Sexual health service delivery challenges in the Pacific.

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A reportedly wise man once mused about four amazing things that he could not fully explain or understand; the ability of a bird to fly, a ship to float, a snake to move, and the way of a man with a woman. Today we can happily cite the science of physics to explain the first three questions, yet it remains challenging to answer that fourth one because “for many people, sex remains an unsolved puzzle.” What exactly is that last question about anyway? Is it simply as St Augustine described “the unclean motion of the generative parts” or is it better explained by Potts and Short as “the behavioural combination of culture and biology that dominates our thoughts... and drives forward the major part of our lives”? In order to explain the wonders of sex we need to consult the fields of genetics, endocrinology, neurobiology, psychology, physiology and sociology – it is not surprising that we still find sexual health service delivery challenging. And that is before we add the politics of public health, the law, economics, immunology, and communicable diseases to the mix.

The predisposing factors implicated in both individual and population sexual ill-health include culture, law, religion, the nature of STI (frequently asymptomatic) lack of provider knowledge and skill, lifestyle (diet, exercise), and sexual literacy deficits generally. These are not small barriers and clinicians globally are struggling to overcome them.

There does appear to be some common sensitivities, avoidance, or discomfort with several topics of which none of us can actually avoid; death, disability, disease, defaecation, and sex. As clinicians we have mostly overcome these taboos through our professional lives as we know we need to engage with the reality of these topics on a daily basis – not only for health promotion and health protection, but also for quality care provision and because our patients need and expect it from us. However, is it not a little strange that a pleasurable life-affirming subject is allocated the same uncomfortable, unmentionable (taboo) status as some of these other difficult subjects? The Pacific has an incredible diversity of cultures ranging from the relatively sexually permissive and tolerant of sexual difference to sexually restrictive cultures which can be intolerant of (for example) non-heterosexual or non-procreative experiences.

For some clinicians, there remains a conflict between their personal belief system and their scientific professional practice. Whereas for others they are able to reconcile the conflict between official church teachings or their own personal religious convictions and what is ethically required of them for the public good – such as condom promotion and provision to young single people, effective contraception provision to a 15 year old girl, a termination of pregnancy for a couple with an unplanned pregnancy, or treating rectal gonococcal infection. Our politicians, policy makers, and health department program managers also face the same potential internalised conflict and sometimes the implementation of sound public health principles can lose out to an ideological opposition that may not deliver the best sexual health outcomes for our people.

There has been a long history of opposition to sexual health provision and the arguments used are surprisingly consistent since the Renaissance against any sort of intervention that does not punish its victims and that may improve individual and population level health. We may like to think that our medical science and epidemiological evidence has proven the benefits of public health interventions for sexual health; however we still face resistance when it comes to condom promotion, sexual health education and even to the bio-medical interventions. These are the false arguments of behavioural dis-inhibition or risk compensation. The common example of this argument is the false belief that promoting condoms promotes sex or talking about condoms encourages promiscuity. It is hard to believe now, that at the time of penicillin’s discovery there
were medical personnel campaigning against the use of penicillin to treat syphilis because to their thinking, making syphilis easy to treat would promote promiscuity and there would then be no punishment for sexual sin. During the first world war there were campaigns against the distribution of condoms to those at risk; in the 1960s the invention of hormonal contraception and again now with the long acting reversible contraceptive (LARC) implant has seen resistance from sections of our communities who cite religious ethics as their rationale. The advent of ART (anti-retroviral therapy) for HIV treatment, and Post-Exposure Prophylaxis and Pre-Exposure Prophylaxis for HIV prevention and male circumcision as HIV prevention in generalised epidemics all face ideological opposition to their implementation. Opponents of public health interventions for sexual and reproductive health seem to use the same arguments; “we cannot do that, because it will encourage more sex”. However, Pacific people like all other humans in the world were having sex prior to and continue to engage sexually regardless of prohibitions or preaching or threats of disease and dysfunction. Fear arousal by itself is not a sustainable behaviour change technique.

Giving options for people to choose what they can do to minimise the harms and maximise the benefits associated with sexual behaviour is the basis of sexual health promotion for the public health. Similarly, implementing medical interventions that have been proven to be cost effective and efficacious for the individual and the public health including Periodic Presumptive Treatment of STI in female sex workers, Post Exposure Prophylaxis (PEP) for STI and HIV in cases of broken or un-used condoms with sero-discordant or unknown status sexual couplings, and prophylactic treatment of sexual contacts of index cases with an STI, will also reduce the prevalence of STI in our populations and improve our sexual health.

Those wanting to continue the use of punishing toxic treatments for syphilis in the 1940s and those now fearing that sex education promotes sex mis-understand human behaviour is largely based on the reward system of dopamine and other opioids released into the pleasure receptors in the brain. The reinforcing factors for human behaviours are the sensations that happen immediately after a certain activity – for example, the physiologic impact of nicotine during inhalation of tobacco, not lung cancer in 20 years’ time; the orgasm induced rush of dopamine and then the satisfaction of serotonin release, not STI in a week’s time; the warm glow of alcohol during a party with friends, not the headache at 6 am the next morning. Belief in fear as an effective tool for behaviour change persists to this day, especially for behaviours that are immediately rewarding and pleasurable (sex and drugs).

Motivations for sexual behaviour are complex involving testosterone and the reinforcing factors in wanting or desiring sex are mediated by the dopaminergic-oxytocin-vasopressin system during and after sex as well as the non-sexual pleasures of intimacy and connection.

If we are afraid of sex, or afraid to talk honestly about sex, we are afraid of being human. In the absence of rapid accurate point of care testing for the common STI, it is incumbent on clinicians to conduct a sound sexual history, clinical examination, prescribe efficacious antibiotic or anti-viral medication, and ensure sexual partner notification and treatments if we are to make the best use of the syndromic methodology. A reticence to conduct a physical examination and reticence to ask personal questions results in sub-optimal management of STIs.

A 2017 data feedback meeting with study participants by the PNG Institute of Medical Research (IMR) again underscored the value to patients with sexual health concerns in having the opportunity to have a detailed respectful discussion with a health professional, consent to a systematic physical examination and targeted screening tests, and receiving the correct treatment for reactive results. Study participants from both the female sex worker and men who have sex with other men populations in their feedback to the study stakeholder meeting cited the chance to have a non-judgemental clinical consultation, examination, testing, and treatment as their main motivator in participating in the study. The IMR Integrated Bio-Behavioural study of populations vulnerable to sexual ill health in Port Moresby, Papua New Guinea provided a safe confidential environment, a skilled local clinician, testing commodities, rapid turnaround for results, and free treatment. The gratitude expressed by the study participants was sincere – despite there being sexual health services present in their city, previous experiences or stories from their peers about poor service, stock outs of medications, disrespectful care provision, lack of examination and lack of testing all added up to these people not accessing services when needed. This has serious public health implications, as these people were sexually active with undiagnosed treatable STI who are at risk of poor outcomes.
due to the delay in treatment of their mostly asymptomatic infections.

Many of our sexual health services are ‘sexual health’ in name only due to programmatic and funding constraints necessitating a focus on the management of STI and HIV, leaving those with other sexual health concerns without recourse to care. Worries about sexual function, pain with intercourse or sexual relationships go largely unaddressed leading to a surging unregulated industry in hocus pocus sexual enhancement products. Men in particular are the main victims of these scammers, although women are also vulnerable to being convinced into buying vaginal drying or thickening agents and vaginal deodorisers. Our men do have questions and concerns that clinicians do answer when they are knowledgeable and comfortable to discuss the topic, however a large gap remains in unmet needs. A recent study in the Solomon Islands underscores men’s sexual function concerns and a 2011 study in PNG reported men had questions and concerns on penile size, rapid ejaculation, erectile difficulties, and desire discrepancy within relationships and were expecting clinicians to have the answers.

The broadening and combination of the definitions of sexual and reproductive health and rights as recently outlined in the Lancet highlights the real developmental benefits that come from working collaboratively to achieve the Sustainable Development Goals. Stable responsible population growth requires effective methods of contraception and couples require the skills to negotiate birth timing, spacing and their sexual relationship. The commission did miss an opportunity though to link sexual function with the rapidly increasing impact of chronic disease on the Pacific. Many of us have seen the negative impact of diabetes on women’s and men’s sexual function due to the effect of high blood sugar on vascular and neurological structures. Abdominal obesity in men is now considered a major risk factor in the “deadly quartet” making up the metabolic syndrome; abdominal obesity, diabetes, high blood pressure and high levels of harmful cholesterol in the blood. While erectile dysfunction is related to age, it is also an early warning sign of coronary artery disease (atherosclerosis) and potential heart attack. The pathophysiology is quite simple; penile arteries are smaller than coronary arteries, and therefore (on average) block up 3 years earlier. If clinicians can talk to men about their sexual function and counsel on lifestyle modification, we may be able to intervene early to prevent a cardiac event. To improve penile and cardiac fitness, men can give up smoking, reduce their abdominal fat and increase physical activity – good advice for everyone.

Sexual health promotion and education really is just ‘life’ promotion. If we can help people be kinder to their partners and themselves, then the quality of their life improves. The true trickle-down effect is kids growing up in households valuing mutually satisfying relationships, affection, respectful communication, non-violent problem solving and with secure emotional attachments. If we are able to deliver comprehensive sexuality education to our community and our health service providers, there will be positive flow on effects to the wider society. People will be able to discuss condom use with their partners, they will be more likely to present without delay when symptoms occur, and we clinicians will be more comfortable with discussing and providing quality care for sexual health concerns.

REFERENCES


