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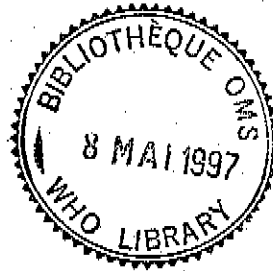


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EPIDEMIC OF SEXUALLY TRANSMITTED DISEASES IN EASTERN EUROPE

Report on a WHO Meeting

Copenhagen, Denmark
13–15 May 1996

1996

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TARGET 5

REDUCING COMMUNICABLE DISEASE

By the year 2000, there should be no indigenous cases of poliomyelitis, diphtheria, neonatal tetanus, measles, mumps and congenital rubella in the Region and there should be a sustained and continuing reduction in the incidence and adverse consequences of other communicable diseases, notably HIV infection.

ABSTRACT

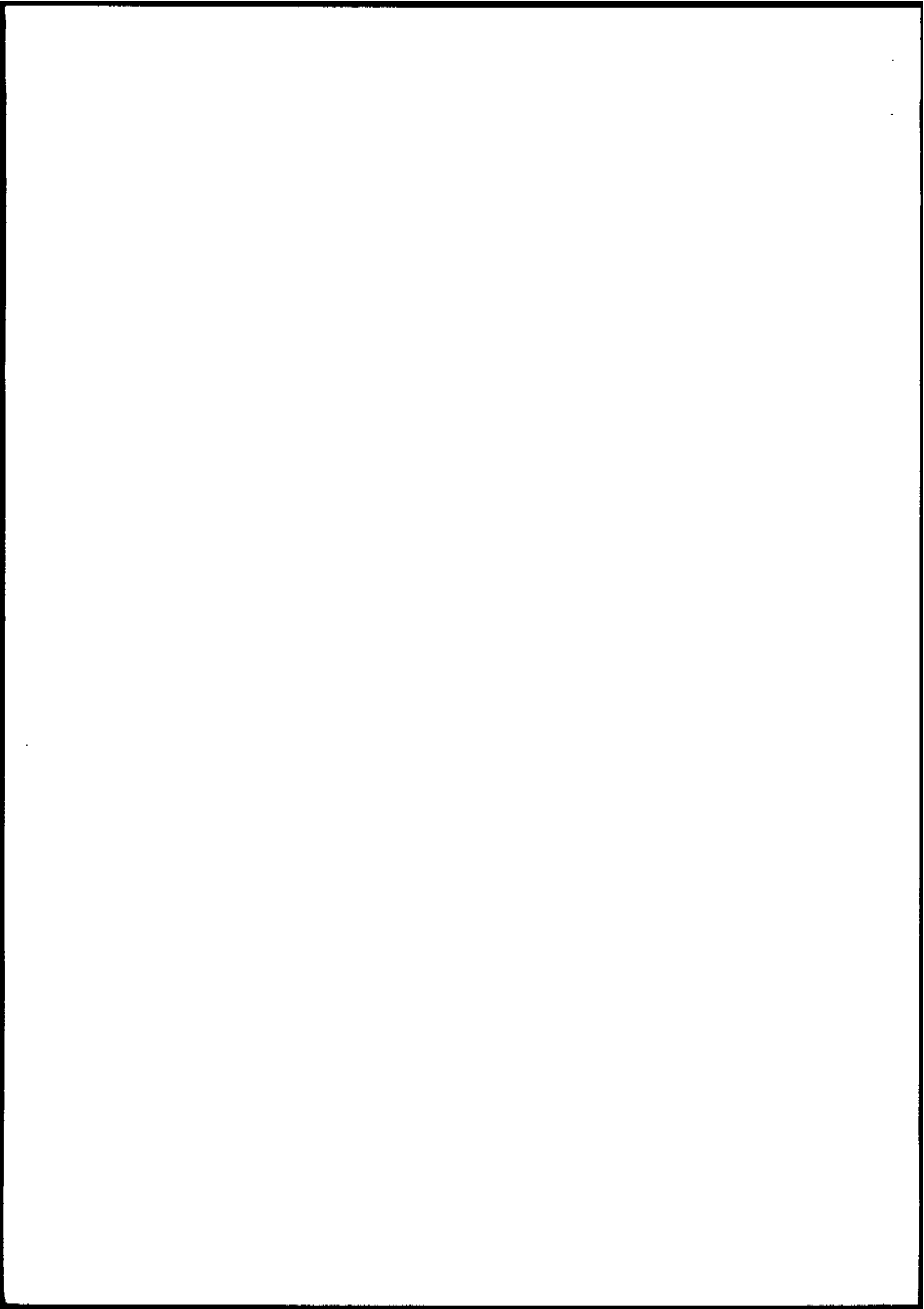
In response to the alarming rise in sexually transmitted diseases (STDs) in the newly independent states, the WHO Regional Office for Europe, WHO headquarters and the Joint United Nations Programme on AIDS organized a meeting of experts from the most affected countries to exchange information and to identify priority actions for the control of the epidemic. The participants included 15 experts from Belarus, Kazakhstan, Latvia, the Republic of Moldova, the Russian Federation and Ukraine. The participants called for urgent action, including a careful assessment of the existing systems for STD control, reallocation of resources among the various activity areas and strong advocacy to generate awareness at the top level of government and strengthen its support for the recommended initiatives. They also urged that national coordination of programmes to promote sexual health and prevent STDs and HIV be strengthened, that statutory services be made more accessible and acceptable to patients and that efforts be made to ensure that all health workers managing patients with STDs, including those in the private sector, provide high-quality care.

Keywords

SEXUALLY TRANSMITTED DISEASES – prevention and control
ACQUIRED IMMUNODEFICIENCY SYNDROME – prevention and control
DISEASE OUTBREAKS
NIS

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Introduction

This report describes the outcome of the Meeting on the Epidemics of Sexually Transmitted Diseases in Eastern Europe held on 13–15 May 1996 in Copenhagen, Denmark.

In response to the alarming rise in sexually transmitted diseases (STDs) in the newly independent states the WHO Regional Office for Europe, WHO Headquarters and the United Nations Joint Programme on AIDS organized an action-oriented meeting of experts from the most affected countries. Professor Sieghart Dittmann, Coordinator of Communicable Diseases, welcomed participants on behalf of the WHO Regional Office for Europe.

The meeting was attended by 15 participants from Belarus, Kazakhstan, Latvia, the Republic of Moldova, the Russian Federation and Ukraine. Dr Jacobsone (Latvia) was the Chairperson and Dr Renton (United Kingdom) the Rapporteur. Each country was asked to designate a representative of the Ministry of Health with full time and full responsibility for control of STD and a clinician working with STD patients on a daily basis and a specialist responsible for laboratory diagnosis. Further, representatives of the WHO Regional Office for Europe, WHO headquarters and the United Nations Joint Programme on AIDS took part in the meeting as well as six temporary advisers with expertise in various fields.

Objectives of the meeting were to exchange information on the current situation and actions taken, and to identify priority actions for the control of the epidemic in the areas of programme management, prevention, case management and surveillance.

Tremendous social and economical changes have been occurring in eastern Europe during the last 10 years. The transition to a market economy system has among other things caused a decrease of the national and per capita incomes, increasing unemployment and impoverishment followed by growing mobility, prostitution and drug use. These factors associated with the process of rapid social change have a considerable impact on the general health of the population and particularly on the incidence of curable sexually transmitted diseases.

Curable STDs are not only a concern because of the discomfort caused by the acute infection. They can also cause severe complications such as sterility, stillbirth, miscarriage, blindness, brain damage, disfigurement, cancer and even death. Moreover, they have proved to be risk factors for the transmission of HIV, and therefore their control is a major concern in the prevention of the spread of HIV.

Since 1989 there has been a very rapid rise in the rate of notified cases of syphilis, particularly in the newly independent states of the former Soviet Union (NIS). In many of the countries the incidence of syphilis has increased 15–30 times. Incidence rates of syphilis higher than 50 per 100 000 population were reported in 1994 in the Belarus, Kazakhstan, Latvia, the Republic of Moldova, the Russian Federation and Ukraine.

The objectives of the meeting were as follows:

- 1) to review the epidemiological situation regarding the occurrence of STDs in the populations of the NIS and other countries of eastern Europe;
- 2) to exchange up-to-date information on the size of the problem and on the action taken in each country;

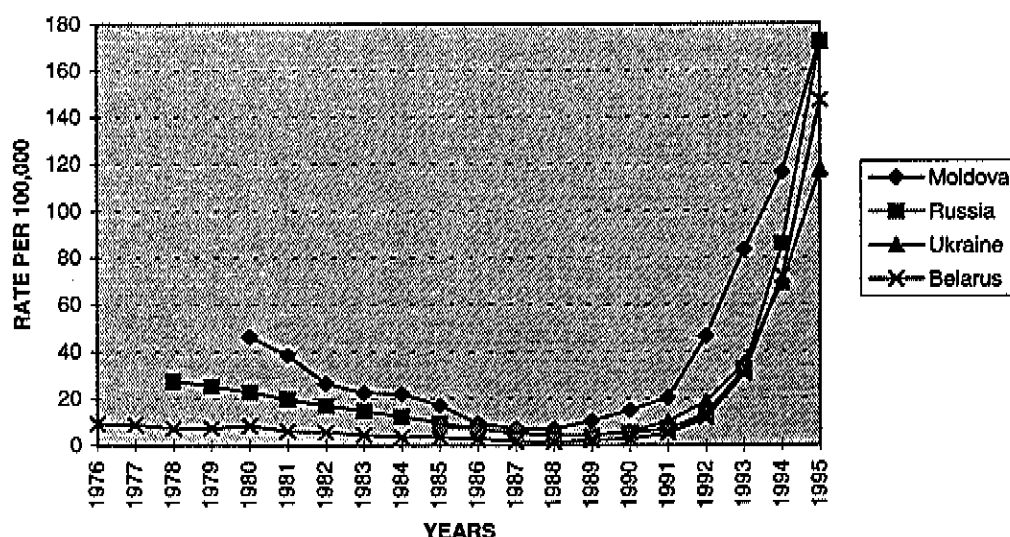
- 3) to consider the origins of the reported epidemics of syphilis occurring in the NIS;
- 4) to consider the strengths and weaknesses of existing control measures for STD;
- 5) to identify priority actions for the control of the epidemic in the fields of primary prevention, health education, clinical services, clinical management of sexually transmitted diseases, laboratory diagnosis, secondary prevention and partner notification, surveillance;
- 6) to identify training needs and technical support needed; and
- 7) to agree on a plan of action.

Current situation and STD trends in the Region

A significant decline of incidence of syphilis and gonorrhoea has been observed in countries of western Europe during the years of 1980–1991 down to below 2 per 100 000 for syphilis and 20 per 100 000 for gonorrhoea. For a number of years these countries have enjoyed an almost negligible rate of syphilis, a disease which is almost practically absent.

A quite different situation is, however, now observed in the eastern part of Europe, particularly in the NIS. Since 1989 there has been an extremely rapid rise in the notification rate of syphilis, reaching in the Russian Federation, for example, 86 per 100 000 in 1994 and 172.1 for the year 1995, a fortyfold increase from 1989 to 1995. The vast majority of notified cases in 1994 were infectious, with an increasing proportion of recently acquired infections. In general, in many of the NIS for the last 4–5 years the incidence of syphilis has increased 15–30 times from 5–15 per 100 000 observed in 1990 to as high as 120–170 per 100 000 of population. Incidence rates of syphilis higher than 50 were reported in 1994 in Belarus, Kazakhstan, Latvia, the Republic of Moldova, the Russian Federation and Ukraine (Fig. 1).

Fig. 1. Incidence of syphilis in Belarus, the Republic of Moldova, the Russian Federation and Ukraine



While the prevalence of HIV infection so far has been considerably lower in eastern Europe compared to western Europe, there is cause for great concern that a rapid rise in HIV

transmission rates is just starting, considering the large increase in reported HIV cases in Poland and Ukraine in 1994–1995. The combination of an epidemic occurrence of STDs, changes in sexual behaviour and increasing HIV transmission among injecting drug users greatly increase the potential for an alarming rise in HIV infections.

Origins of the syphilis epidemic in the Russian Federation

The occurrence of curable bacterial STDs in populations is determined partly by the biological characteristics of the organisms and the influence of medical interventions on transmissibility and natural history, partly by patterns of sexual behaviour. Medical management of cases and their sexual partners reduces the periods for which the infected individual remains infected. The number of partners in unprotected sexual intercourse has an impact on the risk of transmission.

The current process of rapid social change in the Russian Federation has among other things caused a decline in the gross domestic product by an average of 12% per year in real terms during 1990–1994, with a massive increase in income differentials, poverty, unemployment, and migration. These recent developments have a substantial impact on the structure, availability and effectiveness of health services as well as on sexual behaviour.

Increasing proportions of individuals seeking poor quality private care or treating themselves may lead to more treatment failures and fewer contacts notified. The decline in the real value of funding for the statutory STD services reduces the supply of materials and staff time for diagnosis, treatment and partner notification, and the decline in the real value of salaries forces staff to engage in other jobs, leaving less time and energy for the statutory STD services. Increased use of outpatient treatment for syphilis with benzathine penicillin may have improved the effectiveness of treatment, while the less frequent use of the exhaustive contact tracing protocols otherwise required by the legislation may have left some people with infections for longer periods untreated in the community. The growing number of official STD clinics offering anonymity and confidentiality may encourage some patients to present earlier, but such services are charged. Poor people or those with no health insurance (who are usually at most risk for STDs) must still use the traditional clinics. As the acceptability of the approach of traditional clinics further declines, the time period between infection and treatment may actually increase for those who cannot afford to pay for the new services.

There are no systematic studies of sexual behaviour and attitudes in Russia. Still, it is possible to discern a number of changes in sexual behaviour which may have contributed to the current STD epidemics. Internal and international business travel has increased, bringing new opportunities for sexual contact, e.g. with sexworkers, and sometimes in areas with higher STD prevalence such as south-east Asia and Africa. Internal migration and the influx of refugees have increased markedly, and many people experience long periods of displacement from their family, poor living conditions and financial dependence on the informal economy. At the same time there has been increasing unemployment and impoverishment of large sections of the general population, especially women, and reduced resources for education and social services. These changes may have contributed to a general casualization of sexual relationships and a rapid growth in regular and occasional prostitution. Large groups of young people are dropping out of school and are beyond parental influence, which may have contributed to the overall decline in the age of the first sexual intercourse and increasing child and adolescent prostitution.

The process of rapid social change has been paralleled by a change in ideological focus from the collective to the individual, and from collective values to individual values and consumerism. Freedom of print and increased foreign trade have significantly increased the supply of sexually oriented products, images and advertising, including pornography. These factors in combination may have initiated a profound shift in sexual mores and lifestyles within Russia, especially among young people. In addition to explicit prostitution there appears to be an increasing commoditization of sexual relations in a more general sense, extending throughout the social strata, and reflecting the growth of the market attitude and increasing differentials in economic status. Temporary sexual relationships are formed with a clear but implicit economic dependence of one partner on the other. STD contract tracing activities have identified novel structures of sexual relationships in terms of open sexual groupings, with frequent partner changes within the groups. Such structures provide ideal conditions for the rapid transmission of STDs.

Measures taken to control STDs – country updates

Belarus

Belarus has 34 outpatient departments of dermatovenerology and 2594 inpatient beds for a population of 10.4 million people. Coordination and development of STD prevention and treatment is led by the Minsk Medical Institute. Levels of STD staff qualification and training are high. A national programme for STD prevention has been established, with increasing focus on sexual health education. Specific projects targeting youth, schoolchildren and educators have been developed. Condoms are widely available, but are relatively expensive. Clinical management of syphilis and gonorrhoea has advanced, with over 90% cases of gonorrhoea and over 70% cases of syphilis now being managed as outpatients. There have been problems in securing an adequate supply of modern drugs for management of syphilis. There is considerable anxiety concerning the growth of private sector clinics and the treatment of patients on a completely anonymous basis. Contact tracing is in any case becoming more difficult. There are discussions on whether the current legal sanctions and powers to control STDs have become superfluous and should be abolished in view of the ongoing educational efforts through the mass media and other health promotion activities.

Kazakhstan

There are increasing problems with the provision of adequate STD diagnostic services. STD services are centrally organized with 19 regional clinics and 14 municipal clinics as well as private consulting rooms. Modern management of syphilis has been introduced, with benzathine penicillin increasingly used for outpatient treatment (paid by patients) and Benzyc penicillin used for inpatient treatment (free of charge). Health promotion activities include mass media campaigns and outreach projects targeting identified high risk groups such as business employees, cooperative workers, drivers and students. There is an inverse correlation between the decreasing numbers of contacts traced and the increasing number notified cases of syphilis. There are very high costs for diagnosis and treatment at the anonymous STD clinics. There is a need to improve the work with homosexual men, sexworkers and drug users by decriminalizing such groups, and to revise the STD legislation. A coordinating interagency committee for STD control with representatives of ministries of health, justice and education is being established.

Latvia

Treatment of syphilis is by benzathine penicilline. Only 17% of patients (those considered unlikely to control their behaviour appropriately or those considered at risk) are treated as

inpatients. The development of STD services is taking place against a background of a policy of decentralization of health care and the growth of insurance schemes both within municipal and private clinics. It was believed that private service providers did not carry out partner notification effectively, and there was some evidence that partner notification was less effective at the anonymous STD clinics. Around 50% of STD patients were unemployed, and there was anxiety that poor people are being deterred from using the public STD services. There is increased cooperation between the AIDS programme and the STD sector. Activities for sexual health education and promotion are being developed within secondary schools, although it is difficult to find efficient approaches.

Republic of Moldova

There is a considerable involvement of the private sector in treatment of gonorrhoea and syphilis. There is a large STD screening programme. Screening of clinical and occupational groups identifies one third of the cases, while of the remainder one third present themselves to the services and one third are identified as contacts. It is believed that there has been a decline in moral standards of young people, and they no longer have a secure social position. Young people are still scared away from the statutory STD services by the continued identification of the services with and the involvement of the police. An integrated programme for STD and HIV prevention is being developed. The problems of STD control were seen as political and social as well as medical and can only be solved by the development of more acceptable confidential STD services and health education targeting youth. There are considerable problems in securing adequate financial and other resources for the STD services. There are proposals to decriminalize prostitution and the country is experiencing a period of liberalization for sexual minorities.

Ukraine

There are concerns regarding the adequacy of the syphilis treatment recommended by the Ministry of Health and the poor quality of private STD services. The STD legislation is being revised to ensure confidentiality, preserve individual rights and ensure a proper system of licensing for physicians. Confidential and anonymous STD clinics and outreach activities towards sexworkers and homeless people are being developed. Further, the need to increase awareness and understanding of STDs and STD management among primary care physicians is recognized. Financial resources for STD control has declined in recent years. There is a need to increase public awareness on STD through TV and other mass media. A STD control research center and health promotion materials are being developed, and the STD control and the AIDS programme will remain as separate, parallel entities with cross links.

Making STDs a highest health priority for the government

Making STD control a top priority with a high level of funding is an extremely cost-effective strategy for governments. This can be demonstrated through basic statistics describing the widespread occurrence of STDs and the high costs associated with the sequelae of STDs. When the burden of STDs is expressed as disability adjusted life years (DALYs) lost to STDs, these diseases rank second among women aged 15-44 years in India and third among women in Asia (excluding India and China) and the Pacific Islands. Feasible and effective strategies for prevention and control of STD and sexually transmitted HIV infection exist:

- primary intervention to reduce the risk of infection,
- diagnosis and treatment of those infected with curable STDs.

The cost-effectiveness of STD prevention and control can be increased dramatically by reducing the cost of curative services in particular, and by targeting both prevention and curative services to the core groups with high risk of infection and high risk of infecting others. Priorities should be given to such interventions targeting core groups, and to interventions which are inexpensive and effective. This is a very cost-effective strategy, at a cost of US \$0.15 or less per DALY saved for prevention, and US \$0.56 per DALY saved for curative services. Furthermore, STD infections substantially enhance the risk of HIV transmission. Thus, STDs are an important and urgent public health priority.

Principles and policies for STD control

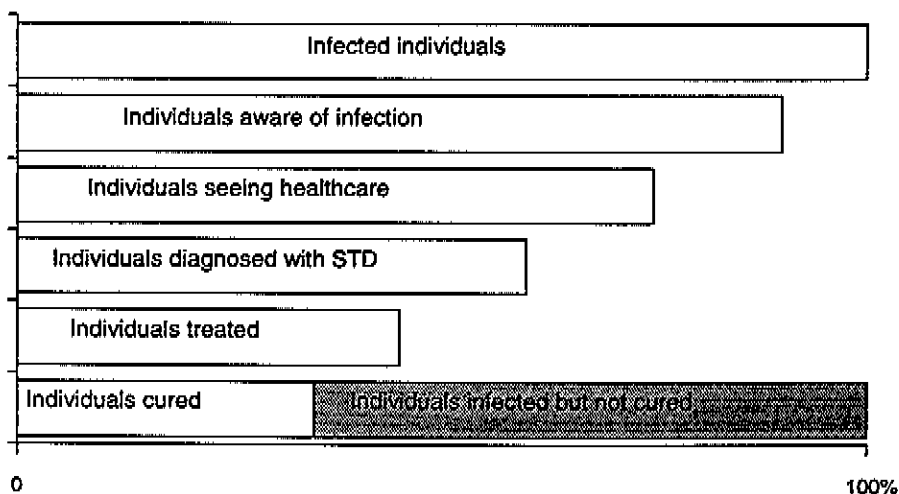
There are great differences in the public health importance of the wide range of bacterial, viral and protozoal organisms which can cause STDs. Priority should be given only to those of high importance.

There are several key reasons as to why STD control has failed: STD control is often considered a low priority for governments and health planners. Control efforts tend to focus too much on symptomatic individuals, and most services are delivered through specialized STD clinics which may not be acceptable to the majority of the population. There has been an exaggerated use of diagnostic tests instead of syndromic treatment, use of ineffective antibiotics and too little emphasis on primary prevention.

There are close relations between HIV infection and other STDs. The sexual risk behaviour is similar. STD may enhance HIV transmission. HIV causes immunodeficiency. Immunodeficiency may increase susceptibility to STD infection and worsen the prognosis in those infected. Modern STD control programmes should benefit the infected person, prevent transmission to others and prevent HIV transmission.

People with STDs may fail to receive treatment for a variety of reasons (Fig. 2).

Fig. 2. Percentage loss of individuals at selected steps between treatment and cure



Consequently, a majority of STD-infected individuals in a population may not be cured. Control of STD can be achieved through strengthening of the following areas.

Health promotion

The objective of health promotion is to educate and enable the individual to adopt safer sexual behaviour. This strategy is relevant for all STDs, including and especially HIV. HIV is a major incentive for the introduction of sexual health promotion programme, and messages can be integrated to cover all STDs. Contrary to other high risk groups for HIV and other STDs, STD patients are easy identifiable and information, education and counselling should be a priority in STD clinics.

Clinical services

Clinical services are crucial to diagnose infected patients and treat infections. Furthermore, patients should be educated and counselled about treatment to ensure treatment compliance and about risk reduction. Sexual partners should be properly evaluated and managed. Constraints on the acceptability of services to patients are:

- lack of privacy and confidentiality
- judgmental and unfriendly staff
- long queues
- inconvenient opening hours
- poorly maintained and unattractive premises
- poor staff communication skills
- failure to relieve symptoms.

Drugs available for treatment of STDs

Highly effective and very cheap drugs are available for all non-viral STDs other than gonorrhoea: Drugs for treatment of chlamydia (doxycycline), syphilis (benzathine penicillin), trichomoniasis (metronidazole), and candidosis (nystatin) are all available as non-propriety preparations (generic drugs). Generic drugs are often ten to twenty times less expensive than propriety preparations, and the use of the latter drugs is rarely justified. Claims from propriety manufacturers that generic drugs are inferior are only very rarely supported by good evidence. The various effective speciality drugs available for gonorrhoea treatment should be selected for use in each region according to the results of population studies of antibiotic susceptibility of gonococci. It is not justified to carry out antibiograms in each patient.

Target groups

Activities should be targeted towards groups at most risk of STDs, including sexworkers and their clients, pimps, military personnel, tourists, businessmen, seafarers, migrants, single men in towns, injecting drug users and men who have sex with men.

Analysis of the STD situation (case study)

There is an important need for STD specialists to broaden their perspective and increase their knowledge and skills on public health matters and prevention activities, and there is a need for research in these areas. The statutory STD services often see only the top of the iceberg of STDs. Ways to achieve effective management of patients in primary care and other non-specialist health

care settings should be found. There is an urgent need to consider how effective treatment can be given where diagnostic tests are not available, and whether there is a general overuse of diagnostic tests.

Experience with anonymous STD clinics in the Russian Federation

There is a growing acceptance of anonymous and confidential STD management among STD specialists. Current STD control mechanisms evolved from the repressive control of syphilis epidemics after the civil war. Anonymous STD clinics have emerged in response to the growing unacceptability of the statutory STD services with their use of legal and civil sanctions, and other stigmatizing approaches. Patients are charged for the services, except patients under the age of 17 years. In spite of the anonymity of the patients, there seems to be no significant reduction in the number of patients who receive treatment. Barriers for the adoption of the principle of anonymous and confidential STD management in the statutory STD sector includes legislation in some areas dictating the identification of infected patients, and centralized decision making which does not allow the individual clinics or chief doctors to make their own choice.

Criteria for choosing drugs for STD treatment

The three key considerations in selection of drugs are high efficacy, low costs and oral administration. Treatment protocols should be developed for any given area and could be standardized.

Gonorrhoea

Treatment protocols for gonococcal infections should be developed in light of local studies of in vitro sensitivity of isolated organisms to antibiotics and local studies of the clinical effectiveness of recommended regimes. Regimes should be specified for respectively uncomplicated infections, complicated infections and ophthalmia neonatorum. Drugs of choice for uncomplicated gonorrhoeas are: ciprofloxacin, cefixime, cephtriaxone, spectinomycin, and, as alternatives kanamycin and cotrimoxazole. All patients with gonorrhoea and their sexual partners should in addition receive antichlamydial treatment.

Chlamydia

Drugs of choice are doxycycline and tetracycline. It is important to follow up to check compliance because of the large number of tablets required. Alternatives include erythromycin and azithromycin.

Role of information, education and communication (IEC) in STD control

The current rise in STD incidence is partly caused by increasing sexual risk behaviour, also with regard to the non-curable HIV infection. Consequently, there is a strong need to inform, motivate and empower people to adopt safer sexual behaviour through a multisectoral effort. STD specialists have an important role in this effort. They can help the health promotion agencies to identify and target groups at high risk. They can promote safer sex among STD patients and their partners, and they can increase public awareness and advocate political commitment with regard to STDs.

Barriers to safer sexual behaviour exist at various levels, including lack of knowledge, attitudes and beliefs, lack of skills and structural barriers beyond the control of the individual, and should be addressed according to their significance. It is essential to identify the groups most at risk of

STD infection and of transmitting the infection to others, and to estimate the size of the groups to set priorities and to target IEC activities. Safer sex behaviour includes correct condom use, reducing the number of sexual partners, mutual fidelity, non-penetrative sex and abstention from sex. Messages should be realistic for each target group and based on the principle that the smaller the change required, the easier to achieve. STD clinics are important settings for safer sex counselling, since STD patients by definition is a high risk group and usually in a state likely to be receptive to advice. Counselling should include discussion of STDs and the treatment regime, risk behaviour, safer sexual behaviour and problems and implications for partners.

Finally, IEC activities should be made to increase the health care seeking behaviour of persons infected with STDs, raising awareness about risk of infection associated with own and partner's behaviour, signs and symptoms suggesting STD infection and the possibility that people may be infected even if they have no signs or symptoms.

STD surveillance

The objectives of STD surveillance are to estimate the magnitude of the STD problem and to monitor trends, distribution of STDs across population groups and sensitivity of organisms to antibiotics. Such information is required to determine levels of services and resources for STD control, to advocate political support, to measure impact and strengthen existing activities and to monitor diagnostic and therapeutic procedures. STD surveillance mechanisms should be simple, sustainable and quality controlled. They should respect human rights and be integrated with STD programmes and general health systems.

Sentinel surveillance can provide high quality information at low costs, and the information can be further improved by ad hoc STD prevalence surveys. Supplementation of the existing universal surveillance systems in CCEE/NIS with sentinel surveillance sites may be highly advantageous, since the sustainability of current system is uncertain and its coverage is reduced because of growing self-treatment and treatment within the private sector.

Role of the laboratory in STD control

The laboratory has a role in the areas of programme management, patient management and research. In the area of programme management the laboratory has a role in conducting epidemiological and microbiological surveys, monitoring antimicrobial susceptibility and in surveillance. The laboratory has a key role in diagnostics, but overuse of expensive diagnostic testing should be avoided. The research role of the laboratory is to contribute to the development of new diagnostic tests, new drugs, and to conduct quality control and diagnostic testing in the field.

Development of a national policy for STD control

A firm national policy for STD control should exist to provide a framework and guide for activities and to ensure political commitment to STD control. The policy should explicitly respect human rights. The policy should be comprehensive, including all elements relating to primary prevention and condom programming as well as case management, and incorporate both the public and private sectors. Maternal and child should be encompassed, too. The policy should prioritize activities targeting those at increased risk of infection. It should be realistic and based on existing resources. The wider social, political and economic contexts of the sexual behaviour

and the STDs should be considered. The policy should be based on empirical evidence of effective intervention and be widely accepted by all involved.

Components should be included to strengthen health promotion and other primary prevention activities, clinical services for the management of STD cases and their contacts as well as the active identification of infections through case finding and screening in high risk and vulnerable groups, and blood and organ donors. In addition, the policy should explicitly support training, provision of laboratory services, research and surveillance activities.

Conclusions

All participating countries are experiencing major epidemics of sexually transmitted diseases, especially of syphilis, mostly affecting young people and adolescents. The epidemics appear to be rooted in the rapid social and economic changes occurring in recent years and the effect of the changes on sexual behaviour and attitudes and the accessibility, acceptability and effectiveness of clinical services.

Actions should be taken to control these epidemics. Such actions include careful assessments of areas of weaknesses and strengths within the existing systems for STD control and reallocation of resources among the various activity areas. Strong advocacy addressing the top level of government is required to generate awareness of the problem and to strengthen political commitment and support for the recommended initiatives.

The absence of effective national coordination of programmes of health promotion in the area of sexual health and STD/ HIV prevention is the most important short-coming of the existing situation.

Further, clinical services are faced with increasing workload and shrinking resources. The traditional form of case management characterized by frequent in-patient care regimes, registration of personal data with lack of confidentiality and anonymity, and strong legal obligations imposed on the patient are becoming impractical and inefficient. Patients are increasingly unwilling to accept such conditions and there is consequently a rapid growth in provision of care by medical and non-medical practitioners outside the law regulated statutory services, and of self-treatment.

Consequently, it is a priority to make statutory services more accessible and acceptable to patients. Still, it is crucial to recognize that the clinical services are well established in terms of expertise and organizational infrastructure, but suffer from a major lack of resources. Further, management of STDs by non-dermatovenereologists is a reality. It is therefore necessary to ensure that all those managing patients with STDs provides high quality care. Training of dermatovenereologists and other sexual health professionals is in general of high standard, but the recommendations of the meeting listed below will generate a need for additional training introducing more rational approaches in clinical management and health promotion within STD clinics.

Active case finding and screening are efficient approaches identifying substantial numbers of individuals with STDs, especially syphilis. Existing surveillance systems have served well, but changing epidemiological circumstances and changing patterns of health care require review of the systems and new initiatives. The present legislation related to STD control were considered largely not useful in controlling the current epidemics.

Recommendations

- 1) Governments should urgently bring together all concerned education and health agencies to develop a strategy to rapidly develop sexual health promotion. This strategy should:
 - functionally integrate existing health promotion activities of respectively STD programmes and HIV/AIDS programmes;
 - target adolescents and youth, in and out of school, and other vulnerable groups such as men who have sex with men, male and female sexworkers and their clients;
 - develop adequate working definitions and practices to allow effective engagement with people involved in the sex industry and men who have sex with men;
 - be integrated in general health promotion programmes;
 - include components to educate people on and promote condom use, and ensure that condoms and lubricants are available to those who need them;
 - use best practice in mass information, peer education and outreach work, harness the influence of key opinion leaders within communities and exploit the full potential of nongovernmental organizations.
- 2) A system of STD care with full confidentiality, where the patients are not forced to identify themselves by name and address, neither at the point of diagnosis nor at the point of treatment, should rapidly be established.
- 3) A shift should be made from in-patient care to out-patient care throughout the statutory services, especially with regard to the management of syphilis.
- 4) Case management guidelines should be reviewed with the aims of:
 - providing where possible same day treatment for conditions and simplification of follow-up routines;
 - rationalizing the use of diagnostic tests in patient management;
 - developing syndromic approaches to diagnosis and management as an alternative where specific diagnosis is not available;
 - developing drug treatment protocols based on local information about effectiveness and, where possible, using generic drugs;
 - developing ways of ensuring that contacts and sexual partners come for examination and treatment which respect the rights of the index patient as well as the contacts.
- 5) Governments should urgently identify and allocate adequate resources.
- 6) Licensing systems should be introduced to regulate and control private STD services.
- 7) Mechanisms should be developed to enhance the role of dermato-venerologists and the dermatovenerology services in provision of services to which other agencies and clinicians may refer patients for specialist management.
- 8) Screening of pregnant women and other clinical and occupational groups which are included in existing programmes should continue, but only with full respect for the confidentiality of these individuals.

- 9) Lists of population groups included in screening should be regularly reviewed, particularly in the light of epidemiological information which may allow better definitions of groups at particular risk
- 10) Training of dermato-venerologists and other sexual health professionals at undergraduate and graduate levels should be modified to incorporate more substantial components on health promotion, ethics of doctor-patient relationships, and confidentiality.
- 11) Dermato-venerologists and their organizations should urgently seek efficient ways to share their knowledge and skills with other clinical specialists and health professionals who are not working primarily in the field of sexual health, but who are likely to see patients with STDs.
- 12) Universal surveillance at the national level should be preserved but simplified by the introduction of anonymous notification of cases.
- 13) Pilot sentinel surveillance schemes should be introduced and evaluated in some dermatovenerology clinics and other health care settings frequented by patients with STD.
- 14) Based on the experience of the pilot schemes for sentinel surveillance, a general and broader introduction of sentinel surveillance sites should be considered in settings in and outside dermatovenerology services.
- 15) Laboratory services should continue to play a key role in supporting dermatovenerology services through quality control, assessment of sensitivity of organisms to antibiotics, and the development of diagnostics. In addition the laboratory services should continue to play a primary role in active case-finding.
- 16) Priorities for research and development should be:
 - the population, with a special focus on groups assumed to be particularly vulnerable
 - research to evaluate health promotion strategies
 - epidemiological research linking social demographical and behavioural factors with STD risk
 - evaluation of syndromic approaches to diagnosis and management at the various levels of the services
 - evaluation and development of sentinel site surveillance.
- 17) Urgent priority should be given to improve communication among health professionals of all disciplines, governmental and nongovernmental organizations, and the general population and vulnerable population groups. Already existing journals and other channels of communication should be utilized and more innovative ways to enhance communication developed.
- 18) Legislation related to STD control should urgently be modified to make it less oppressive and, at the same time, preserve the rights of individuals who may be at risk of infection from people known to have STDs.
- 19) Fora allowing countries to share experiences with programme development and innovation should be set up, eventually in the framework of a regional standing conference on STD control in eastern Europe under auspices of international health organizations.

Annex 1

PARTICIPANTS

Belarus

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