



WHO

REGIONAL OFFICE FOR EUROPE



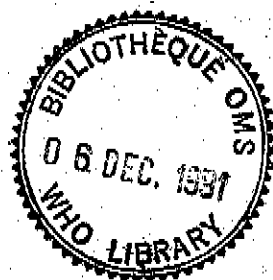
GLOBAL PROGRAMME ON AIDS

34708

EUR/ICP/GPA 079 A
6047n
ENGLISH ONLY
UNEDITED

REVIEW OF AREAS OF INTEGRATION BETWEEN STD SERVICES AND AIDS PREVENTION AND CONTROL PROGRAMMES

Report on a Working Group



Copenhagen
5-6 December 1990

SCHERFIGSVEJ 8
DK-2100 COPENHAGEN Ø
DENMARK

TEL.: (45) 39 17 17 17
TELEFAX: (45) 31 18 11 20
TELEX: 15348

1991

EUR/HFA TARGET 4

This activity was organized by the WHO Regional Office for Europe to promote work aimed at achieving the following target in the health for all strategy.^a

TARGET 4

REDUCING DISEASE AND DISABILITY

By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.

Index terms

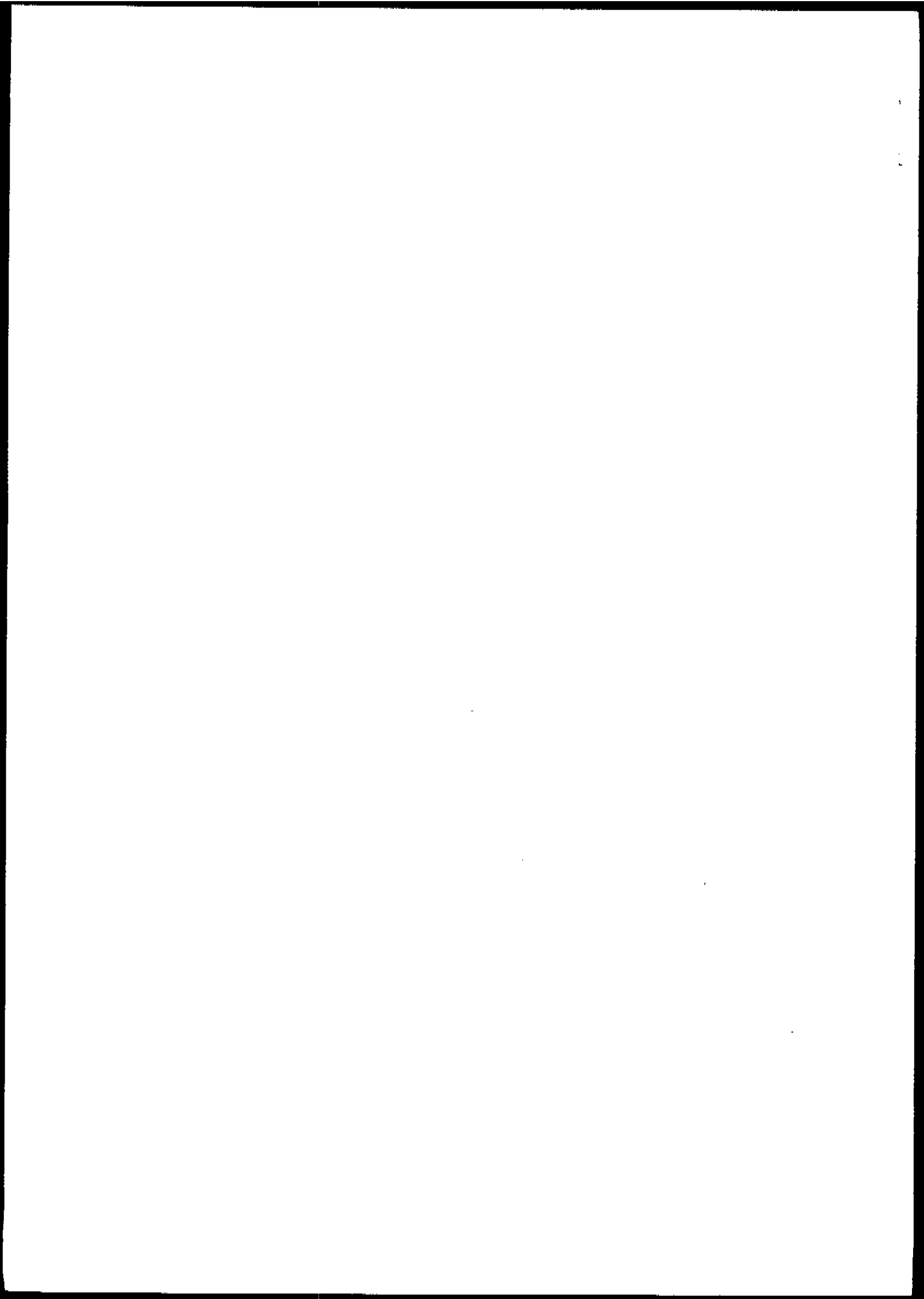
SEXUALLY TRANSMITTED DISEASES - prevent/control
ACQUIRED IMMUNODEFICIENCY SYNDROME - prevent/control
EUR

All rights in this document are reserved by the WHO Regional Office for Europe. The document may nevertheless be freely reviewed, abstracted, reproduced or translated, but not for sale or for use in conjunction with commercial purposes. Any views expressed by named authors are solely the responsibility of those authors. The Regional Office would appreciate receiving one copy of any translation.

^a *Targets for health for all. Copenhagen, WHO Regional Office Europe, 1985 (European Health for All Series, No. 1).*

CONTENTS

	<u>Page</u>
Introduction	i
Discussion	1
Consensus Statement on Global Strategies for Coordination of AIDS and STD Control programmes	3
1. Programme planning and management	3
2. Clinical services	4
3. Laboratory services	4
4. Health promotion: information, education and communication . .	4
5. Training	4
6. Surveillance	4
7. Evaluation	5
8. Research	5
Conclusions	5
Recommendations	6
Annex 1. List of participants	7



Introduction

The importance of sexually transmitted diseases (STD) as an epidemiological marker and measure of behavioural change relevant to AIDS and HIV infection has been proven. Nevertheless, the integration between STD and AIDS within the WHO Regional Office for Europe (EURO) has been limited, and within the Member States it appears the same may be true although this has been largely unexamined. In this context, EURO convened a working group to explore the role of STD services in AIDS programmes and vice versa. Five areas were identified by the secretariat for discussion. These were:

- the current situation and information available concerning STD in the European region;
- known linkages between STD and AIDS programmes in the region.
- the experience in other regions;
- what further information must be collected and how this might be accomplished; and
- possible strategies for the integration of AIDS and STD, and the role of the Global Programme on AIDS in EURO.

The outcome of meeting was expected to provide guidance as to the means and the extent that AIDS and STD prevention and control programmes should be integrated within the European Region and on the role of the Regional Office.

Discussion

Among communicable diseases in the European region, the incidence of STD is second only to respiratory infections and influenza. Moreover, experience with other communicable diseases has shown a tendency for vast underreporting. For example, in a single year, France reported 500 cases of measles where sentinel surveillance indicated in excess of 500 000 cases. STD and HIV infection reporting suffer potentially from the same deficiency. Compounding the problem, there is no European-wide surveillance system linked to HIV infection, although AIDS cases are reported to WHO, and a European-wide compendium on STD has not been updated since 1976.

Within the European Economic Community (EEC), a number of initiatives have occurred including a working party on AIDS, and STD research within the framework of medical research. In addition, a concerted action programme to monitor HIV infection within sentinel populations is underway in association with the COS countries. STD patients were identified as a good group for study, as HIV prevalence is high enough to be of interest. The pilot study has been completed. The results, however, were not definitive. It was found that it is difficult to establish national networks for the study and to integrate HIV and STD monitoring. In addition, the refusal rates by STD patients for voluntary HIV testing were as high as 30%. Prior experience has shown that rates of HIV within refusers are significantly higher than those who agree to be tested.

Nevertheless, the study is to continue with several additional questions to be answered. For instance, the trend and reason of refusal, and comparison

with other sentinel sites. This last point provides an additional challenge in that "site" of STD attendees is often different by country and may not refer to categorical STD clinics.

There are few, if any, truly common or linked programmes for AIDS and STD in the region. The only exceptions may be Iceland and Sweden where HIV infection is classified as a STD. Yet the different objectives and possibilities for action between HIV and STD make this a tenuous relationship. STD reporting is aimed at detection and cure; the same possibility does not exist for HIV.

Belgium has a well organized system for the diagnosis and treatment of STD patients where a network of general practitioners (GPs) are the principle players in this area. Of persons with an STD, 90% are seen by the GP. Treatment is the goal including that of partners where contact tracing is initiated by the GP and is voluntary. Case finding and screening occurs where approximately 50% of pregnant women are screened for HIV per year; abortion patients are screened for chlamydia; STD patients for syphilis and HBV and offered an HIV test; and women (especially teenagers) obtaining an IUD are encouraged to be tested for chlamydia. HIV tests are anonymous and a higher proportion of HIV positives are identified in anonymous testing centres than in GPs' offices. Over time, it has been found that GPs present a good opportunity for primary prevention, the testing centres for secondary prevention. There is a growing interest in the area of health promotion and sexual health.

Denmark introduced HIV surveillance in the country in 1990. It is primarily laboratory-based with anonymous reporting of positive HIV test results which include some patient information. Most testing occurs in GPs' offices and over two-thirds requesting the HIV test do not have commonly regarded risk behaviours. Unlinked anonymous testing is to start in 1991 and will include pregnant women and STD attendees. There is an intent to link the HIV results to STD. One important result to date is that one-third of STD attendees who were found to be HIV positive presented with a new STD following HIV diagnosis.

Sweden's experience with STD surveillance commenced in the early 1900s with mandatory reporting of STD. With the advent of HIV diagnosis, HIV infection was added to the list of reportable STD. The question being asked relative to HIV surveillance, however, is whether STD sentinel populations are representative of the whole population. Most physicians have said no. On the issue of obtaining national surveillance figures for STD and HIV, it is felt that the medical sectors contact with people and its attitudes concerning reporting are more important than the behaviour of the population. Contact tracing is mandatory in Sweden and is the responsibility of the attending physician.

The United Kingdom, as with Sweden, has a long experience with STD. There have been STD clinics since 1916, as well as surveillance programmes and reporting. Currently, the genitourinary medicine (GUM) clinics see over 80% of STD cases. These clinics also provide HIV testing and provide counselling and contact tracing. AIDS and STD are also integrated to differing degrees in the district health authorities with AIDS coordinating committees which include GUM/public health specialist, and the Department of Health with their AIDS unit and STD section. The true level of integration appears to lessen as the hierarchical level increases. The information systems for STD and HIV

surveillance are considered good with quarterly return from the GUM clinics, laboratory reporting, AIDS reports, and serosurveys in GUM clinics, antenatal clinics, hospitals and IVDU centres. The issue tends to be one of timeliness rather than lack of information.

Two important points were identified from the United Kingdom experience relevant to the integration of STD and AIDS. First, some important HIV activities, particularly contact tracing, is often taken seriously only by GUM physicians. As such, there is a need to integrate these activities into other medical specialities. Second, the attitudes and behaviour of the medical community may have as great an impact on integrating AIDS and STD as that of the population which reinforces Sweden's observation.

The United States presentation was not country-specific but rather focused on one AIDS organization's experience in integrating AIDS and STD. The original entry point was sexual behaviour as the primary vector of AIDS transmission with STD as an indicator of behaviour change only. Over time, this evolved as STD clinics were viewed as prime locations for prevention and intervention of HIV. It was quickly recognized, at least in the developing countries, that existing STD infrastructures could be used as a basis for AIDS programmes plus STD examined as a co-factor for AIDS transmission. The integration takes place in all areas - surveillance, prevention and management.

From experience in the United States the facilitating factors, obstacles and approach were identified. Facilitating factors were past experience, in-house experience and a mandate to pursue the approach. Obstacles were lack of interest, discrimination, weak STD infrastructure, a disinclination to raise the profile of STD at the expense of AIDS, and lack of interest by the AIDS programme in delivering services required for STD. A positive approach to integration in the American case included a written and explicit strategy, the inclusion of STD experts at staff and at policy (board) level, seeking appropriate technical advice at all levels and stages of development, training or at least sensitizing staff in both areas, and overlapping research and evaluation efforts.

Consensus Statement on Global Strategies for Coordination of AIDS and STD Control Programmes

As a basis for further discussion, the Consensus Statement on Global Strategies for Coordination of AIDS and STD Control Programmes (WHO/GPA/1990) was reviewed. The statement followed an international consultation convened by WHO's Global Programme on AIDS and the Programme on Sexually Transmitted Diseases on 11-13 July 1990 in Geneva. The following observations relating to the eight content areas of the Consensus Statement were made by the working group.

1. Programme planning and management

Before considering integration of AIDS and STD programmes, it was seen as necessary to investigate the characteristics and health care seeking behaviour of both STD and AIDS patients, what services were currently available or would be required, and perhaps most importantly what are the attitudes and behaviours of the health care providers; for instance, do they see HIV infection as an STD.

A review of sectors other than health care was seen as useful to determine what services were available that could benefit both AIDS and STD patients. Where there were areas of mutual benefit, promoting coordination would be a useful activity. For example, HIV service organizations could also address STD and sexual health.

2. Clinical services

It was thought that STD clinical services would not have a major role in AIDS beyond diagnosis, surveillance and referral. In this context, however, STD clinical services should be made aware of the complexities of HIV infection and the areas to refer HIV infected individuals. Within the care component, there is less overlap between AIDS and STD due both to the needs of the AIDS patient and the training and interest of the providers. In addition, the care of AIDS patients will often require many types of health professional.

3. Laboratory services

While there may be opportunities for integrating AIDS and STD laboratory services, there were enough differences not to make a definitive statement on integration. This is primarily due to the departmentalization within laboratories for the different types of testing. Moreover, the training of technicians varies. Nevertheless, there could be an advantage to informing technicians on other tests being performed so as to help distinguish and interpret results of individual tests. Laboratories may also have a function in providing guidelines to clinicians in what test or series of test are most appropriate. Laboratories remain an important means of HIV and STD surveillance.

4. Health promotion: information, education and communication

In clinical settings outside STD clinics, health promotion may not be considered cost-effective given the generally low prevalence of HIV. In the STD setting, information, education and communication (IEC) is well justified. Coordinating the messages for both HIV and STD into a package oriented to positive sexual health is a logical approach and perhaps a good opportunity for integrating AIDS and STD services. Two areas of particular relevance are condoms and contact tracing. Increasing condom use prevents both STD and HIV; and the experience of STD personnel in contact tracing could be transferred to HIV.

5. Training

The content of the training must relate to the person to whom the training is directed. It varies greatly by profession. Target groups must be identified, as should the objective of the training exercise. It must be recognized that in a number of areas there are clearly different objectives between AIDS and STD, however both groups should be sensitized to the issues of the other.

6. Surveillance

STD surveillance was thought to be the area where HIV programmes could benefit most through integration. This related both to programme planning and evaluation. The area of STD is a sensitive marker, where changes in prevalence or incidence can be identified and often linked to changes in

behaviour. It was pointed out that certain STD are better markers, specifically non-viral STD. The site of infection is also important in that it indicates certain types of behaviour. A combination of STD data would be needed to draw any conclusions on HIV epidemiology; STD surveillance has the added advantage that patient data is often included with surveillance results whereas much of HIV surveillance is anonymous and/or unlinked.

7. Evaluation

Evaluation was clearly seen as an important component of both AIDS and STD prevention and control programmes. It was added, however, that evaluation efforts should also be oriented to the success of the integration of AIDS and STD, and whether the integration is effective and efficient.

8. Research

It was agreed that there were opportunities for coordination in behavioural and social sciences research and this overlap should be pursued. It was less clear where basic science would overlap.

Conclusions

The coordination of AIDS and STD programmes, as an alternative to integration, was discussed and thought to be preferable. Currently, both AIDS and STD programmes exist, each with their own budgets. If integration occurred, resources would then be pooled and shared. It was felt, however, that integration might result in the subservience of one programme which would be an unfortunate and undesirable occurrence. The question was asked whether the goal was integration of the programmes or the prevention and control of HIV infection; if it is the latter, then closer coordination and joint planning might be preferable to an explicit integration of services.

One disease is generally more prominent at any given time and as such extra effort is warranted. At this time the disease is AIDS. Its background includes that of a sexually transmitted disease, however, and this thought should be retained. Even without integration, HIV infection should be partly conceptualized in that way as sexual transmission remains the primary transmission route. The prevention of HIV will prevent STD, and vice versa. As such, it follows that the STD patient presents an opportunity to reduce the spread of HIV.

The coordination of AIDS and STD programmes is also dependent on educating physicians and others involved in either AIDS or STD programmes. They should be made aware of the interdependence of the two programmes and the opportunity through one area to make a positive impact on the other. The three broad areas for coordination are prevention, surveillance and care. Coordination between AIDS and STD in prevention is a positive step, in surveillance it is a useful step, and within care it is of minor value.

Where and at what level was an important consideration prior to any attempt to coordinate AIDS and STD services. It was thought that there was definite benefit at the individual and community level but less so at the macro policy level. As time passes, there may be opportunity to evolve to a single programme focused on sexual health but this occurrence would vary greatly by country and region.

Recommendations

1. Reducing HIV infection is closely linked with the prevention of STD from the behavioural perspective and perhaps as a co-factor in infectivity. There should be explicit recognition of this in AIDS prevention and control programmes.
2. AIDS information should maintain a high profile, at least in the foreseeable future, because AIDS attracts resources and attention. AIDS programmes implicitly support STD programmes given the sexual transmission route of HIV.
3. While there is a close relationship between AIDS and STD, it must be remembered that HIV can be transmitted through routes other than sexual transmission.
4. Funding for STD programmes should be increased but not at the expense of AIDS. Some funding might be considered for joint AIDS/STD projects where there are obvious economies of scale.
5. STD surveillance should be encouraged and supported by Member States as a surrogate indicator of the impact of AIDS prevention and control programmes and as a basis for programme planning.
6. The importance of STD to AIDS prevention and control will vary by country and region. There is no single model that would be applicable to all and any decision on the coordination or integration of AIDS and STD programmes should be considered in the light of national context and past experience.
7. Attempting to collect and compare STD data across national or subregional boundaries may present too many obstacles. As such, this should not be a priority.
8. If crossnational comparisons are undertaken regarding the coordination or integration of AIDS and STD programmes, background information on the programmes and the approach taken should be included. Differences between countries might simply be a function of surveillance, laboratory practice or the behaviour of the medical community.
9. WHO/GPA/EURO should establish guidelines for the collection and interpretation of data, and coordinate sentinel surveillance activities in the Member States, that include AIDS, HIV and STD. While providing useful information on programme effectiveness this could also serve as an alarm function.
10. WHO/GPA/EURO should encourage and provide financial and technical support as necessary to the countries of central and eastern Europe (CCEE) to join the EC's concerted action programme on AIDS and STD.
11. Research should be encouraged on STD repeat patients, especially those previously diagnosed as HIV positive.
12. The working group participants strongly endorse the recommendations of the meeting on Surveillance and Monitoring of Sexually Transmitted Diseases, Rome, 12-14 December 1989.

Annex 1

LIST OF PARTICIPANTS

TEMPORARY ADVISERS

- Dr Dirk Avonts
Interprovincial AIDS Coordinator, Nationale Straat 155, B-2000 Antwerp,
Belgium
- Dr Michael A. Catchpole
Medical Epidemiologist, Communicable Disease Surveillance Centre,
London, England
- Professor Per-Anders Maardh
Head, WHO Collaborating Centre on Sexually Transmitted Diseases,
University of Uppsala, Sweden
- Dr Doris Mugrditchian
Family Health International/AIDSTECH, P.O. Box 13950, Research Triangle
Park, NC 27709, USA
- Dr Else Smith
Head, Department of Epidemiology, Statens Seruminstitut, Copenhagen,
Denmark
- Dr André Stroobant
Chef de Travaux à l'Institut d'Hygiène et d'Epidémiologie, Brussels,
Belgium

WORLD HEALTH ORGANIZATION

Regional Office for Europe

- Dr B. Bytchenko
Regional Officer for Communicable Diseases
- Dr Svein-Erik Ekeid
Regional Coordinator, Global Programme on AIDS
- Dr A. Gromyko
Medical Officer, Global Programme on AIDS
- Mr S. Wayling
Consultant, Global Programme on AIDS