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*Scaling up sexually transmitted
infection prevention and control
in the WHO European Region*

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Abbreviations

| | |
|--------|--|
| CBO | Community based organization |
| CC | Collaborative Centre |
| CISID | Centralized Information System for Infectious Diseases |
| DHS | Demographic and health surveys |
| ECDC | European Centre for Disease Control |
| EE | Eastern European |
| EENSRH | Eastern European Network of Sexual and Reproductive Health |
| EU | European Union |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HIV | Human immunodeficiency virus |
| HBV | Hepatitis B virus |
| HPV | Human papilloma virus |
| IDU | Injecting drug users |
| IUSTI | International Union Against Sexually Transmitted Infections |
| LGV | Lymphogranuloma venereum |
| MARPS | Most at-risk populations |
| MDG | Millennium Development Goal |
| MIC | Minimum inhibitory concentration |
| MS | Member States |
| MSM | Men who have sex with men |
| NGO | Nongovernmental organization |
| NIS | Newly independent states |
| OSI | Open Society Institute |
| PN | Partner Notification |
| SCM | Syndromic case management |
| SRH | Sexual and Reproductive health |
| STIs | Sexually transmitted infections |
| TAMPEP | European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| USAID | United States Agency for International Development |
| VCT | Voluntary testing and counselling |
| WHO | World Health Organization |

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1. Purpose, organization and main issues discussed at the meeting:

The Technical consultation took place in Ljubljana, 2-4 August 2010. The consultation brought together national and international STI and public health experts, policy-makers, managers of national STI and HIV programmes, representatives of national and international nongovernmental organizations, civil society, people living with HIV and members of communities at high risk of STI, and representatives of other United Nations agencies and donor organizations.

The main objectives of the consultation were to:

- review current STI policies and practice in the WHO European Region;
- identify needs, challenges and opportunities;
- provide feedback on the development process and content of the draft Regional framework for the implementation of Global Strategy for the Prevention and Control of STIs prepared by the WHO Regional Office for Europe; and
- discuss the feasibility of implementing the recommended policy interventions.

The control of STIs remains a priority for WHO. In May 2006, the World Health Assembly endorsed the Global Strategy for the Prevention and Control of STIs¹. The strategy urges all countries to control the transmission of STIs by implementing some recommended interventions.

One of the main issues addressed at the consultation was a development of the Regional Framework for the implementation of the Global STI Strategy in the WHO European Region. The meeting provided a good platform for the detailed discussion of the draft Framework and development of the recommendations for its improvement. The consultation aimed to:

- Discuss whether the draft “Regional framework for the implementation of Global STI Strategy” recognizes all the key issues, challenges and opportunities for STI control in the WHO European Region and puts forward a logical, coherent and feasible framework for future action.
- Review input on the draft “Regional framework for the implementation of Global STI Strategy” received from consultation participants, national and international technical and public health experts, NGO/CBO, civil society, international partners prior to the meeting.
- Suggest changes, additions and deletions to be made to the draft “Regional framework for the implementation of Global STI Strategy” taking into consideration the feasibility of implementation of recommended policy interventions.
- Discuss how the Framework should reflect differing needs and resources in Western, Central and Eastern areas of the European Region

¹ Global strategy for the prevention and control of sexually transmitted infections: 2006 - 2015. Breaking the chain of transmission. WHO, 2007.

- ❑ Promote harmonization of STI policies, strategies, control, prevention, treatment and care. Special attention was given to the enhancing and
- ❑ harmonization of surveillance including gonococcal antimicrobial resistance monitoring and its expansion to all countries within European Region
- ❑ Promote exchange of relevant expertise between all countries in the WHO European Region
- ❑ Discuss further steps in the development of the final version of the “Regional framework for the implementation of Global STI Strategy” including ways for broader input from stakeholders in WHO Europe Member States (MS), as well as dissemination and implementation and evaluation of activities set out in the final document

The meeting was organized as a series of themed sessions, covering key issues mentioned above. Individual country presentations included updates of national STI control, prevention, treatment and care policies, strategies, programmes within individual countries and an account of specific challenges being faced. Innovative approaches meeting with success were highlighted from many countries. In addition to presentations on individual countries some speakers dealt with broader issues and transnational initiatives within the European Region. These topics among others also included:

- ❑ Detailed discussion of pros and cons of STI surveillance systems and possibilities for implementation in other countries; harmonization of surveillance systems
- ❑ Regional STI surveillance with special emphasis on the growing trends of gonococcal resistance and threat of untreatable gonorrhoea.
- ❑ Civil society perspectives were shared by TAMPEP, All Ukrainian network of people living with HIV, Slovenian colleagues and other presenters.
- ❑ The eastern European Network of Sexual and Reproductive Health (EENSRH) shared work done in the eastern part of the region.
- ❑ A Presentation by a GFTAM colleague sharing opportunities offered by the GFTAM attracted high interest.
- ❑ Along with opportunities offered by the GFTAM, capacity building opportunities in STI surveillance offered by the WHO Collaborative Centre (CC) for Capacity Building in HIV surveillance were also discussed.
- ❑ Integration of STI policies /services
 - Reproductive health (HPV prevention), National HIV programmes
 - Services within HIV/TB-projects (Ukraine), services for IDUs

2. Key themes emerging from participant presentations and panel discussions

Wide regional variation in availability of STI care, in access to STI care and quality of STI care integrated with other services were reported across the region and within individual countries. The greatest needs for prevention and care tend to be found among key populations at risk of and vulnerable to STIs, who are disadvantaged mainly through factors such as stigmatization, discrimination, criminalization, sexual orientation, detention, migration status, low income etc. TAMPEP has estimated that only 30% of sex workers are covered by health services in the countries where it operates.

The target of offering an appointment at a genito-urinary medicine clinic to all patients within 48 hours of contacting the service by 2008, established as part of the United Kingdom National Sexual Health Strategy, sets a high standard for the region, but it seems unfeasible to currently have it as a pan-European one. After discussion it was agreed that adopting a target of this type across the European Region would not be feasible for many countries in the medium term because of resource implications, weak health systems, shortage of staff and education/training and many other existing challenges facing by the majority of countries. It was noted that while appointment to see a service provider could be offered, it might be problematic to arrange all the services required within a 48 hour timeframe.

Sharp contrasts in degrees of STI service integration were evident. In the Netherlands the majority of STI care takes places in primary health care settings. By contrast in countries in the Eastern Region a common pattern of service provision is through specialist dermatovenereologists and there are often legal restrictions to testing and treatment by non-specialist providers. STI settings remain strongly vertically organized in the majority of eastern European countries. Nonetheless, syndromic case management of STIs at primary health care level has been introduced in some of these countries, e.g. Tajikistan, Turkmenistan and some others. In general, attitudes towards syndromic management in eastern Europe are negative among the majority of STI service providers. During discussion it was clear that there remains a high level of specialist resistance to moving to more integrated forms of care. Reasons for this include concern about lower standards of care by non-specialists and private sector providers and fears of loss of professional standing and income. Confirmatory tests of rapid tests from drop-in centres often have to be performed in clinics, leading to high drop-out rates. For syphilis, development of tests with higher sensitivity and specificity, like the RPR-tests recently developed by US CDC, should help to re-evaluate current strategies.

Integration of care seems to be particularly important for female drug users, as well as to reach people infected by “secondary transmission” (provide services for the shift of the epidemic i.e. to partners of IDUs). In other settings, STI care has to be integrated into services provided by various NGOs, like for Roma, who are very mobile and hard to reach. Through integration of drop-in centres into STI-clinics, women’s clinics, family-planning clinics and gynaecologic outpatient wards, the offering of health-care institutions can be broadened.

Standards of STI care in many countries have improved in recent years with the adoption of nationally-approved evidence-based treatment guidelines and adoption of regular clinical audit to confirm adherence to their use. The WHO Regional Office for Europe has made significant efforts to promote evidence-informed and human rights policies and practices. Very successful projects in collaboration with IUSTI Europe, supported by USAID and OSI were implemented in several of the newly independent states (NIS) of the former USSR a couple of years ago that further promoted these issues. Work is being continued by IUSTI Europe involving also leading technical experts from EE as board members as well as including them in guidelines editorial boards being developed by IUSTI Europe.

Outstanding issues in the quality of STI care identified at the meeting included:

- Insufficient levels of provider-initiated HIV testing and counselling

- ❑ Integration of risk reduction counselling in clinical settings often neglected
- ❑ Continued use of STI treatments (especially for syphilis) not supported by best scientific evidence or international treatment guidelines
- ❑ Unregulated STI care in private sector, e.g. in Armenia, Uzbekistan
- ❑ Use of poor quality diagnostic tests
- ❑ Lack of quality control for laboratories providing STI diagnosis

An innovative approach in education for STI prevention elaborated in Germany was presented, reminding participants of the important opportunities that exist for delivering education about STI prevention in health care settings, counselling organizations and educational settings. Well designed visual materials on STI, HIV and FP specially developed for low education/migrant populations were demonstrated. Participants felt that this important development should be taken into consideration by the respective national programs including the STI ones and wide promotion and implementation into national settings be initiated. An English translation of the STI/HIV prevention curriculum for doctors was highly appreciated and could improve quality of care.

Heterogeneity of epidemiological surveillance of STIs and existing challenges related to the increasing trends of gonococcal resistance were discussed in detail. The majority of countries in the WHO European Region have surveillance systems in place. Combined data from EU countries is published by the European Centre for Disease Control while the WHO Europe Central Information System for Infectious Diseases publishes information from 53 MS of the WHO European Region. There is a striking degree of heterogeneity in diagnostics, screening approaches and reporting systems which makes difficult to compare data from across the region. STI surveillance systems across the region vary significantly in the following aspects:

- ❑ voluntary or mandatory reporting requirements
- ❑ universal or sentinel, clinical or laboratory reporting
- ❑ aggregated versus case-based reporting systems
- ❑ variations in diagnostic methods and adoption of more sensitive tests
- ❑ increasing number of tests performed and the existence of screening programmes for some populations

Data from countries that have faced changes in their reporting systems or testing strategies over time have to be interpreted cautiously. Particularly in eastern Europe, more and more patients seek care from private sector providers, who tend to under-report STIs. A striking example of the impact of changes to screening strategies is the reported data for Chlamydia which are conspicuously higher for the 4 countries which have national Chlamydia screening programmes compared to those which do not. These 4 countries account for 60% of chlamydia reported to ECDC. Electronic reporting systems have shown to improve data quality.

Monitoring of trends in sexual behaviour takes place in many countries in the European Region. The methodology of these surveys shows considerable heterogeneity. Favourable trends in the use of condoms at first sex and with casual partners and among MSM are reported from many countries. Less conducive to STI prevention are falls in the age of sexual debut, higher numbers of sexual partners, later marriage, and rises in numbers reporting paying for sex in many countries.

Neisseria gonorrhoeae has become resistant to a wide array of antibiotics, including penicillins, tetracyclines and fluorinated quinolones in much of the European Region.

Extended spectrum cephalosporins remain useful but there is concern about rising MICs being observed with this class (already >5% of isolates in some countries) and the lack of any viable new options if resistance to these cephalosporins emerges. The importance of pharyngeal gonorrhoea was highlighted, as infections are frequently asymptomatic, difficult to treat and present a reservoir for further infections.

A European Network for gonococcal resistance covers many EU countries. The eastern European Network of Sexual and Reproductive Health (EENSRH) are supporting the extension of gonococcal surveillance to newly independent states. Countries without established gonococcal surveillance programmes need to build up services step-wise, starting with the establishment of facilities and staff training, followed by culture and strain preservation before moving on to a full resistance monitoring programme.

The EENSRH also shared work done in the eastern part of the region with its main focus on developing STI laboratory capacities and preparing related national tools. Eastern European participants of the meeting expressed high appreciation of the support being provided by the EENSRH.

Impact of legislative frameworks on STI control and prevention. A number of countries reported the legislation that can have significant impact on STI prevention and control:

- ❑ Lack of evidence- and human rights based national STI policies, strategies, practices
- ❑ Criminalization of infectious disease transmission
- ❑ Criminalization of sex work, drug use and homosexual behaviour
- ❑ Criminalization of failure to cooperate with partner management for STI
- ❑ Criminalization of failure to cooperate with in-patient treatment of STI
- ❑ Compulsory STI examinations on a regular basis for some key at risk and vulnerable populations, professional groups (like teachers, bus drivers, food-handling personnel, etc.), relevant for countries of eastern part of the region; enforcement through legal action (police involvement, high fines)
- ❑ Lack of entitlement to health care among at risk and vulnerable populations including youth, illegal migrants, ethnic minorities etc
- ❑ Requirements for “patient passport” data for at risk and vulnerable populations including drug users, MSM, SW, migrants etc
- ❑ Ordinances requiring confirmatory testing of STIs, restriction of STI management to specialist dermatovenereologists, occupational testing of low risk populations for STI/HIV, mandatory inpatient treatment for STI for key at risk populations as well as syphilis in pregnancy
- ❑ Treatment regimes for STI mandated by health ministries which are out-of-date or not supported by robust scientific evidence
- ❑ Police involvement in STI case management including contact tracing in some countries

Along with above mentioned there are good examples in the region to follow: for instance, both the Netherlands and Switzerland have taken steps to avoid criminalization of HIV transmission; sex work in the Netherlands is legal and regulated in ways to foster public health; there are also examples on other countries.

STI prevention and control among key at risk and vulnerable populations was recognized among the leading issues requiring major efforts for improvement. Many speakers emphasized the importance of devoting a significant proportion of available resources to interventions with those groups, whilst acknowledging the difficulties of establishing successful interventions. Civil society working through CBOs and NGOs has a key role in facilitating this process.

In Ukraine it was reported that IDU interventions tend to focus on harm reduction, substitution therapy and HIV care, while sexual health and hepatitis B vaccination are often neglected. NGOs working with IDU find it difficult to support screening and treatment for STIs. The All Ukrainian network of PLHIV is actively involved into the STI control and prevention among at risk and vulnerable populations. Thanks to the GFTAM support there is ongoing work to adjust proposals aiming at meeting existing STI needs in the country with a major emphasis on the optimization of the normative environment and provision of STI services meeting needs of key at risk and vulnerable populations.

The problem of STIs in MSM in western Europe is widely recognized and specialist services are relatively well developed. Although many impressive prevention programmes have been established, rates of STIs and HIV remain considerably higher among MSM than the general population, e.g. 60% of syphilis and 20-30% of gonorrhoea seen in MSM in Switzerland. Data from Switzerland strongly support greater screening of asymptomatic MSM for STIs notably syphilis and rectal chlamydia, coupled with counselling for risk reduction. Apart from integration of STI-in HIV-services, the most important messages remain a combination of information (1), condom usage (2) and motivation for VCT and treatment (3). In some western European countries screening guidelines for MSM and sex workers including defined intervals have been implemented. Few STI prevalence studies of MSM have been conducted so far in the eastern part of the Region. An exception is a recent study from Zagreb which showed very high rates and points to the need to conduct further studies in the eastern part of the Region².

It was pointed out that clinical training in management of rectal infections is neglected or non-existent in some countries, e.g. Slovenia and many others. In eastern Europe MSM population is mainly highly stigmatized and hidden making implementation of STI control and prevention interventions especially challenging. Local experience on offering innovative services for MSM accumulated in Slovenia was discussed gaining a high interest of the participants and providing excellent example to follow by other countries in the Region. The elaboration and implementation of innovative approaches and their implementation, wide scale involvement of civil society settings into the policies, strategies, programs development and implementation is vitally important.

Arguments were made for highlighting MSM much more strongly within the Regional Framework and devoting a separate section to this important issue.

The TAMPEP network which works with sex workers in 25 EU countries reported that 70% of sex workers in western Europe are migrants and that migrant status poses major barrier to services, through lack of health insurance. Reported rates of infection among sex workers tend to be lower than those in MSM, but risk remains in high

² Božičević, Ivana et al. AIDS and behavior, 13 (2). pp. 303-309.

among those who are also IDU, MSM or migrants, especially from Africa. Female sex workers have multiple needs that need to be addressed in addition to sexual health such as their stigmatization and high vulnerability to violence and police harassment.

STI prevalence data on key at risk and vulnerable populations in eastern part of the Region is scarce and inconsistent being mainly available on Syphilis prevalence as part of second generation HIV surveillance activities in some countries. Participants recognized the necessity of having quality prevalence data especially on at risk and vulnerable populations among important priorities for National STI Programs to monitor trends and guide national STI control and prevention efforts.

Declining state funding for STI prevention was reported from several countries. The necessity to strengthen advocacy efforts for increasing state allocation and for addressing discrimination/stigmatization was emphasized. WHO was asked to assist national STI programs in their advocacy efforts. Participants voiced concern about possible changes to criteria for funding from the Global Fund and pleaded for criteria friendlier to countries of the eastern part of the Region.

A presentation of a GFTAM colleague sharing opportunities offered by the GFTAM attracted high interest. Participants, especially those representing eastern Europe showed high interest and willingness to be better aware about the opportunities and potential support that could be received from the GFTAM. It was emphasized that such opportunities are not well known in national STI settings. The GFTAM was requested to better describe/reflect on the GFTAM web site the opportunities that STI settings could benefit from as well as reflect that in the next call for proposals to be issues by the GFTAM. There is a false belief in some EE countries that an inclusion of STI issues into the GFTAM proposals might lead to their rejection. It would be highly appreciated if this could be taken into consideration by the GFTAM and addressed/described in the respective guidelines for the GFTAM proposal development. The presentation given by the GFTAM colleague was very informative, encouraging and was highly appreciated by the participants. The participants asked the GFTAM colleague to follow up on the issues described above, promoting support for STI issues to be possibly provided by the GFTAM. There was a hope expressed to get stronger support from GFTAM for improving STI control and prevention in GFTAM eligible countries.

The capacity building opportunities in STI surveillance offered by the WHO Collaborative Centre (CC) for Capacity Building in HIV surveillance was also discussed. The CC is based at the "Andrija Štampar" School of Public Health, School of Medicine, University of Zagreb. Support in strengthening of STI surveillance is part of activities offered by CC. It was emphasized that this CC is a unique centre which brings together an interdisciplinary group of scientists and policy-makers across the University of Zagreb and institutions of excellence in HIV/STI surveillance from all over the world. The Centre mission is to contribute to increasing capacities in the implementation of effective, sustainable and context-specific HIV/STI surveillance and monitoring and evaluation systems which enable evidence-based development of prevention, care and treatment. Sharing knowledge and building research capacities are the key components of Centre's work. Since the Centre establishment in 2003, more than 600 professionals from 53 countries in Europe, North and Central Africa and the Middle East have been trained in HIV, STI

surveillance and monitoring and evaluation. The Centre is committed to helping countries to develop strategic information to guide a more effective response to the epidemic by providing innovative training programmes and technical assistance, as well as developing partnerships and collaborative networks that bring together a wide range of expertise in the field.

3. Summary of feedback on draft European Regional STI Framework for the implementation of the WHO Global STI Strategy

Following the themed sessions, participants split into 4 groups to discuss specific sections of the draft Regional STI Framework and make recommendations for its revision and general recommendations from the meeting.

This section summarizes feedback gathered during the meeting as well as comments on the draft framework received from participants prior to and following the meeting. All participants expressed high appreciation to the Regional Office for the initiation of the regional STI Framework development for the implementation of the WHO Global STI control and prevention Strategy in the WHO European Region. It was emphasized that the development of a sound Regional Framework will be a highly important document, helping to put STI issues higher on the public health agenda as well as guiding WHO Europe Member States in their efforts to improve STI control and prevention, treatment and care. During discussion, the issue was raised whether to split the Regional Framework for the 53 countries into separate sections for East and West, as they are facing varying difficulties.

Feedback on the Draft Regional Framework called for a stronger emphasis on a public health approach, involvement of civil society and focus on key at risk and vulnerable populations. It was suggested that the priorities for immediate action should be modified from the Global Strategy to lay greater stress on education for prevention, identification of infection in asymptomatic individuals, interventions with MSM and other at risk and vulnerable populations, promotion of high ethical and scientific standards and enhanced surveillance including that for gonococcal resistance.

Comments and recommendations on specific aspects of the draft Framework are summarized below.

Target audience:

It was suggested that the document should state more explicitly who is the primary target audience for the document, whilst acknowledging that it will be of interest to a much wider array of stakeholders. It is suggested the primary target along with national STI program coordinators should be policy-makers within ministries of health with responsibility wider than just STI control and prevention e.g. thus ensuring wider involvement, sharing responsibilities and promoting collaboration and integration.

Situational analysis:

It was suggested that:

- Global STI statistics require updating with the latest WHO estimates

- ❑ Citations to European studies of STI prevalence need updating with more recent studies using superior test technology.
- ❑ The importance of injecting drug use as a driver of HIV transmission in the Eastern Region should receive greater emphasis. At the same time the trends of sexual transmission should be better described.
- ❑ The European and eastern European Harm Reduction Network (EuroHRN) should be highlighted as key regional partner organization.
- ❑ The decline of STIs should be mentioned with caution.
- ❑ The elimination of CS initiative should be actively promoted and given priority attention as a regional success story.
- ❑ The limitations of the data available through CISID need greater emphasis. WHO should be asked to improve the completeness of data monitoring, data collection and analysis
- ❑ The data on service delivery in the European Region by Dehne et al. is over 10 years old and of limited value. WHO should be asked to implement a new survey to get updated data and feed this into the framework under development. The analysis of challenges facing Newly Independent States should be more accurate and better balanced.
- ❑ Data on access to condoms, monitoring and evaluation, and promotion of testing (MSM, time-interval) should be added

Rationale for STI control should:

- ❑ Include health economic data that demonstrates the *public health benefits of improved STI control*
- ❑ Stress more strongly the critical importance of *not* excluding key at risk and vulnerable populations from prevention efforts
- ❑ Include more references on evaluation of rapid tests and the efficacy of HBV and HPV vaccines
- ❑ Emphasize the evidence base for all interventions recommended in the document

The Strategic focus of the framework under development should avoid being too close to the global strategy with its strong focus on Africa-specific problems. The Framework should:

- ❑ Have a stronger emphasis on prevention and a public health approach involving civil society. Important features of a public health approach include low thresholds for access to STI care, free care and improved access for key at risk and vulnerable populations and more screening for asymptomatic infection.
- ❑ Emphasize the importance of incorporating STI prevention within a broader sexual and reproductive health perspective as laid out in the WHO European Strategy for Sexual and Reproductive Health, published in 2001.
- ❑ Explicitly recognize the importance of tackling gender-related risks and vulnerabilities and advocate an approach that conforms to the gender equality strategy promulgated by the Global Fund
- ❑ Make a stronger emphasis on human rights, reduction of stigma and legislative reform to underpin STI prevention, treatment, care
- ❑ Emphasize more strongly the importance of developing interventions for key at risk and vulnerable populations. The importance of STI prevention at all

points of contact between key at risk and vulnerable populations and those working with these groups should be highlighted.

- Show unequivocal acceptance of internationally recognized standards in care of patients and laboratory technology based on the best available scientific evidence.

Identification of priority components for immediate action

The huge diversity of incomes and resources across of the WHO European Region mean that priorities vary from country to country as well as the steps required and the amount of work required. For example, HPV vaccination programmes are appropriate for high income countries, whereas they risk consuming valuable resources that might better directed to other priorities in lower income countries. The elimination of congenital syphilis has largely been achieved in high income countries but remains a worthwhile objective for countries which continue to see cases. Aiming at elimination in the entire Region looks feasible based on the data available and might become a regional success story.

Issues raised:

- Promotion of safer sexual behaviour including condom use, better health-seeking behaviour and should head the list of priorities to underline the public health approach.
- Improving diagnosis of STIs, including use of rapid tests, quality control of STI testing and identification of STIs in asymptomatic individuals should all be prioritized.
- The highest ethical standards for provision of information, testing, medical care, counselling, partner notification, surveillance and data handling should be promoted.
- Access to STI care, the *quality* of STI care should be improved
- The elimination of congenital syphilis should be retained as a priority for the European Region as a whole, although it has been largely achieved in many high income countries and quite some resource-constrained settings. It is clearly a feasible regional initiative.
- The priority component relating to bacterial genital ulcer disease should be replaced by priorities to eliminate congenital syphilis and reduce STIs incidence among at risk and vulnerable populations starting with MSM.
- Greater surveillance across all countries of the European Region for gonococcal resistance should be promoted to a priority component for immediate action
- MSM have very significantly higher rates of STI in many countries of the European Region and this issue merits a separate section in the Regional Framework.
- The European Regional Framework should harmonize its priorities with those of the Global STI strategy and the WHO European Regional Sexual and Reproductive Health Strategy (2001-2010)
- HPV vaccination is too expensive to be adopted as a priority in low-income countries in the European Region and risks taking resources from more important activities.
- Review and revise all targets and indicators in the document in consultation with WHO expert advisors. Define terms clearly, ensure indicators are measurable and realistic, and define methods for collection and reporting, link

to existing reporting structures. Ensure measures of impact are included as well as process indicators. Use more established indicators where these are already available.

- ❑ Screening strategies should be mentioned, particularly for Chlamydia in western European countries, and how it can be improved (web site, invitation letters, home-test kits etc.)
- ❑ Data acquisition through solid reporting systems should be emphasized

Recommended activities to support STI control

- ❑ Add initiatives to address stigma and discrimination and creation of a safe, non-judgmental environment
- ❑ Promote effective and equal involvement of civil society in STI prevention
- ❑ Advocate free care and treatment for most at-risk persons
- ❑ Place greater emphasis on provision of STI care at primary points of care. These primary points of care should include not just primary health care as traditionally understood, but also unconventional environments where key at risk and vulnerable populations may be encouraged to seek health care.
- ❑ Improvement of STI-training for doctors and counsellors
- ❑ Laboratories should work to international standards adhering to evidence-based guidelines, supported by regionally accredited reference laboratories.

Style and format

- ❑ Shorter document preferred
- ❑ Favour graphical over tabular presentation of figures in main text
- ❑ Reduce use of acronyms
- ❑ Add examples of good practice from the Region in boxes
- ❑ Improve structure of recommendations
- ❑ Take greater care avoid use of language with moralistic overtones
- ❑ If possible choose an alternative (softer) expression for the term “STI control”
- ❑ Replace United Kingdom definition of sexual health with accepted WHO definition
- ❑ Convey a more positive attitude to sexuality
- ❑ All dates in document to be reviewed and revised where necessary; make explicit rationale for choosing specific target dates

4. Recommendations from the Meeting

The following recommendations to Member States came out as a result of presentations and discussions held at the meeting:

- ❑ There is an urgent need to optimize the prevention of STIs in key populations being at risk and vulnerable to STIs
- ❑ Because STIs are facilitating HIV transmission and taking into consideration the fact that countries are facing HIV and STI epidemics, the existence of quality strategic information is vitally necessary to guide national efforts addressing both epidemics, improve prevention, control, treatment and care, enabling achievement of internationally approved goals including those of MDG and Universal access
- ❑ Sustainable state funding for STI control should be ensured across the region as currently in many countries state funding is either of short-term nature or just specific projects are being financially supported
- ❑ Threat of increasing gonococcal resistance should be addressed in a comprehensive and sustainable manner by developing and promoting national capacities for antimicrobial resistance monitoring first of all by expanding gonococcal antimicrobial susceptibility program (GASP) covering also eastern part of the Region.
- ❑ Heterogeneity of surveillance systems throughout the Region should be urgently addressed by promoting harmonization and ensuring availability of quality STI data and its comparability across the Region
- ❑ The elaboration of innovative approaches addressing STI needs of MSM including scaling up prevention, treatment and care also including needs of MSM living with HIV and co-infected with syphilis, hepatitis C and LGV thus preventing further growth of the existing epidemics among this group of population. Civil society involvement into the policy formulation, strategies, program development, and service provision should actively be promoted.
- ❑ Effective control and prevention approaches as well as ensuring access to quality treatment and care for young people should be elaborated and implemented responding, to the growth of Chlamydia infection in young people
- ❑ Responding to the increasing migration within and outside of the Region notably from Africa to western Europe, efficient approaches should be applied, aiming at prevention as well as ensuring equal access for migrants to services
- ❑ Special attention should be given to elaborate and implement appropriate interventions addressing needs for SW many of whom often are also migrants thus experiencing additional challenges. Along with sufficient prevention interventions, access to treatment, care and support services should be ensured for them
- ❑ Promote integration of STI services into non-specialist, primary health care settings
- ❑ Enhance access to services by key at risk and vulnerable population; ensure prevention of stigma, discrimination, violence and other possible abuse
- ❑ Bring STI case management including laboratory testing for STIs up to international standards

- ❑ Promote and implement syndromic case management in sites where aetiological management is not feasible
- ❑ Revise and abolish all kinds of mandatory, compulsory STI policies and practices such as mandatory testing and treatment (e.g. compulsory testing for certain professions where no scientific evidence proof of benefit or forced in-patient treatment) (1), criminalization of risk behaviours (2), limiting access to care on basis of age or restriction of care to dermato-venereologists (3), punitive measures for those who fail to take treatment or name sexual partners (4), police involvement in contact tracing (5)
- ❑ Ensure that treatment and care are always voluntary and based on informed voluntary consent

The Regional Office was requested to:

- ❑ promote the development of a Regional Framework for the implementation of the WHO Global STI control and prevention Strategy in the WHO European Region
- ❑ advocate for promotion of the STI agenda at national and international level
- ❑ establish a regional STI panel that would serve as advisory body to the Regional Office on STI issues
- ❑ revise the list of national STI counterparts as it seems to be outdated especially in eastern part of the region taking into consideration high turnover there
- ❑ implement a survey of current STI policies and strategies in the Regional Office as it would provide an important input to feed in the current Framework development
- ❑ validate CISID data
- ❑ accelerate congenital syphilis prevention efforts and movement towards its elimination in the region
- ❑ convene regular annual/biannual meetings of national STI focal points/coordinators as well as establish a mechanism of dynamic contacts with them, aiming at having working contacts on a permanent basis that would allow monitoring of progress made and provision of inputs required
- ❑ support expansion of gonococcal antimicrobial susceptibility program (GASP) covering also eastern part of the region by establishing of dedicated collaborating centre
- ❑ support further collaboration, partnership, sharing of good practice examples, capacity building as required, aiming at and contributing to the closing existing gaps across the region; establishing a “West for East” movement might be a promising initiative.

The GFTAM was requested to:

- ❑ further increase support for STI issues to be possibly provided by the GFTAM to get stronger help from GFTAM for improving STI control and prevention in GFTAM eligible countries

- ❑ better describe/reflect on the GFTAM web site the opportunities that STI settings could benefit from as well as reflect that in the next call for proposals to be issued by the GFTAM.
- ❑ address a false belief that exists in some EE countries that an inclusion of STI issues into the GFTAM proposals might lead to their rejection by providing respective explanations in the guidelines for the GFTAM proposal development.

The meeting called on participants to:

- ❑ advocate for promotion of STI agenda in their respective countries
- ❑ raise awareness of and ensure follow up on the implementation of meeting's recommendations in their respective countries
- ❑ raise awareness of the Regional Framework in their own countries
- ❑ get actively involved and provide input into the further steps of Regional Framework development
- ❑ promote dissemination and implementation of the Regional Framework when the final version becomes available
- ❑ ensure monitoring of Regional Framework's implementation
- ❑ promote closer working contacts with WHO including country offices as appropriate

Participants expressed a high appreciation to the Regional Office for the planning and the implementation of the Ljubljana STI consultation. It was widely acknowledged that a good representativeness of all the parts of the region – centre, east, west – as well as wide diversity of national and international stakeholders including policy-makers, program coordinators, civil society settings, national and international public health and STI experts, representatives of international organizations made a wide variety of perspectives possible and to address most important challenges and ways forward, giving hope that this consultation will be an important milestone on the way to improvement of STI control and prevention in the whole WHO European Region.

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| | <p><u>Discussion points:</u></p> <p>a) What is the current status of STI epidemic, progress made, challenges and opportunities;</p> <p>b) What are the roles of syndromic case management, laboratory testing or mixed models of care in different settings?</p> <p>c) How can standards of care be improved including that among private practitioners who offer STI care?</p> <p>d) What is needed to eliminate congenital syphilis at national level</p> <p>e) Are we doing enough to manage STIs among HIV positive populations?</p> | <p>1. Controlling STIs in Slovenia – E. Leskovšek</p> <p>2. Increasing STI prevalence in HIV infected MSM: implications for STI control and prevention: the Swiss experience – R. Staub</p> <p>3. STI epidemic, control and prevention in Kazakhstan - A. Sagyndykova</p> <p>4. STI epidemic, control and prevention in Kyrgyzstan - A. Myrzamamytova</p> |
| 10.30 – 11.00 | Questions & Discussion | |
| 11.00 – 11.30 | Coffee Break | |
| 11.30 – 12.30 | <p><u>Panel discussion I (cont'd)</u></p> <p><u>Co-Chairs/Co-Facilitators:</u> M. Dudas /A. Litzroth</p> | <p><u>Panelists:</u></p> <p>1. STI epidemic, control and prevention in Ukraine – O. Kolliakova</p> <p>2. STI epidemic, control and prevention in Uzbekistan - S. Ibragimov</p> <p>3. Strengthening national STI surveillance system: experience from Belgium – A. Litzroth</p> <p>4. STI surveillance and epidemiology in the EU/EEA - M. Van der Laar, ECDC</p> |

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| 12.30 – 13.00 | Questions & General Discussion | |
| 13.00 – 14.00 | Lunch | |
| 14.00 – 15.00 | <p align="center"><u>Panel discussion II</u></p> <p align="center">Strengthening STI surveillance. Improving quality of STI services.</p> <p align="center"><u>Co-Chairs/Co-Facilitators:</u> T.Varleva / R. Butylkina</p> <p align="center"><u>Discussion points</u></p> <p>1. What are the current gaps, challenges in STI data collection, monitoring, presentation and data use?</p> <p>2. How can STI surveillance be improved?</p> <p>3. How can countries be encouraged to follow international best practice with regard to evidence-based STI case management including partner notification and management ensuring anonymity/confidentiality?</p> | <p align="center"><u>Panelists:</u></p> <p>1. Addressing STI data quality. Strengthening national STI surveillance capacities: experience from Hungary – M. Dudas</p> <p>2. National STI notification and sentinel surveillance system -challenges and opportunities: experience from Germany – K. Haar</p> <p>3. Growing challenges for STI case management: threat of untreatable Gonorrhoea. Actions including monitoring of antimicrobial resistance (AMR) in GC are crucial! M.Unemo (Sweden)</p> <p>4. Improving quality of STI services: experience from Poland – B. Chodynicka</p> |
| 15.00 – 15.30 | Questions & General Discussion | |
| 15.30 – 16.00 | Coffee break | |
| 16.00 – 17.00 | <p align="center"><u>Panel discussion III</u></p> <p align="center">Promoting integration, collaboration, partnership. Improving STI prevention.</p> <p align="center"><u>Co-Chairs/Co-Facilitators:</u> B. Chodynicka/ O. Kolliakova</p> <p align="center"><u>Discussion points:</u></p> | <p align="center"><u>Panelists:</u></p> <p>1. Promoting HPV prevention. Role of combined integrated efforts in accelerating access to RH services and STI/RTI Prevention – G. Lazdane, WHO Europe</p> |

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| | <ul style="list-style-type: none"> a) How can STI prevention be strengthened b) What should be the priority actions to scale up STI care in different settings? c) What is needed to eliminate congenital syphilis at national level? d) How can sex education be improved? e) How can condoms' availability/promotion be scaled up? | <ul style="list-style-type: none"> 2. How can education for STI prevention be improved within healthcare settings: experience from Germany - C. Winkelmann 3. Promoting collaboration, networking supporting strengthening of STI control and prevention: experience of Eastern European Network of Sexual and Reproductive Health (EE SRH) – M. Domeika 4. Role of postgraduate education settings in improving of STI prevention, promoting collaboration, integration: experience from Azerbaijan – F. Alyev |
| 17.00 – 17.30 | Questions & General Discussion | |

DAY 2, 3 August 2010

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| 09.00 – 10.15 | <p style="text-align: center;"><u>Panel discussion IY</u></p> <p style="text-align: center;">Ensuring a supportive social, policy and legal framework for STI control and prevention.</p> <p style="text-align: center;"><u>Co-Chairs/Co-Facilitators:</u> R. Staub / L. Brussa</p> <p style="text-align: center;"><u>Discussion points</u></p> <ul style="list-style-type: none"> a. Why is a supportive social, policy & legal framework a prerequisite to efforts to scale up STI control? b. What is the situation in countries in the region with regard to providing such a framework? c. How can countries be encouraged to follow evidence- and human rights based policies and practices with regard to STI prevention, treatment, control including partner notification/management? | <p style="text-align: center;"><u>Panelists:</u></p> <ul style="list-style-type: none"> 1. Abolishing mandatory polices and practices in STI testing, treatment, and prevention, including that on partner notification and management: experience from Armenia – K. Babayan 2. Promoting evidence- and human rights' based STI policies and practices: experience from Latvia - V. Mavčutko 3. Progress and challenges in ensuring supportive policy & legal environment : |
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| | <p>d. What are priority actions to form supportive environment for strengthening STI prevention and control?</p> | <p>experience from Lithuania - R. Butylkina</p> <p>4. Ensuring a supportive social, policy & legal framework for STI control and prevention: Soa Aids Nederland perspectives – M. Diaz</p> <p>5. Role and potential of postgraduate education in promoting supportive social, policy and legal framework for STI control and prevention: experience from Belarus - O. Pankratov</p> |
| 10.15 – 10.45 | Questions & General Discussion | |
| 10.45 – 11.15 | Coffee break | |
| 11.15 – 12.30 | <p><u>Panel discussion Y</u></p> <p>Scaling up access to quality STI services for at risk and vulnerable populations. Role of civil society settings in expanding STI services.</p> <p><u>Co-Chairs/Co-Facilitators:</u> K. Lezentsev/ M. Diaz</p> <p><u>Discussion points:</u></p> <p>a) What are the needs for the expansion of STI services in the region?</p> <p>b) What should be the priority actions to scale up STI care for MARPs and vulnerable populations?</p> <p>c) What are the best models of care for working with different vulnerable populations, e.g. mobile clinics outreach or static services?</p> <p>d) Who are the most suitable partners for delivering effective to vulnerable populations?</p> | <p><u>Panelists:</u></p> <p>1. Offering STI services to at risk and vulnerable populations: progress and challenges in Estonia - M. Leimann</p> <p>2. Access to STI services for SW: Tampep perspectives – L. Brussa (Italy, International NGO Network)</p> <p>3. Access to STI services for at risk populations: progress and challenges in Bulgaria – T. Varleva</p> <p>4. Improving STI care for migrant populations in Tajikistan - A. Kosymov</p> <p>5. Access to STI services for MARPs and vulnerable groups. Civil society involvement in STI control and prevention – experience from Georgia – I. Mzavanadze</p> |
| 12.30 – 13.00 | Questions & General Discussion | |
| 13.00 – 14.00 | Lunch | |

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| <p>14.00 – 15.30</p> | <p style="text-align: center;">Plenary session</p> <p style="text-align: center;">Developing Regional Framework for the implementation of the WHO Global STI Strategy the WHO European Region</p> <p style="text-align: center;"><u>Co-Chairs/Co-Facilitators:</u> O. Pankratov/ S. Ibragimov</p> <p>1. Key aspects of the WHO Global Strategy for the Prevention and Control of Sexually transmitted infections</p> <p>2. Presentation of the draft:” Regional Framework for the implementation of the WHO Global Strategy for the prevention and control of STIs in the WHO European Region” and general feedback (including a brief overview of comments received to date)</p> <p style="text-align: center;"><u>Discussion points:</u></p> <p>a) What do you particularly like about the draft? b) What don’t you like about the draft? c) What is missing in the draft?</p> <p style="text-align: center;">Questions & Discussion</p> | <p style="text-align: center;"><u>Presenters:</u></p> <p>1. F. Ndowa, WHO HQ</p> <p>2. J. Richens, WHO consultant</p> <p>All participants</p> |
| <p>15.30 – 15.45</p> | <p style="text-align: center;">Coffee break</p> | |
| <p>15.45 – 15.50</p> | <p>Introduction to Working Group session</p> | <p>L. Khotenashvili, WHO Europe</p> |
| <p>15.50 – 18.00</p> | <p style="text-align: center;"><u>Working Group session</u></p> <p><u>Facilitators:</u> WHO HQ, WHO Europe Participants will be asked to divide into 4 groups</p> | |

DAY 3, 4 August 2010

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| <p>09.00 – 10.00</p> | <p style="text-align: center;">Plenary session</p> <p style="text-align: center;"><u>Co-Chairs/Co-Facilitators</u> V. Mavčutko / B. Reymkuliev</p> <p style="text-align: center;">Working Group presentations</p> <p style="text-align: center;">Questions & General Discussion</p> | |
| <p>10.00 – 10.15</p> | <p style="text-align: center;">Coffee break</p> | |
| <p>10.15 – 11.15</p> | <p style="text-align: center;">Plenary session</p> <p style="text-align: center;">Working Groups' presentations (<i>cont'd</i>)</p> <p style="text-align: center;"><u>Co-Chairs/Co-Facilitators</u> C. Winkelmann / I. Mzavanadze</p> <p style="text-align: center;">Questions & General Discussion</p> | |
| <p>11.15 – 11.30</p> | <p style="text-align: center;">Coffee break</p> | |
| <p>11.30 – 12.00</p> | <p style="text-align: center;">Plenary session</p> <p style="text-align: center;">Offering opportunities</p> <p style="text-align: center;"><u>Co-Chairs/Co-Facilitators:</u> A. Sagyndykova / A.Kosymov</p> <p>1. Global Fund support to prevention and management of STIs'</p> <p>2. Knowledge HUB on second generation HIV surveillance: opportunities for STI surveillance capacity building</p> | <p style="text-align: center;"><u>Presenters:</u></p> <p>1. P. Baijal, TGF</p> <p>2. I. Bozicievic, Zagreb KH</p> |

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| 12.00 – 12.30 | Questions & General Discussion | |
| 12.30 – 13.00 | <p style="text-align: center;">Plenary session</p> <p style="text-align: center;"><u>Co-Chairs/Co-Facilitators:</u></p> <p style="text-align: center;">A. Myrzamamytova /F.Alyev</p> <p style="text-align: center;">General Discussion</p> <p style="text-align: center;">Next steps</p> <p style="text-align: center;">Closing remarks</p> | <p>All participants</p> <p>L. Khotenashvili WHO Europe</p> |

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