



GLOBAL MEDIUM TERM PROGRAMME
SEXUALLY TRANSMITTED DISEASES



1. Policy basis

WHA 28.57 and WHA 31.58 requested WHO to stimulate activities leading to more effective methods of prevention and control suitable for use in primary health care and to cooperate with Member States to provide training for the control of sexually transmitted diseases (STD). WHO is also requested to obtain extrabudgetary funds to support planning, programming, conducting and evaluating control programmes.

WHA 13.52 instructs WHO to periodically review technical definitions and standards of the Brussels Agreement.

2. Situational analysis

As comprehensive health care systems develop, control of STD becomes feasible and improved planning at global, regional and national levels is justified. Increasingly, STD are recognized as important health problems because of their frequency, complications, and perinatal transmission.

2.1. Uncomplicated STD

STD are extremely common infections, particularly in developing countries. In some developing countries, the incidence of gonococcal infections is estimated to be as high as 3-8000 and syphilis as 500 - 1000 per 100,000 with disease prevalence as high as 10-25% for gonorrhoea and 5-10% for syphilis. Both trichomoniasis and chancroid are as common as gonococcal infections in many developing countries and genital chlamydial infections may be nearly as common as gonorrhoea. As a result, STD-related problems generate 5-15% of health facility attendances in many countries.

STD afflict adolescents and young adults in all social economic strata and are one of the most common precipitating causes for encounters of these individuals with the health care system. That encounter might determine important future attitudes towards personal responsibilities for health promotion and disease prevention. Thus, poor management of STD by health workers leads to missed opportunities for general health promotion as well as persistence of the STD problem.

2.2. Complicated STD

The major adverse economic, social and health effects of STD, however, result from their consequences. Most important among these is acute salpingitis which occurs in 15% of women not treated early in the course of gonococcal infection. At least 20% of these women will become infertile and additional women will have a subsequent ectopic pregnancy. Salpingitis also results from untreated chlamydial infection of the genitalia with similar long-term results. Untreated early syphilis in pregnant women causes abortion or stillbirth in 25% of

18 January 1980

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted or quoted without the agreement of the World Health Organization. Authors alone are responsible for views expressed in signed articles.

Ce document ne constitue pas une publication. Il ne doit faire l'objet d'aucun compte rendu ou résumé ni d'aucune citation sans l'autorisation de l'Organisation Mondiale de la Santé. Les opinions exprimées dans les articles signés n'engagent que leurs auteurs.

such pregnancies, neonatal death in 15%, and congenital disease in 40% resulting in lifelong health problems beginning in childhood or adolescence. Untreated gonococcal infection in pregnant women results in neonatal eye disease and may contribute to post partum endometritis. Acute epididymitis may occur in 15% of men untreated for gonococcal urethritis causing infertility in some. Acute epididymitis is also caused by chlamydial infection and may result in infertility. Urethral stricture formation with obstructive nephropathy and hypertension is a well-recognized late consequence of gonorrhoea. Genital mutilation from chancroid occurs in untreated patients, though its frequency is unknown.

The direct health service costs of STD complications are enormous including those related to attendances for chronic infection, deformities, and infertility and to surgeries for ectopic pregnancies and pelvic infection. Productivity is diminished by the sequelae of congenital infections (blindness, deafness, mental retardation) and by complications of acquired disease. Finally, the social handicap of infertility is extreme in many countries, preventing infertile individuals from filling a customary role in the society. Since STD complications are common among adolescents and young adults, the burdens of these problems may exist throughout adulthood.

2.3. New problems

Many factors contribute to the increasing incidence and spread of STD including rapid urbanization, population movement between rural and urban areas and tourism. These and other factors, such as mass communications, rapid transportation and a monetary economy, disrupt traditional relationships, including those governing sexual behaviour. These factors are expected to become even more important in many countries over the next two decades. As a result, the STD problem is expected to increase at an even faster rate in the future.

During the past 20 years, gonococci have become less sensitive to penicillin treatment. This is particularly evident in countries where antibiotic use is poorly controlled. However, using a large (4-5 mega units) penicillin dose combined with probenecid, to inhibit renal secretion of penicillin, patients can be cured with single-dose treatment. In 1976, however, gonococci were discovered which produced penicillinase rendering them resistant to penicillin. Since this initial discovery, penicillinase-producing gonococci have been found in more than 27 countries and have established high prevalence (up to 30% of all gonococci) in some countries.

2.4 Developmental activities of the STD Control Programme

The STD control programme has emphasized training activities including: regional seminars and workshops (AMRO: 1970-1979; AFRO: 1978 & 1979; SEARO: 1978; WPRO: 1979); national workshops (WPRO: 1977; AFRO: 1979); and preparation of guidelines for laboratory personnel (LAB, BVI), private practitioners (EURO), trainers of primary health care workers (HMD, PHC). The collaborating centres and cooperating laboratories continue their basic and applied research. In addition, operational research on simplified control methods (AFRO: 1977, 1979), therapeutic efficacy (WPRO: 1978, 1979) and simplified laboratory procedures (WPRO: 1978, 1979) have contributed to improved implementation. Finally, collaboration with MCH, HRP and HED has influenced programme plans and development.

3. Objectives

3.1. Long-term

To prevent STD occurrence and consequences to a degree such that STD are no longer a major public health problem.

3.2. Medium-term

3.2.1. To promote national self-reliance in developing or strengthening STD control programmes within comprehensive health services.

- 3.2.2. To reduce pregnancy wastage and neonatal and congenital disease resulting from STD infections.
- 3.2.3. To reduce STD complications, particularly salpingitis causing recurrent disease, infertility and ectopic pregnancies, and especially among adolescents and young adults.

4. Strategies

New information from developing countries provides the epidemiological basis for simplified approaches to control. Diagnostic criteria, applied by auxiliary health workers after limited training, separated patients into groups at high risk for STD and those at very low risk for STD. Treatment was provided to all patients at high risk and to their sexual partners. Adaptation of this approach in one country produced a substantial decrease in disease incidence and was accepted readily by the community and the health staff. These observations suggest that control of STD is feasible even prior to the extension of laboratory diagnostic technology into peripheral health units. As with all new technologies, this simplified approach must be further tested and adapted for local needs, manpower and material resources.

Two approaches to STD control, primary prevention of disease transmission and secondary prevention or limitation of disease consequences, are complementary. Primary prevention limits disease transmission by altering sexual behaviours and by decreasing transmission through prophylaxis use or through reduction in disease prevalence. Such interventions decrease disease incidence and prevent consequences as a result. Secondary prevention limits consequences through treatment of infected partners early in their disease course. Thus, secondary prevention mostly decreases disease consequences, though incidence also decreases since the duration of infectiousness is shortened.

Health education will be essential to reduce disease acquisition. This education effort must identify behaviours which contribute to disease acquisition, attitudes towards control measures and effective methods for altering behaviours. Such an approach must elicit the cooperation of individuals, community leaders and governmental and nongovernmental agencies. Health education is also essential for programmes designed to reduce the consequences of infection. Consequences are the result of prolonged infection, particularly in women. To minimize the duration of infection and therefore the consequences, individuals must promptly seek health care when symptomatic, or otherwise at high risk, and must be motivated to ensure sex partner care. To influence these health behaviours appropriate health education efforts must begin with an analysis of the situation followed by the testing of various strategies.

Selective mass treatment attempts to shorten disease duration, reducing disease consequences and disease transmission. Therefore, treatment must be accessible and acceptable to people at high risk and their partners, and feasible for implementation. Adaptation of current technology to local situations will enhance the capacity of current health facilities to undertake this role. Improved local information and further development of technologies appropriate to local conditions will ensure that treatment resources are used most effectively for case-finding or risk assessment and follow up.

5. Targets

5.1. Operations

- a) Develop appropriate plans for STD control at national, regional and global levels by mid-1980, emphasizing linkage at all levels with other relevant programmes.
- b) Prepare a document for donors by early 1981 which identifies plans and needs for the global, regional and national programmes, in order to obtain extrabudgetary funds for STD control.
- c) Establish a programme Steering Committee by 1981.

- d) Expand programme participation among developing countries resulting in 25 developing country participants by 1983.
- e) Prepare a revised and updated issue of the World Directory of Venereal Disease Treatment Centres at Ports by 1982.

5.2. Training

- a) Develop plans for training of personnel for programme functions by end-1982.
- b) Implement training for all levels of personnel by 1983.
- c) Prepare technical documentation for STD diagnosis, treatment and control.

5.3. Research

- a) Develop plans for operational research necessary for STD programme development by late 1981.
- b) Implement research in at least one developing country in each region by 1981.
- c) Incorporate operational research into all participating programmes by end 1983.
- d) Continue to orient researchers to programme needs.

5.4. Evaluation

- a) Develop methods to evaluate national programmes and implement in participating countries by 1983.
- b) Develop plans to monitor gonococcal susceptibility and implement these in each region by 1983.

6. Output indicators

- 6.1. Number of countries with STD control programmes;
- 6.2. Extent to which perinatal and neonatal STD are reduced;
- 6.3. Extent to which STD complications are reduced;
- 6.4. Extent to which STD morbidity is reduced;
- 6.5. Number of countries with national treatment guidelines for STD;
- 6.6. Number of countries with evaluation systems;
- 6.7. Number of countries with training programmes;
- 6.8. Number of manuals and guidelines distributed;
- 6.9. Number of research activities supported;
- 6.10. Number of countries with operational research support;
- 6.11. Number of collaborating or cooperating institutions;
- 6.12. Extent to which research leads to improved control strategies.

7. Resources needed

Regular headquarters budget allocations for the STD programme have been approximately \$ 110 - 120.000 annually. This funding level is not expected to change substantially in the near future. These funds are adequate to provide limited consultation with regional offices, countries and experts if the current levels of support of basic research and collaborating centres are maintained. Therefore it is proposed to reduce current support of basic research and collaborating centres in 1980 and thereafter to ensure appropriate consultations for development of programme guidelines and to convene the programme Steering Committee. Extra-budgetary and/or regional office funds will be necessary for the health services research, approximately \$ 50.000 in 1980 and \$ 100.000 annually thereafter, and for limited, short-term support to countries, approximately \$ 20.000 in 1980 and \$ 75.000 annually thereafter, primarily in the planning and early implementation phases. Operation of national programmes will basically depend on national commitment and allocation of sufficient national resources.

TABLE 1

STD CONTROL PROGRAMME: OPERATIONS

Activities	1979	1980	1981	1982	1983
1. Develop plans for STD control programmes at national, regional and global levels.	Regions, HQ				
a) Prepare global plans with assistance of regional offices.			Regions, HQ		
b) Assist in preparation or revision of regional or national plans when requested.					
2. Establish a programme Steering Committee.					
a) Formulate programme guidelines, priorities and activities on the basis of Member State and expert advice.		HQ			
b) Assist in obtaining technical and financial support for the programme.				Regions, HQ	
c) Monitor programme progress periodically.				Regions, HQ	
3. Obtain extrabudgetary resources for STD control					
a) Prepare a document identifying plans and needs of participating countries, and regional and global programmes.			Regions, HQ		
b) Present STD programme to potential donors				Regions, HQ	
c) Prepare annual summary of resource use and an update of programme document for donors/potential donors.				Regions, HQ	
4. Expand programme participation among developing countries.					
a) Continue to present the importance and feasibility of STD control to health decision makers.			Regions, HQ		
b) Encourage development of national programme planning.			Regions		
c) Implement national programmes				Regions	
5. Prepare revised World Directory of Venereal Disease Treatment Centres at Ports					
a) Obtain current treatment centre information.			HQ		
b) Compile and publish the directory.				HQ	

TABLE II
STD CONTROL PROGRAMME: TRAINING

Activities	1979	1980	1981	1982	1983
1. Develop plans for training necessary to implement programme.					
a) Identify programme functions at all levels: national, regional, global			Regions, HQ		
b) Identify skills/knowledge necessary for each job and those for which training/retraining is necessary.			HQ	HQ	
c) Develop training strategies.			Regions, HQ	Regions, HQ	
2. Implement training programme.					
a) Identify resources necessary			Regions, HQ	Regions, HQ	
b) Coordinate resources and begin phased implementation.				Regions, HQ	
3. Prepare technical documentation.					
a) Prepare laboratory guides for <u>N. gonorrhoeae</u>	Regions, HQ				
b) Prepare TRS document on treponemal infections		HQ			
c) Prepare TRS document on STD control strategies			HQ, AMRO		
d) Convene expert committee on venereal infections.				HQ	
e) Prepare guide for simplified techniques for viral STD.					HQ

TABLE III
STD CONTROL PROGRAMME: RESEARCH

Activities	1979	1980	1981	1982	1983
1. Develop plans for the operational research necessary for STD programme development. a) Draft research plans with expert advice. b) Revise plans with regional offices to reflect country needs.		HQ Regions, HQ	Regions, HQ		
2. Implement research activities. a) Identify interested countries and researchers through regional offices. b) Prepare details plans of work. c) Obtain necessary support and implement research.			Regions, HQ	Regions, HQ	
3. Incorporate research findings into programmes. a) Evaluate findings and experiences. b) Revise methods for broad implementation and distribute.					Regions, HQ Regions
4. Continue to orient researchers to programme needs a) Maintain dialogue with researchers through meetings, symposia, publications. b) Convene expert advisory groups as necessary		HQ HQ			

TABLE IV
STD CONTROL PROGRAMMES: EVALUATION

Activities	1979	1980	1981	1982	1983
1. Evaluate impact on STD programmes on country health problems. a) Prepare protocols for programme evaluation in three countries specifying methods to monitor cases and consequences. b) Implement protocol. c) Evaluate and revise protocol. d) Implement in all participating countries.		Regions, HQ	Regions, HQ	Regions	Regions, HQ Regions
2. Monitor gonococcal susceptibility trends. a) Develop plans with a region for evaluation of trends. b) Identify resources and needs. c) Implement monitoring system. d) Evaluate monitoring system. e) Implement monitoring system in other regions		HQ, WPRO HQ, WPRO	HQ, WPRO	W P R O	HQ, WPRO Regions
3. Improve reporting of STD.			Regions		