



UNAIDS

*IMPLEMENTATION OF WHO/UNAIDS
POLICIES AND STRATEGIES ON
PREVENTION AND CONTROL OF
SEXUALLY TRANSMITTED DISEASES*

Report on a WHO/UNAIDS Intercountry Workshop

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Communicable
Diseases and
Immunization

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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

The WHO Regional Office for Europe, in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS), organized a meeting in May 1996 on the epidemic of sexually transmitted diseases (STDs) in eastern Europe. The present Workshop was convened to review progress in implementing the recommendations of that meeting as well as the problems encountered by countries, and to formulate further action to control the epidemic. It was attended by representatives of the six countries attending the meeting and of six other countries experiencing a major increase in syphilis. It was found that the implementation of the recommendations of the meeting varied between countries. There was agreement on the need to continue the process of reform of general STD services by basing them on principles of confidentiality and anonymity, abolishing obsolete arrangements for the management of STD patients and their contacts, offering ambulatory treatment with modern drugs, collaborating closely with nongovernmental organizations, and providing accessible and affordable STD care for vulnerable groups. The participants also identified priorities in STD case management, and agreed to urge their national governments to accord the current epidemic of STDs the status of a national emergency.

Keywords

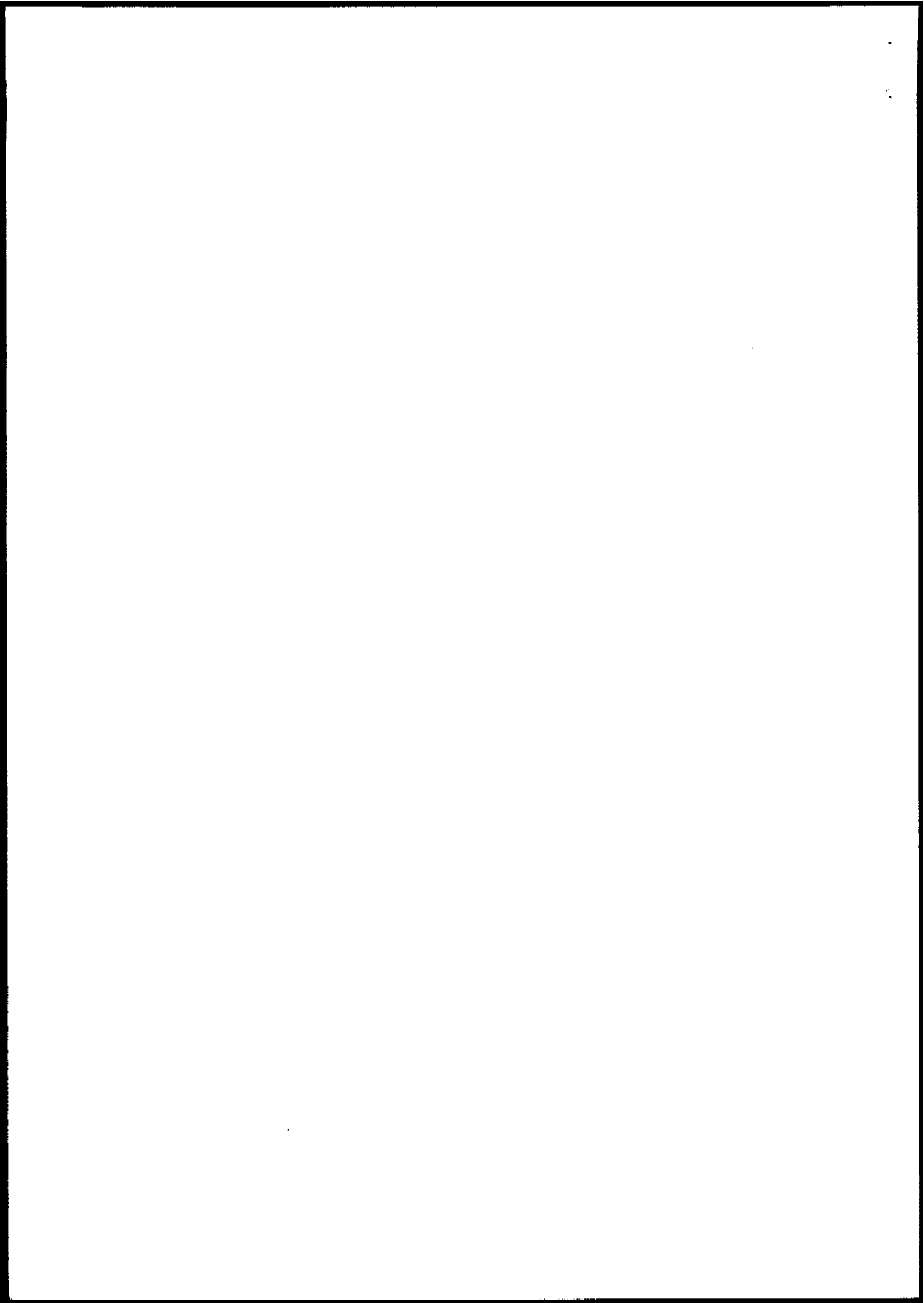
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Introduction

In response to the alarming rise of incidence of sexually transmitted diseases (STDs) in the newly independent states of eastern Europe, the WHO Regional Office for Europe, in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS), organized a meeting of high-level officials responsible for STD control in the six countries most affected (Belarus, Kazakstan, Latvia, the Republic of Moldova, the Russian Federation and Ukraine) and other experts from the clinical and laboratory fields. The meeting was held in Copenhagen in May 1996. It was the first opportunity for these countries jointly to address the important issues related to the internationally adopted principles of STD care, such as confidentiality and anonymity of testing and treatment, the right of the patient to choose a physician and place for treatment, partner notification and treatment based on confidential dialogue with treating physician, and other issues.

The participants came from countries where the management of STD patients has long been characterized by compulsory contact tracing and for compulsory treatment of patients, compulsory hospitalization of syphilis patients under strong containment conditions, application of drugs requiring multiple daily injections for at least 2–3 weeks, laboratory confirmation of the disease as a proper condition for initiation of treatment, reference of STD care only to a specialized dermato-venereological service, and registration of patients until a cure has been confirmed (which was required for patients to secure various social benefits). This system was based on legislation or special instructions to which health personnel had to adhere.

At the Copenhagen meeting, all participants agreed on recommendations for a new system of STD case management in their countries. These recommendations were essentially directed towards:

- replacing obligatory hospitalization with outpatient care for the treatment of STD patients;
- abolishing obsolete legislation requiring hospitalization and contact tracing;
- introducing treatment based on modern drugs, such as benzathin penicillin for uncomplicated syphilis;
- introducing anonymous treatment respecting the right of the patient to confidentiality and choice of STD service facility;
- introduction of syndromic approach to STD treatment;
- involving in STD treatment other health professionals, such as gynaecologists, urologists, and primary health care personnel;
- involving STD services in primary prevention of STDs; and
- targeting vulnerable groups for interventions and STD care.

WHO and UNAIDS held a workshop in Riga to review the progress made in implementing these recommendation, to identify the problems encountered by countries and to formulate further action to be taken to control the epidemic. The need for this workshop was highlighted by the continuing rise of the already extremely high incidence of STDs, particularly syphilis, in most of the newly independent states (NIS) of the former USSR; in many countries, incidence has increased to 50–60 times its former level during the last 5–6 years.

The workshop was attended by 22 participants from 12 of the most affected countries (Armenia, Belarus, Estonia, Georgia, Kazakstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan and Ukraine), and 4 experts in STD case management, planning and evaluation, and the provision of STD care for the most vulnerable groups in the population. WHO and UNAIDS staff also attended the workshop (Annex 1).

Each country was asked to designate two participants: one representative of the health ministry with responsibility for control of STDs and one person primarily involved in primary prevention of STDs, including HIV/AIDS, and working with the most vulnerable groups.

Objectives of the workshop

The objectives of the workshop were:

1. to review and update the epidemiological situation on STDs in the NIS;
2. to review the implementation of the WHO/UNAIDS policies reflected in the recommendations of the Copenhagen meeting (Annex 3);
3. to exchange information on countries' progress and problems and obstacles in implementing the recommended policies;
4. to outline further actions to counter and curb the STD epidemic in the areas of:
 - STD care in general
 - STD/HIV prevention and care of people with high-risk behaviour (young people, prostitutes and their clients, men having sex with men, injecting drug users, people with the lowest socioeconomic status);
5. to outline the most urgent actions to be taken by countries to counteract the epidemic (Annex 2); and
6. to formulate needs and outline proposals for international assistance.

Current STD situation in the NIS

During 1996, the incidence of STDs continued to increase in practically all NIS. Syphilis is an important marker disease, since syphilis is reported by law and non-reporting could be considered a criminal act in all these countries. Trends in the incidence of syphilis indicate the magnitude of the epidemic of STDs. As seen from Table 1, the incidence of syphilis has reached 100–250 per 100 000 population in most of the NIS. As STDs are a co-factor in the spread of HIV, this has facilitated HIV transmission and Belarus, the Russian Federation and Ukraine reported an abrupt increase in HIV incidence in 1996.

Table 1. Incidence of syphilis in some NIS, 1990–1996 (cases per 100000 population)

	1990	1991	1992	1993	1994	1995	1996
Russian Federation	5.35	7.22	13.41	33.8	86.0	172.1	254.6
Kazakstan	1.45	2.10	3.48	8.2	32.6	122.9	230.6
Belarus	2.68	5.10	11.8	30.6	72.1	149.0	210.0
Republic of Moldova	15.8	20.40	46.6	83.3	116.3	173.0	200.1
Kyrgyzstan	1.97	2.10	2.5	4.36	21.6	32.5	137.2
Ukraine	5.98	10.11	18.8	35.1	69.0	118.5	143.8
Latvia	4.79	8.11	10.37	31.8	59.3	91.1	116.6
Lithuania	2.5	7.0	10.0	18.0	59.0	86.5	98.7
Estonia	3.37	7.4	11.4	22.5	56.6	69.7	69.6
Turkmenistan	4.62	5.44	6.3	8.3	15.0	22.7	28.5
Bulgaria	4.2	6.7	7.2	10.7	13.9	19.2	25.9
Romania	23.16	25.85	26.03		24.2		
Uzbekistan	1.78	1.9	2.5	4.4	11.4	25.0	23.7
Tajikistan	1.63	1.64	2.9	5.8	8.3	19.7	12.2

The continuing major epidemic of syphilis has a major impact on the sexual and reproductive health of individuals and the population in general, particularly adolescents and young adults. Taking account of the current increase in HIV infection, mainly in drug users, in such countries as Belarus, the Russian Federation and Ukraine, the epidemic of syphilis and other STDs could become the basis for a dramatic spread of HIV.

Progress with STD prevention and control

Movement towards more liberal and confidential STD case management and contact-tracing regimes

The movement towards confidential management regimes has been characterized in many countries by the introduction of anonymous services for which the patient pays. Some countries have moved to a de facto confidential service, such as the Baltic states and Georgia, where the conflict has destroyed old mechanisms for named notification. In many countries, however, laws requiring notification by name are still in place.

Along with moves towards confidentiality in the management of index cases, some progress has been made towards liberalizing contact-tracing mechanisms. Belarus and Tajikistan are still using the old system. Lithuania has fully moved to patient notification of partners. The Russian Federation has been making revisions to the law that have loosened the sanctions around contract tracing.

Rationalization of use of diagnostic tests and move to more cost-efficient syndromic management approaches

The extent to which immediate treatment of patients presenting with STD syndromes has been achieved varies with the extent of use of diagnostic tests. In Belarus, Estonia, Kazakstan, Latvia, the Republic of Moldova and the Russian Federation, patients can in general be treated within 24 hours, as tests results are generally available within this time. In Lithuania, the patients presenting first to a polyclinic (a considerable proportion of patients) can experience a substantial delay before the legally required referral to dermato-venerologists. In Kyrgyzstan, Tajikistan, and Ukraine standard practice is to wait for results of laboratory tests before treatment can be started.

Courses on syndromic management have been organized in most countries. In general, however, only pilot experiments have been run and there is a need for further efforts to rationalize diagnosis and treatment. The situation in the larger countries varies considerably from place to place. In major cities management tends to be more diagnostic, especially in private clinics, while in some public clinics few diagnostic tests may be used and diagnosis is likely to be on clinical impression rather than systematic use of syndromic protocols. In the periphery, diagnostic tests are often not available, or only available on payment.

Movement towards ambulatory care

Considerable progress has been made towards making outpatient treatment the primary mode of syphilis management in many countries. The Russian Federation, for example, reported on the saving of about US \$12 million, owing to the replacement of hospital care with outpatient care.

Services targeted towards people with high-risk behaviours

Estonia, Latvia and Lithuania are providing STD services for vulnerable groups. Nongovernmental organizations (NGOs) have an increasing role in providing information, education, psychosocial support and care for vulnerable groups. In many countries NGOs have become partners in working with groups at particular risk of being infected with STD and HIV. These include: GANIMED in Ukraine, *Vosrozenie* and SANAM in the Russian Federation, and numerous organizations and associations in the Baltic states.

Obstacles towards the progress of health care for STDs and objectives for further actions

A number of important discussions took place on:

- developing more effective services and ambulatory services;
- achieving fully confidential services;
- developing acceptable partner notification mechanisms; and
- making effective services available, acceptable and affordable to groups with high-risk behaviours.

In general the participants agreed that barriers to progress could be identified in two broad categories:

- ideological barriers, including STD control personnel's lack of belief in and commitment to new ways of working; and
- economic and financial constraints.

Effective and ambulatory services

The participants agreed that further moves need to be made towards securing the earliest possible treatment of STD syndromes and avoiding wasteful use of diagnostic tests. After considerable discussions, the participants agreed that barriers to achieving this include the following.

Some doctors (including some participants) still feel that diagnostic testing is preferable to the use of syndromic approaches, even if it results in a delay of treatment. In addition, patients take diagnostic tests as an indicator of service quality. Doctors are therefore able to charge for tests and this has become an approach to cost recovery.

In addition, the participants generally agreed that further moves should be made to establish ambulatory treatment for the management of syphilis as a universal norm, excepting certain clinical groups, such as people with complicated syphilis and pregnant women with syphilis. It was agreed that barriers to achieving this include:

- the remuneration of services for work performed, which often continues to be related to the number of filled inpatient beds, rather than the numbers of people seen as outpatients; and
- reluctance to lose beds, since the demand for and shortage of inpatient beds for dermatological diseases is still reported as considerable, although the rationale for hospitalization for these diseases needs to be reconsidered.

Developing fully confidential services

There was considerable discussion on developing confidential services. In general, the participants recognized a pressing need to develop fully confidential services across the range of the state and private sectors for two reasons.

First, STD in the population can only be controlled where a sufficiently large proportion of cases of infection are detected sufficiently early. This in turn depends on patients' having confidence in the available services. Only services that protect the patients from the negative social consequences of an STD diagnosis can achieve this.

Second, respect for people's basic human rights and progress towards the appropriate restructuring of relationships between doctors and patients demand trust based on confidentiality.

Progress towards a fully confidential service in which confidentiality is not linked to cost recovery is being obstructed by the following forces.

First is the view that only anonymity can work at present. It seems to be a widespread belief that, although the service can present itself to prospective patients as confidential, patients may not accept this, but suspect the contrary.

Second, STD services currently cannot function in any NIS without user charges or cost recovery, as state budget contributions are diminishing. The provision of a deluxe service is distinguished from the routine service by the fact that it is anonymous, and the ability to charge for this is a key source of income to the services.

Third, until other ways of recovering costs can be found, the pressures to maintain a two-tier system with anonymity in only one tier will be hard to resist.

Fourth, there are still remnants of an ideology that opposes confidentiality in principle, on the grounds that society needs to be protected against people with STDs.

Nevertheless, the participants agreed that in principle linking patient charges and cost recovery to anonymity is immoral. Charges for anonymity have two major negative consequences. Patients get the impression that confidentiality is available only from paid services, not free-of-charge services. The sections of the populations most affected by the STD epidemic, the poor and even those with average income, are excluded from anonymous (and often confidential) services. High user charges for anonymity are major obstacles to the acceptability of services to the majority of the population.

Major efforts should therefore be made to support countries in finding approaches to cost recovery which do not de facto sell anonymity.

Developing acceptable partner notification mechanisms

The considerable discussions of partner notification mechanisms focused on the question of whether there was support for the idea that patient notification of partners can replace provider notification and tracing of contacts (operational units in most cases). There is a certain unwillingness to accept this at the ideological level. It was generally felt that getting contacts into diagnostic and treatment services early is an important tool of epidemic control, and there was a scepticism as to the effectiveness of the contact tracing based solely on patients' notifications. It was noted that the proportion of contacts traced is still used as a key indicator of service performance, but that, in countries with experience of patient notification of partners (Estonia, Latvia and Lithuania), it has not reduced the number of contacts traced and treated.

Making effective services available and acceptable to groups with high-risk behaviours

Extensive discussion followed presentations on services for vulnerable groups. Many NIS still lack the skills, knowledge and means to work with vulnerable groups; the medical personnel of the dermato-venereological service does not have time and their job description does not include the primary prevention of STDs and involvement in outreach work. In general terms, many countries have no capacity to provide STD care to the groups at particular risk, such as prostitutes and their clients, men having sex with men, drug users and street youth.

Summary and conclusions

There is a need to continue the process of reform of general STD services to ensure that:

- STD ambulatory care becomes the general rule;
- hospitalization is restricted as much as possible because of high cost/ineffectiveness, and the considerable risk of nosocomial blood-borne pathogen transmission (HIV, HBV, HCV); and
- forced hospitalization is abolished.

Confidentiality – anonymity

1. STD/HIV services should aim at full confidentiality for both patients and their sexual contacts.
2. Laws that work against full confidentiality should be abolished or not applied.

3. Anonymity may be a necessary (temporary) measure to generate confidence in the patients and the population for the STD services.
4. Anonymity should not be linked to increased cost recovery.
5. STD services have to function with some element of cost recovery through the patients; alternative methods of cost recovery or increase of resources urgently need to be developed.

Partner notification (contact tracing)

1. The use of force or intimidation in eliciting and tracing sexual contacts is unacceptable.
2. Methods of contact tracing should be restricted to involving patients themselves (patient notification or referral), or specialized health/social workers operating under medical secrecy.
3. Rates of sexual contacts elicited and traced are not to be used as a major measure of service performance.

Recommendations

1. Governments should acknowledge the severity of the STD epidemic, take their responsibility and declare the epidemic a national emergency.
2. Governments should speed up the process of developing and approving a national multisectoral control STD programme.
3. Governments should review and adjust the financing of STD care, to facilitate confidential, ambulatory and affordable (ideally or preferably free of charge) care for STDs for all people in need. Income generation (cost recovery) through user charges should not be linked to anonymous treatment, and alternative approaches should be urgently developed. Health promotion, information and education aimed at health and treatment-seeking behaviour should be an integral part of STD services.
4. Governments should abolish obsolete laws and regulations that interfere with the principles of confidentiality and voluntary attendance of STD care services.
5. STD services tailored to the needs of groups with high-risk behaviour should be established. NGO involvement in prevention and in care for those groups should be promoted.
6. Governments and NGOs should act to raise the population's awareness of the STD epidemic and to increase its knowledge on STD prevention.
7. WHO should advocate and mobilize international assistance to affected countries.
8. Governments should give priority to identifying which high-risk sexual behaviours are at the centre of the epidemic, and in which settings they occur.

9. Interventions should be targeted at these behaviours and settings when they are identified and assessed. In many countries, these behaviours and settings will be among prostitutes and their clients, and men having sex with men.
10. Such interventions should include:
 - information, education and communication;
 - provision of STD services tailored to those in need;
 - promotion of safe sex including condom use.
11. As NGOs have a critical role in the development of these interventions, the responsible governmental organizations should develop mechanisms for collaboration and partnership with them.
12. The necessary capabilities, knowledge and skills should be developed. These require technical assistance, available either locally or internationally. Financial resources must be allocated by governments specifically for these purposes.

Annex 1

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Annex 2

**PROJECT TO BE INITIATED BY COUNTRIES
AND AREAS REQUIRING INTERNATIONAL ASSISTANCE**

Armenia

Actions to be taken by the country:

- To request adequate and regular financial support of STD and AIDS services.
- To create an appropriate legislative environment:
 - to abolish old repressive articles from the penal code
 - to abolish compulsory detection of contacts.
- To develop and introduce the system of confidential, anonymous, and free of charge service of STD patients by the Governmental STD services.
- To introduce the system of syndrome treatment and to ensure permanent surveillance of the epidemiological characteristics of the causative agents.
- To develop and introduce in schools the educational programmes on sexual health.
- To limit dissemination of pornographic products in the country.

Proposals for international assistance:

Name of the project: Prevention of HIV and STD among people practising high risk sexual behaviour (PPHRSB).

Goal:

To reduce the incidence of HIV/STD among PPHRSB such as commercial sex workers, their clients, and men having sex with men.

Steps of the projects:

- Assessment of the situation in Armenia
 - to estimate the approximate number of PPHRSB
 - to comprehend the structure and methods of delivering sex services
 - to identify the NGOs which represent and work with the PPHRSB
 - to detect the main areas or points where they deliver sex services.
- Development and formulation of the programme.
- Designing of necessary materials, methods of work, capacity building.
- Implementation of programme
 - health promotion activities
 - deliver STD care in close collaboration with dermato-venerological service or other health care providers (partners: scientific association of medical students of Armenia, Armenian AIDS association).

Duration: Jan 1998 – Jan 2000.

Needs for implementation:

- International consultant for assessment
- Technical and financial support.

Belarus

Priorities in STD prevention and control in the Republic of Belarus:

- To develop intersectoral republican programme on STD prevention and control and get it approved at high governmental level.
- To declare the current situation in the Republic as an epidemic.
- To organize a republican centre on operational research in the field of STD prevention and control.
- To abolish the repressive legislation in relation to STD case management.
- To appeal to the Government for financial support for vulnerable groups with individual means of protection from STD and HIV.
- To appeal to the Government to change the financial support of STD service with the aim of ensuring free of charge outpatient treatment of STD patients.
- To develop forms and methods of cooperation with NGOs working in the field of STD care and prevention.
- To integrate preventive activities undertaken by STD and AIDS infrastructures.
- To continue introduction of syndromic approach in STD treatment and transfer to outpatient treatment on the basis of confidentiality.
- To train medical professionals and staff from other disciplines in the methods of work with groups of population practising high risk behaviour.

Estonia

Priorities for the Government:

- To approve the national state programme on STD and AIDS prevention and control.
- To consider STD and AIDS as social diseases and to change the system of financial support in the following directions:
 - to introduce free of charge diagnosis and treatment, i.e. to ensure accessibility and affordability of STD diagnosis and treatment for all groups of population based on anonymous free of charge diagnosis and treatment.
- To introduce the international principles and WHO recommendations on STD case management as compulsory for all medical facilities of the country.

The existing infrastructures on prevention and control of STD and AIDS should have:

- common methodological approaches
- joint evaluation and assessment
- joint planning of future actions.

Support to NGOs engaged in prevention of AIDS and STD in the following directions:

- methodological assistance

- financial assistance to some concrete projects (work with vulnerable groups)
- joint practical work (links between the medical facilities, scientific societies, specialists in both areas).

To support the already existing NGOs with which it is possible and necessary to work:

- IDS Center (work with vulnerable groups) - " AIDS - Tugikeskus"
- Association "Anti-SPID" - work with youth
- ESPO - organization of HIV-infected
- gay organizations (STD and HIV prevention among men having sex with men)
- family planning organizations.

Proposals for International assistance:

For UNAIDS

Prevention of STD and AIDS among schoolchildren
based on WHO programmes

Prevention of HIV among injecting drug users

Exchange of syringes
Methadone programme

STD prevention among drop-outs of schools and street children.

For WHO

STD and AIDS prevention among gay men
(care, treatment and prevention)

STD and AIDS prevention among sex workers
in the town Pyarnu (Estonia) - care, treatment, prevention.

Similar work in Tallinn and Tartu has started already in December 1996 according to the International project " Starstar" (Estonia- Finland) supported by EU for the next three years.

Georgia

To initiate a project on control of STD and AIDS by the year 2000.

Aim: to control the epidemic of STD and AIDS.

Strategy:

STD/AIDS as a national state problem

- To raise the problem of STD/AIDS control as a problem of national state importance.
- To give priority to preventive interventions.
- To develop a system of monitoring and evaluation of effectiveness of the project.

To achieve these:

- To create at the highest governmental level an intersectoral coordination committee on STD control
- To create an appropriate patient-friendly legislative basis for the above interventions
- To define concrete objectives for each sector.

STD case management

- To ensure acceptability of STD care for all STD and HIV/AIDS patients.
- Step by step implementation of primary prevention of STD and AIDS (for this the country asks assistance from WHO and other agencies):
 - to develop new approaches to contact the vulnerable groups, groups practising high risk behaviour
 - to develop specific interventions aimed at effective primary prevention.
- Creation of an effective information system for the medical community, for the general public and for the state level.
- To promote screening for STD (the country asks for provision of test systems, medical equipment).
- To introduce free of charge treatment of STD and HIV primarily through outpatient treatment (the country asks for assistance in supply of appropriate drugs).

Training

- To develop training programmes for:
 - medical professionals
 - educational sector (country asks to assist with appropriate literature).
- To create management group for intersectoral collaboration and exchange of information.
- To ensure continuity of contacts with international organizations such as WHO and others on issues related to control of STD and AIDS.
- To develop a system of evaluation and assessment of economical and social effectiveness of the implemented interventions and measures on control of STD and HIV/AIDS.

Kazakstan

To establish a multisectoral committee on STD control at the highest Governmental level.

To get approved at the highest Governmental level the state programme on control of STD epidemic and to get the Government to approve the adequate financial support of the programme.

To introduce changes in the current legislation: to abolish the penal prosecution of homosexuals, for using drugs and to strengthen the persecution of the intentional infection of others and for unlicensed medical services in the STD field.

To promote safe sex.

To adopt WHO/UNAIDS recommendations for treatment of STD, particularly syphilis, to seek international assistance in supply of appropriate drugs for introduction of STD care delivery through outpatient services.

To seek international assistance in establishment of exchange of information inside the country and at an international scale.

Kyrgyzstan

In Kyrgyzstan starting from 1991 the incidence of syphilis has increased 77 times. What is extremely serious is the appearance of congenital syphilis and the high rise of incidence among children and adolescents. The main reasons for that are:

- Low status of moral norms and poor medical and hygienic information among the young age groups of population.
- Extremely insufficient financial support of dermato-venereological service.
- Very poor equipment of STD facilities (absence of proper medical equipment and diagnostic reagents for syphilis and other STDs).

Based on this situation the country identified the following areas for a possible support:

- Development of educational programmes, development of manpower resources on medical and moral education of population and youth particularly, and skills in working with vulnerable groups.
- To equip the existing STD services in order to develop capacity in conducting of proper treatment and diagnosis (test systems, drugs).

Latvia

- To study models of sexual behaviour and on the basis of this research to formulate the national programme on sexual health.
- To initiate a pilot project for socially deprived population groups (prostitutes, street kids, drug users, social minorities, people without housing). To train them in the means of primary prevention of STD and HIV/AIDS, the skills and tools to practice safe behaviour.
- To introduce health hours in all schools of the country with information on STD and HIV/AIDS, on safe sexual behaviour.

Areas for international assistance:

For UNAIDS

Information for sex workers (to print materials).

For UNICEF

Education of prevention of STD and AIDS in orphan homes, Russian teenagers (based on WHO programme).

For Tacis and Phare

Prevention of STDs and AIDS among sex workers in Riga, prevention among street workers, development and maintenance of hotline.

For WHO

STD and AIDS prevention among gay men
(care, treatment and prevention).

STD and AIDS prevention among sex workers
in some big cities (such as Daugavpils, Ventspils).

Lithuania

National priorities and areas for international assistance:

- To ascertain the minimal cost of anonymous syphilis testing or to perform the test without any charge.
- To provide free medication for syphilis treatment.
- To provide free medication for syphilis as well as for curable STD for treatment of prostitutes (programme with UNAIDS).
- To introduce a register for syphilis, gonorrhoea and chlamydial infection in order to develop the modern STD epidemiological surveillance system.
- To intensify the work in the area of vulnerable target groups education, laboratory diagnosis and treatment of STD without any charge (along with UNAIDS).
- To ascertain the minimal cost of chlamydial infection test in venereology clinics (along with UNAIDS).
- To distribute educational printed matters among STD patients, target groups (prostitutes, gays, drug users) (UNAIDS).
- To include dermato-venereologist in the staff of primary health institution.
- In attempts to change the old mentality of dermato-venereology service, to intensify the work with the target groups.

Republic of Moldova

Priorities in STD control for the next two years:

- To ensure fast transfer to the out-patient, free of charge treatment of STD patients (syphilis, gonorrhoea) based on principles of confidentiality. The contact tracing should be done with the help of the patient only.
- To enforce primary prevention, promotion of safe sex in groups with high risk sexual behaviour.
- To continue medical examination of population including vulnerable groups.
- In order to detect as much as possible infected persons to continue serological testing for syphilis of all patients attending medical facilities.

Russian Federation

Plan of action:

- To review and to get approved at high Governmental level the Federal Programme on STD control.
- To adopt the law on protection of population from STDs.

- To organize collaboration of governmental (medical, social and other organizations) in order to provide STD care services and preventive interventions close to the vulnerable groups.
- To support development of private practice on STD care and support to organization of new private clinics and sites and to develop requirements for the private practitioners in order to ensure a high quality care and statistical reporting.
- To organize in STD care facilities special units which could undertake primary prevention working in schools, educational facilities, medical institutions, and work closely with vulnerable groups and thus be responsible for primary prevention at the territories assigned to these facilities.
- To undertake assessment of the current epidemic situation in the country on the reproductive health of the population as a means of advocacy to the Government to apprehend the impact of the epidemic for the demographic pattern of the country.
- To support 2-3 STD facilities as a best practice sites in conducting the WHO-recommended practices of STD case management such as:
 - introduction of syndromic approach to STD care
 - introduction of free of charge confidential treatment of STD
 - to popularize through the mass media the initiatives initiated at the best practised sites.
- To appeal to the Government to provide financial support to STD high quality care totally free of charge in some areas which are currently in a desperate economical situation, where due to the disruption of economical links after the dissolution of USSR, there is an extremely high unemployment such as for example in Altay, Tuva, Ivanovo and other regions).

Tajikistan

- To review and rearrange the STD infrastructure aiming at creating outpatient services – by 1998.
- To conduct national training seminars on outpatient and confidential treatment in the following regions:
 - Dushanbe
 - Kurgan-Tyube
 - Kulyab
 - Garm.
- To develop and disseminate recommendations on outpatient and confidential STD care.
- To establish close contacts with vulnerable groups of population (prostitutes, drug users, homosexuals). To assess the level of risk behaviours and their environment. To identify those people from these groups who could be a trainers for preventive interventions. To involve taxi-drivers, bar-keepers and others in the prophylactic activities.
- To develop leaflets on STD/HIV/AIDS prevention for vulnerable groups, particularly for prostitutes.
- To support organization and development of NGOs working among vulnerable groups.
- To review and abolish the legislative instruments which contradict the patients rights such as confidentiality, voluntary choice of STD service facility, comprehensive service and treatment.

Areas for assistance from international organizations

- Advocacy to high government level to acknowledge the seriousness of the epidemic.
- To define the vulnerable groups of population such as prostitutes, homosexuals.
- To assist in spreading widely the STD services in order to satisfy the needs of the population in need. To provide condoms for such services.

- To assist in organization of NGOs and in establishing good contacts between the governmental services and NGOs.
- To develop the potential of knowledge and skills at the local levels using international experience.

Ukraine

- To develop plan of assessment and evaluation system of STD control in Ukraine.
- To undertake an assessment of the system of STD care delivery in Ukraine.
- To widen and to improve the system of anonymous testing and treatment.
- To review and to improve the system of surveillance and reporting of STD.
- To improve attendance and treatment of contacts of STD patients based on the principle of confidentiality.
- To undertake a study of the sensibility of aetiological agents of STDs to antibiotics.
- To open reference laboratories.
- To introduce widely in the system of STD care the currently available modern test systems.
- To deliver STD care mostly through out patient departments retaining hospital care for a certain contingents of patients such as pregnant women, children, and people at a socially and economically extremely low level.
- In order to introduce delivery of STD care through outpatient departments the STD service of the country needs assistance in supply of appropriate antibiotics such as benzathin penicillin.
- To support two model best practice clinics which could be functioning on the technology recommended by WHO.
- To test the syndromic approach in STD treatment.
- To introduce sentinel surveillance based on the methodology recommended by WHO.

Annex 3

RECOMMENDATIONS OF THE WHO MEETING ON
THE EPIDEMIC OF SEXUALLY TRANSMITTED DISEASES
IN EASTERN EUROPE
Copenhagen, 13–15 May 1996
(EUR/ICP/CMDS 08 01 01)

- 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.