

HIV/AIDS prevention: The role of the general practitioner in sex education for adolescents

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Introduction

HIV is an ever increasing epidemic, especially in South Africa, where 10% of the infected people worldwide live.¹ Of the 5.3 million adults and children living with HIV/AIDS in South Africa, 2.9 million are women. The HIV prevalence in people aged 15-18 years is 4.8%, while it is 16.5% in those aged 20-24.²

The prevention and treatment of sexually transmitted infections (STIs) is imperative, as they affect the mucosal integrity of the genital tract, increasing the risk of HIV infection in HIV-negative individuals. Furthermore, an HIV-positive person sheds more HIV virus in the presence of an STI and hence is more infectious.³ HIV infection has a positive correlation with syphilis. In 2002, the HIV prevalence in women with syphilis at antenatal clinics in the Western Cape was 30.8%, which was significantly higher than in syphilis-negative women (12%).⁴ The syphilis prevalence rates were 3% amongst women younger than 20 years, 1.2% in those aged 20-24 and 2.6% in those between the ages of 25 and 29.⁴

STIs also have an impact on reproductive and child health. The complications include infertility, chronic pain, spontaneous abortion

and ectopic pregnancy. STIs contribute to perinatal morbidity and mortality, including premature births and neonatal infections.³

Sex education and STI and pregnancy prevention programmes are important amongst adolescents, who are especially vulnerable to high-risk behaviour. The general practitioner (GP) has an important role to play in teenage sex education. The HIV/AIDS Directorate in the Western Cape Province has recognised this role by implementing a pilot programme amongst a few GPs, who provide counselling on and the diagnosis and treatment of STIs in an alternative setting to a primary healthcare facility. The client pays a consultation fee, but the treatment is provided free of charge.⁵

Adolescent sexual behaviour

"Adolescent sexuality is not pathologic but part of normal development as human beings."⁶ Data collected in a national cervical abnormality survey in the late 1990s showed that the average age of first sexual intercourse in women in South Africa was 16.8 years, compared with 19.3 years 40 years previously.⁷ According to a cross-sectional survey of Cape Town high school students in grades 8 and

11, 29.9% had participated in sexual intercourse.⁸ A total of 23.4% of males and 5.5% of females had already had sexual intercourse by the age of 14, and by the age of 19 the rates were 71.8% and 58.2% respectively. These statistics are comparable to those in the United States of America (USA), where 18-19% of adolescents have engaged in sexual intercourse by the age of 15 and 4-5% have had sex by the age of 12.⁹

The Cape Town scholars stated that, during their last sexual encounter, 65.4% had used contraception, of which only 67.7% had used condoms.⁸ The prevalence of using condoms by the females was 40.2% in grade 8, compared with 62.1% in grade 11.⁸ Flisher *et al.* suggest that this may be due to an increased awareness of safe-sex practices among the older girls, or an increased capacity to negotiate using condoms with their partners.⁸ This substantiates the view that younger adolescents are more likely to have unprotected sex and are more vulnerable to infections. They also experience more barriers to accessing health care than do older adolescents and adults.¹⁰ Therefore, sex education should be given to primary school children before they enter high school, which

corresponds to an average age of 14 years.

Barriers to sex education as experienced by GPs

Guidelines provided by health departments and medical organisations in the UK and USA require that health professionals routinely provide adolescents with advice and treatment on contraception and on sexual and reproductive health.^{11,12} There are, however, a number of barriers to meeting these ideals.

Firstly, consultation time is a major constraint for both patient and GP when dealing with this sensitive issue. The GP might also feel that it would be inappropriate to broach the subject of sex and STIs when a patient presents for another complaint. However, in a recent trial done on a brief intervention to reduce STI risk in young adults aged 18-25 years in a family practice setting, it was found that 83% of participants had no objection to receiving information on safe sex. They did not disapprove of being asked about their sexual orientation, sexual practices, number of partners or about drug taking.¹³

The family physician's own beliefs and attitudes will also affect his or her ability to initiate and maintain a discussion on STI prevention. He or she might disapprove of sexual intercourse in such young patients on the basis of his or her own religious or cultural background. A survey done in the US on the primary care doctor's attitudes regarding STI prevention and treatment strategies showed that the physicians' attitudes directly influenced whether and how they provided information on STI prevention and counselling.¹⁴ These doctors stated that they had limited confidence in their ability to change their patients' behaviour, felt that their

undergraduate training was lacking in this regard, did not feel that it was their responsibility to deliver STI-prevention services, and that time and financial constraints limited their ability to provide these services. The doctor who was most likely to discuss STI prevention with his or her patient was more likely to be female, under the age of 40, with previous obstetrics and gynaecology experience, and one who practised in a clinic setting.

An approach to sex education and STI prevention

Know your patient and his or her needs

The GP is often a respected and trusted figure in the family and community and is well positioned to provide sex education and information on STI prevention to its young citizens. Confidentiality and privacy are key elements required if the GP hopes to have open discussions with teenagers.⁶ The GP must consider the patient's cultural background, knowledge, religion, the gender-based differences in the perception and experience of sex, and the current teen culture.⁶ In addition, he or she should be aware of local beliefs and misconceptions, for example some patients might think that safe sex implies only pregnancy prevention and as a result practise anal sex.

The developmental stage of the teenager will also influence the physician's approach. Risk behaviour is influenced by the fact that adolescents often feel invincible and believe that bad things will not happen to them.¹⁵ Furthermore, younger teenagers are at the stage where they are trying to formulate their own identity irrespective of their family's ideas and beliefs, and feel that the opinions of their peers are more important.⁶ Girls are more likely to

have decreased self-esteem and negative feelings towards their rapidly changing bodies, and need to feel loved in relationships.⁶ This affects their capability of negotiating sexual practises with their partners. It is important to highlight that girls often experience sexual aggression and that 28% of women say that their first sexual experience was unwanted.²

Practical approach

A sexual history is important, as it helps the GP identify high-risk behaviour and to direct education where it is needed the most. A brief sexual history should include sexual contact in the last three to six months, the gender of the partners, sexual orientation of the patient, type of sexual intercourse, use of condoms and contraceptives, and previous STIs.¹⁶ The GP must always consider asking about alcohol, tobacco and drug usage, as these are often associated with high-risk sexual behaviour.

To be effective, the GP must communicate in a non-critical manner with open-ended questions, speak in age-appropriate language and display active listening skills. When initiating the topic in young adolescents, the GP can use open-ended questions such as: "Girls and boys your age have started having sex. What do you think? Have you considered having sex?"¹²

The information on the prevention of STIs for adolescents should include ways that will encourage them to delay the initiation of sexual intercourse and to abstain from sex, to use condoms irrespective of other contraception, and to select a low-risk partner.¹⁷ Furthermore, the GP can provide a role in educating them about the physiology of sexual intercourse, help provide information on contraceptive choices for a teenager considering

initiating sex, and educate them on safe sex and condom usage. This may help the teenager to make the appropriate choices before becoming used to unsafe sexual practices.

For teenagers already engaging in sexual intercourse, the sex education will need to have a different emphasis. The GP should promote sexual health, encourage teenagers to make responsible decisions about their sexual behaviour and inform them of how this will influence their future. These discussions should be constructive. Surveys show that teenagers do not want to be only told why they should not have sexual intercourse or be informed of the negative consequences thereof.^{6,15}

Regarding efforts that try to change sexual behaviour, it has consistently been found that sex education is not sufficient for actually maintaining safe sex practices.¹⁸ Sex education on its own initially influences sexual behaviour, but this is commonly not maintained on long-term follow-up. Like any high-risk behaviour (e.g. smoking), the process of change can be a long and difficult one with many relapses. The Transtheoretical Model is often used to guide the counsellor through the stages and processes of change.¹⁹ The five stages include precontemplation (no intention to change behaviour), contemplation (seriously considering change but unable to take action), preparation for action (planning to change and have made unsuccessful attempts to do so), action (recently engaged in a new behaviour) and maintenance (consistently engaging in the new behaviour for at least six months). The individual can cycle through these stages. The GP is in a situation where he or she is more likely to see the patient more than once and help the patient through this behaviour modification. The GP can encourage

teenagers to have better communication with their partners, provide knowledge and help teach them verbal and practical skills that enable them to move through the different stages towards the action stage.

The GP can also play a role in advising parents on how they should discuss sexual behaviour and STI prevention with their children. Open communication and a higher quality parent-child relationship are associated with fewer risk behaviours in adolescents.²⁰ Teenagers also express a desire for their parents to have an improved ability to talk to them about sexuality and sexual behaviour.¹⁵

Sex education should be a routine part of the GP's family practice. In addition to proactively raising the topic for discussion, the practice could display posters and provide pamphlets on HIV/AIDS, voluntary counselling and testing services, STIs, contraception and sexuality. These media may also provide access to educational material for the more inhibited teenager.

Conclusion

In promoting sexual health in adolescents, it is not adequate to only provide sex education, but young people should be empowered to determine their own healthy sexual behaviour. This should take the form of a comprehensive approach that provides knowledge, encourages the development of positive attitudes and self-esteem and provides skills to cope with negative social and cultural norms.²¹ Whereas large, organised STI and HIV prevention programmes for teenagers remain the preserve of the education department, government organisations and private media, the GP has a vital role in the nation's fight against HIV/AIDS, which

threatens our most precious commodity – our youth. 🙋

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