

Challenges to sexual health care in today's society



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Meeting the sexual health demands facing young people in today's society

The issue of sexual health in adolescent people is a vast topic with an associated vast literature on the subject. In this essay we aim to consider some of the major themes and critically analyse some of the peer reviewed literature to act as an evidence base for further consideration. (Berwick D 2005)

In broad terms, sexual health can be divided into areas of physical health and emotional (or psychological) health. The adolescent age is classically one of turmoil, of establishing identity, values and ideals. This is arguably the time when the emotional turmoil relating to sexual identity comes to the fore.

We should remind ourselves, before perhaps dismissing the notion of psychological health as being on a different level of seriousness as an overtly physical problem such as a sexually transmitted disease, (Coyle KK et al 2001), that one of the commonly accepted definitions of health is a state of complete physical, mental, and social well being, and not just merely the absence of disease or infirmity. (UN 1995). One can argue that it is an essential component part of the developing person's ability to become well adjusted, responsible and productive (in every sense of the word) members of society (UN 2002)

Issues of sexuality have, ideally, to be resolved. The apparently eternal adolescent dilemmas of " am I sexually attractive?" " am I gay or straight?" or " am I ready to have sex?" clearly have a direct relevance to the psychological health of a person but the behaviour patterns that these

questions can engender in an attempt to resolve them, can pose clear risk patterns to the physical sexual health of the adolescent. (Larson, R., et al. 2002.)

To a large extent the issues that concern the adolescent have their origins in earlier life. As they progress through childhood, adults treat boys and girls differently, and thereby establish different expectations for their behaviour. These expectations are clearly influenced by their culture and a myriad of more subtle influences. They largely determine life outcomes. They also shape the adolescent's introduction to sexual practices, sexuality and relationships generally. (Aarons SJ et al 2000)

The reason for dwelling on these factors is that they have a fundamental bearing on the possibility of adverse reproductive and sexual health outcomes in later life, including events such as unwanted pregnancy, unsafe abortion and sexually transmitted diseases, all of which have major socio-economic components. (Churchill D et al 2000), Differential gender expectations and social treatment in childhood and the early adolescent period are thought to be frequent causal factors in adolescent problems.

The bulk of this essay will be on the issues surrounding the major issues of STDs in the adolescent community. One of the most pressing issues in this regard (at least in terms of sheer numbers) is the issue of chlamydia. (Fenton KA et al 2001). In the specific terms of meeting the demands of the adolescent population we will begin this examination with a consideration of the National Chlamydia Screening programme.

The programme was originally set up after the realisation that chlamydia was responsible for a large amount of morbidity in the community which had, hitherto been unrecognised (Cates W, et al. 1991). It is now seen as the single most commonly transmitted STD in the UK today. A huge proportion of what used to be called NSU is now recognised as being due to the chlamydia pathogen (Duncan 1998).

If we consider the issues behind the screening programme, on one level the issues appear fairly straightforward and simple. Because we know that many cases of chlamydia are asymptomatic and that it can cause considerable damage and that it is also easily treatable, why not screen for it and minimise its impact? (Kufeji O et al 2003)

On a more sophisticated level one must consider the cost-effectiveness considerations together with issues such as feasibility, efficiency and use of resources.

If we examine the published rationale behind the National Chlamydia Screening programme as set out by The National Institute for Clinical Excellence (NICE) we can see that it states that:

- Genital Chlamydia trachomatis is the commonest Sexually Transmitted Infection (STI) in England
- Genital chlamydial infection is an important reproductive health problem ~ 10-30% of infected women develop pelvic inflammatory disease (PID).

- A significant proportion of cases, particularly amongst women, are asymptomatic and so, are liable to remain undetected, putting women at risk of developing PID.
- Screening for genital chlamydia infection may reduce PID and ectopic pregnancy.

They also concluded that there was not a great deal of data on the cost effectiveness of the possible procedure (Harry et al 1994)

The paper itself is extremely detailed and, in essence, it points to the fact that it is extremely cost effective to detect and treat asymptomatic patients before they develop complications that then need treatment. Complications are outlined in the paper by Berry (et al 1995) and include the sequelae of infertility, pelvic inflammatory disease and ectopic pregnancy in women together with the complications that can occur in the male partners (infertility and prostatitis).

The authors point to the fact that their screening programme reduced both the incidence and prevalence of pelvic inflammatory disease by 60% when compared to the unscreened population. Of particular relevance to our theme, we note that the screening programme became cost effective when the incidence of infection in the population of asymptomatic women rose above 1.1%. Figures quoted by Pimenta J (et al 2001) suggest that in our target age range the prevalence is approaching 11%.

If we examine the literature on the subject we can see that the adolescent age range has the fastest growing proportion of chlamydial infections (Gilson et al 2001). This finding is therefore at odds with the logic of the report

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commissioned by the Chief Medical Officer (CMO 1998) which suggests that the groups to be screened under the National Programme should be:

Everyone with symptoms of chlamydia infection,

All those attending genitourinary medicine clinics,

Women seeking termination of pregnancy.

Opportunistic screening of young sexually active women under 25 years

Women over 25 with a new sexual partner or two or more sexual partners in the past year.

It will therefore be immediately apparent that there is no provision for screening for asymptomatic men and also that the adolescent population are not to be specifically targeted unless they attend clinics.

On the subject of screening young men, there are a number of well written papers on the subject. Notable amongst them is the Duncan paper (Duncan et al. 2001) which looks at the issues of male screening from both a Public Health viewpoint and it also considers it from a feminist sociological angle which makes it, (in our examination of the current literature), almost unique.

It is a thoughtful and well written document and tackles the thorny issue of the fact that many young women are reluctant to attend screening clinics as being screened for STDs has overtones and perception of being “dirty” and “unattractive”. A positive screening result can be associated with considerations of promiscuity. Such feelings are clearly counterproductive,

particularly in the light of our earlier comments relating to the developing psyche of the adolescent. Duncan puts forward the hypothesis that by not screening men, it not only fosters gender inequalities, but it sends of negative messages regarding the man's responsibility for sexual health (Pierpoint et al 2000).

Critical analysis of this point suggest that although it may be intuitively true, the authors don't produce any counter evidence with regard to the cost effectiveness of screening adolescent males (or any other age group for that matter) in the population (Stephenson et al 2000)

Other authors do also make the point that it appears to be a generally accepted fact that women are actually easier to target than men as they tend to be heavier health care users than men in this age range (Stokes T 2000).

The main practical thrust of this paper however, is in its call for a greater understanding of the woman's point of view when organising and running screening clinics in order to broaden their appeal to the intended target groups (Santer et al 2000). Clearly this point is central to our considerations here as clearly there is no point in providing services to meet a perceived need if there is no uptake from the targeted population.

If we turn our attention to the second most common STD in this age range we need to consider genital herpes. (Schacker T et al 2000)

There are many common arguments in the areas of screening for genital herpes and chlamydia. Qualitative studies have shown a greater level of

concern relating to genital herpes amongst the adolescent population that there is for chlamydia, and it is second only to HIV/AIDS (Corey L et al 2001). The specific problem with the age range that we are specifically considering here is that there is a general perception that genital herpes is a nuisance and a comparatively trivial condition. Indeed the majority of infections are either mild or subclinical. Serious complications are actually comparatively common and there is an increasing body of evidence that suggests that genital herpes infection is a potent facilitator of sexual transmission of the HIV virus. (Tripp J et al 2005)

The major epidemiological factor that is relevant with genital herpes is the fact that transmission can occur in a long-standing monogamous relationship. Its immediate problem is that the longer the period of infectivity, the greater the potential for transmission. In the adolescent years when there is a greater likelihood of a number of sexual partners, infections can be contracted only to be passed on at a considerably later time due to the fact that subclinical or unrecognised reactivation in the infected partner is intermittent. (Hopkins J 2005)

There is another element of sexual health that is specific to the adolescent age range. As we have already observed, adolescence is a time of considerable turmoil not only in terms of psyche but also in terms of hormones. There is an eye-catching paper by Brabin (2001) which considers the impact of fluctuating hormone levels on the body's susceptibility to STDs

It is already established that sex hormones play a role in the host's resistance to STDs (Hewitt RG et al 2001). We can show this by considering

sex differences in susceptibility to infection, variations in the clinical manifestations of infection during the menstrual cycle (Greenblatt RM et al 2000) and also during pregnancy (Brown ZA et al 1997) and also by the fact that the OC Pill predisposes to some infections (Wang CC et al 1999)

The paper considers the implications of these facts with particular reference to the adolescent age group. It points to the sex differences in the acquisition of STDs with the adolescent girl getting infections such as genital herpes and chlamydia with greater frequency than the adolescent boy. (Obasi A et al 1999)

Sex differences also have an effect on the efficacy of a genital herpes vaccine trial which showed a limited protective efficacy against genital herpes in women but none in men. (Stephenson J 2000).

The whole area of the ability of the NHS to meet the demands of the sexual health needs of the adolescent is vast. We have not presumed to cover all of the relevant areas in this particular essay.

In the areas that we have selected for examination and consideration we have been at pains to critically assess the evidence base as this is fundamental to the acceptance of the comparative validity of the various papers used.

The adolescent age group has certain unique characteristics which set its sexual health related problems apart from the rest of the population. In short, they can be encapsulated in the turmoil of the characteristic psychological and physical changes that are typical of the age. We have

examined how the psychological issues impinge on both the sexual behaviour patterns and therefore the disease exposure risks and also the willingness to attend clinics if a sexually acquired disease process becomes apparent. We have contrasted this pattern with the pattern of screening that is currently advised and implemented under the auspices of the National Chlamydia Screening Programme. We have also examined the negative aspect of the disproportionate concentration of resources of the older female population and therefore, by inference, the impact that this will have on the adolescent population.

Issues such as genital herpes also have unique implications for the adolescent, particularly with the long period of infectivity that is relevant to this disease process.

We also have examined the implications of the hormonal differences that are amplified by the hormonal changes that are apparent in this age range.

References

Aarons SJ, Jenkins RR, Raine TR, El-Khorazaty MN, Woodward KM, Williams RL, et al. 2000

Postponing sexual intercourse among urban junior high school students. A randomised controlled evaluation.

J Adolesc Health 2000; 27: 236-247

Berry J, Crowley T, Horner P, et al. 1995

Screening for asymptomatic Chlamydia trachomatis infection in male students by examination of first catch urine.

Genitourin Med 1995; 71: 329-30.

Berwick D 2005 Broadening the view of evidence-based medicine Qual. Saf. Health Care, Oct 2005; 14: 315 - 316.

Brabin L 2001

Hormonal markers of susceptibility to sexually transmitted infections: are we taking them seriously?

BMJ 2001; 323: 394-395 (18 August)

Brown ZA, Selke S, Zeh J, Kopelman J, Maslow A, Ashley RL, et al. 1997

The acquisition of herpes simplex virus during pregnancy.

N Engl J Med 1997; 337: 509-515

Cates W, Wasserheit JN. 1991

Genital chlamydial infections: epidemiology and reproductive sequelae.

Am J Obstet Gynecol 1991; 164: 1771-1781

Churchill D, Allen J, Pringle M, Hippisley-Cox J, Ebdon D, Macpherson M, et al. 2000

Consultation patterns and provision of contraception in general practice before teenage pregnancy: case-control study.

BMJ 2000; 321: 486-489

CMO 1998

Chief Medical Officer. Main report of the Chief Medical Officer's Expert Advisory Group on Chlamydia trachomatis.

London: Department of Health , 1998.

Corey L, Wald A. 2001

Genital herpes. In: Holmes KK, Mårdh PA, Sparling PF, eds. Sexually Transmitted Diseases. 4th ed.

New York, NY: McGraw Hill; 2001: 285-312.

Coyle KK, Basen-Engquist KM, Kirby DB, Parcel GS, Banspach SW, Collins JL, et al. 2001

Safer choices: reducing teen pregnancy, HIV, and STDs.

Public Health Rep 2001; 116(suppl 1): 82-93

Duncan B, Hart G. 1998

Screening for Chlamydia trachomatis: a qualitative study of women's views. Prevenir 1998; (suppl 24): 229.

Duncan B, Graham Hart, Anne Scoular, and Alison Bigrigg 2001 Qualitative analysis of psychosocial impact of diagnosis of Chlamydia trachomatis: implications for screening BMJ, Jan 2001; 322: 195 – 199

Larson, R., et al. 2002.

Changes in Adolescents' Interpersonal Experiences: Are They being Prepared for Adult Relationships in the Twenty-first Century?"

Journal of Research on Adolesence 12(1): 31-68; 2002

Fenton KA, Koroivessis C, Johnson AM, et al. 2001

Sexual behaviour in Britain: reported sexually transmitted infections and prevalent genital Chlamydia trachomatis infection.

Lancet 2001; 358: 1851-4.

Gilson RJC and Mindel A 2001 Recent advances: Sexually transmitted infections BMJ, May 2001; 322: 1160 - 1164

Greenblatt RM, Ameli N, Grant RM, Bacchetti P, Taylor RN. 2000

Impact of the ovulatory cycle on virologic and immunologic markers in HIV-infected women.

J Infect Dis 2000; 181: 82-90

Harry T, Saravanamuttu K, Rashid S, et al. 1994

Audit evaluating the value of routine screening of Chlamydia trachomatis urethral infections in men.

Int J STD AIDS 1994; 5: 374-5

Hewitt RG, Parsa N, Gugino L. 2001

The role of gender in HIV progression.

AIDS Reader 2001; 11: 29-33

Howell MR , TC Quinn, CA Gaydos. 1998

Screening for Chlamydia trachomatis in asymptomatic women attending family planning clinics.

Annals of Internal Medicine 1998 128: 277-84

Kufeji O, R Slack, J A Cassell, S Pugh, and A Hayward 2003 Who is being tested for genital chlamydia in primary care? Sex. Transm. Inf., June 1, 2003; 79(3): 234 - 236.

Obasi A, Mosha F, Quigley M, Sekirassa Z, Gibbs T, Munguti K, et al. 1999

Antibody to herpes simplex virus type 2 as a marker of sexual risk behavior in rural Tanzania.

J Infect Dis 1999; 179: 16-24

Pierpoint T, Thomas B, Judd A, et al. 2000

Prevalence of Chlamydia trachomatis in young men in north west London. Sex Transm Infect 2000; 76: 273-6.

Pimenta J, Catchpole M, Gray M, Hopwood J, Randall S. 2001

Screening for genital chlamydial infection.

BMJ 2001 321: 629-631

Santer M, Warner P, Wyke S, et al. 2000

Opportunistic screening for chlamydia infection in general practice: can we reach young women?

J Med Screen 2000; 7: 175-6.

Schacker T, Zeh J, Hu HL, et al. 2000

Frequency of symptomatic and asymptomatic herpes simplex virus type 2 reactivations among human immunodeficiency virus-infected men.

J Infect Dis. 2000; 178: 1616-1622.

Stephenson J. 2000

Genital herpes vaccine shows limited promise.

JAMA 2000; 284: 1913-1914

Stephenson J, Carder C, Copas A, et al. 2000

Home screening for chlamydial genital infection: is it acceptable to young men and women?

Sex Transm Infect 2000; 76: 25-7.

Stokes T, Mears J. 2000

Sexual health and the practice nurse: a survey of reported practice and attitudes.

Br J Fam Plann 2000; 26: 89-92

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Tanne JH 2005 US teenagers think oral sex isn't real sex BMJ, Apr 2005; 330: 865 ;

Tripp J and Viner R 2005 Sexual health, contraception, and teenage pregnancy BMJ, Mar 2005; 330: 590 – 593 ;

UN 1995

United Nations. 1995.

Population and Development, vol. 1: Programme of Action adopted at the International Conference on Population and Development: Cairo, 5-13 September 1994, paragraph 7. 2.

New York: Department of Economic and Social Information and Policy Analysis, United Nations. 1994

UN 2002

United Nations. 2002.

World Youth Report 2003: Report of the Secretary- General (E/CN. 5/2003/4), para. 16.

New York: Commission for Social Development, United Nations. 2002

Wang CC, Kreiss JK, Reilly M. 1999

Risk of HIV infection in oral contraceptive pill users: a meta-analysis.

J AIDS 1999; 21: 51-58

Wilson JS, Honey E, Templeton A, et al. 2002

A systematic review of the prevalence of Chlamydia trachomatis among European women.

Human Reproduction Update 2002; 8: 385–94.

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