek to deal with situations accordingly. In this case, the failure or success of this aspect of health promotion is largely influenced by the interpersonal skills of the nurse. Health promotion is also everyone's responsibility and the government has incorporated community needs in health promotion programmes to try and meet individual needs.

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