

Sexually transmitted diseases: policies and principles for prevention and care



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The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners - governmental and NGO, business, scientific and lay - to share knowledge, skills and best practice across boundaries.

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WHO/UNAIDS

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Abbreviations

UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
AIDS	Acquired Immunodeficiency Syndrome
STD	Sexually Transmitted Disease
HIV	Human Immunodeficiency Virus

Summary of recommendations

The prevention and care of sexually transmitted disease is an intervention which improves the health status of the population and prevents HIV transmission. Consequently UNAIDS and WHO recommend that high priority be given to the development of programmes directed at this goal.

The objective of this document is to outline the policies and principles for the prevention and care of sexually transmitted disease (STD) to assist Ministry of Health officials who have the responsibility of developing and implementing STD programmes. Although the document is not intended to be a detailed description of activities that may be used in implementation, some areas have been amplified in annexes to serve as models that can be adapted to suit local situations.

UNAIDS and WHO recommend that every country should have a programme for prevention and care of STD which should be integrated or closely coordinated with National AIDS Programmes. The services that form part of the programme should always be delivered with due respect for human rights and maintenance of the dignity of persons with STD.

STD programmes should:

- deliver primary prevention activities (promotion of safer sexual behaviour, condom provision) in conjunction with National AIDS Programmes;
- promote accessible, acceptable and effective case management of persons with STD through public and private health care systems, including first-level health care, using simple algorithms based on syndromic diagnosis;
- include STD prevention and care services in maternal and child health, antenatal and family planning services;
- target acceptable and effective STD care services to populations identified as being particularly vulnerable to infection with STDs, including the human immunodeficiency virus (HIV);
- promote early STD health care-seeking behaviour together with education related to sexual behaviour.

CHAPTER I

1. Background

UNAIDS is the Joint United Nations Programme on HIV/AIDS, a programme cosponsored by six United Nations system organizations UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank. UNAIDS' main focus is to strengthen, influence and exert leverage on the United Nations system, particularly the cosponsors, in order to assist countries to respond effectively to the epidemic of the acquired immunodeficiency syndrome (AIDS). Towards that end UNAIDS is pooling the knowledge, experience and resources of the United Nations system organizations on HIV/AIDS and sexually transmitted diseases (STDs) in order to assist countries to strengthen their response to these diseases.

There is growing recognition of the public health importance of STDs because of the degree of morbidity and mortality they cause and the well established evidence that STDs facilitate the transmission of infection with the human immunodeficiency virus (HIV). This document is the result of collaboration between WHO (a specialized agency of the United Nations with primary responsibility for international health matters and public health) and UNAIDS. It is intended as a guideline to assist countries in formulating policies and principles in programme development for the prevention and care of STDs.

In the past decade sufficient knowledge and expertise have been gathered in the fight against HIV/AIDS/STD to enable effective prevention and care interventions to be established. No single strategy will work on its own and no one nation can work in isolation in the fight against these diseases. A unified approach based on sound principles needs to be implemented globally, regionally and locally in order to have an appreciable impact.

1.1 The significance of STDs

STDs¹ are not only a cause of acute morbidity in adults but may result in complications with sequelae such as infertility in both men and women, ectopic pregnancy, cervical cancer, premature mortality, congenital syphilis and fetal wastage, low birth weight, and prematurity and ophthalmia neonatorum.

The STDs that are caused by bacterial, mycological and protozoal agents have been curable by appropriate antibiotics and chemotherapeutic agents for more than 40 years. In spite of this, such STDs have continued to be a public health problem in both industrialized and developing countries. An equilibrium has been reached, however, in most industrialized countries with low (and often still falling) rates of infection. In contrast, the equilibrium reached in many developing countries has been with highly endemic levels of disease. In many developing countries STDs have for several decades ranked among the top five diseases for which adults seek health care services. Reliable surveillance is rarely in place and the exact magnitude of the problem is frequently unknown. Where data are available they show significantly greater rates in the 15-44 age group.

¹ The term sexually transmitted disease (STD) is used throughout this document to describe sexually transmitted infections and the diseases, complications and sequelae which result. For instance, a sexually transmitted infection, gonorrhoea, results in a disease, cervicitis, which may lead to a complication, salpingitis. Permanently impaired fertility would be a sequela.

Using information on STD prevalence from developing countries (including those in Africa, Asia, Latin America and the Caribbean), official STD prevalence estimates from industrialized countries and WHO archival information from country-specific reports, prevalence rates of gonorrhoea, chlamydia, syphilis and trichomonas infections have been estimated by sex and by region. Regional adult prevalence for 1995 was calculated using mid-year population estimates of adults 15-49 years of age.

Chancroid estimates could not be obtained by using the same method as for syphilis because of the poor understanding of the epidemiology and natural history of the disease and the absence of a good test. An idea of the magnitude of the chancroid problem was obtained on the basis of the ratio of syphilis to chancroid in the previous WHO (Delphi) estimates for syphilis and chancroid, and the 1995 estimates for syphilis. As more published data on chancroid become available these estimates will be revised.

On the basis of this calculation, the total number of curable sexually transmitted diseases per annum is estimated at 340 million new cases, including chancroid. The estimates are illustrated in Tables 1 and 2 below. Table 1 shows the 1995 estimates for curable STDs and Table 2 breaks down the figures by region (excluding chancroid).

Table 1: Estimates of annual cases of curable STDs worldwide, 1995

Disease	New cases
Gonorrhoea	62 million
Chlamydial infection	89 million
Syphilis	12 million
Chancroid	7 million
Trichomoniasis	170 million
Total	340 million

Table 2: Estimates of annual cases of new infections with curable STDs (excluding chancroid) in the 15-49 years age group worldwide, 1995

Region	Total new cases/year (x 1000)	Incidence/1000 15-49 year old
North America	14 000	91
Latin America and the Caribbean	36 000	145
Western Europe	16 000	77
Eastern Europe and central Asia	18 000	112
East Asia and the Pacific	23 000	28
South and south-east Asia	150 000	160
Australasia	1 000	91
North Africa and the Middle East	10 000	60
Sub-Saharan Africa	65 000	254
Total	333 000	113

Identifiable reasons for the continuing unacceptably high rates, in spite of the existence of some STD services in most developing countries, are shown below.

Failure to control STDs

- Low priority has been afforded by policy-makers and planners in allocating resources. Reasons include an association of STDs with perceived discreditable behaviour, failure to associate the diseases with the complications and sequelae, and failure to recognize the size of the problem.
 - Control efforts have been concentrated on symptomatic patients (usually men) and have failed to identify asymptomatic individuals (usually women) until complications develop.
 - Service delivery has often been through specialized STD treatment facilities which provide inadequate coverage and are stigmatizing.
 - Treatment strategies have focused on unrealistic requirements for definitive diagnosis rather than on practical decision-making.
 - Ineffective low-cost antibiotics continue to be used for reasons of economy.
 - There has been little emphasis on educational and other efforts to prevent infection.
 - There has been a lack of authoritative guidance on a rational, practical and well defined package of activities that could be the basis for prevention and care programmes.
-

By virtue of their frequency of occurrence and their potential for morbidity, STDs are a public health priority in their own right. However, it has been the appearance of a new sexually transmitted pathogen (HIV) and the phenomenally rapidly developing pandemic of its fatal complication (AIDS) that has led to urgent reappraisal of STD control.

1.2 STD and HIV/AIDS

In 1990, WHO convened a consultation on global strategies for coordination of AIDS and STD programmes. A consensus statement from this meeting recognized cogent reasons for close coordination or, where appropriate, combination of the programmes (see below).

The relationship between AIDS and STDs

- The predominant mode of transmission of HIV and other STDs is sexual. Other routes of transmission for both include blood, blood products, donated organs or tissue and vertical transmission from an infected mother to her fetus or newborn infant.
 - Many of the measures for preventing sexual transmission of HIV and STDs are the same, as are the target audiences for these interventions.
 - Clinical services for STDs are important points of contact with persons at high risk of both AIDS and STDs, not only for diagnosis and treatment but also for education.
 - Other STDs, when present, facilitate the transmission of HIV, making early diagnosis and effective treatment of STDs an important strategy for the prevention of HIV transmission.
 - Trends in STD incidence and prevalence can be useful early indicators of changes in sexual behaviour and are easier to monitor than trends in HIV seroprevalence or incidence.
-

An additional relationship between HIV and other STDs which has not only been postulated but also experienced by some clinicians in high HIV/STD prevalence areas is the alteration of the natural history of an STD in an individual with coexistent immunodeficiency associated with HIV. The severity of manifestations may be increased, infectiveness prolonged and increased, and the response to conventional treatment regimens reduced.

On account of these proven relationships between conventional STDs and HIV, UNAIDS and WHO have designated the control of STDs as one of the priority interventions for the prevention of HIV transmission.

1.3 STD control

In Mwanza, Tanzania a randomized trial to evaluate the impact of improved STD case management at primary health care level demonstrated HIV incidence over two years of 1.2% in the intervention community, compared with 1.9% in the comparison group. This 40% reduction averted an estimated 254 infections.

This study has demonstrated that STD treatment is an important prevention strategy in HIV infection in a general population.

Lancet, 1995, **346**:530-36.

The main aims of STD control in the past have been:

- to interrupt the transmission of sexually acquired infections;
- to prevent the development of diseases, complications and sequelae.

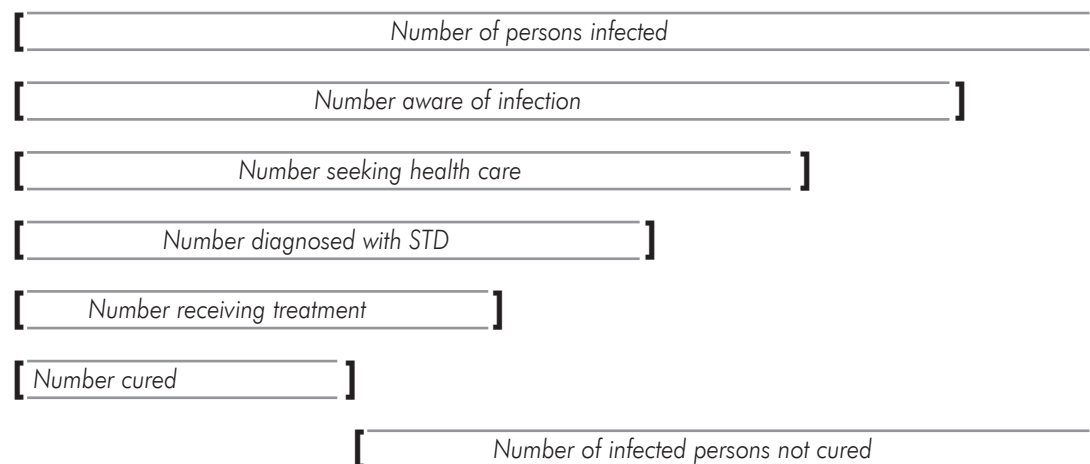
To these must now be added:

- to reduce the risk of HIV infection.

These objectives can be achieved by programmes through primary prevention directed at reducing the incidence of disease, and through secondary prevention directed at reducing prevalence by shortening the duration of disease, thus minimizing the probability of complications or sequelae.

Efforts to strengthen care for persons with STDs largely focus on ensuring that the treatment delivered is effective. This approach is unlikely to have a major impact on the situation in view of the large number of people with infection who fail to obtain treatment. Some of the levels at which individuals may fail to obtain cure through a health system are illustrated in Fig. 1.

Fig. 1. Loss of individuals at selected steps between infection and cure



Note: The ratio of cured to non-cured persons will vary from place to place according to the actions taken by the individual or by the health care service at each step.

The above conceptual model is useful to identify and quantify “leakage” at each step, determining what proportion of patients is lost from treatment at successive points in the process from infection to possible cure. It is anticipated that a simple decision model can be developed to assist countries in setting priorities for improving STD service delivery by identifying the most cost-effective interventions for addressing significant “leakage” at each stage and setting. At each stage of the assessment it must be remembered that factors determining leakage may vary with age and sex. For instance, disease awareness may be lower in the adolescent age group than in the adult population.

CHAPTER II

1. Prevention

The determinants of STD epidemiology are as multifaceted as the approaches to prevention and care should be. The interventions for preventing the spread of STDs and HIV should take into consideration the role of human physiology, human behavioural patterns and sociocultural influences. STD and HIV prevention cannot be addressed by behaviour and barrier methods alone. Other factors such as family units and values, provision of housing to minimize disruption of family life, employment, education, religion, culture, age, gender and so on need to be kept in mind at all times. Although coverage of these determinants is beyond the scope of this document, governments and programme managers need to address these issues in the planning and establishment of STD prevention and care programmes.

1.1 Primary prevention

Primary prevention activities are essentially the same for classic STDs as for sexually transmitted HIV because the primary mode of transmission for both is sexual intercourse. The primary prevention activities and the audiences are the same. It is logical that there should be close coordination between those responsible for AIDS/HIV prevention and those responsible for STD prevention activities. Indeed, it is recommended that there should be full integration.

In primary prevention the aim is to prevent the acquisition of infection and disease. This can be done by promoting:

- **safer sexual behaviour;**
- the use of **condoms** for penetrative sexual acts.

Only primary prevention activities can have an effect on those presently incurable STDs resulting from viral infections.

Primary prevention activities will be the responsibility of integrated or coordinated AIDS/STD programmes. Providing STD clinical care offers an important opportunity for primary prevention by providing education, treatment and effective cure to persons who are, by definition, at increased risk of infection and of transmitting infection. One person's treatment and cure for an STD is primary prevention for a potential contact!

In most countries the National AIDS Programme (NAP) is developing prevention strategies and has interventions already in place. It is important that these interventions include education on STDs. It is probable that this will be mutually beneficial; for instance, education on possible STD complications such as infertility may be persuasive in reducing risk activity for STDs, including HIV. In low AIDS/HIV settings, STDs may seem more relevant to people than HIV.

In some places existing STD programmes have developed expertise in primary prevention which can be shared with the NAP.

Most of the prevention messages will apply to both HIV and conventional STDs but the educational messages which specifically relate to STDs will include:

- information that many STDs can be treated and cured;
- information that early treatment is necessary to avoid complications and permanent sequelae;
- information that symptoms and signs may not be noticed, particularly in women, until complications appear;
- description of recognizable signs and symptoms;
- a list of places where STD advice may be obtained (i.e. basic health care services) and, where available, categorical STD clinics and voluntary counselling centres;
- assurance that wherever services are obtained in the public sector privacy, confidentiality and respect are guaranteed;
- advice on assessing one's personal risk of having acquired an STD, and also that of sexual partner(s). (If the assessment suggests a possibility of STD, attendance for STD advice is indicated).

In order to provide realistic, acceptable and culturally appropriate STD messages it is important to appreciate the knowledge, attitudes and practices of the audience. Simple research will be needed to obtain information from communities including:

- knowledge and perceptions of the importance of STDs;
- health care seeking behaviour;
- constraints to seeking STD care.

1.2 Secondary prevention

Secondary prevention entails the provision of treatment and care for infected and affected persons. The activities should include:

- promotion of health care seeking behaviour directed not only at those with symptoms of STDs, but also at those at increased risk of acquiring STDs, including HIV infection;
- the provision of clinical services that are accessible, acceptable and effective, and which offer diagnosis and effective treatment for both symptomatic and asymptomatic patients with STDs, and their partners;
- support and counselling services for both STD and HIV patients

Knowledge and experience in promoting health care-seeking behaviour for women, men and young people in relation to STDs is limited. UNAIDS and WHO recognize as a priority the development of best methods for different settings in this area. Guidance will be provided as information is acquired. More operational research is needed in this area of STD care.

2. STD care services

The provision of accessible, acceptable and effective care services is a cornerstone of any programme for the control of STDs.

2.1 Access to services

In most developing and industrialized countries, patients will have a choice of services from which to seek STD care. Possible sources are shown below.

Potential sources of STD care

The public sector:

- specialized STD clinics or dermato-venereology clinics;
- outpatient departments of other specialities in hospitals;
- first-level care, including emergency rooms, dispensaries, health centres;
- reproductive health/maternal and child health clinics;
- family planning clinics.

The private sector:

- private STD clinics;
- outpatient departments of private hospitals;
- private physicians providing first-level health care and care in various specialities (dermatology, gynaecology, urology, general medicine etc.);
- pharmacists (where it is legal to dispense antibiotics without prescription);
- nongovernmental organizations through first-level health care, hospital outpatient departments;
- specialized clinics;
- workplace clinic services.

The informal sector:

- traditional healers;
 - pharmacists (where it is illegal to dispense antibiotics without prescription);
 - unqualified medical practitioners (“quacks”);
 - vendors of antibiotics.
-

In ensuring universal access to appropriate STD care programmes, it should be recognized that patients seek care from a mixture of public and private sources. In many countries most STD care is obtained outside the public sector. Planning of a balanced and comprehensive programme will need to consider strengthening any health care providers that are able to provide a quality service.

2.2 Public services

STD services in the public sector should be integrated into existing health care structures such as outpatient departments, first-level health care facilities, maternal and child health clinics and family planning clinics. Attention should be paid to ensuring coverage for women, men and young people.

2.3 Categorical STD clinics

Vertical service delivery through specialized STD or dermato-venereology² clinics is often unsatisfactory in both industrialized and developing countries for reasons that include poor accessibility and acceptability. It is virtually impossible to provide specialized clinics that are easily accessible to all populations in both rural and urban areas. Furthermore, attendance at such clinics may be stigmatizing, particularly for women. Thus, even when the public sector STD services are delivered through a vertical system, there will still be a requirement for STD care through general health care services. If this is not provided in the public sector there will be pressure on private practitioners and the informal sector to provide it.

It is argued that high-quality STD care can be delivered by specialist clinical staff in categorical STD clinics, but inaccessibility, unacceptability and the many human and economic resources required make this an impractical method of service provision for the general population. STD clinics can, however, serve as reference/referral centres (see below).

The role of specialized STD clinics

Although UNAIDS and WHO recommend that routine STD services be integrated into primary health care, clinics specializing in STDs (sometimes called categorical clinics) may be useful in providing primary care in urban settings for specific groups such as sex workers and their clients, migrant workers, truckers, and any other group with poor access to health care.

Additionally, because of a concentration of STD expertise, these clinics can offer referral services for primary care services, hospital outpatient departments, private practitioners etc. In a few selected cases the specialized clinics should also be strengthened as reference centres to provide health care provider training in STDs, epidemiological information (e.g. prevalence of etiological agents within syndromes and antimicrobial susceptibility), and operational research (e.g. studies on the feasibility and validity of algorithmic approaches).

² STD care is still provided through dermato-venereology clinics serving both skin and STD problems. To some extent this reduces the stigma associated with clinics that deal only with STDs. Such clinics often, however, concentrate on treatment of symptomatic, self-presenting patients and ignore public health issues, prevention and case-finding in asymptomatic patients. Dermato-venereology services are common, for example, in Asia and Latin America.

2.4 General health care structures

General health care services, with their potential to reach the whole community, offer large and currently mostly untapped resources for reduction of the STD problem.

A major thrust of programmes should be towards providing access to acceptable and effective routine STD care through general health care services.

In many situations the public health sector is experiencing financial and personnel crises. It is therefore essential that efforts to integrate STD services put as little pressure as possible on existing structures. The recommendations on the provision of acceptable and effective STD care given below are made with this in mind.

Some of the strategies for integration of routine STD care into the general health care structure are explored in Annex 1.

2.5 Referral services

Where routine STD care is provided by the general health services there will be a proportion of patients probably between 5% and 10% who will require referral for specialist care. This secondary care can be provided by categorical STD clinics or dermato-venereology departments where they exist. It is recognized that, for the rural community, access to referral services is hampered by long distances, poor transport services and travel costs. For this reason, decentralization of referral services to be provided in regional general health care facilities is important. Consideration should be given to the strengthening of referral services at intermediate health care levels, such as district hospitals or equivalent.

2.6 Private services

STD programmes usually concentrate on services provided by the public sector. It is important to recognize, however, that in many settings a substantial sector of the market in health care is captured by the private sector. This is unlikely to change significantly until the long-term goal of overall strengthening of health systems infrastructure is achieved. This influential private sector, which in many settings may provide more than 70% of STD treatment, should not be ignored. It is important to improve as far as possible case management at all sources of care.

The provision of treatment guidelines, training of the respective health workers, availability of information on effective drugs, and information on condom provision and use will need to be addressed by the STD programme.

3. Effective STD care

STD care must be of high quality at the first point of contact with a patient with an STD. The provision of high-quality care is not unattainable, even for programmes with limited financial resources. Furthermore, assuring quality of care is more likely to result in a more efficient use of resources because the public and personal health benefits of interventions will be greater.

Whatever choice an individual makes for obtaining advice, whether in the public or private sector, the STD programme should ensure that appropriate and effective case management is available.

STD care, whether being provided in a resource-rich or resource-poor country, should aim to provide the same comprehensive case management that includes diagnosis (syndromic or laboratory-based), curative treatment, reduction of risk-taking behaviour and the treatment of sexual partners. To ensure effective STD care, the following factors need to be put in place.

3.1 National guidelines for case management

The objective of case management of patients with STDs is:

- to make a correct diagnosis;
- to provide effective treatment;
- to reduce/prevent future risk-taking behaviour;
- to advise on treatment compliance;
- to promote and provide condoms;
- to ensure sexual partners are notified and appropriately treated.

In order to promote consistent quality case management, guidelines based on identified patterns of infection and disease should be developed and circulated to all health personnel offering STD care. The preparation of such guidelines may be a task for a National STD Technical Advisory Committee, while their adaptation to the circumstances and capabilities of different health care facilities and providers may be undertaken by programme staff.

UNAIDS and WHO strongly recommend the adoption of the **syndromic diagnosis and treatment** of STDs.

Syndromic case management is based on classifying the main causative agents giving rise to a particular clinical condition (syndrome), such as the syndrome of urethral discharge in men. It then uses flowcharts which help the health service provider reach a diagnosis and decide on treatment. The treatment covers all the important causes of the syndrome.

National guidelines for the management of a patient with STD must be produced and distributed. The guidelines must be comprehensive but easy to follow. They should address the issues of diagnosis, treatment protocols, partner notification, health education and condom provision. The guidelines and rationale for syndromic treatment of STD are explored further in Annex 2.

3.2 Training of health care providers

Guidelines alone are not enough. Training in STD case management for basic-level and other health care workers providing STD care is key to the success of an integrated service. Activities may include:

- on-the-job training;
- training within basic courses;
- post-basic courses utilizing venereology expertise concentrated in those specialized clinics selected as referral/reference centres;
- training of trainers so that the health workers are encouraged to train their colleagues (“cascade” principle);
- distribution of national guidelines in a form that can be understood and used without special additional training.

Detailed guidelines on training strategies are discussed in Annex 3.

3.3 Availability of the means for consultation and examination

The feasibility of providing case management must be assured within any health care setting which offers STD care, whether in the public or private sector.

An essential requirement will always be privacy for consultation. Depending on the source of care there may also be need for:

- examination tables or couches with adequate lighting;
- consistent facility supplies as appropriate (e.g. gloves, syringes, specula, sterilization equipment and laboratory supplies where appropriate).

The UNAIDS and WHO recommendations on case management minimize requirements for the delivery of STD services so that effective care can be provided even in settings with meagre resources.

3.4 Consistent availability of appropriate drugs

Therapeutic protocols for treatment of specific organisms responsible for syndromes will form part of the guidelines on case management produced by the National STD Technical Advisory Committee. Having reviewed the antibiotic susceptibility of prevalent organisms, the committee should recommend drugs that are effective in that particular country to the national drug policy-making bodies.

The availability of effective treatment is an absolute requirement in an STD control programme.

Coordination with the Essential Drugs Programme is necessary to ensure that the required drugs are included in the country's essential drugs list and that there is timely and adequate delivery. Coordination must be ongoing so that the drug list can be modified as changes in the antibiotic sensitivity of STD organisms are recognized.

For effective treatment to be provided, the drugs selected as part of the national guidelines must be consistently available. This will be a major budget item in any public setting, and responsible authorities, whether at national, state/provincial or district level, are likely to be reluctant to commit large resources without any return. In many countries patients are accustomed to paying for drugs, or at least making some contribution, and a policy of cost recovery may be considered as an option.

Drugs for effective treatment must also be available and used in the private sector. Training to encourage their use will be necessary.

3.5 Consistent supplies of condoms

The means by which national condom procurement and distribution is carried out in the public sector may differ from country to country. It will be the responsibility of the AIDS/STD programme to ensure that the method is efficient and adequate. Condoms should be available through all regular health care services and, therefore, to patients with STDs. Additionally, the AIDS/STD programme will need to ensure that condoms are available in categorical STD clinics and via any outreach services to target groups and the general population.

The STD programme should also facilitate the introduction of social marketing mechanisms in order to supplement and increase the availability of quality condoms to the public.

3.6 Acceptable STD care

However accessible and effective services may be, they are valueless unless potential patients are prepared to use them. The acceptability of services is likely to be greatest when care is integrated into routine health services; care is less acceptable when provided through dermato-venereology departments, and is poorest when delivered through specialized STD clinics. Examples of the constraints on acceptability, some of which overlap with access and effectiveness, include:

- inconvenience of opening times and long waiting periods;
- poorly maintained and unattractive physical facilities;
- judgemental staff attitudes;
- poor staff communication skills;
- stigmatization of those seeking advice about STDs;
- failure to relieve symptoms;
- unaffordable charges;
- lack of privacy and perceived lack of confidentiality.

Constraints on acceptability of STD clinics

Inconvenient opening times:

Men and women usually find it difficult to ask for time off work to seek treatment for STDs. This results in delay in seeking treatment or in self-medication. Programme planning should explore ways in which integrated STD services can overcome such difficulties.

Judgemental staff attitudes:

Where necessary retraining of health workers should be undertaken in order that STD care is given without undesirable judgemental and moralistic attitudes. Such attitudes can be a deterrent to seeking health care, especially for adolescents and unmarried young women.

Poor staff communication skills:

It takes special effort and a sense of awareness to appreciate the different disease perceptions of adults and adolescents. Communication needs to suit the audience for which it is intended and health workers should be aware of this. Where necessary, training of health workers should be started to improve communication skills, especially regarding STD care in adolescents

Stigmatization:

Stigma originates in societal values and can be increased by institutional systems. STD services for commercial sex workers, for instance, may stigmatize the very people they are meant to serve. An integrated service that caters for the needs of sex workers along with other population groups will help to destigmatize STDs.

Unaffordable charges:

Programmes must examine which population groups are affected by user fees, even if these are not exorbitant. Provision must be made to ensure means of providing care to such groups. This should not apply only to the provision of STDs but should encompass other health needs in such groups, (e.g. unwanted pregnancy, substance use).

Lack of privacy and confidentiality:

The very nature of STDs and some of the legal aspects of treating STDs in minors may give the impression of eroding the principle of confidentiality. Confidential matters need to be handled in an environment of privacy. STD services should be seen to provide both privacy and confidentiality. This is especially important for adolescents.

3.7 The role of the laboratory in STD services

Cost and inconsistent availability of supplies, support and expertise severely limit the practicality and availability of laboratory investigations in low-resource settings. For some sexually transmitted organisms, even in the presence of good resources, laboratory diagnosis is not reliable. For instance, *Haemophilus ducreyi*, which causes chancroid, is a fastidious bacterium which cannot easily be cultured. Tests for *Chlamydia trachomatis* are expensive and the collection of specimens is invasive and unpleasant for both men and women. The diagnosis of primary syphilis requires a special microscope and training, and even in the best hands the spirochaete may not be visualized.

For these reasons and others mentioned above, the case management guidelines recommended by UNAIDS and WHO (discussed in Annex 2) allow effective STD care with little or no recourse to laboratory support. Laboratory support should be confined to situations where it is essential for clinical or programmatic decisions, as in the following tasks:

Programme management

- training of health workers and laboratory personnel;
- epidemiological and microbiological survey;
- antimicrobial susceptibility monitoring;
- validating flowcharts;
- sentinel surveillance.

Patient management

- for syphilis case-finding in all pregnant women;
- diagnostic confirmation of selective cases at referral centres.

Research

- development of new diagnostic tests;
- development of new drugs;
- clinical research.

It will be the responsibility of the STD programme manager to assess the capacity and requirements for laboratory support in the area of STDs.

Any surplus laboratory capacity is best directed towards diagnosis and case-finding of gonorrhoea and chlamydia in women, for whom syndromic diagnosis is least sensitive and specific.

4. Partner notification

Partner notification should be considered whenever STD is diagnosed in any setting.

Partner notification comprises those public health activities in which sexual partners of individuals with STD are notified, informed of their exposure and offered treatment and support services. To achieve success in limiting the transmission of STDs, partner notification should aim to:

- treat all sexual partners (at least within the previous three months) of the STD patient;
- treat the partners for the same STD (and any additional ones found) as in the index patient.

Partner management must also observe the principles of confidentiality and non-compulsion. It is important to address the issue of gender in partner notification. The implications and impact of notifying a partner may be different if the index patient is male rather than female. The necessary support and counselling needs should be provided.

4.1 Approaches to partner notification

There are two approaches to contacting sexual partners. Each approach can be examined and adapted to a particular setting. Provider referral is a costly exercise and will usually not be successful if it is perceived to threaten patient confidentiality. UNAIDS and WHO recommend patient referral after adequate education and counselling.

Patient referral

In this option the patient is given the responsibility, after adequate health education and counselling, to contact sexual partners and ask them to present for treatment.

Provider referral

This is the situation where the patient is asked to provide the names and addresses of the partners to the health worker so that members of the health staff can contact the partners. The health worker asks the partner to present for treatment.

Partner notification is discussed further in Annex 2.

5. Additional activities for STD prevention and care

As with other communicable diseases, the prevention of STDs cannot be achieved solely by the provision of care to those individuals self-presenting to health facilities.

It is important to identify and provide treatment to infected individuals who do not spontaneously seek health care. Many of these will be women in whom symptoms may be absent or minimal, or who do not recognize the significance of the symptoms or, indeed, who ignore the symptoms for reasons of embarrassment, fear or stigmatization. Additionally, in some countries men who have sex with men, particularly bisexual and non-identifying homosexual men, may fail to seek and obtain treatment for similar reasons.

Young people may have particular difficulty in accessing health care facilities. This may be due to financial difficulties, difficulty in communication or the attitudes of health care workers. Similarly, women in general may experience difficulty in communicating about STDs. In some cultures if a woman has an STD this implies inability on her part to satisfy her man who has in turn sought sexual satisfaction elsewhere. The woman, therefore, may blame herself for her infection or feel embarrassed to present for STD care.

There are several approaches which should be incorporated into an existing STD programme. These are discussed in the following six subsections.

5.1 Promotion of appropriate health care-seeking behaviour

Development and strengthening the provision of STD care needs to be accompanied by the education of potential service users on the availability and advantages of the services. This should take into account the reasons why many individuals fail to seek early treatment. Some may not seek treatment at all until the disease is identified when they attend a medical service for another unrelated condition.

Some of the commonly encountered reasons for not seeking health care are:

- ignorance of STDs and possible outcomes;
- absence of signs or symptoms, especially in women;
- lack of knowledge of where to seek health care;
- reluctance to discuss sexual matters;
- fear that others will find out (especially in the case of adolescents);
- fear of a judgemental approach by the health care provider;
- reluctance of women to be examined, particularly by a man;
- lack of confidence in public sector services.
- laws and restrictions (some of religious or cultural origin) on health care for minors.

Although this forms a basis for programmes to react to and institute intervention strategies, a local understanding of the reasons for lack of appropriate health care-seeking behaviour should be explored by STD programmes. This will enable suitable intervention strategies to be developed. UNAIDS and WHO are giving high priority to the development of approaches to improve health care-seeking behaviour.

STD health care-seeking behaviour

Client motivation

The need for STD health care-seeking behaviour may be appreciated by an individual because of personal risk assessment:

- recognizing risks of infection resulting from an individual's own sexual behaviour;
- recognizing risks resulting from a partner's sexual behaviour.

The importance of early recognition of sexually acquired diseases and obtaining treatment needs to be emphasized in the educational component of all AIDS and STD programmes.

Methods of promoting health care-seeking behaviour include:

- national and local media campaigns;
 - education for youth in and out of school;
 - community initiatives (e.g. peer education initiatives, clubs);
 - education in health facility waiting areas;
 - education as part of the STD clinical consultation;
 - education targeted at populations with behaviours putting them at increased risk (e.g. sex workers and clients);
 - workplace AIDS/STD education programmes.
-

Messages on health-seeking behaviour alone may not be enough to motivate people to use clinical services for STD. Other complementary measures will need to be put in place concurrently. Most important among them is improvement of the provision of health services.

STD health care-seeking behaviour

Provision of services

Personal risk may be appreciated by patients and the need for treatment accepted, but without appropriate services patients may not seek treatment. It is important for the STD programme to embark on a campaign of:

- improving attitudes of health care workers towards patients with STDs;
 - improving the clinical services and the provision of drugs;
 - making health centres accessible and acceptable for patients;
 - integrating STD services into other health disciplines to minimize stigmatization.
-

5.2 Targeting of services

Individuals with multiple sexual partners are particularly vulnerable to acquiring STDs and thereafter transmitting infection to further sexual partners. The members of such “core groups” are likely to play an undue role in the maintenance of high rates of STDs and it is expedient to target STD services and prevention activities at them.

People in these core groups may well be reluctant to seek STD care or to reveal their risky behaviour. One of the coordinating activities of the AIDS and STD programmes will be to obtain the information necessary to plan useful interventions, such as:

- What and where are the vulnerable groups?
- What is the STD health care-seeking behaviour of these populations?
 - Where do they seek care?
 - What are the reasons for their choice?
 - What are the constraints to receiving health care?

Examples, though not exhaustive, of people in vulnerable categories are given below. Depending on the answers from the basic research, some of the possible interventions may be as shown in the second one.

Potential vulnerable groups

- Sex workers (prostitutes) - female and male
 - Identifiable groups of clients of prostitutes, such as:
 - military personnel;
 - long-distance truck drivers;
 - tourists/businessmen;
 - seafarers;
 - migrant workers, refugees, displaced persons;
 - single men in urban settings.
 - Men who have sex with men, such as:
 - self-identifying homosexual men;
 - bisexual and covert homosexual men.
 - Substance users, e.g. injecting drug users and their sexual partners (particularly of importance where there is a high HIV level amongst injecting drug users and/or where prostitution is used to support a drug habit).
 - Prisoners, especially where juveniles are mixed with long-stay inmates.
 - Young people (age 10-24 years), especially when out of school and unemployed (e.g. street children).
-

Targeted STD care provision

- STD care services directed specifically at vulnerable (core) groups:
 - integrated services designed to be acceptable to sex workers, young unmarried women and individuals practising anal or oral sex (e.g. convenient hours, nonjudgemental staff approach, fringe benefits such as child health care, and advice on legal and social services);
 - services conveniently accessible for client groups;
 - voluntary counselling and treatment centres.
 - Improved existing services:
 - increased sensitivity to vulnerable (core) group existence;
 - training staff in interpersonal skills (e.g. reduce judgemental attitude towards women with multiple sex partners, men who have sex with men, substance users);
 - explore the possibility of extended opening hours for clinics.
 - Activities for accelerated reduction in STD rates:
 - epidemiological/mass or selective mass treatment;
 - periodic examination and treatment of identifiable vulnerable (core) groups.
-

The case management delivered to vulnerable groups will depend on the source of care. It is recommended that the national guidelines recommended by the STD programme be promoted and followed in both private and public health facilities.

5.3 Case-finding

Case-finding is the testing for STD in individuals seeking health care for reasons other than STD. A very important application of case-finding is the provision of STD care in maternal and child health and family planning services. Such services provide an opportunity to offer STD care in acceptable and nonjudgemental circumstances and also enable health care providers to assess the probability of infection in women who are unaware of having been at risk of infection. Supplementing routine STD care provision by the integration of STD services in such gender-specific services should receive careful consideration by any STD control programme.

An example of case-finding which should always receive high priority is the routine testing of pregnant women for syphilis at antenatal clinics and maternity units. Treatment of those with positive syphilis serology prevents long-term disease in the mother and congenital infection in the child. This control of maternal syphilis has been shown to be highly cost-effective. Sexual partners should also be offered treatment, bearing in mind the implications of partner notification where the index patient is female. Support and counselling services, where necessary, should be provided.

There is a particular potential for infringement of individuals' rights in screening activities. Confidentiality must be preserved (e.g. information obtained at screening should not be passed to the administration or to employers). Employment should not be denied unfairly and unjustly. Provision should be made for counselling and treatment, and advice given on the need for treatment and where it can be obtained.

Apart from during antenatal care, case-finding and screening are optional services to be implemented where resources are available.

5.4 Screening

Screening is the testing for STD in individuals not directly seeking any health care. Donors of blood, tissue and semen should be screened at least for syphilis, HIV and markers of hepatitis B virus infection in order to protect the recipient. This is the responsibility of the blood transfusion services rather than the STD programme but coordination will be necessary in order to ensure that donors found to be infected can be offered appropriate case management.

Although the potential exists for screening for curable STD of populations such as military personnel (during routine medical examinations) or employees (as part of occupational health schemes) and other groups, UNAIDS and WHO recommend that where this is contemplated it should be done with due regard to confidentiality and safeguards for human rights.

5.5 STD in children and adolescents

WHO has defined adolescents as persons in the 10-19 years age group, while youth has been defined as the 15-24 years age group. "Young people" is a combination of these two overlapping groups covering the range 10-24 years (*The health of youth: Facts for action. Youth and Nutrition, Document A42/Technical Discussions/2*. Geneva: World Health Organization - WHO, 1989a).

Provision of care for STD in for sexually active adolescents and sexually abused children should be on the agenda of an STD control programme.

There is increasing evidence to indicate that STDs are a serious problem among adolescents in both urban and rural environments. The magnitude of the problem is not fully realized, especially in developing countries, because of lack of sufficient studies in this population.

A recent WHO review of adolescent reproductive behaviour has demonstrated that in many developing countries there are particularly high rates of sexual experience and childbearing among adolescents. These same behaviours are associated with the acquisition and transmission of STDs.

Age-specific data from many countries indicate that the peak incidence of STDs is seen in the 15-29 year group. Among sexually active adolescents, the incidence of infection is highest in the youngest. Population-based surveys among open communities and student populations in Africa and the Middle East provide evidence that the prevalence of gonorrhoea is higher among persons aged 15-29 years, and that within the 15-29 year age band the prevalence tends to be highest among those aged 15-19 years (*Sexually transmitted diseases amongst adolescents in the developing world: A review of published data*. Geneva: World Health Organization, 1993 - WHO/ADH/93.1).

However, services for prevention and care of STDs are frequently not accessible, acceptable or appropriate to this section of the population. It is essential, therefore, that adolescents are recognized as an important target group for STD prevention and care

programmes. STD programmes should put in place mechanisms to address the issue of curable and non-curable STD in children and adolescents, with particular attention to those below the legal age of majority. Governments should have clear policies to guide programme planning in the provision of STD care in individuals below the age of majority, as well as in sexually abused male and female children. Mechanisms for counselling should be explored and put in place. It should be borne in mind that the parents may also be in need of education and counselling.

Given the legal framework within which one has to work, differing cultural norms, different levels of infrastructure for health service provision between areas, and the different categories of adolescents, more local initiatives are needed to address the provision of STD services for this group.

5.5.1 Child abuse, rape and STDs

Child sexual abuse is becoming a serious social and medical problem requiring the attention of policy-makers, educators and other professionals who deliver social and health services. The treatment of child victims is an important aspect of child health care in both industrialized and developing countries.

Health care workers should be made aware of the possible link between sexual abuse and STDs in children and adolescents. Conversely, children and adolescents with STDs should not be assumed to have acquired infection from nonsexual contact.

In cases of rape, guidelines should be provided on the steps to take (e.g. what specimens to take in readiness for possible future legal proceedings). Collection of specimens should be performed skilfully in order to avoid or minimize trauma to the child.

5.5.2 Strategies for control

Access to information

- Information, skills and services which can help children and adolescents understand their sexuality and protect themselves from unwanted pregnancies, STD/HIV and subsequent risk of infertility and untimely death are important.
- Provision of sex education and negotiating skills before adolescence and puberty ensures that information is passed on before young people become sexually active. Mechanisms should be put in place to address groups both in and out of school. In some societies this is particularly important for girls.
- Information and skills have to be provided in different settings in order to reach different sets of young people and should take gender issues into consideration.

Access to services

- Existing clinical services should be adapted to make them more child-friendly and adolescent-friendly. This will certainly involve retraining of health workers to change attitudes and mode of delivering health services. Health workers will need to be provided with information and knowledge to refer young people to other settings that can assist in building up interpersonal skills.

- Existing treatment protocols will need to be evaluated to validate their efficacy in identifying infection, especially in female adolescents of whom up to 95% may be asymptomatic with chlamydial infection. The questions currently recommended for risk assessment score are inappropriate and will not identify positive risk in adolescents. More research is necessary among adolescents to identify more sensitive methods of establishing positive risk for STD infection.
- Availability of drugs is important for the treatment of young people. If young people leave the clinic with a prescription to purchase medicines they are unlikely to obtain them because they may have to ask parents for the money. Furthermore, it is particularly important that education on compliance is given in full.
- Access to barrier methods (condoms) to protect from unwanted pregnancies and infection should be facilitated and funded. The provision of such methods encourages safer sex in those already sexually active and has not been shown to promote sexual promiscuity.
- In order for services to be trusted and used by young people, they must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent.

Policy on abused children

- There should be a clear policy, or guidelines for health workers to follow, on the management of children or adolescents who have been sexually abused. Such policy and guidelines should be drawn up in collaboration with the country's legal department and the Department of Social Services or equivalent.
- The guidelines should outline the role of the health care-giver, the role of the child's parent or guardian, counselling and follow-up services, and the legal aspects of child abuse.

5.6 Confinement and STD services

People in confinement, such as those in prisons, psychiatric hospitals, refugee shelters and children's homes should have access to health services and preventive medicine. The health services should provide prevention messages against STD/HIV and the means to protect against acquiring or transmitting infection. It must be borne in mind that people in confinement interact not only within their area of confinement but also, when later no longer confined, with the general population.

CHAPTER III

1. STD programme management

The activities required for the control of HIV/AIDS and those required for the control of STDs are complementary. It is recommended that AIDS and STD programmes should be either fully integrated or, if separate, should have coordinated planning or integration of selected activities (see Annex 4).

1.1 The role of programme management

The exact form of an STD programme will depend on the general health care system. The existence of a clearly defined management structure, however, is crucial to the success of STD control. It is recommended that there be a specific budget allocation. The implementation of programmes should be decentralized as far as possible, but the areas for which the central management structure will remain responsible may include:

- political advocacy;
- national policy decisions, including selection of priorities in the implementation of activities;
- allocation of resources for prevention and treatment of STDs;
- planning and guidance on routine service delivery and necessary referral systems;
- ensuring sustainability of services;
- planning of specific activities for STD control (e.g. interventions targeted at vulnerable groups);
- developing and monitoring training;
- developing and distributing guidance on case management;
- ensuring that recommended drugs are available;
- supervision of coverage and quality of services;
- situation analysis, and ensuring that essential operational research is performed;
- surveillance systems;
- evaluation of the programme.

Thus, ideally, the role of the national programme management involves promotion, implementation, planning and coordination.

1.2 National STD Technical Advisory Committee

There should be a National STD Technical Advisory Committee to provide advice to the STD programme manager on technical/scientific and policy-making issues related to the control of STDs. This committee should include expertise on the clinical care of STDs, women's issues, public health, microbiology, epidemiology, HIV and AIDS, behavioural sciences and health administration. Representation of academic and professional organizations, the community and nongovernmental organizations that provide STD care should also be considered.

2. Supervision, monitoring and evaluation

2.1 Supervision

Supervision is a two-way process by which the manager observes and keeps in touch with events, which enables the implementer to give feedback, discuss and be reassured and supported.

2.2 Monitoring

Monitoring is an ongoing process used to assess programmes, make modifications and improvements, and detect shortfalls. Supervision and monitoring are normally done concurrently.

2.3 Evaluation

Evaluation is the process of examination of the system and activities and estimation of the degree of achievement in meeting set goals.

The management and supervision mechanisms of the health care system at district level will include the STD services integrated into the general health structure. Mechanisms should be in place for feedback from facilities to districts and further to the central management of information such as active reporting of data on cases and epidemiology.

Monitoring and evaluating the extent to which STD control is being achieved provides essential information for further improvement of both STD and HIV programmes. The monitoring and evaluation process should answer the following questions:

- Is the programme appropriate?
- Does the package of programme activities match the environment in which it is implemented?
- Are specific activities implemented correctly and in time, do they provide adequate coverage, and are they within the budget?
- Are the activities achieving the objective?

This area is further discussed in Annex 5.

ANNEX 1 - INTEGRATION OF STD SERVICES INTO THE GENERAL HEALTH CARE SYSTEM

Definition of integrated health services

Integration can be defined in both functional and organizational terms. In functional terms it is a series of operations concerned with bringing together otherwise independent administrative structures, functions and mental attitudes in such a way as to combine these into a whole. In organizational terms, integration means bringing together those services necessary for the health protection of a given area and provided under a single administrative unit, or under several agencies, with proper provision for their coordination (WHO Technical Report Series, No. 295, 1965).

In practical terms integration of health services is defined as the process of bringing together common functions within and between organizations to solve common problems, developing a commitment to shared vision and goals and using common technologies and resources to achieve these goals (WHO Technical Report Series, No. 861, 1996).

Integration is not a strategy to fall back on when vertical programmes run out of funds, nor is it achieved by adding to the responsibilities of service providers without a corresponding increase in resources. Equally, integration does not mean that specialized disciplines, programmes, personnel and services will be abolished. It does not necessarily mean that all services will be provided by multi-purpose workers.

Given the range of epidemiological, historical and organizational situations, no standard blueprint can be made for the introduction of STD care and prevention into general national health care systems. Nevertheless, experience with programmes that address other health care problems makes it possible to identify some guidelines, as follows:

- Start from existing primary health care structures and, more specifically, from those that function reasonably well. Far from proposing pilot approaches it is essential that, during the advocacy phase, integration of an STD package into the general health care system should be carried out under favourable conditions. It makes no sense to integrate an STD package into a virtually non-existent or poorly functioning structure. Where a health district functions reasonably well, the chances are that integration of an STD package will go smoothly, produce results and act as an incentive and model for other districts.
- As far as possible make the STD package simple so that it can be easily incorporated into the everyday routine of health facilities. The less the routine is disturbed, the less resistance there will be from staff.
- First integrate the STD prevention and care package. Once routine STD prevention and care is functioning it is possible to move on to the second stage, with specific activities directed at case-finding, outreach to high-risk core groups, etc.
- Devise a concrete strategy to overcome resistance that is likely to be encountered, particularly since work overload and low salaries are probably constraining factors. Two common types of resistance are:
 - resistance of health workers based on fear of the unknown, prejudice and reluctance to take on further responsibilities (health education and skills development must start with health care workers);

—resistance of STD specialists based on fear of loss of quality and fear of loss of their power position (this can be overcome by demonstrating the usefulness and possibilities of decentralization, and by providing specialists with a clear task description in the new system (referral, quality control, training, operational research and surveillance).

- Incorporate a system of follow-up and supervision from the very beginning. Simply making STD prevention and care possible is insufficient encouragement to deliver is also required.

Politicians, planners and medical advisers may find it attractive to concentrate on high-visibility specialized services for prevention and care programmes. Any development of specialized structures such as referral laboratories, high technology investigations, categorical STD clinics or hospitalization facilities should meet the following criteria:

- the tasks of these specialized structures are essential and cannot be undertaken by existing facilities as they are, or after upgrading;
- no new needs are created before the basic established needs are met;
- investments in these specialized structures are not at the expense of the support required to integrate STD care in the general health services;
- the comparative advantage of specialized structures is valid in both the long term and the short term.

Experience shows that if such criteria are not met, specialized structures divert resources from the strengthening of the primary health care network and are difficult to dismantle even if they prove ineffective, inefficient or counterproductive.

The sustainability of STD activities

Ensuring sustainability of improved STD services should be a priority for the central STD programme management.

Some reasons for low sustainability of public health interventions are:

- weak economic and political commitment;
- weakness of health institutions;
- centralization and lack of local participation in planning and management;
- low salaries for health professionals;
- costly vertical programmes.

Means of promoting sustainability include:

- addressing broader development issues;
- strengthening institutional development;
- increasing involvement of communities;
- taking local circumstances into account;
- decentralization of STD management;
- innovative financing schemes that explore increased cost recovery from the users of the health system.

Introduction of cost-recovery mechanisms should not discriminate against STD patients and should not ignore people's needs.

ANNEX 2 - CASE MANAGEMENT OF PATIENTS WITH STD

The objectives of case management

The objective of STD case management is to provide treatment, obtain cure, reduce infectiveness, reduce or prevent future risk-taking behaviour, and ensure that sexual partners are appropriately treated. This requires that the patient receives:

- a correct diagnosis;
- effective treatment;
- education and counselling on risk reduction;
- advice on treatment compliance;
- condoms (male and/or female);
- encouragement to notify sexual partners;
- clinical follow-up where appropriate.

The national programme management will need to arrange for guidelines on case management to be developed that are appropriate to the capabilities of the various sources of STD care. This will be a task for the National STD Technical Advisory Committee, and the programme staff will have responsibility for distributing appropriate guidelines to the different kinds of health care workers. For instance, different versions of the guidelines will be required for referral clinics with laboratory support, first-level health services using syndromic approaches, and pharmacists advising patients on appropriate referral. These national guidelines will ensure consistent and effective case management wherever and whenever a patient may seek care.

Diagnosis

The ideal would be etiological diagnosis identifying the causative infectious agent of the disease. However, this depends on expensive and, in most situations in industrialized and developing countries, impractical laboratory support with results that usually are not available during the patient's initial visit. Thus a decision on treatment needs to be made either without the results or at a follow-up visit. Many patients fail to come back, however, and remain untreated or go to a private provider.

A common alternative is for the health worker to make an educated guess based on previous experience and clinical acumen. Studies have shown that even highly experienced STD specialists using this system of clinical diagnosis will fail to make the correct diagnosis and/or will miss concurrent infections in a significant number of cases.

It is very strongly recommended that flowcharts for national guidelines intended for routine use by clinicians, other than those in specialist clinics, be based on syndromic diagnosis.

Syndromic case management is based on identifying consistent groups of symptoms and easily recognized signs which constitute a definite syndrome. Syndromic case management algorithms/flowcharts are then used to guide treatment.

In order to maximize its value, the syndromic approach needs to be backed by scientific data and supported by appropriate health education and health care-seeking behaviour by the clients.

The following scientific and epidemiological data are needed:

- local etiologies of STD syndromes;
- drug susceptibility of the etiological organisms;
- local prevalence of STD.

Syndromic case management is better than the clinical or laboratory-based approach in that patients receive immediate treatment, thus interrupting the chain of infection early, and without the expense of laboratory costs.

The algorithms for urethral discharge in men and genital ulcer in both men and women have been evaluated and have been shown to be valid and highly sensitive. From a public health perspective a high sensitivity of a diagnostic approach is more important than a high specificity.

The algorithm for vaginal discharge is weak in detecting the presence of cervicitis (gonorrhoea and/or chlamydial infection), and studies are in progress to improve the sensitivity of this algorithm. For the present it is the best available, and the alternative of laboratory diagnosis is not feasible in most resource-poor settings. Even where laboratory facilities are available, most women with cervicitis are asymptomatic and would not benefit from the presence of a laboratory. Research is needed to develop a simple diagnostic tool for detecting asymptomatic sexually transmitted infections, especially in women.

A strategy which promotes and improves on partner notification for men presenting with urethritis and genital ulcers will expand STD services to more asymptomatic women. Partner notification should, therefore, be strengthened and local initiatives should be put in place to maximize its benefits.

Treatment

The availability of effective drugs is an essential requirement for effective STD services. Ideally STD treatment should offer a cure rate of at least 95%. Unfortunately, the low-cost antibiotics and chemotherapeutic agents which initially provided high cure rates often no longer do so, partly owing to inappropriate use and self-medication and partly owing to the adaptability of the organisms themselves. Treatment regimens should use currently effective, and sometimes more expensive, drugs in a rational manner so as to delay, as far as possible, the emergence of organism resistance.

Mainly for reasons of cost some programmes accept regimens offering 85-95% cure rates, with the intention that failures be treated with second-line drugs of higher efficacy. Not only may this policy increase the prevalence of resistant strains and rapidly limit the usefulness of these drugs, but it may also undermine secondary prevention through the provision of STD care by eroding confidence in public services. Such a policy relies on patients presenting for the second-line treatment when the first-line treatment fails. Experience suggests that this frequently does not happen, particularly where access to services is limited by distance or long waiting times. People whose symptoms do not improve may well seek care in the private or informal sectors and may also do so for future episodes of the disease. There is also a risk of sub-curative effects leading to carrier states and transmission to sexual partners.

One way in which this kind of two-tier drug policy is sometimes applied is to provide less effective drugs at the peripheral health care level and the most effective, and usually more expensive, drugs at referral level. UNAIDS and WHO do not recommend this system since it may erode confidence in the public sector. All drugs used to treat STDs in all health care facilities should have an efficacy of more than 95%.

While the cost of newer drugs is substantial, it must be weighed against the cost of inadequate treatment (which includes complications, relapse, further transmission, the development of antimicrobial resistance and, very importantly, increased transmission of HIV).

Therapeutic regimens for treatment of specific organisms within syndromes will form part of the national guidelines on case management produced by the National STD Technical Advisory Committee. After reviewing the antibiotic susceptibility of prevalent organisms, this committee should recommend drugs to the national drug policy-making bodies. Cost should be a secondary consideration. The full criteria for drug selection are listed below.

Criteria for selection of STD drugs

Drugs selected by the National STD Technical Advisory Committee should meet, or approximate to, the following criteria:

- high efficacy (at least 95%);
- lowest cost;
- acceptable toxicity;
- organism resistance that is either unlikely to develop or will be delayed;
- single dose;
- oral administration;
- not contraindicated for pregnant or lactating women.

Inclusion of appropriate drugs in the essential drugs list should be ensured. When choosing drugs, consideration should be given to health personnel's knowledge of the drugs. Training requirements should be addressed without delay.

Education and counselling on risk reduction

The STD clinical care setting is a unique opportunity to promote safer sexual behaviour in individuals who are by definition at increased risk of both conventional STDs and HIV. Individuals are likely to be particularly receptive of such education at this time because their current illness is a reminder of their personal vulnerability.

Constraints on the delivery of education include:

- health care workers in the general health care system may have little experience in health education;
- there may often be significant cultural barriers to discussing sexual matters and few health care workers have experience in this;
- the time available is very limited (in many primary health care settings, patient care lasts about five minutes).

Training of health care workers in educational skills and the development of messages appropriate to particular settings are essential activities in this area. A consistent element in education should be the promotion of condoms as a means of reducing risk. The clinical setting offers a useful distribution point and consistent supplies of free or affordable quality condoms should be assured.

Partner notification

Patients should be encouraged to make sure that all sexual partners who are accessible should receive treatment. Partner notification offers an important opportunity for identifying asymptomatic persons, particularly women, at an early stage and prior to the development of complications.

All syndromic case management algorithms specify that partners of patients with STDs must also be treated. This is particularly important in the case of gonorrhoea and chlamydial infections. There are no easy answers to partner notification.

It is unethical and not recommended to defer treatment of patients with STDs until a sexual partner is also brought in for treatment. Further, it is not recommended to treat patients only if they guarantee that a sexual partner will be brought in, or to ask them to pay a refundable deposit or higher user fee than that charged to patients with other diseases.

Provider referral (active contact tracing) should be explored fully before being it is begun, especially in low-resource situations. It is generally too labour-intensive and too expensive to be a sustainable practice in such situations. Where resources are available, however, and the benefits clearly articulated, especially in a relatively small community, a local initiative may be started to carry out active partner notification. In such a situation the exercise must be regularly evaluated to demonstrate true cost-benefit.

Partner notification should be considered whenever an STD is diagnosed, irrespective of where care is provided.

In partner notification, particular care should be taken to observe human rights and respect the dignity of the individual. Partner notification should always be voluntary and non-coercive. It should be gender-sensitive, bearing in mind that the implications for the patient and the partner will differ according to their sex. Confidentiality and trust must be preserved. The implications and impact of partner notification may require other services to be available to provide support and counselling. This can be done through collaborative institutions offering such services or by training existing health workers to meet this need.

Partner notification

Partner notification involves the sexual partners of an individual with an STD (or HIV infection) being notified, informed of their exposure and offered services.

Patient referral:

The infected patient is encouraged to notify sexual partners of their possible exposure. The patient may:

- personally inform partner(s) of the risk of infection;
- accompany partner(s) to a health care facility;
- simply hand over a "contact card".

Provider referral:

Health care workers, with the agreement and cooperation of the infected patient, seek and inform the sexual partners. Provider referral requires considerable economic and human resources and its feasibility and cost-benefit should be carefully considered before implementation.

The use of flowcharts

Flowcharts or algorithms which describe diagnosis, treatment and the other essentials of case management in the form of a decision tree are an essential part of national guidelines.

Publications providing training in the use of flowcharts are available from WHO and UNAIDS. These contain flowcharts for urethral discharge in men and genital ulcer disease in men and women which have been shown to be valid, sensitive and feasible.

Field trials of the flowcharts for case management of women with and without symptoms of vaginal discharge are being carried out. It has so far proved difficult to design flowcharts that are sensitive and specific for gonococcal and chlamydial infection in women. The new flowcharts are based on an assessment of the risk of the patient being infected. The risk assessment in such flowcharts will be site specific and will, therefore, require some operational research to validate or adapt them in any particular setting.

Research is also under way to identify simple tests, such as dipstick tests, that could be carried out in first-level health care facilities by nonspecialist clinicians and that would increase the sensitivity and specificity of flowcharts.

ANNEX 3 - TRAINING

Training is an integral part of health care programme management and focuses on developing human resources in a way that supports the programme policies, activities and outcomes.

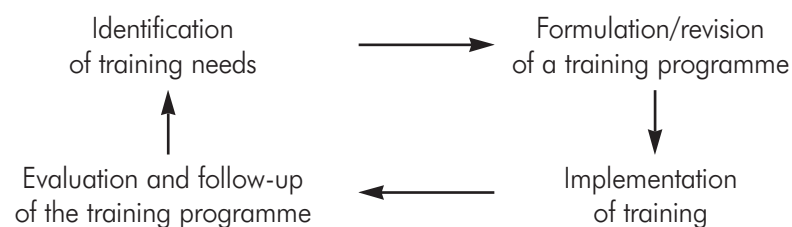
In integrating routine STD services into first-level health care, training will be the major activity. The expected outcomes of training are:

- improved quality of STD service provision (better care for patients, better disease control, less transmission of infection);
- improved efficiency and utility of services (services are cheaper to run);
- improved public perception of STD care services (more appropriate health care-seeking behaviour, better general health of communities);
- improved professionalism and morale of staff (lower rates of attrition)

The training cycle

In preparing an operational plan, it is important to consider each step in the training cycle. Ideally a training programme starts with the identification of needs, though in practice training activities will already be in place. Training can begin at any point in the cycle.

The training cycle



Identification of training needs

There are both qualitative and quantitative aspects to the identification of training needs. Managers need to target training at those service providers who need it and will benefit from it. This follows identification of discrepancies between what service providers are required to do and what they are actually able to do. This lack of skills and/or knowledge is the principle reason for conducting training.

When enumerating training needs, programme managers should identify:

- the staff categories and skill levels (to determine what training modules will be required);
- the nature and content of the course (by doing task analysis to find out the skills required at each level);
- the facilities that will be providing services (to determine the numbers to be trained, and the duration and frequency of training).

The example below shows district manager's form for recording the number of individuals in each staff category. It indicates that, depending on the skills required, several different training modules may be needed.

Level	Staff category			
	Medical officer	Nurse	Midwife	Clinical assistant
Trainer				
Supervisor				
Experienced				
Recent entry				

Not everyone needs to know about everything, not everyone needs to be able to do everything.

Formulation of a training programme

Training policies

Training policies need to be developed to reflect the overall programme mission and provide clear guidance on:

- who will be trained to provide what specific service;
- the expected standards of care and the indicators for that care;
- where training will take place (including the types of institutions);
- who will be responsible for training and follow-up;
- who will conduct the training;
- when the training should occur (e.g. during basic training, on induction into service, as continuing education);
- how training should contribute to accreditation, licensing or staff development.

Training content

Those responsible for training will need to plan its content. This will in turn facilitate the selection of the trainers, who will be a multidisciplinary team. The team of trainers will need to cover:

- clinical aspects of sexually transmitted diseases;
- nonjudgemental communication skills;
- health education and counselling principles;
- the legal and social context of STDs;
- the special needs of different groups such as adolescents, sexually abused children and rape victims.

Operational planning

Managers need to prepare a workplan that includes:

- specification of targets and indicators;
- time-frame for implementation;
- responsibility for activities, etc.

Budgeting

A budget will need to be prepared, submitted and funds allocated through the appropriate mechanism.

Management information system

Some simple system of record-keeping will be needed to keep track of trainee data, trainers/facilitators, courses, schedules, materials and course completion data for accreditation.

Implementation of training

Curriculum development includes selecting:

- technical content;
- teaching methods;
- objectives;
- provision for feedback;
- performance assessment.

Instruction materials

Consideration should be given to the needs of trainers and/or learners. Training materials can often be adapted from existing locally-available materials.

Training of trainers

Trainers/facilitators need to be prepared to conduct and/or supervise the training.

Training sites

Sites need to be selected to allow learners to take full advantage of the curriculum and supporting instruction materials. Training can take place effectively using a combination of sites including home, clinical facilities, community facilities and educational institutions.

Selection of trainees

Participants should be selected on the basis of an agreed policy and according to an agreed process, and supervisors informed.

Schedule

The training will need to be implemented according to a schedule which may include:

- courses, venues and dates;
- workshops;
- meetings of trainers, learners, supervisors;
- site visits with learners and supervisors for preparation, selection and monitoring.

Schedules will be based on the training targets.

Distribution of materials

Training materials need to be distributed to agreed storage points and supervisors informed of their availability.

Follow-up

After training it is important to monitor progress and provide support. Support visits to service providers allow identification of problems and joint exploration of possible solutions. This can be an incentive for the development of post-training skills.

Evaluation of training

Using prevention indicators for monitoring

Indicators for care and case management can be used both as baseline data and for monitoring progress of training. Changes in these indicators are very gradual and cannot be assumed to be the direct result of training.

Monitoring progress against workplan targets

The training programme can also be measured against targets in the national plan. This is the usual method of progress evaluation, but gives no indication of the impact of training.

Internal process evaluation

Trainers who are competent in evaluation methodology can conduct internal evaluations to identify whether any changes are needed to the methods, curriculum or organization of training.

ANNEX 4 - PROGRAMME MANAGEMENT

The relationship between the AIDS and STD programmes

Because the activities required for the control of HIV/AIDS overlap with those required for the control of STD, it is essential either that AIDS and STD programmes are fully integrated or, if they remain separate, that there is coordinated planning with coordination or integration of selected activities. This will ensure effectiveness of both programmes and will minimize duplication of effort and wastage of scarce resources.

Areas for coordination or integration include care, health education and counselling, promotion of safer sexual behaviour, provision of condoms and evaluation.

The model for coordination is a single manager for both programmes enabling total coordination of overlapping functions. Those areas relating most specifically to STDs, such as provision of case management, can be undertaken by a second level of management supervised by the AIDS/STD manager.

National programme management

Whatever the level of coordination between programmes, UNAIDS and WHO recommend that there should be a clearly defined national STD programme management structure within the general health services and with a specific budget allocation. The focal point for STDs, the programme manager, should have defined terms of reference.

While programme implementation should be decentralized as far as possible, the central or national management structure will have a number of responsibilities.

Political advocacy

One of the constraints to control of STDs has been the low priority given to it by policy-makers and planners when allocating health resources. The programme manager will need to present arguments proactively on the public health importance of STD control, particularly in relation to HIV/AIDS.

Establishment of a national advisory body

It is important that the STD programme manager should have expert advice in developing a control strategy. It is also important that those who will implement activities should be consulted so that they have a sense of ownership and their informed and willing cooperation is ensured.

It is recommended that a National STD Technical Advisory Committee be established by the programme manager and convened at regular intervals. Representation on this committee should include expertise in areas such as:

- STD clinical care;
- public health;
- legal and human rights;
- women's issues;
- microbiology;
- epidemiology;
- HIV and AIDS;

- training;
- information, education and communication;
- behavioural sciences;
- health services planning and management at primary and secondary health care levels;
- evaluation.

Academic and professional organizations, nongovernmental organizations and members of community groups should also be considered for membership.

The terms of reference of the National STD Technical Advisory Committee will be to provide guidance to the programme manager on technical/scientific and policy issues, and in particular on:

- case management of patients with STDs;
- laboratory support;
- drug recommendations;
- delivery of STD services in referral clinics and at the first level of health care;
- training of medical officers, nurses and primary health care staff;
- delivery of services to groups at increased risk of infection;
- operational research;
- information, education and communication that is appropriate for STD patients and community groups.

Resource allocation

Resources are unlikely to be sufficient for all activities and the central management will need to prioritize their allocation and distribution.

National policy decisions

Although the management of service delivery should as far as possible be decentralized, the general policies on how services are delivered need to be made centrally to ensure consistency and quality of care. Planning and guidance should be provided on the means for routine service delivery and referral systems.

Additional activities directed at STD control

The national programme will have an overall awareness of the epidemiology of STDs in the country. It will be in a position to select the most valuable activities for STD control (e.g. interventions targeted at vulnerable groups) and to advise local management on the planning and implementation of such activities.

Training

In order to establish and maintain an acceptable and consistent quality of care, the national programme will need to play a part in developing and monitoring the training of health workers in relation to STDs. The role of the national programme will vary from organizing training to advising institutions on the type of workers to be trained, and the content of curricula based on recommended case management (Annex 3).

Case management

It is important that case management guidelines for use by different levels of health care workers should be developed and distributed. The National STD Technical Advisory Committee will have an important role in this activity (see Annex 2).

STD drug availability

The case management guidelines will recommend drugs for the treatment of STDs and the national programme will need to ensure that these drugs are included in the essential drugs list and that supplies are available. In addition, cost-recovery policies may need to be clarified.

Supervision

Even when services are fully decentralized, national programmes will need to monitor and supervise coverage and quality of service delivery.

Operational research

The national programme should ensure that necessary operational research is carried out. In order to plan and deliver services appropriately, the STD programme needs to have information on:

- the population groups most at risk of STDs;
- the geographical distribution of these groups;
- the prevalence of STD syndromes and the etiologic agents;
- the antimicrobial sensitivity of the etiologic agents;
- the services available for STD prevention and care;
- the STD health care-seeking behaviour of the population (e.g. where particular groups seek care for STDs, what their reasons for doing so, and in particular what constraints exist to seeking health care from public services).

As behaviours that place individuals at risk of conventional STDs and sexually transmitted HIV are the same, the task of obtaining information on the populations at risk needs to be coordinated between the AIDS and STD programmes.

Selected specialized STD clinics, acting as reference centres and strengthened by laboratory support and expertise so that etiologic diagnosis can be made, should monitor patterns of infection, disease and antimicrobial resistance. In the absence of such reference centres, or while appropriate strengthening takes place, information from neighbouring countries may be cautiously extrapolated for similar settings. Other areas for operational research will include:

- determining feasibility and validity of case management flowcharts;
- assessing risk factors for infections in women for use in flowcharts;
- determining prevalence of STDs in sentinel populations.

Surveillance systems

A surveillance system should be an integral part of the STD programme in order to provide the information required for programme decisions. It is recommended that a system of sentinel surveillance with reporting from selected sentinel sites be used. This may be supplemented by specific surveys conducted over short periods to monitor variations in the distribution of STD pathogens and their antimicrobial susceptibility.

It will be the responsibility of the STD programme to ensure that this system is set up and to advise peripheral health authorities on the selection of sentinel sites and the collection of data. The programme will also be responsible for the analysis of data on a nationwide basis and timely feedback to the data providers. The programme will determine where and when additional surveys will be required.

STD Surveillance

The main objectives of STD surveillance

- The magnitude of the STD problem should be estimated to:
 - define the resources needed;
 - advocate necessary support from policy-makers.
- The frequency and distribution of STD pathogens and antimicrobial sensitivity should be measured to define and monitor diagnostic and therapeutic procedures.
- Trends should be monitored to reinforce political support and to improve the existing programme.

General recommendations for STD surveillance systems

- STD surveillance is necessary because it provides the data needed:
 - for programmatic decisions and design of interventions which will benefit the community;
 - for monitoring the impact of the STD care and prevention programme;
 - for training health care workers.
- Sentinel surveillance is recommended in a limited number of selected sites because:
 - sentinel sites can be chosen so as to be representative of different regions and can include various facilities delivering STD services;
 - it is flexible;
 - specific surveys can be added without interfering with the basic structure;
 - it is the most feasible for implementation and supervision.
- Routine STD surveillance activities should be complemented by specific surveys, including:
 - STD prevalence in vulnerable populations at increased risk of infection;
 - specific research projects.

STD surveillance should not stand alone but should be integrated within the STD Programme and as far as possible in the general health system. Only information that is useful for the planning and monitoring of the programme should be collected.

Monitoring, supervision and evaluation

It is the role of the national management to assist the periphery to identify indicators and set realistic targets. Monitoring and supervision of activities should lie with the peripheral, district or regional management but the responsibility for organizing overall evaluation of the national programme will lie with the central management. This important area is further expanded in Annex 5.

Management at peripheral level

Where STD services are delivered as recommended through the general health care system, no separate management structure will be required. Categorical STD clinics will require a separate management system which should be combined with the system that is in place for other secondary and tertiary care facilities.

Experience has shown that decentralization of the management of services increases efficiency. Management should be as close to the level of the health facility as possible.

ANNEX 5 - MONITORING AND EVALUATION

Rationale

Monitoring that includes surveillance, supervision and evaluation should be considered as a continuous process for the purpose of maintaining and improving the delivery of efficient and high quality STD services. Managers need information for planning and implementing effective programmes for the prevention and care of STDs. Effective monitoring and evaluation will provide a process for describing successes, identifying problems and indicating potential solutions.

A variety of sources will provide the information that should be compiled in optimal combination: e.g. information from monitoring such as “central level stock records over the past 12 months show only 80% of estimated condom needs were delivered and distributed”, and from supervisory reports such as “35% of individuals seeking STD care in health facilities received appropriate advice on condom use and partner notification”, and “29% report using a condom during the most recent act of sexual intercourse”. Additional breakdown by age and gender will provide valuable information for subsequent intervention strategies. This combination of information can be more useful to programme managers than individual items in focusing on key problems and pointing to solutions.

Monitoring

The purpose of monitoring is to ensure that work is progressing as planned and to anticipate or detect problems in implementation. Monitoring provides managers with information about the level of achievement measured according to standards of performance, and allows them to assess implementation by comparing actual progress to expenditure. Monitoring will help to validate results of outcome evaluation.

Monitoring focuses on implementation (adequacy of supplies, appropriateness of training, performance of service providers) rather than on intermediate outcomes (changes in knowledge or behaviour, changes in health systems) or impact (decreases in morbidity and mortality, improvement in health).

Surveillance

Surveillance traditionally describes trends and patterns of disease in a given population over time. This information is necessary to managers in order to concentrate efforts and resources where there is the greatest need.

A surveillance system provides the information for estimating the size of the problem, its frequency and distribution and antimicrobial susceptibility of STD pathogens. Surveillance enables managers to reinforce and improve programme management. For example, surveillance of syphilis, chlamydial infection or gonorrhoea may reflect trends in condom use or the most appropriate selection of drugs for STD treatment.

Experience has shown that universal reporting for surveillance purposes is seldom sustainable and it is recommended that routine surveillance activities are confined to a number of sentinel sites and to periodic surveys for additional information on disease patterns and antimicrobial susceptibility. The sentinel sites can be promoted and strengthened to ensure compliance and efficiency.

Supervision

Supervision is one of the most important aspects of monitoring in that it assesses performance and outputs in the light of the situation and the resources available. Effective supervision narrows the margin

between what exists and what potentially can be achieved through allocating resources and training on the basis of the needs of individual facilities or health care workers.

Supervision is a way of ensuring competence through observation, discussion, support and guidance.

Evaluation

The purpose of evaluation is to assess progress towards programme objectives and targets at a given point in time.

Evaluation focuses on the periodic review and use of information to improve health programmes and guide allocation of resources. It assembles information from surveillance, monitoring and supervision to determine whether planned outcomes are being achieved.

Method

Selection of programme indicators

Before implementing activities, targets which reflect the priorities of the programme must be carefully selected. WHO has identified and field-tested four prevention indicators directly related to STD programmes.

WHO prevention indicators (PI)

- **WHO PI 6: STD case management**

$$\frac{\text{Number of individuals presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards)}}{\text{Total number of individuals presenting with STD in health facilities}}$$

- **WHO PI 7: STD case management**

$$\frac{\text{Number of individuals seeking STD care in health facilities who received appropriate advice on condoms and on partner notification}}{\text{Total number individuals seeking STD care in health facilities}}$$

- **WHO PI 8: STD prevalence, women**

$$\frac{\text{Number of pregnant women aged 15-24 with positive serology for syphilis}}{\text{Total number of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened}}$$

- **WHO PI 9: STD incidence, men**

$$\frac{\text{Number of reported episodes of urethritis in men aged 15-49 in the last 12 months}}{\text{Total number of men aged 15-49 surveyed}}$$

Setting of programme targets

For the indicators to be useful it is necessary to set targets. For example, for WHO PI 6 the programme should determine a realistic level of achievement and set a programme target. A programme target could be “by 1996, 50% of individuals who are seeking STD care in a facility will be assessed and treated in an appropriate way”. Indicator data can be synthesized in programme evaluation to determine whether targets have been met.

Selection of activity indicators and targets

When planning the activities to be carried out as part of an intervention, the programme can set activity targets. These focus on activities that will be implemented in order to achieve the programme target. An activity indicator could be, for example, “the proportion of health facilities with an adequate supply of appropriate drugs for STD treatment”. The activity target set for this particular indicator could be “by 1994, 75% of health facilities will have adequate supplies of appropriate drugs for STD treatment”.

Selection of performances and outputs

In order to carry out the activities, it is necessary to select and plan for performances that compare current practices with established standards of performance and outputs which quantify numbers of items used to carry out activities.

A critical qualitative aspect of “performance” that may be monitored in relation to the above activity target is to check if “training of health care workers follows national STD case management guidelines”.

An example of a quantified “output” that would be monitored is “the number of health facilities with adequate supplies of appropriate drugs for STD treatment”.

Supervision

Supervisory checklists should be based on the importance of items for achieving the STD activity and programme targets. For example, a supervisory checklist should take into consideration the following points:

- the importance to the overall implementation process (e.g. the number of women attending antenatal clinics tested for syphilis);
- the sensitivity to previously experienced difficulties with performance standards or operational guidelines (e.g. the number of health facilities with adequate supplies of condoms and appropriate drugs for STD treatment);
- the frequency intervals needed to measure particular information on performance (e.g. collecting routine stock reports to measure timely delivery of treatment drugs and condoms to facilities providing STD services).

The relationship between the items to be monitored can be demonstrated by organizing them according to programme targets, activities, activity indicators, activity targets, performances and outputs. Each item has a causal link to the other items and reveals important information about what is and is not being done for the STD programme.

Responsibilities

Where STD services are fully integrated into the general health care structure their monitoring and supervision will be part of the general monitoring activities and will be the responsibility of peripheral management (e.g. district health authorities). Supervision checklists for the STD programme should match its contribution to the overall health care programme.

The STD programme will have the responsibility of selecting programme indicators and targets and providing advice to regions/provinces and districts on monitoring activities such as selecting appropriate activity indicators.

The monitoring of categorical STD clinics that provide a referral service will follow the existing process for all secondary and tertiary care services and may require selection of specific activity indicators.

The analysis of surveillance data will be the particular responsibility of the STD programme.

Responsibility for the overall evaluation of the STD programme will lie with the programme itself, although it will be carried out in close collaboration with peripheral health management.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners - governmental and NGO, business, scientific and lay - to share knowledge, skills and best practice across boundaries.



Joint United Nations Programme on HIV/AIDS

UNAIDS

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