



UNAIDS

*CAPACITY-BUILDING
IN SECONDARY PREVENTION
OF SEXUALLY TRANSMITTED DISEASES
IN COUNTRIES OF EASTERN EUROPE
AND CENTRAL ASIA*

Report on a WHO Meeting

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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

Recognizing the urgent need for a response by the international community to the alarming rise in sexually transmitted diseases (STD) in the countries of eastern Europe and central Asia, the Regional Office and the Joint United Nations Programme on HIV/AIDS (UNAIDS) organized a meeting of representatives of international and bilateral organizations. The aim of the meeting was to develop and strengthen concerted international efforts in supporting capacity-building in the secondary prevention of STD in the affected countries, which would complement efforts made in the primary prevention of STD and HIV infection. The participants exchanged information on the current STD situation and on the activities of the organizations represented, identified current needs and gaps in international assistance, and developed a joint strategic approach. They agreed to prepare for the establishment of a task force for urgent response to the STD epidemics in eastern Europe, and designated the WHO Regional Office for Europe as focal point for the task force.

Keywords

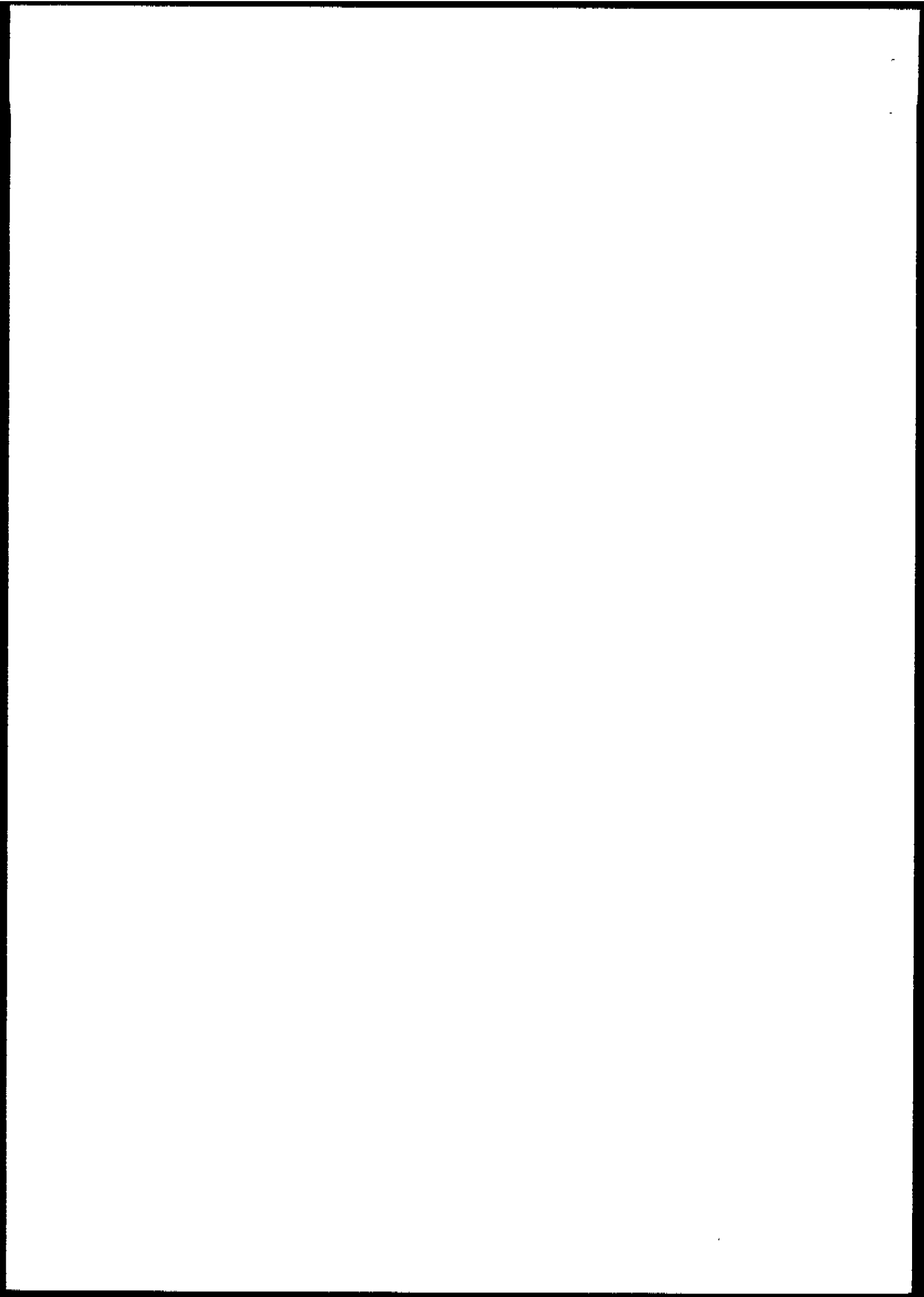
SEXUALLY TRANSMITTED DISEASES – prevention and control
HIV INFECTIONS – prevention and control
ACQUIRED IMMUNE DEFICIENCY SYNDROME – prevention and control
HEALTH RESOURCES – organization and control
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CENTRAL ASIA
RUSSIAN FEDERATION
LATVIA
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1. Introduction

Recognizing the need for an urgent response of the international community to the rapidly developing epidemics of sexually transmitted diseases (STDs) and HIV in countries of eastern Europe and central Asia, the WHO Regional Office for Europe (WHO/EURO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) called for a meeting of international and bilateral organizations. Organizations invited were those already involved or with a potential to become involved in supporting capacity-building in secondary prevention of STDs in the affected countries. Officers of the meeting were Dr Alexander Gromyko, WHO Regional Adviser for AIDS and Sexually Transmitted Diseases, Dr Gabriele Riedner, WHO Short-Term Professional, and Mr Henning Mikkelsen, UNAIDS Intercountry Technical Adviser. Professor Sieghart Dittmann, Coordinator of Communicable Diseases and Immunization, welcomed participants on behalf of WHO/EURO. Professor Dittmann stressed the need for concerted efforts and pointed to the successful experience of the Interagency Immunization Coordination Committee, a mechanism for international cooperation initiated by WHO/EURO in response to the epidemics of diphtheria, polio and other vaccine-preventable diseases in the newly independent states.

The meeting was attended by 19 participants, including representatives of Gesellschaft für Technische Zusammenarbeit (GTZ)/Germany, the Norwegian Board of Health, Department for International Development/Know How Fund (KHF)/the United Kingdom, Médecins sans frontières (MSF)/Belgium, United Nations Population Fund (UNFPA), the World Bank Group (World Bank), UNAIDS, WHO headquarters (WHO/HQ), WHO/EURO and four WHO temporary advisers.

The aim of the meeting was to promote and support capacity-building in the affected countries on secondary prevention of STDs through early case-finding and effective treatment of STDs. Early case-finding and effective treatment of STDs do not only prevent the serious health complications of STDs. Efforts in this area have an important role in primary prevention of STDs and HIV by reducing the period of infectiousness and the heightened vulnerability to HIV infection. This initiative should be seen as complementary to and in coordination with the concerted efforts made in the area of primary prevention of STD/HIV by UNAIDS and its cosponsors.

Social and economic factors related to the process of rapid change in countries of eastern Europe and central Asia have resulted in an epidemic rise in sexually transmitted diseases (STDs) and an associated rise in the potential for substantial and immediate HIV epidemics. The incidence rate of syphilis has increased more than 40–50 times during the last few years; in 1996 it was 100–200 per 100 000 population (in some areas up to 500). The same factors have undermined the capacities of the countries to respond to these health and social emergencies.

As a first response to the epidemics, a meeting of experts from the most affected countries was organized by the WHO/EURO, WHO/HQ and UNAIDS in Copenhagen in May 1996. The participants called for urgent action to strengthen primary and secondary prevention of STDs. Subsequently, some of the affected countries have begun reviewing and restructuring the policies and practices of STD care in accordance with international guidelines. To consolidate, broaden and strengthen these efforts there is an immediate need for strong political, financial and

technical support from the international community for advocacy and capacity-building in the countries. Thus, the specific objectives of this meeting of international organizations were:

- to review the current STD situation in eastern Europe,
- to identify organizations actively involved in or with a potentially key role in supporting advocacy and capacity-building in secondary prevention of STDs in the Region:
- to develop a joint strategic approach and guiding objectives for international support:
- to develop mechanisms and a joint workplan for coordinating and strengthening international assistance.

2. The STD epidemics in the countries of eastern Europe and central Asia: recent trends and the response of the affected countries

2.1 Trends in incidence of HIV and STDs in the European Region

The STD epidemics in the countries of eastern Europe and central Asia are unfolding at a time when the European Region is experiencing for the first time since 1995 a small decline in the number of reported AIDS cases. This decline reflects a stabilization of the HIV/AIDS epidemic in the north-western part of the Region, while the situation in the south-west of the Region is still deteriorating. In countries of eastern Europe and central Asia the HIV/AIDS epidemic is much more recent: from a situation with a very low HIV prevalence, countries such as Ukraine, the Russian Federation and Belarus have since 1995 experienced a rapid increase in the number of diagnosed cases of HIV, primarily among injecting drug users. Ukraine, so far the most severely affected, experienced a rise from 44 cases in 1994 to 12 280 cases in 1996. In the Russian Federation, 189 cases were reported in 1995 and 1500 in 1996, with cases reported from all regions of the Federation. In Belarus, the number of cases rose from 8 in 1995 to 757 in 1996. The STD epidemics in the countries of eastern Europe and central Asia lend a special and alarming significance to the emerging HIV epidemic, prefiguring the mounting vulnerability of the region to the sexual transmission of HIV.

The dramatic rise in STDs in countries of eastern Europe and central Asia is best demonstrated by the increasing number of reported cases of syphilis, since syphilis treatment by regulation is only allowed in state dermato-venereology clinics. Thus the number of reported syphilis cases can be considered a marker for other STDs which are not registered, or, as in the case of gonorrhoea, are likely to be subject to massive underreporting. In all evidence the increase of reported syphilis cases reflects a real increase in sexually transmitted infections. The small changes which may have occurred in bias factors such as STD health care-seeking behaviour, the number of persons screened or the sensitivity of the tests give a negative bias towards underreporting of cases rather than the opposite.

During the 1990s the annual incidence of syphilis has stabilized to a level below 1 per 100 000 population in European countries such as Austria, Denmark and Sweden. This is in sharp contrast to developments in countries of eastern Europe and central Asia. In Estonia, Latvia and Lithuania, annual incidence of syphilis rose in 1996 to between 70 and 117 per 100 000 population, and only Estonia showed indications of a levelling-off of the epidemic during 1996. In the central Asian republics the situation varies: the rates per 100 000 population in Kyrgyzstan and Kazakstan are high at 137 and 231, respectively, but much lower in Tajikistan (12),

Uzbekistan (24) and Turkmenistan (29). In Belarus, the Republic of Moldova, the Russian Federation and Ukraine incidence varies from 150 to 254 per 100 000 population (lowest in Ukraine and highest in the Russian Federation). Importation of cases is increasing to countries outside the area. In Finland the number of newly diagnosed syphilis cases rose from 37 in 1992 to 118, mainly due to importation.

2.2 Epidemiology and control of syphilis in the Russian Federation

A total of 376 084 newly diagnosed cases of syphilis was reported in the Russian Federation in 1996, by far exceeding rates back before the Second World War. In the Kaliningrad region the incidence rate is as high as 400 to 500 per 100 000 population, representing a hundredfold increase of newly diagnosed cases since 1992.

Some 470 cases of congenital syphilis were reported in the Russian Federation in 1996, and data on prevalence of syphilis (all stages) among pregnant women in the Moscow region reveal an increase from 0.02% in 1991 to 0.33% in 1995.

The highest increase in syphilis incidence is found among young people. In the Russian Federation between 1985 and 1995, the number of newly diagnosed syphilis cases among the group aged 15–17 years rose from 304 to 18 216, and among those aged 18–19 years from 640 to 26 787. Of particular concern is the increasing number of cases among children aged 14 years or less, from 75 to 1539 cases, presumably reflecting earlier sexual relations as well as increasing child prostitution. While male and female incidence rates are almost identical, females are particularly affected among the group aged less than 20 years.

According to data from St. Petersburg, the distribution according to social strata is changing. In 1976 the vast majority of cases (81%) were found among people in work, against only 31% in 1995. The proportion of syphilis cases among people in education rose from 4% to 7%, but the highest increase was found among people out of employment or education, from 16% in 1976 to 62% in 1995. This change presumably reflects both the growth of this particular population group due to social changes as well as its high vulnerability. Other data from serological screening of various occupational groups do, however, show a great increase in syphilis incidence in all groups, indicating that the population at large is affected by the epidemics. There is, unfortunately, no collection of data on the sexual preferences of patients or whether they are involved in prostitution.

Data from the different districts and regions of the Russian Federation show a wide geographical distribution. STD epidemics occur everywhere and there is a levelling of the differences in incidence rates, with the highest increases in areas with previously low rates.

Social determinants of the STD epidemics include greater social polarization, increasing poverty and the decline in capital spending on the social infrastructure, which influences patterns of sexual behaviour as well as the factors determining the period of infectiousness. At this stage there is hardly any research to reveal and document these dynamics, but anecdotal explanations point to the following key factors.

There appears to be a rapid increase in the numbers of individuals seeking poor quality private care or self-treatment. People are now experiencing a freedom of choice and tend not to select the state services due to the coercive regimes, police involvement in partner-tracing and extensive hospitalization. The lack of confidentiality constitutes an important barrier, as applicants for jobs,

visas and drivers' licences are requested to show certificates documenting that they have not been suffering from STDs. The decline in funding of state dermato-venereology services is leading to poorer management in these services. There are wide local variations in the quality of such services, and many of them overemphasize sophisticated laboratory investigation at the cost of prompt and effective treatment. Further, the availability of anonymous services encourages early presentation of patients who can pay. However, the great majority of people cannot afford these services and therefore have no access to them.

A number of sexual behaviour changes may have occurred, increasing the risk of infections. Evidently, there seems to be a rapid increase of prostitution and casual sexual contacts. Due to the social and economic hardships and uncertainty sex is increasingly becoming commodified. Novel structures of sexual relationships and networks and open sexual groupings have emerged. Finally, the initialization of sexual intercourse appears to be happening at an earlier age.

In addition to the significant human suffering associated with acute sexually transmitted infection and the sequelae of longer-term infection, the high prevalence of STDs sharply increases the potential for a vast sexually transmitted HIV epidemic.

2.3 The response to the STD epidemic in Latvia

Responding to the rapid increase of STDs since 1990 and as a part of the health care reform, the Latvian Government has taken a series of steps to reform the STD care system in accordance with WHO recommendations. These changes were motivated by economic hardship as well as the STD crisis.

In 1990, almost all syphilis patients were hospitalized while today more than 70% receive outpatient treatment. Patients are only hospitalized following social or medical indications such as homelessness or in the case of complicated pregnancies. They have freedom of choice as to where they receive treatment – from state or municipal STD services, private practitioners or clinics. There is practically no forced treatment of STD patients, and the criminal code clause on liability for avoiding treatment is abolished. From 1997 a national STD care programme has been in operation with a budget of US \$250 000, covering medical care for all STDs in children and syphilis diagnosis and treatment for all patients. Most of the treatment costs of patients with other STDs are covered by the municipality. The charge for patients is around US \$1, covering drugs and a small patient fee.

There are still some major barriers and unsolved problems for the effective control of STDs in Latvia, including the lack of a coordinated national programme for sexual health education and prevention among vulnerable groups. Still, even in these areas a range of initiatives has been taken, including introduction of sexual health education in many schools, promotion of safer sex in collaboration with the family planning and sexual health association and the sexual minority medical centre, media campaigns and the distribution of educational materials. The most serious shortcomings are in the areas of prevention among highly vulnerable groups such as drug users and sexworkers. According to police data there are more than 10 000 sexworkers in Riga.

In spite of these shortcomings, the progress in STD control effected in 1997 through the above-mentioned changes is visible in the stabilization of the numbers of reported syphilis cases compared to the year before. There is a significant increase in the number of patients seeking STD care, e.g. an increase in the number of patients attending the federal centre for STDs from 9000–10 000 in 1995 to more than 11 000 in 1996.

2.4 Progress and problems in controlling the syphilis epidemic in the Russian Federation

The syphilis surveillance system enabled very early recognition of the emerging syphilis epidemic. Subsequently, a range of particular problems in achieving control of the epidemic was identified. There were no primary prevention activities in terms of promotion of sexual health. The continuing management of syphilis cases with the traditional hospitalization regimes was considered very costly and inefficient. People were increasingly reluctant to tolerate the coercive regime associated with the state dermato-venereology clinics. The real value funding for the dermato-venereology services was declining at a time where demands were escalating rapidly. There was no legal basis for prevention among vulnerable groups such as sexworkers or men who have sex with men. The STD programme and the AIDS programme were operating in complete separation.

The general response to the syphilis epidemic and the associated problems was a move towards more confidential state sector dermato-venereology clinics and the introduction of up-to-date clinical management and treatment regimes, officially sanctioned by a ministerial decree in 1993. The decree legitimized the introduction of anonymous state dermato-venereology clinics with no requirements for patient identification. Further, the decree laid out the basis for outpatient management of syphilis with benzathine penicillin and issued guidelines with criteria for hospitalization. The principle of licensing people trained in dermato-venereology to treat STDs was reinforced, and a review of dermato-venereology training and the provision of diagnostic and treatment materials was launched. Dermato-venereologists were exhorted to undertake safer sex education and counselling with their patients. Finally, the decree included proposals to develop programmes aimed at raising the "sexual culture" in the population, especially young people; to establish a federal programme of STD control; and to introduce legislation on registration and regulation of sexworkers. These proposals are, however, still to be accepted and implemented.

Subsequently, all WHO recommendations for reform of the STD care system, including the introduction of syndromic management, have been officially adopted by the Government of the Russian Federation and have been incorporated into plans and resolutions. Alongside the traditional clinics, over 350 anonymous dermato-venereology clinics have been set up on a fee-paying basis. The private pharmaceutical industry has become a major shaping force in this development. At the anonymous clinics patients are typically charged US\$200 for diagnosis and treatment of syphilis. Some previously free state services, are, however, also introducing various user charges, e.g. for drugs, syringes and needles. Patients diagnosed with syphilis are still often obliged to identify themselves. Little progress has been made in patient education and counselling. There has been some progress in implementing sexual health awareness programmes for the general population, but in other areas major shortcomings persist. School sexual health education has not been properly carried out, as it has become an area for political conflicts. There has been little progress in integration or collaboration with the reproductive health services, the AIDS programme or primary health care, and effective approaches to primary prevention among sexworkers and other vulnerable groups have not been developed.

In spite of the good intentions demonstrated by the adoption of the WHO recommendations, some major barriers are preventing a significant improvement of the STD control. There is a lack of resources and political will to expand the existing programmes. The vast majority of the population is still excluded from confidential services and can only choose between nonconfidential services or no treatment at all. Important facts about epidemiology and

behaviour are ignored, hindering targeting of interventions. The scarcity of resources reinforces competition between the different sectors, such as the AIDS programmes, the reproductive health programme, the dermato-venereology sector and primary health care, and make the necessary collaboration difficult.

Several factors prevent the transfer of resources from low to high cost effective activities. There is a lack of technical capacity in public health approaches to STD control, and the focus on individual approaches is further reinforced by the marketization of STD services, which is tending to increase the autonomy of service providers. Market forces drive service providers towards charging for services, with elaborate diagnosis and treatment practices, and away from more efficient syndromic approaches. Key elements of STD control such as health education and health promotion, including outreach to vulnerable groups, are not generating income and therefore tend to be neglected, especially in the absence of an infrastructure to create and support activities in these areas. This problem is further compounded by continuing legal barriers to prevention work among vulnerable groups such as sexworkers and men who have sex with men, and lack of experience in the design and implementation of such activities.

In conclusion, there are continuing needs to advocate the urgency and principles of STD control, mobilize international support, enhance technical support and capacity-building, and build an epidemiological and social knowledge base for design of interventions.

3. The role of different organizations in helping to prevent and control STDs

3.1 Médecins sans frontières (MSF)/Belgium, Azerbaijan

As regards STD control in Azerbaijan, Médecins sans frontières have focused on improving family planning services in the wider framework of their work to provide medical care and other assistance to local populations, the internally displaced, and refugees in the cities of Baku and Barda, five other districts and the Nagorno-Karabakh enclave. In this context MSF has analysed the STD situation in Azerbaijan. In addition to the general problems described in the previous sections, access to STD services is further impeded in Azerbaijan by economic hardship as well as religious and cultural barriers, hindering access to diagnosis and treatment, especially for women. Consequently, self-treatment or treatment by service providers who are not adequately trained (e.g. village midwives) appears to be common. There is a need for more epidemiological research on STD etiological agents and resistance, introduction of case management guidelines based on WHO recommendations and a reform of the STD legislation.

3.2 Gesellschaft für Technische Zusammenarbeit (GTZ), Germany

GTZ functions as an implementing agency on behalf of the German Government, not as a donor agency. Consequently, new activity areas have to be incorporated in the planning process. GTZ is currently not directly involved in STD control activities in the newly independent states. A reproductive health project is starting up in Azerbaijan, focusing on women, and including a twinning arrangement with a German university. In Uzbekistan a reproductive health project proposal has been prepared and is now awaiting approval. The project will be decentralized to two districts. Further, GTZ is running two advisory projects for the Ministry of Health in Kyrgyzstan, one on health care reform with a focus on health insurance, and the other on family planning services. Finally, smaller bilateral activities are running in Tajikistan, Turkmenistan and

the Caucasian republics, mainly facilitating information exchange between German institutions and local counterparts.

3.3 Department for International Development/Know How Fund (KHF), United Kingdom

The KHF offers technical advice and expertise to support the transition process in the countries of central and eastern Europe. In the Russian Federation the KHF supports health reform at district level, focusing on three districts, and at general level, advising on the drafting of new health care legislation to promote higher health care standards throughout the Federation. The objectives of the support at district level is to reorganize health services, improve health care practice and management, and improve reproductive health services for women.

3.4 United Nations Population Fund (UNFPA)

UNFPA has been working in the region since 1995. With a budget of US\$4 million for 22 countries in this region, UNFPA is focusing on reproductive health and works with STD care only as an integrated part of reproductive health. At country level, UNFPA is represented in the UN Theme Groups on HIV/AIDS. UNFPA has identified the following gaps and shortcomings for STD control: inadequate diagnostic and treatment, lack of guidelines and protocols, centralized services by specialist physicians and special clinics and laboratories, registration of patients, treatment and transportation costs and a non-coercive service provision.

3.5 World Bank Group

Since 1970 the World Bank has included health and nutrition among its lending activity areas. Some 24% of funding goes to health and nutrition, divided according to basic health services and aiming at developing and strengthening primary health care (75–80%), nutrition (5–10%) and reproductive health (20%).

In the European and Central Asia region of the World Bank, covering 30 countries in Europe and Asia, 16 projects totalling US\$90.7 million are in operation. Currently loans are only being made in 8 of the 30 countries. Future lending is planned for US\$200 million per year, but the Group can only act on demands from governments. In all the countries the World Bank is advising on reform of the health sector away from curative focus towards a primary health care structure. The World Bank is currently preparing a country strategy paper for the health sector, including joint efforts with other agencies.

In the 1993 World Development Report *Investment in health*, early diagnosis and treatment of STDs is described as a highly cost-efficient intervention in its own right and crucial to the effort against AIDS. The World Bank is currently supporting several STD secondary prevention projects around the world. There appears to be some discrepancy between policy statements in official documents and the actual design of assistance, and there seems to be room to strengthen the STD component at country level. To that effect it is important that organizations like WHO clarify how secondary prevention of STDs fits into overall health investment priorities. Secondary prevention of STDs should be targeted and prioritized. Indicators of achievement should be set in the form of targets which can be monitored. Specific interventions should be designed in detail and costed.

3.6 The Office of AIDS and Sexually Transmitted Diseases (ASD), WHO headquarters

ASD serves as the focal point for activities related to sexually transmitted diseases and HIV/AIDS in WHO, functioning as a bridge with UNAIDS. ASD has an important role in facilitating the integration of STD/AIDS in WHO programmes. Eighteen WHO programmes are currently involved.

Promotion of safer sex and reduction of the incidence of curable STDs are considered the two key strategies for prevention of sexual transmission of HIV. Historically it became important to focus more attention on the latter, which tended to be neglected. ASD works on STD integration through the interdepartmental STD working group, involving *inter alia* the Reproductive Health Division, the Maternal and NeWorld Bankorn Health – Safe Motherhood Programme and the Division on Emerging and Other Communicable Diseases Surveillance and Control. ASD supports the WHO Regional Offices which are increasingly addressing and allocating more funds to STDs. In addition, ASD is currently preparing/providing:

- a policy document
- a data base on STDs
- an advocacy paper for health professionals on the necessity of a STD reform
- a 1997 update on the global STD situation
- a book describing the current situation as regards to the syndromic approach
- an STD case management training manual (available in Russian)
- WHO strategic plan for HIV/STD
- technical assistance to other agencies, including UNAIDS.

Planned activities include:

- prioritization of WHO's effort in the strategic plan
- research on vaginal discharge care
- training courses at regional and intercountry levels
- development of national surveillance guidelines
- re-establishing contact with WHO collaborating centres
- exploring the possibility of using the revolving condom funds for STD drugs for the European region.

3.7 Division of Reproductive Health (RH)/Maternal and NeWorld Bankorn Health – Safe Motherhood Programme (MSM)

Integration into other programmes is a key challenge of STD care: the STD battle cannot be won by STD specialists alone. Reproductive health programmes offer a variety of options for integration:

- antenatal care clinics, often visited 10–15 times by women
- obstetric-gynaecological departments
- family planning/abortion care clinics (not yet well developed)
- youth clinics
- (increasing numbers of) general practitioners.

There are numerous barriers to this development, such as overmedicalization, overspecialization, doctor orientation, too many hospital beds, no promotion of self-care, too many old doctors, varying research traditions and the weak position of ministries of health. It is important to consider the impact of the health sector reforms. It can be difficult to launch intersectoral initiatives at local level, where it is important to acknowledge the roles of the often powerful department chiefs, and the local sanitary control units. There is, however, a will to change, and important allies can be the growing number of organizations of health professionals. Finally, midwives and nurses are becoming more independent and may assume important roles in the future STD control effort.

3.8 Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva

UNAIDS was established in 1996 following an agreement among its six co-sponsoring agencies: WHO, UNICEF, UNDP, UNFPA, UNESCO and the World Bank in 1993. The key roles of UNAIDS are in the areas of policy development and research, technical support, advocacy and coordination. UNAIDS considers the HIV/AIDS epidemic deeply dependent on socioeconomic development and the social forces. UNAIDS is facilitating the development of a division of work between the cosponsors at regional level, taking into account their different strengths as regards their presence at regional and country level, experience in AIDS, normative authority, financial resources and programmatic and administrative flexibility. At country level UNAIDS is identical with the joint action of the cosponsors through the UN Theme Groups, and the support provided by the UNAIDS secretariat.

3.9 National Board of Health, Norway

The Norwegian Board of Health has for long time been concerned about the lack of attention regarding HIV/AIDS in eastern Europe, and fears that the same may happen with the current STD crisis. It has been very difficult to make European foreign aid agencies work in eastern Europe, since they tend to stick to their traditional geographic working areas and ignore developments in this area. The Norwegian Board of Health therefore works with multilateral organizations to support multilateral efforts. At first attention in Scandinavia was on the threat on own doorstep, and a number of initiatives were made in the Baltic Sea area, but in recent years Norway has become engaged in the effort against communicable diseases in other newly independent states. By actively supporting the Interagency Immunization Coordinating Committee, the Norwegian Board of Health has demonstrated positively that it is possible to pool technical and financial resources efficiently.

3.10 Sexual and Family Health (SFH), WHO/EURO

The SFH team provides technical assistance and information on all aspects of women's issues, maternal and child health and reproductive health, with the aim of enabling Member States to build national family planning programmes and services suited to their circumstances and needs. Through the CARAK (Central Asia, Armenia, Kazakstan) country projects, financed mainly by UNFPA but also by WHO and other donors, the team focuses on the countries with high rates of abortion and maternal illness and death – those in greatest need of good family planning services. SFH has an integrated approach to STDs. STD counselling forms part of the CARAK projects and is included in the training in maternal and child health. Information on STDs is included in the European family planning magazine, *Entre nous*, which is produced (including in Russian) by the team and widely distributed in the region. Future plans are to strengthen the STD component in training materials and to improve the maternity care capacities, e.g. by including STD care.

4. Towards a comprehensive and coordinated approach to the strengthening of STD control (emphasizing secondary prevention)

4.1 Strategy developed by WHO

4.1.1 Introduction

A strategy on secondary prevention of STDs, which aims at the development of a joint strategic approach, developed by WHO was presented for discussion and modification by participants. It was emphasized that the strategy should be seen in the framework of a broader strategy on STD/HIV prevention and care of WHO, UNAIDS and other cosponsors of UNAIDS. The strategy is based on the general principles of close links or integration of prevention and care programmes, and integration of the respective HIV/AIDS programmes and the STD programmes.

The aim of the strategy is to support the affected countries in reforming STD care service provision, in the framework of and in line with the principles of the general health care reforms. As discussed throughout the meeting, the current STD care system is characterized by overtreatment (e.g. extensive and unnecessary hospitalization) and an absence of cost-efficiency. There is a strong need to develop user-friendly services, contrary to the current coercive, or in some cases even violent regimes. Finally, there is a need to strengthen active case-finding through the introduction of cost-effective screening programmes and partner notification procedures which respect human rights and confidentiality.

The strategy builds on three major components: advocacy within the affected countries, mobilization and coordination of international assistance and capacity-building.

4.1.2 Advocacy

In the affected countries there is a need to advocate the public health priority of STD control and the internationally recommended approaches to STD control. The objectives are to strengthen political commitment and financial support and to facilitate the introduction of effective systems and methodologies for STD prevention and care. Possible advocacy activities include:

- sustaining and strengthening a spokesperson network of professionals and policy-makers, by maintaining personal contacts with representatives of ministries of health and other influential dermato-venereologists; with the support and involvement of the UN Theme Groups on AIDS;
- shaping public opinion through mass media work;
- mobilizing selected ministers of health through personal contacts with ministers who are open and support policy changes, to act as peer educators of colleagues in other countries;
- preparing information for policy-makers and care providers on the STD epidemics and control recommendations.

4.1.3 Mobilization and coordination of international assistance

The objectives of mobilizing and coordinating international assistance are to:

- increase the commitment of international donors and implementing agencies to support STD control programmes;

- forge links between donors and governments/nongovernmental organizations;
- establish twinning partnerships between western and eastern European institutions;
- set up coordination mechanisms for international assistance.

These objectives may be achieved through the following activities:

- advocacy of increased international assistance to STD control at meetings and conferences;
- provision of information to donor and implementing agencies;
- meetings of technical and financial aid organizations to establish a coordinated approach to assistance to STD control in the affected countries

4.1.4 Capacity-building

The objectives of capacity-building are to make up-to-date international methodologies available for adaptation and adoption, where appropriate. Further, capacity-building should facilitate the development and implementation of revised STD control systems in countries and promote the self-sufficiency and sustainability of the new approaches. Capacity-building is needed in the following areas:

- policy and national programme development
- provision of comprehensive STD care
- efficient active case-finding programmes
- epidemiological surveillance
- promotion of early treatment-seeking behaviour

Capacity-building in these areas may be achieved through:

- training
- twinning: establishing close links between eastern and western European institutions
- establishment of best practice sites.

4.1.5 Critical issues

Several critical issues require careful consideration.

Best practice sites should be part of a national strategy for STD care reform, facilitating the evaluation and adoption of new approaches and catalyzing the reform process. To that effect it is essential to plan for the sustainability and replication of the sites, including future financing.

The treatment protocols in WHO publications and training manuals on the syndromic approach, promulgated since the early 1990s, were primarily developed on the basis of the epidemiological situation in Africa, which is why they include, for instance, chancroid (a frequent STD pathogen in that region). These treatment protocols are wrongly often considered to represent the WHO recommended syndromic approach in general, thereby creating an understandable resistance against the adoption of the protocols as well as the syndromic approach. There is an urgent need for studies on the pattern of causative agents in countries of eastern Europe and central Asia for the development of appropriate treatment protocols and the adaptation of WHO publications.

The past history and the coercive, punitive STD control approaches still in force regarding vulnerable groups such as sexworkers and men who have sex with men, have created a wide gap

of credibility and thrust which it will be very difficult to overcome. Further, there is very little experience of how to promote care-seeking behaviour and create user-friendly services.

Finally, confidentiality is often confused with anonymity.

4.2 Comments and recommendations

The aim of the discussion was to develop a joint strategy for the coordinated efforts of the participating agencies, based on the strategy presented and developed by WHO/EURO. Although the discussion naturally often touched upon recommended strategies for STD control at country level, it was emphasized that the focus was on developing a strategy for international cooperation, since national strategy development obviously requires involvement of national counterparts.

4.2.1 Economic aspects of the STD crisis and control

For the purpose of advocacy and mobilization of international assistance, it is important to preface the strategy with a clear definition of the magnitude of the problem (including in economic terms) and the relative priority of STD control in relation to health investments in other sectors. Estimates of the direct and indirect costs associated with STD epidemics, including any presumptive affects on HIV epidemiology, should be made within the Region and preferably within countries. The estimates may include costs of sequelae such as infertility and cervical cancer. It may be possible to develop generic models to estimate the costs of the epidemic based on key indicators, e.g. syphilis prevalence in antenatal clinics. Existing information on the cost utility (costs per disability-adjusted life years of investment in primary prevention and in STD management), for example the information presented at the WHO meeting on the Epidemics of Sexually Transmitted Diseases in Eastern Europe, Copenhagen, May 1996, should be highlighted. Proposed interventions should be specified in detail and costed.

4.2.2 Multisectoral involvement

The strategy should to a greater extent stress the involvement of professional groups and services others than dermato-venereologists and dermato-venereology services, in recognition of the important role of the emerging reproductive health and primary health care sectors, the vested interests of some dermato-venereologists in maintaining a status quo, and last but not least the fact that STD patients in many places are treated by primary care physicians or midwives or treat themselves with drugs bought from pharmacies. This recommendation also applies to the area of advocacy: the spokesperson networks should involve the growing numbers of national associations for health professionals which can become key agents for change.

4.2.3 Role of primary prevention

The focus on secondary prevention for this strategy may, unintentionally, give a wrong message regarding the overall priorities for STD control, de-emphasizing the role of primary prevention. The preamble should stress the significance of the primary prevention of STD/HIV, and clarify that while early diagnosis and treatment constitutes secondary prevention of STDs in individuals, it is primary prevention in the population at large since it reduces the period of infectiousness. Further, consideration could be given to producing a second strategy document describing primary approaches such as information, education and communication activities, social marketing of condoms, etc., and including a reference to it in the preamble.

4.2.4 Public health capacity:

In the affected countries there is a lack of people working in the area of sexual health with an adequate public health perspective. The tendency to focus attention on individual patient management rather than public health is further reinforced by the economic drive towards income-generating activities. The strategy should seek to reinforce and support public health capacity in the affected countries in the area of sexual health.

4.2.5 Twinning partnerships

The idea of creating twinning links between institutions in western Europe and institutions in the countries of eastern Europe and central Asia, was in general endorsed as a very useful model for exchange of information, skills and experience, reinforcing the notion of partnership among equals as opposed to more traditional paternalistic interventions. In this context consideration should be given to using the experience and infrastructure of the WHO Healthy Cities Project, constituting a vast network of cities in all parts Europe working together on health matters, and the existing network of reproductive health research centres. Further, it will be equally important to establish channels for exchange of experiences among institutions in eastern Europe and central Asia now becoming engaged in the process of STD reform. It is, however, very important to guide and monitor the twinning process to avoid the tendency that partners often tend to pick up the wrong issues. Regional diversities should be recognized as a possible barrier. While twinning arrangements and the Healthy Cities Project have apparently worked well with countries of central and eastern Europe with a similar social and cultural backgrounds to countries in western Europe, it may be more difficult with other countries.

4.2.6 The status of best practice sites

While best practice sites should ideally be planned as part of a national strategy for STD reform, this may in many cases not be feasible. One of the objectives of setting up such pilot projects is precisely to advocate the necessity of reforming STD care and demonstrate that the new approaches work. Thus it would be premature to expect full governmental endorsement as part of a national strategy before the projects have made such a demonstration.

4.2.7 Collaboration between the STD sector and the AIDS programmes

The STD sector and the AIDS programmes were historically established as separate and vertical structures. Attempts to create better collaboration and integration between the STD sector and the AIDS programmes should recognize and find ways to overcome the fear that more unified operation will result in the loss of jobs, creating considerable resistance at both sides. Further, the different approaches and backgrounds of professionals working in the STD sectors and the AIDS programmes, respectively, tend to create additional resistance. It may be useful in any document promoting the integration of HIV and STD services to include a preamble explicitly recognizing the role and contributions of the two sectors in the following points:

- AIDS prevention campaigns and activities have had a significant impact on STD incidence and provided some very useful lessons on STD control, which may be further enhanced by including promotion of health care-seeking behaviour;
- AIDS prevention activities should be broadened to have a role and include a specific objective to stop the transmission of curable STDs;
- the early diagnosis and treatment of STDs are important in HIV prevention through reducing the period of infectiousness and thereby the incidence of STDs and the associated greater vulnerability to HIV infection; they should be strengthened and allocated new resources.

4.2.8 Syndromic approach

Elements of the syndromic approach, in particular the principle of ensuring treatment of patients at the first encounter with the health care system (whenever possible) are very important and relevant to the situation in the countries of eastern Europe and central Asia. The syndromic approach should not, however, be dogmatically pushed in a simplistic way, but adapted to the local situation and the availability of laboratory facilities. The key is to develop a best public health approach to case management. There is a great need for research in the etiological pattern of STD syndromes in order to develop appropriate diagnosis and treatment protocols for syndromic case management in the countries of eastern Europe and central Asia.

The sophisticated diagnostic capacity of reference STD centres will remain essential in assuring quality control, confirmatory testing in screening programmes and the evaluation of complicated cases of STDs.

4.2.9 Sustainability

While the long-term sustainability of best practice sites may be less important, as their main function is to serve as pilot demonstration sites, the long-term sustainability of the STD reform should be considered. In that context a financing model with limited user charges for STD services may be more realistic than free services in most countries, except in countries with established policies of free health services in general.

4.2.10 Anonymity/confidentiality

Currently, people in the affected countries only have the options to pay high fees for anonymity, if they can afford it, or using the non-anonymous, non-confidential services, often located side by side. Ideally STD services should be confidential, and not necessarily anonymous, on the principle that STDs should be treated like any other disease and not made something special. To that effect efforts should be made to abolish the legal barriers and install procedures to safeguard confidentiality. Given the historical role of the dermato-venereology clinics in coercive contract tracing and providing personal individual data for public authorities, however, the promise of confidentiality may not be trusted by many patients. Therefore consideration should be given to promoting confidentiality alongside anonymity until confidence has been established and it has become feasible to move to confidentiality alone. It is, however, important that the issue of anonymity is not linked to payment, because it deprives the poor and most affected population groups access to confidential services. Since the expensive anonymous services are currently often offered at the same sites as the free non-anonymous, non-confidential services, providing an extra source of income for the staff and clinics, considerable resistance may arise due to the loss of this income source in the move to anonymous and/or confidential free or low charge general services.

4.2.11 Approaches to vulnerable groups

Integration of STD care in reproductive health programmes/facilities is recognized as an important step forward, but it will not have a major impact on the STD epidemics, especially not for the groups most vulnerable and at highest risk of infecting others. Consequently, STD care should be integrated in all possible outlets, in particular the emerging primary health sector, striving towards increasing accessibility for all users, in particular those in vulnerable groups such as young people, sexworkers and men who have sex with men. The establishment of special projects reaching out to vulnerable groups may be difficult due to the lack of experiences in the affected countries, but considering the crucial role of such groups in STD control both approaches should be pursued.

4.2.12 Prioritization

Priorities should not only be made on the basis of the magnitude of the problem in a given country. The country's capacity for change should also be considered.

5. Mapping out current/planned assistance in relation to the strategy

5.1 MSF

MSF will provide the results of the epidemiological research and continue the integration of STD care in family planning programmes in Azerbaijan. In Azerbaijan, MSF ask for international assistance for assessment of prevalence of STD and antimicrobial sensitivity, development of national treatment protocols and revision of the STD legislation.

The Belgian and Dutch branches of MSF are also operating in Georgia and Armenia in the areas of family planning and STD control/epidemiology, in Romania in the area of family planning, in Kyrgyzstan with a case management project in one district, and in the Russian Federation with STD epidemiology and primary prevention. The MSF representative will collect and feed back more information about current activities and plans of MSF in other countries of relevance to the strategy.

5.2 GTZ

GTZ seeks to integrate STD control in the reproductive health project in Azerbaijan now starting up and the proposed reproductive health project in two districts in Uzbekistan. The advisory project on family planning services in Kyrgyzstan is actively integrating STD. GTZ is interested in training materials on STD case management. GTZ was encouraged also to integrate STD control in projects others than the reproductive health projects, e.g. the advisory project on health care reform in Kyrgyzstan and the exchange projects involving German institutions, for example by bringing STD issues to the attention of the project managers. In addition to GTZ, it may be worth approaching Kreditanstalt Für Wiederaufbau, KfW, another unit of the Ministry of Economic Collaboration which can provide grants.

5.3 KHF

The reproductive health projects in three districts, Samara in the Volga region, Sverdlovsk in the mid Urals and Kemerovo in south-west Siberia, include the introduction of systems and training for physicians and midwives on improved diagnosis and treatment of STDs. Training of trainers is now being organized at colleges for midwives. Further, the KHF has a five year association with the "Juventa" youth centre in St Petersburg. This centre provides a variety of services, including counselling on family planning and STDs, and STD diagnosis, but current legislation does not allow the centre to provide STD treatment. It should be recommended that such youth centres be allowed to provide contraceptives and STD treatment. Support is provided to the Russian Family Planning Association through the International Planned Parenthood Federation, which may include training in STD/HIV counselling. In Kazakstan, the KHF is involved in sexual health education training of physicians and midwives. It was suggested that KHF should also seek to incorporate promotion of care-seeking behaviour in its training activities.

5.4 UNFPA

The objectives of UNFPA's work in the area of STD control as an integrated component of reproductive health are to generate high awareness in the population and adequate quality service delivery through advocacy; information, education and communication; training (STD training as part of reproductive health training); and logistics/supply. UNFPA is integrating STD training into the curricula of nurses and gynaecologists in Armenia and Georgia. It will be important to consider a review of guidelines for prescription of contraceptives in the light of the developments of the HIV/STD epidemics.

5.5 WHO/EURO (ASD and SFH)

A range of activities was planned in the area of secondary prevention of STDs. A policy-making intercountry meeting was to take place in Riga on 15–17 July 1997, aiming among other things at developing country-specific plans for assistance with a particular focus on service provision for vulnerable groups. It is planned to establish best practice sites in selected countries, starting in Kyrgyzstan, the Russian Federation, Turkmenistan and Uzbekistan. Intercountry STD case management training will be conducted in the central Asian republics, as well as a seminar on integration of STD/HIV in Belarus. Support will be provided to a review of the STD care system in Ukraine, including a cost analysis. This review may, among other things, serve to clarify how STD control can become an integrated element of reproductive health programmes and primary health care, e.g. whether STDs can be managed at this level. A series of activities is planned as part of the advocacy plan, including preparation of a press kit and other media activities. The STD case management training manual has been translated and is available in Russian, and it is planned to translate other relevant materials. ASD/EURO should strengthen collaboration with the WHO reference centre for gonococcal infections and identify a WHO collaborating centre on STD surveillance.

The reproductive health magazine *Entre nous* will provide information on STDs. It is planned to strengthen the STD component in the CARAK reproductive health projects and, where feasible, to integrate the STD best practice sites with the CARAK projects. The STD component will also be strengthened in the execution of the UNFPA programme in the Caucasian republics by the SFH unit, and in the reproductive health training network.

5.6 World Bank

The World Bank representative expressed a strong interest in supporting a study assessing the economic impact of the STD epidemics and their control in the European and Central Asia region through its special research grants. It was considered that EURO would be in a natural position to initiate, lead and coordinate such a study, in collaboration with other possible partners such as the Centers for Disease Control, Atlanta, and WHO headquarters. An economic modelling of STDs in the ECA region will also serve as a model of good practice for collaboration between the World Bank and WHO in other areas. Further, from a World Bank perspective the financial needs for international assistance to STD care reforms in the affected countries – for drugs, training and technical assistance – were considered minor and funding could be made available. In addition, the World Bank representative pointed to the Asian Development Bank as an important collaborating partner. The Asian Development Bank is doing a lot of analytical work and provides resources to the newly independent states.

As STD care management should be available at the level of primary health care services, the World Bank has a key role in supporting the STD reforms through its assistance to the ongoing health care forms towards a primary health care structure. For that purpose STD case

management should be included in training programmes for primary health care staff. Efforts should be made to ensure that the STD issues are recognized in World Bank documents and budgets. Technical inputs are required for the country strategy reports for the health sector, and for the World Bank health sector reform document in preparation.

The World Bank representative pointed to the need for developing a short-term strategy in response to the immediate STD crisis as well as a long-term strategy for STD control in the affected countries.

5.7 National Board of Health, Norway

The Norwegian Board of Health is funding WHO/EURO's STD activities, particularly in the central Asian republics. Further, bilateral support is offered to the northwestern part of the Russian Federation for training trainers and supporting local health service reforms.

5.8 WHO HQ

Among ASD/HQ activities, the development of national guidelines for STD surveillance and the preparation of an advocacy paper for health professionals on the necessity of an STD care reform, to be adapted at regional level, are particularly relevant for the countries of eastern Europe and central Asia. The Aide-Mémoire for AIDS/STD Programmes: "Prevention and control of STDs: a public health approach" should be translated into Russian and distributed to these countries. Further, the countries should be informed about the possibility for bulk purchase of Benzathine penicillin (16 cents per dose). ASD can provide technical assistance (consultants) to countries and to other agencies, and financial assistance to strengthen STD surveillance.

RH/HQ is prepared to support a study on STD care-seeking behaviour, and will strengthen STD integration in the reproductive health project in Turkmenistan.

6. Gaps in the international response to the STD crisis in countries of eastern Europe and central Asia

Considering the vast geographical distribution of the STD epidemics and the many countries affected, the most significant gap is clearly the insufficient coverage, e.g. in the establishment of best practice sites. A further significant gap was identified in the research field, where there is a need for studies on:

- the prevalence of STD pathogens
- gonococcal sensitivity
- STD care-seeking behaviour
- sexual behaviour
- vulnerable populations
- the integration of STD in family planning services/primary health care structures
- the economic impact on the STD epidemics and STD control.

In planning research, a distinction should be made between short-term research needs, e.g. on STD pathogens or vulnerable populations, and those which can only be addressed on a longer term, e.g. economic impact studies or operational research on integration of STD in structures.

Further, there is a need to establish contact and strengthen collaboration with professional organizations others than the dermato-venereologists, and to strengthen advocacy at large.

Support is required to assist the affected countries in the development of national plans for STD control.

There is a need to map other organizations' STD control activities, and to mobilize other potential partners such as USAID and the European Union.

WHO and the World Bank should collaborate to ensure that STD issues are properly addressed in the health care reforms.

7. Future coordination of international assistance

Presentations were made on the experiences of the Interagency Immunization Coordination Committee, set up in response to the epidemics of diphtheria, polio and other vaccine-preventable diseases in the newly independent states, and the UNAIDS Task Force on HIV Prevention Among Injecting Drug Users in Eastern Europe. It was found that there was a need for similar mechanisms to coordinate and strengthen the international response to the STD epidemics in countries of eastern Europe and central Asia in the area of early diagnosis and treatment. Participants therefore made the following recommendations:

- 1) A task force should be formed to respond urgently to the STD epidemics in eastern Europe.
- 2) This task force should be officially founded at a follow-up meeting to be organized by WHO/EURO before the end of 1997, preferably in two to three months' time, eventually in combination with the international STD conference in Seville, Spain, 19–22 October 1997.
- 3) WHO/EURO should act as focal point/lead agency for taking the task force initiative forward.
- 4) A proposed structure for the task force should be prepared for discussion and adoption at the forthcoming meeting, including a draft mission statement, secretariat arrangements, modus operandi, membership criteria and external relations.
- 5) A focused strategic plan based on the recommendations of this meeting should be prepared for formal adoption as a joint plan for the task force at the forthcoming meeting.
- 6) In addition to the official founding of the task force, the agenda for its first meeting should include agreement on a joint workplan. If feasible, the meeting may be combined with some public relation/advocacy event launching the task force.

Annex 1

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