STOP AIDS STD

STOP SYphilis CHLAMYDIA HERPES GONORRHEA
USE CONDOMS

STOPPING THE SPREAD OF SEXUALLY TRANSMITTED INFECTIONS IN EUROPE
ENTRE NOUS
The European Magazine for Reproductive and Sexual Health

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COMBATING THE SPREAD OF STIs IN EUROPE

The spread of sexually transmitted infections (STIs) in Europe has reached an alarming level. In addition to HIV/AIDS, to which there is still no known cure, the incidence of infections such as syphilis, chlamydia and gonorrhea is reaching epidemic proportions. The causes of this extraordinary rise in STI incidence are manifold. They include the tremendous social and economic upheavals associated with the newly independent states (NIS) and transitions to democracy in Eastern Europe, massive poverty: more than 30 million people in Russia alone live below the poverty line, and the refugee crisis on the Balkan Peninsula.

As discussed in this issue of Entre Nous the spread of STIs is especially prevalent among adolescents. In England, for example, the highest sex and age-specific incidence of genital chlamydia trachomatis infection was seen in women aged 16-19. In general, chlamydial infection was most common among sexually active people under the age of 25 (see the article by Carr in this issue for details).

The change in political systems in Eastern Europe has led to changes in lifestyle by all sectors of the population, though most notably adolescents. WHO technical advisor Ken Legins has reported that in Albania: “Young people are now free to buy condoms, receive family planning services, go to disco’s and watch late-night pornography on TV”. This has resulted in a change in social and sexual behaviour. In 1994 the first case of HIV was officially diagnosed and in 1995 the first case of syphilis was officially reported.

UNFPA and WHO have responded quickly and comprehensively to the new developments. In 1998 the Task Force for the Urgent Response to the Epidemics of Sexually Transmitted Diseases in Eastern Europe and Central Asia (TF/STD) was established, with its secretariat at the WHO-European headquarters in Copenhagen. The task force, as discussed on pages 4-5, has identified priority areas for controlling the STI epidemics and has co-ordinated with major international organisations and donor agencies. Moreover, UNFPA funded projects throughout the region work locally and nationally to develop strategies and respond to real situations.

A key strategy to preventing and treating STIs is the integration of STD prevention and care into family planning services. The University of Heidelberg recently conducted a survey on this topic in Eastern Europe and Central Asia. The conclusion was that the advantages of integrating STD prevention and care tasks into reproductive health services clearly outweigh the perceived disadvantages, such as the need to train FP providers in STI counselling. Ultimately, integration of services will allow a greater proportion of the population to be treated for STIs.

In April 1999 UNFPA and WHO held the annual meeting of WHO-EURO Reproductive Health Project Co-ordinators. The scope and purpose of the meeting encompassed a discussion of new technical developments in reproductive health including the introduction of emergency contraception and integration of STD and RH services. Here, it was again agreed that in spite of the obstacles, efforts at the country level should be focused on achieving integration of services.

In giving an overview of examples of newly initiated country programmes and projects, this issue of Entre Nous aims to inspire colleagues working in the field to take up similar challenges in their own professional surrounding. Only a concerted effort of forces working in public health, reproductive health and health promotion will be effective in rolling back the epidemic presently threatening men, women and young people throughout central and Eastern Europe.

Finally, many readers will notice the change in terminology regarding sexually transmitted diseases and infections. The term disease is regarded as inappropriate for asymptomatic infections which are a major problem in the management of STDs. Additionally, many professionals working in this area would like to see the term STD used in the context of reproductive tract infections (which include endogenous and exogenous sexually and non-sexually transmitted infections). A new public health approach linked to HIV/AIDS prevention and to management of reproductive health issues has driven this change. Therefore, the new term Sexually Transmitted Infections (STI) should replace Sexually Transmitted Diseases (STD).

Upcoming issues of Entre Nous will focus on social deprivation and poverty and reproductive health (RH), genetic disorders and the role of men in RH. As always, contributions from our readers are welcome.

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THE EUROPEAN STD TASKFORCE

The Task Force for the Urgent Response to the Epidemics of Sexually Transmitted Diseases in Eastern Europe and Central Asia (TF/STD) was established in February 1998 in response to the extraordinary rise in incidence of sexually transmitted diseases (STDs) in that part of the world. In addition, the advent of an STD epidemic of the scale depicted in the graph below, poses a very real threat of a devastating HIV/AIDS epidemic.

Background
During the last 10 years tremendous social and economic upheavals have occurred throughout what is now called the newly
independent states (NIS), in the wake of the transition to a market economy. The fragmentation of the USSR has led to the collapse of industrial and economic links between the various republics, which in turn has led to very high levels of unemployment and severe poverty.

Moving from a situation of full employment to one where over 30 million people in the Russian Federation, alone, now live below the poverty line, has had dire consequences on the population. Up to 80% of the unemployed are women, many of whom have turned to prostitution in order to survive — now more frequently referred to as the commercialisation of sex. Many so-called sex workers operate on a part time or periodic basis, travelling away from the rural areas towards the larger urban areas. These women, as well as their clients, run terrible risks of catching diseases — particularly STDs. Frequently, they are not aware of the risks; they are not able to protect themselves; or they do not know how to protect themselves.

Extreme poverty has also led to a significant weakening of the physical and moral condition of the population, particularly among young people, due to:

- drug abuse;
- the increase in alcohol consumption;
- malnourishment;
- heavy smoking;
- an increase in violence both within the family as well as on the streets — organised crime has become rife;
- an increase in refugees and homeless.

Young people start sexual relations at an increasingly early age and often in an unsafe environment, in which they are unaware of the consequences of their behaviour. As a result the rise in incidence of STDs has been most significant among young people.

Many young girls have also turned to prostitution, often forced into it as a result of poverty and because there is a demand for younger girls by men who mistakenly believe that they will run a lesser risk of catching disease.

**Syphilis**

Because the reporting of syphilis cases is compulsory, this disease has become the benchmark of all STDs when looking at trends. While the average incidence of syphilis in the Russian Federation is 270, this rate can vary tremendously from region to region, as shown on the map below:

The incidence of the other two major STDs: gonorrhoea and chlamydial infection, are also high. However, the statistics regarding these two diseases are considered unreliable due to under-reporting.

The medical services in most of the NIS still operate as they did during the Soviet era, though with a significantly reduced budget. Discrimination and stigmatisation of STD patients and vulnerable groups still persist. Treatment methods are very outdated and very unpleasant. As a result, private STD services have blossomed, though they are often run by unqualified treatment providers, offering an alternative to the unpopular public service, at a price. The alternative for the poor has given rise to a distortion of the statistics: an estimated 30% of the infected people remain outside any registered health-care services — often they simply do not consider the symptoms and signs as a manifestation of an STD.

In the present economic climate, the manifestation of diseases are aggravated by poor nutrition, anaemia, alcohol abuse, etc. In the case of syphilis, unusually severe gangrenous forms of primary lesions can be observed.

STDs are not only a concern because of the discomfort caused by acute infection. They can also have terrible consequences, such as causing damage to the nervous system, infertility, ectopic pregnancy, urethral stricture, cervical cancer, premature mortality, congenital syphilis, fetal wastage, low birth weight, prematurity, opthalmia neonatorum and other complications.

"In the case of syphilis, unusually severe gangrenous forms of primary lesions can be observed."
About the STD Task Force

The founding meeting of the TF/STD was held at the WHO Regional Office for Europe (WHO/EURO) on 23-24 February 1998. The meeting, which was co-sponsored by WHO/EURO and the Joint United Nations Programme on HIV/AIDS (UNAIDS), was a follow-up to the meeting on 30 June-1 July 1997 at which representatives from international organisations agreed on the necessity to establish a task force to mobilise and coordinate international assistance for STD control in the region. The TF/STD met twice in 1998, and plans to meet twice during 1999 and 2000.

The TF/STD now covers the following 18 priority countries: Albania, Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Romania, The Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Priority areas have been identified for controlling the epidemics:

- the introduction of sexual health promotion;
- the integration of STD and HIV prevention;
- the introduction of confidentiality into the health-care system, allowing patients to choose where they will be treated;
- the abolition of obsolete repressive legislation which exists towards patients and their sexual contacts;
- a shift from in patient to out-patient care;
- the provision of affordable and free-of-charge STD services, including condom distribution;
- the abolition of obsolete treatment regimes requiring long-time hospitalisation.

Major international organisations and donor agencies have agreed to coordinate their efforts in order to assist the countries in such areas as programme planning, management, monitoring and evaluation, designing interventions and services, developing and pre-testing educational messages and material, STD case management, counselling and communication skills, laboratory methods for reference level laboratories, provision of drugs, diagnostics, condoms, qualitative and quantitative research methods, epidemiological surveillance for STDs and behavioural studies.

Besides WHO and UNAIDS, participants have included international organisations such as UNICEF, UNFPA, World Bank, IFRC, International donor organisations: USAID, DIFD UK, The Open Society, Centre for Disease Control (CDC), implementing agencies such as Médicins sans Frontières (MSF), American International Health Alliance (AIHA), Russian Association against Sexually Transmitted Diseases SANAM; government agencies such as DANIDA (Denmark), GTZ (Germany), National Institute of Public Health (Norway), the Ministry of Foreign Affairs (Finland); academic and research institutes as well as representatives from the countries in question. Participation will be widened to include further organisations in 1999 and 2000.

Data on the incidence of syphilis for 1998 is not yet available. However, the data that is available, given above, shows that the rate of increase in syphilis cases in the region has begun to stabilise recently, and in some areas has declined. Clearly, some of the efforts being conducted at a local level and at a national level, together with the support and assistance from international organisations and governments abroad, may be beginning to pay off. However, there are also an increasing number of patients who are unable or unwilling to go to the STD services. There are a number of reasons for this:

- Sex workers often travel away from their home district to the larger cities where the prospects of more clients is greater but where they cannot use the public STD services because they are registered in another district.
- With the advent of alternative, more caring STD facilities the public STD services have become increasingly unpopular.
- In rural districts, in particular, extreme poverty means that some patients cannot afford the bus fare to get to the nearest public STD facility.

The key words identified by the TF/STD in developing the STD care facilities in the region are: affordability, acceptability and accessibility.

In pursuit of these, WHO has, amongst other actions, established some “best practice sites” in the region. Drugs have been provided to these best practice sites so that they can be administered to patients free of charge. Training programmes are being conducted by a number of organisations in order to update treatment methods as well as to develop counselling skills, etc. Women’s wellness centres are being established, providing a more integrated approach to STIs. More up-to-date treatment methods and drugs are being provided and tried. In more that 15 cities in the Russian Federation the STD services can now provide anonymous treatment for patients. Condoms are being provided by donor agencies to some of the centres so that patients can obtain them free of charge. Informational material has been and is being developed in local languages. Efforts are also being made to introduce sex education in schools; this, however, is a slow process owing to prevailing attitudes which have remained static over the past 70 years. Advocacy work at the governmental and local level is also an ongoing process.

Many of the projects being carried out in the region seem very local, and could almost appear to be like a drop in the ocean, considering the scale of the problem. However, the members of the TF/STD are very aware of the importance of working at a local level, working with the people who are dealing with the problems on a day to day basis - because this is the most effective way of disseminating knowledge, know-how and information.

There is still a great deal to be done. Priorities for the immediate term are as follows:

- Continuation of advocacy for the reorientation of STD services, towards the WHO recommended public health approach to controlling the STD epidemics;
- To broaden the “best practice sites” concept to best practice areas, zones, oblasts and eventually to best practice republics;
- Building in appropriate STD case-management;
- The promotion of sexual health and primary prevention;
- The provision of drugs and condoms;
- Assistance at local STD centres.

The Secretariat of the TF/STD is based at WHO’s European office in Copenhagen. Copies of the reports of the TF/STD meetings can be obtained from:

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STD PREVENTION AND CARE

Integrating STD prevention and care into family planning services

Preliminary results of a regional survey carried out in Eastern Europe and Central Asia.

Since the early 1990s the countries of Eastern Europe and Central Asia have been confronted with rapidly expanding STD epidemics. In Central Europe and South-eastern Europe, STD have spread less dramatically. The main elements and features of the traditional STD control system of the USSR and the other Eastern European countries were vertical clinical services that provided free high-quality diagnosis and treatment, exhaustive procedures for tracing the sexual contacts of infected individuals; an extensive programme of routine screening in clinically and occupational defined groups; the requirement for patients to produce identity documents, and the use of criminal and civil sanctions to enforce treatment, contact tracing and screening. Primary prevention was neglected.

The system was reported to be effective within the political, social and ideological environment of that time, but during the economic transition, STD (including HIV /AIDS) cases throughout the region have multiplied while the capacity to deal with these problems has shrunk. Public STD services now increasingly rely on the voluntary participation and attendance of persons at risk of or affected by STC, rather than on active case finding through screening and case and partner tracing. To be effective, services must be re-oriented towards client’s needs. They must be easily accessible, affordable, non-judgemental and confidential.

One potential strategy to adapt STD services to this new reality is to combine them with other reproductive health services, notably with mother-and-child health care and family planning (MCH/FP). Among other benefits, it is expected that the quality of the combined service improves, e.g., when doctors and nurses of different specialisations are trained in and practice sexual counselling and health education.

Access to STD care might also improve, as the number of facilities that diagnose and treat STIs increase. Finally, services might not only become more client-friendly but perhaps also more cost-effective, as several tasks can be performed on one visit and by the same provider.

Based on this regional and conceptual background, a preliminary review of the current status of reproductive health pro-

grammes and of existing experience with the integration of STD and FP services was initiated by WHO and UNAIDS. National MCH/FP focal points in 22 Eastern European and Central Asian countries in the region (Azerbaijan, Belarus, Bosnia, Bulgaria, Czech Republic, Croatia, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Lithuania, Latvia, Moldova, Poland, Russian Federation, Romania, Slovenia, Slovakia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan) were requested to fill in a short questionnaire on the provisional of STD care and prevention, including STD information and health education, STD screening, STD diagnosis and treatment through FP services, in their countries. In addition, focal points have been asked about their personal views concerning the advantages and disadvantages of STD/FP integration and on expected obstacles to the successful integration in their countries. By February 1999, 17 out of the 22 Focal Points (Belarus, Bosnia-Herzegovina, Bulgaria, Czech Republic, Croatia, Estonia, Georgia, Kazakhstan, Lithuania, Moldova, Poland, Romania, Slovakia, Slovenia, Tajikistan, Turkmenistan, Ukraine) had responded to the questionnaire, while information is still awaited form several important countries, including the Russian Federation.

STD screening among women attending FP services is routine practice in many countries, while in Belarus, Bulgaria, Czech Rep., Estonia, Georgia, Lithuania, Kazakhstan, Slovakia, Turkmenistan and the Ukraine. In Bosnia-Herzegovina, Moldova and Tajikistan, only “suspect” clients are screened. (The criteria for being considered as “suspect” were not stated). Most screening is carried out for syphilis.

Whether gynaecologists and FP providers treat STDs appears to depend, to a large degree, on policies and regulations governing STD treatment. In Belarus, Estonia, Georgia, Kazakhstan and Ukraine gynaecologists are allowed to treat all STDs except syphilis, while in Lithuania, Moldova, and Poland gynaecologists are licensed to treat all STDs other than syphilis and gonorrhoea. In Turkmenistan gynaecologists may treat trichomoniasis only. Other respondents did not specify whether gynaecologists were allowed to treat all STDs, or whether certain etiologies were excluded. Only in the Czech Republic were gynaecologists not allowed to treat any STDs, but this information might require confirmation.

In some of the Central European and Baltic countries general practitioners (GPs) provide both, FP and STD services. These are countries where health sector reforms aiming to establish health insurance schemes and comprehensive family practitioner type services are most advanced.

Given the great demand for STD services in most countries of the region, it would appear likely that where gynaecologists and GPs are permitted to treat STDs, they also do so. The extent to which STD treatment has already become routine or remained the exception in the daily work among gynaecologists and GPs in these countries nevertheless needs further investigation. Another issue which needs further assessment is whether services are genuinely integrated or simply provided at the same location, but by different providers or at different times. For instance, some reproductive health service providers might consider the risk of STDs when deciding on the prescription of a specific contraceptive method, whereas others do not. Some might routinely include messages on STD prevention and sexual counselling in family planning counselling, others not.

"STD information and education appears to be an integral part of the work of FP providers and gynaecologists in most countries."

STD information and education appears to be an integral part of the work of FP providers and gynaecologists in most countries. Respondents from all countries except Bosnia-Herzegovina and Kazakhstan reported that public FP service providers working from gynaecological departments and “Women’s Consultation Clinics” (WCCs) inform and educate their clients about STDs. Details on the type of information and the messages disseminated have not been provided, however, and it is therefore not clear whether each FP client or only selected clients, for instance those considered at risk or found to have STD symptoms, are provided STD information. For example, the respondent from Estonia stated that only those clients “who need it” receive STD information.
The most important advantage of FP/STD integration perceived by the national FP/MCH Focal Points was the better accessibility, convenience and acceptability of integrated services for female clients, while its most important limitation was the failure of integrated services to address and attract male clients. Only the respondents from Belarus and Croatia expected a positive effect on male involvement in family planning from combined FP/STD services. For the respondent from Slovenia, reaching the male part of the population through FP services appeared difficult because “men are not used to attend FP services and FP services are not used to deal with men”. It would be “difficult to treat spouses” as men would have to be referred to STD clinics (Lithuania). None of respondents mentioned that integrated FP/STD services might treat the male partners of their female STD clients at the FP clinic site too.

The following advantages of integrated services have been mentioned. Integrated services are perceived to be more “user-friendly” (Moldova) or “more convenient for the patient” (Slovakia) as “both services would be provided by one doctor” (Moldova). Integrated services may also be more effective as “doctors and patients know each other better” (Bosnia) and “FP providers often have the trust of their clients” (Georgia). In countries where FP specialists are specifically trained on counselling skills, they may easily become competent counsellors on STD and HIV (Romania). FP services are preferred by women in need of STD care, because they are perceived to be less stigmatised than STD clinics. “Women think it is less shameful to attend a FP service” (Lithuania). By contrast, STD clinics lack trust and popularity. “STD care provided through Dermatovenerology clinics is simple and effective”, but there is “bad compliance on the part of the population” and such clinics have a “bad reputation in the society” (Czech Rep).

“Improved access to STD services and thus an increase in coverage of STD prevention and care is also expected from integration.”

Improved access to STD services and thus an increase in coverage of STD prevention and care is also expected from integration (Georgia, Georgia, Romania). STD may be detected earlier (Croatia), as women may use “both services at the same time”. FP clinics often represent the only contact with the health care system” (Georgia), and

the combination of both services in one should therefore be more cost-effective (Georgia). FP services provide excellent “opportunities for STD education” (Georgia). Integrated reproductive health services should be made accessible to women (Romania).

In addition to the difficulties with regard to male motivation, the respondent mentioned the following disadvantages and limitations of integrated services. The integration of either STD prevention and STD care or both would increase the workload for FP providers (Slovenia, Georgia). There would be a lack of STD diagnostic facilities in FP services (Romania). FP providers might neglect FP counselling in favour of financially more lucrative STD care services (Ukraine). Finally, traditional FP services do not attract populations at an increased risk of STD, like “young, single and sexually active women”, “sex workers” and “homosexuals” (Czech Rep, Georgia).

The additional cost of STD prevention and care service provision (Belarus, Croatia, Estonia, Slovenia) and the lack of skills in STD counselling and case management among non-venerologists (Belarus, Slovenia, Tajikistan, Lithuania) are regarded as major obstacles for the integration of STD services into FP services. The lack of adequate STD diagnostic facilities (Tajikistan) is also seen as an important barrier. Several respondents also mentioned either restrictive regulations on STD treatment and the objection of venerologists to STD/FP integration (Moldova, Turkmenistan, Ukraine, Lithuania, Kazakhstan), or resistance to merge or overcome separate administrative arrangements for STD and FP service provision within the Ministry of Health (Ukraine).

Respondents from Romania and Bulgaria stated that the health sectors in their countries are at present undergoing reform processes and that these processes, because of their slowness, effectively hinder a fast RH service integration. Nevertheless, the ultimate aim of health reforms is the integration of services including STD at the primary care level. In countries where health insurance systems are already in place, they either do not include STD prevention and care (Slovenia) or they usually do not allow for the adequate coverage of costs for education and counselling (Estonia).

In summary, in the views of most eastern European national FP/MCH Focal Points, the advantages of integrating STD prevention and care tasks into family planning services, in terms of improved quality of services, client satisfaction and access to STD services, outweigh the perceived disadvantages, such as increased workload and the need to train FP providers in STD counselling and case management skills. Nevertheless, major legal and economic barriers exist that have so far prevented successful integration of services. Policies and regulations that prevent FP service providers and gynaecologists from treating STDs need to be modified, and the cost-effectiveness of integrating either STD prevention, screening and treatment or a combination of these tasks into Family Planning services need to be further investigated.

References are available from the authors.

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Sexually Transmitted Diseases

The increase in the incidence of STDs and more specifically syphilis over the past 12 years (1990: 378 cases, 1998: 2520 cases) has been identified as a high priority problem in Bulgaria, where DWB has been working since 1997.

Even if the prevalence of AIDS is still low, there is a risk of an outbreak of an AIDS epidemic, given the interaction between AIDS and other sexually transmitted diseases. This has been the case in the Ukraine and in Albania, countries belonging to the same geographical and political context. Until 1998, only 300 cases of seropositive individuals had been registered in Bulgaria, a statistic which seriously underestimates the real incidence of the disease. In fact, WHO estimates that the number of cases is ten times higher.

The official treatment for syphilis which has been in effect since 1978 is based on a treatment procedure using crystalline penicillin, which necessitates hospitalization of the patients, very often for a period of several weeks. The cost of this treatment varies between 22,000 and 50,000 BGL, without taking into account the costs of hospitalization and the patients’ food. In addition, one must not forget the high socio-professional cost suffered by syphilis patients as a consequence of their hospitalization.

Other treatment procedures which are in accordance with the recommendations of WHO and which are based on delayed-release penicillin are much more suitable in our opinion. They are less expensive (1,200 to 3,500 BGL) and their administration is facilitated by the fact that hospitalization is no longer necessary, which therefore also makes the procedures more acceptable to patients.

In the light of this problematic, Doctors Without Borders (DWB) Switzerland set up a pilot project in July 1998 in six hospitals, motivated by a recommendation from the National Chair of Dermato-Venereology for the implementation of a new treatment procedure based on WHO recommendations. Our general objectives were to support the implementation of the new recommended treatment procedure and to encourage the Bulgarian Minister of Health to adopt a new ordinance regarding syphilis treatment.

An initial assessment was undertaken in January, 1999 in order to evaluate the evolution of the project within the hospitals involved but also to find out the reasons why the new recommended treatment procedure was not being implemented by the practicing physicians.

The methodology applied was the review of patients’ medical files, collating the following information: total number of patients treated, age, sex, stage of the disease (primary, secondary, latent), treatment procedure implemented, number of contacts located and treated.

The total number of patients treated between the months of July and December was 274, of which 50% were under the age of 25. The numbers of patients of each sex were identical.

Approximately half of the patients were in the primary stage at the time of diagnosis, which indicates a high rate of incidence of primo-infections.

The treatment procedures which were implemented throughout the project were very varied in terms of the medication used and the length of treatment.

This mixture of different treatment procedures results in an increase in the cost of treatment. It also indicates a lack of coherence in the criteria espoused by the physicians prescribing treatment.

Resistance to adopting a new treatment procedure is in many cases related to the fact that the old ordinance of 1978 is still in effect. It is therefore urgent to annul the old ordinance in order to ensure the rapid implementation of the new treatment procedure, based on the WHO recommendations.

It is clear that the low number of contacts located (between 30% and 65%) in the majority of hospitals and the high number of patients lost in the course of treatment or serological follow-up is due to the nature of the treatment itself, as well as to the need to have retesting done every month. In effect, this involves a significant commitment on the part of the patient, both in social terms and economically. In addition, confidentiality is difficult to ensure, due to the length of hospitalization among other reasons.

Until now, treatment went hand in hand with certain methods of bringing pressure to bear on the patient, such as police escort. Such methods may have been effective during the Communist era, but that is certainly no longer the case, as we have been able to determine in the course of this pilot project.

It is clear that once again, the young age of the patients, of whom half are under 25, forces us to take into account the fact that the target population is no longer the same as before and that the means to be employed must be adapted as a result.

This project has highlighted the urgent need to supplement the treatment of syphilis (and other sexually transmitted diseases) with systematic action involving counseling, health education, and the distribution of condoms, activities which at present are wholly neglected by the specialists, very often due to a lack of means and information.

For these reasons, DWB is planning to implement a programme in the near future for the control of STDs and AIDS. This new programme is to be developed in a dispensary clinic for dermatovenerology in the city of Sofia. It will aim to introduce revised treatment procedures which do not involve hospitalization for STDs including syphilis. The programme will involve national specialists, so that the confidence level of the patients is raised and consequently their cooperation and the coverage of the programme is enhanced. The project will aim to demonstrate the usefulness of these treatment procedures for a rapid, effective and inexpensive diagnosis and cure of the disease.

Emphasis will be placed on training the Bulgarian professionals to respect the patients and their contacts, their right to confidentiality, and to reinforce therapeutic services and health education, as well as the distribution of condoms and access to HIV testing with pre- and post-counseling.

The purpose is to create a service for the treatment of STDs which is accessible and attractive to the most vulnerable populations and which can serve as a model for other similar centres which exist in the country.

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ALBANIA

STDs and Youth Culture

Leather Italian shoes with zippers and snaps, MTV sex talk shows and the love losses of Forrester on the soap opera Beautiful are topics of discussion, when once chatting about or knowing of these things was forbidden. Albania has found itself inundated with the “modern world’s” popular culture, and with that exposure has come the freedom of looking and behaving differently.

Young people are the most adamant purveyors of the emerging Albanian culture trends. The common games of youth are apparent in the streets of Tirana. Young people are now free to buy condoms, receive family planning services, go to discos and watch late-night pornography on TV.

What has this meant for the health of young people, and Albanians of all ages? Sexually transmitted diseases (STDs) have emerged. This may have been no surprise to international health experts, but it was a surprise to Albanians. For nearly 20 years there were no diagnosed cases of syphilis and HIV/AIDS was practically unknown. In 1994 the first case of HIV was diagnosed, while in 1995 the first case of syphilis was reported. Gonorrhoea has been present in the population for many years. However, it is difficult to assess trends because of a lack of reporting and diagnostic tools coupled with the physician’s inability to clinically evaluate patients because of their lack of knowledge about STDs.

Additionally, Albanian law requires that physicians report the names and addresses of any patients diagnosed with a STD. Given the prevalent sense of community, even in urban areas, revealing your name is an obstacle to seeking health care services.

Along with the epidemiological evidence of emerging health concerns, the traditional stereotypes of individuals with STDs have also surfaced in Albania. “The evil of prostitutes and refugees”, is a phrase that characterises many Albanians’ thoughts on STDs. Refugees, according to Albanians, are those who travel to foreign countries and are returned to Albania after being arrested for illegal immigration. This often happens with young girls who become or are lured into becoming prostitutes in the hope of achieving a better life.

Considering the lack of STD knowledge among service providers, the lack of anonymity in health care centres, prevailing myths about the transmission of STDs including HIV, and the return of Albanian refugees, young people face many challenges as they integrate Western popular culture into their lifestyles. An interview with Koloreto Cukalli, an administrator at a youth centre in Tirana, explains that young people still do not consider STDs a threat to their health. He says that young people still believe that STDs and HIV are problems of prostitutes and drug addicts. And even if they had concerns they would not be sure where to go.

UNFPA, WHO and the Academy for Educational Development (AED) are embarking upon an ambitious project to educate Albanians about the risks of STDs and HIV, in addition to working with maternal health issues. During a recent information, education, and communication (IEC) roundtable over one hundred Albanian professionals in the areas of reproductive health, family planning, sexual health, health education and social journalism convened to discuss problems and priorities to facilitate the development of a national IEC strategy.

The problems of greatest concern to Albanian key professionals were STDs/HIV/AIDS, maternal mortality, unwanted pregnancy and the excessive use of abortions. Other problems that were of moderate to low concern were gender violence and genital cancers. Many professionals stated that much needs to be done about infant mortality. Social journalists cited a need for centralised distribution of health-care materials to better inform the public about health concerns. Health educators, along with most of the participants in the IEC roundtable, were very concerned about the lack of sexual education in the school system.

Discussions concerning target groups revealed that young people, women and services providers in the rural areas are in the greatest need of IEC interventions. JNFPAs, WHO and AED in conjunction with international and national NGOs will be collaborating to address the health problems named by key Albanian professionals. As STDs are a major concern of key persons, youth will be the focus of many interventions. The lifestyle changes that young people face today are different than their parents, and more importantly young people are eager to be successful and healthy in the new Albania. The means and knowledge to obtain healthy lifestyles is the goal.

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ARMENIA

Reducing Morbidity Due to STDs

Although the level of STD/HIV infection in Armenia is not as high as in the other republics of the NIS, the situation as regards some STDs is alarming (Table 1). However, it is important to note that the high incidence of STDs in the other NIS countries has a direct impact on the situation in Armenia due to constant migration between Armenia and neighboring republics.

Data analysis has shown that during the past 5 years the incidence of syphilis has continued to increase. Concomitantly, the presentation of the disease itself is also transforming, i.e. the proportion of early and late stages show a higher prevalence of the latter, whilst in 1994 there were 61% of early forms vs. 39% of late stages in 1994, to 46% early vs. 54% late in 1997. The finding of the sources of infection decreased from 62% to 53%. Cases of congenital syphilis have once again been registered while congenital syphilis was unknown for decades: 5 cases in 1996, 8 in 1997 and 10 cases in 1998.

Control of STDs decreases the incidence of genital ulcer syndromes as well as discharge syndromes, leading to a decrease in the incidence and prevalence of HIV infection. One of the activities to control the spread of STDs, mainly syphilis, is the screening of all women with pelvic inflammatory disease (PID).

In order to further prevent the spread of STDs, it is necessary to design and implement government programmes for their control, including methods of diagnosis, treatment, prevention as well as educational and sociological surveys. Another form of control is the screening of all pregnant women for STDs during the course of pregnancy (twice). Along with the screening, educational materials should be distributed.

During the past couple of years the Medical-Scientific Centre of Dermatology & STDs organised 18 TV and 21 radio broadcasting programmes on safe sex, sexual hygiene and prophylactics.

For the education of the population at large, two booklets were published. As for training of medical personnel a national curriculum on STDs and an atlas are being prepared with 220 colour slides on the clinical manifestations and diagnostics of STDs (for STD specialists as well as for gynecologists, urologists and sexopathologists).

The scientific staff of the Centre has already published 22 scientific articles and 1 book on STD problems.

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**TABLE 1**

STD INCIDENCE IN ARMENIA 1994-1998

| Year/Category               | 1994 Actual no. of reported cases | Per 100,000 population
|------------------------------|----------------------------------|--------------------------
| Syphilis                     | 428                              | 11.5                     | 448 | 12.1 | 657 | 17.7 | 626 | 16.9 | 497 | 14.2 |
| Gonorrhea                    | 1253                             | 33.9                     | 1374 | 37.1 | 1429 | 38.6 | 1050 | 28.4 | 1115 | 31.9 |
| Trichomonas                  | 3111                             | 84.1                     | 3262 | 88.1 | 3473 | 93.9 | 2425 | 65.5 | 2204 | 62.9 |
| NGU*                         | 2324                             | 66.4                     | 4081 | 116.1 | 4125 | 117.9 | 5248 | 149.9 | 4826 | 137.9 |
| Scabies                      | 7927                             | 214.2                    | 8577 | 231.8 | 17114 | 462.5 | 10426 | 281.8 | 6091 | 174.1 |
| Candida                      | 418                              | 11.3                     | 507 | 13.7 | 480 | 13.1 | 551 | 14.9 | 1789 | 51.1 |
| Genital Herpes               | 119                              | 3.2                      | 108 | 2.9 | 133 | 3.6 | 174 | 4.7 | 427 | 12.2 |
| Genital warts***             | 85                                | 2.3                      | 78 | 2.1 | 91 | 2.5 | 124 | 3.3 | 204 | 5.8 |
| HIV/AIDS**                   | 3                                 | 0.08                     | 11 | 0.3 | 25 | 0.7 | 24 | 0.68 | 11 | 0.3 |

* Chlamydia, ureaplasma and Gardnerella
** according to HIV/AIDS Centre
*** Possibly caused by human papilloma virus
CHLAMYDIA: A problem for family planning services

Chlamydia is the commonest cause of infertility world-wide. Sexually transmitted, it affects young people around the globe. Of the estimated 333 million new cases of sexually transmitted disease occurring worldwide, one third of those are in people under the age of 25. The UK prevalence in males is 80 per 100,000 inhabitants and in females it is 104 per 100,000.

In England, amongst attendees at genitourinary medicine clinics, the highest sex and age-specific incidence of genital chlamydia trachomatis infection was seen in women aged 16-19, followed by females aged 20-24 and males aged 20-24. Other surveys have reported similar findings and in Scotland over 90% of all positive chlamydia tests on females are in women under the age of 30. About 80% of infections in women and 50% of those in men are asymptomatic. Chlamydia is an organism which, if left untreated, is associated with many unwanted sequelae.

Pelvic inflammatory disease (PID), which is inflammation of the upper reproductive tract, carries a 17% risk of future infertility. Chlamydia has been isolated in between 5-50% of women seeking care for symptoms of PID. Some studies on chlamydia and PID in infertile women have shown that only a small proportion of women with tubal factor infertility reported a past history of salpingitis. This appears to confirm that the majority of infections go undetected.

Infertility affects 1 in 7 couples in the United Kingdom. 36% of this is associated with tubal disease. Of these cases 75% are associated with chlamydia. Ectopic pregnancy is more prevalent in women with tubal disease. Chlamydia is associated with 40% of ectopics.

At Risk Population
Increased risk of chlamydial infection has been shown in sexually active people under the age of 25. Those who are single, nulliparous, have a new sexual partner within the last three months, left school at a young age and who are either using the contraceptive pill or no contraception. Ethnicity is also a factor. Ultimately, age, recent sexual partner change and two or more partners in the previous twelve months are the most common risk factors.

Genital chlamydial infection is also associated with cervical abnormalities, vaginal discharge and other sexually transmitted diseases. As chlamydia causes ophthalmia neonatorum and pneumonitis in the newborn, young pregnant women are an important "at risk" group.

Screening
At present, there is no evidence base for population screening. However, as more than 50% of chlamydial infections are asymptomatic it is essential to try to detect these infections in order to treat and eradicate the infection. All patients who are symptomatic should be tested for chlamydia. In addition, those groups which have risk factors for the infections and are able to be accessed by clinical services should also be screened. These groups are those under the age of 25, all attendees at genitourinary medicine clinics, women requesting termination of pregnancy, those seeking emergency contraception, men and women with recent change of partner, couples being investigated for infertility, and sperm and egg donors. It is also considered good clinical practice to screen all women before instrumentation of the cervix, particularly pre-IUCD insertion.

Laboratory Tests
Currently, the new molecular approaches to diagnosis such as Ligase chain reaction (LCR) or polymerise chain reaction (PCR) can detect very low levels of chlamydia trachomatis infection. Confirmation is required. There are still unresolved questions about the presence of inhibitors of the amplification procedure.

No single clinical sample for a patient is 100% sensitive. The new tests, however, provide a higher sensitivity than that of the previous gold standard which was chlamydia culture (See Figure 1).

Education
It has been shown that in areas where there is solid provision of sex education, there is a lower prevalence of sexually transmitted diseases (STDs) in young people. Therefore, teaching about STDs including chlamydia should ideally be included in quality, school-based sex education programmes. Sadly, in the UK this health education provision is frequently inadequate, and knowledge of chlamydia is the population is low. It is therefore of vital importance to take advantage of every appropriate opportunity, especially with young people, to provide the information needed to make healthy choices about sexual activity.

Service Provision
There are a variety of services which provide testing and treatment for chlamydia. In the UK these are predominantly genitourinary medicine clinics (GUM), family planning services or general practitioner surgeries. There is now a move towards better integration of sexual health services. However, it is essential to be able to deal with the patients where they present, as they may never access other services. The median prevalence of positive tests from these settings has been reported as 16.4% in GUM, 8% in women requesting termination of pregnancy, 5.1% in family planning and 4.5% in general practice. A recent pilot study of urinary testing in patients requesting emergency contraception in a family planning clinic in Scotland showed a 10% prevalence, suggesting that this is also a high risk group.

Figure 1
Relative limits of detection of different technologies used to diagnose C. Trachomatis. The data are log numbers of chlamydial elementary bodies detected.

Treatment
Treatment is by appropriate antimicrobial medication. Azithromycin 1g stat, Doxycycline or Tetracycline can also be used. In pregnancy Amoxycillin or Erythromycin are the drugs of choice. Sexual partner contact is very important, although rot always possible. Advice to abstain from sexual intercourse until both partners have been treated should be given. The opportunity should be taken to deliver appropriate health education.

Continued on page 12
TAJIKISTAN

STD Survey Results

There has been an increasing number of new sexually transmitted disease (STD) cases diagnosed throughout the world during the last years: nearly 300 million cases every year according to WHO. Chlamydia and trichomoniasis vaginalis are the most frequent. The increasing prevalence of STDs also affects Tajikistan, which continues to suffer from difficulties related to the transition period and consequences of civil war.

The increase in internal and external migration due to the need to earn money, widespread poverty, inadequate sexual health services and a lack of a clearly formulated youth education programme are just a few of the reasons resulting in an increased incidence of STDs.

The State Statistical Centre was hindered from presenting a true picture of STD prevalence due to financial difficulties, the lack of means to diagnose the different forms of STDs and a low level of qualified health care.

As a result, an agreement between the Government of Tajikistan and WHO for implementation of the UNFPA project “Improving Reproductive Health Services and Access to Family Planning” was signed in 1996. Within the framework of this project a survey on STD incidence in the predominantly rural region of Choton was conducted. This survey was carried out by the Republican Reproductive Health Centre, headed by Dr Kasymova Mavjuda.

1,034 women filled in the questionnaire on all aspects of STDs: awareness, symptoms, methods of prevention, etc. 400 women were examined; vaginal swabs, and studies of the cervix and urethra were performed. In addition, 200 specimens of blood were tested for syphilis, hepatitis B and C, and HIV.

In 75.7% of the examined cases different STDs were discovered. These were:

- Trichomoniasis: 25.3%
- Candidiasis: 17.9%
- Chlamydia trachomatis: 14.9%
- Gonorrhea: 0.2%
- Syphilis: 5.6%
- Virus of hepatitis B: 0.2%

In 11.3% of the cases there was a mixed infection. This included:

- 4.1% - chlamydia trachomatis + trichomoniasis:
- 5.1% trichomoniasis + candidiasis:
- 0.5% Chlamydia + trichomoniasis + syphilis

The questionnaire results revealed that STDs were most commonly found in the 21-39 age group. More than half of those infected had a secondary education.

The lowest rate of STDs was revealed among women with a high level of education - only 1.89% of the cases. It should be added that despite their educational status more than half of those diagnosed with a STD live in extreme poverty.

Investigations have revealed a low awareness about STDs among the population. 72% of those questioned knew nothing about STDs, especially housewives and rural workers in the 17-18 age group. 62.8% of all housewives knew nothing about how to prevent STDs.

Screening

STD screening carried out among the 17-20 age group revealed that 30% showed genital skin changes, 77.7% of the 19-20 age group have vaginal discharges. At the same time, 74.3% responded negatively to the question: “Do you suspect that you may be infected with a STD?”

Unfortunately, the survey results confirmed a high prevalence of STDs in Tajikistan. The high level of morbidity dictates the necessity to promote urgent social and medical remedies in order to improve the situation. The strategy to combat STDs should have 3 main goals:

1. To improve the quality of life;
2. To decrease the risk of infection through primary prevention;
3. To diagnose and provide early treatment to people who are infected with curable forms of STDs.

In order to achieve these goals it is necessary to increase the population’s awareness about STDs, how infection is spread, the symptoms and the methods of prevention; to stimulate the population’s approach to qualified medical care when they suspect they might be infected with a STD; to ensure that laboratories be equipped with the necessary facilities to test for chlamydia trachomatis, urethral herpes and hepatitis B among others.

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Since 1991 the prevalence of STDs, especially syphilis, has increased markedly in the Kyrgyz Republic. The morbidity rate from syphilis increased from 2.0 per 100,000 inhabitants in 1991 to 143.7 in 1997.

The incidence of syphilis among children and adolescents is increasing at an especially alarming rate. In 1991, for example, only 5 cases of syphilis were registered; in 1997 the number of cases increased to 117. Physicians working with maternal and child health (MCH) were faced with an increase in congenital cases of syphilis; in 1995 there were 12 cases, and in 1998, 67 children were born with congenital syphilis.

As a result of the STD epidemic, on 30 June 1997 the Government of Kyrgyz Republic adopted the Decree “Emergency Situation Due to the STD Epidemic”, in which the principal measures on STD prevention were declared. Following this the Ministry of Health signed a Decree in which the following measures on STD prevention were envisaged:

- Widespread implementation of the outpatient approach for syphilis treatment;
- An expansion of anonymous examination and treatment;
- Broad use of mass media for popularisation of safe sex principles;
- Increased financing for STD services.

Ultimately, the work of the Republican Emergency Epidemiological Commission was strengthened. Field meetings where the current situation was analysed and further measures developed were held in Bishkek and at the oblast levels. Local authorities and community leaders began to take an active part in the field work.

Training of specialists
In order to improve the knowledge of modern methods of diagnosing and treating STDs, especially syphilis, the staff of the Republican Dermatology and STD Dispensary, the Kyrgyz State Medical Academy and the Republican AIDS Centre have organised and conducted seminars in all oblasts, during which all concerned specialists were retrained with the financial support of UNDP and technical assistance from WHO.

Implementation of Out-patient Methods
In accordance with WHO recommendations out-patient treatment of patients with syphilis was implemented throughout the country. Whereas in 1995 only 9.2% of all patients with syphilis passed through outpatient treatment (the rest were treated as in-patients), in 1996 this increased to 52.2% and in 1997 it was 49.4%. Specialists continue to work on sending patients with syphilis for ambulatory treatment. In 1998 WHO/EURO donated Penicillin to the Ministry of Health for use in treating syphilis.

Expansion of Anonymous Examination and Treatment
Since 1996 anonymous examination and treatment have been provided in the Dermatology and STD clinics of all oblasts.

Broad Use of Mass Media for Popularisation of Safe Sex Principles
In the framework of the Project “Safe Sex City of Bishkek”, financed by UNFPA, in 1996-1997 a hot line service was set up in Bishkek for consultation on STD and AIDS issues. 50,000 leaflets, brochures and booklets were produced and distributed. As a result of the increase in communicable diseases special work was carried out by specialists in the field of youth education on safe sex, including the regular presentation of information by the mass media.

Centre on STD Care for Sex Workers
Following WHO recommendations and technical assistance from WHO/EURO, the Centre on STD Care for Sex Workers was recently opened at the Dermatology and STD Clinic. Sex workers will be treated in order to prevent the spread of STDs and to train them in the principles of safe commercial sex. A number of concerned NGOs are also involved in this process.

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Chief physician of the Republican Dermatology and STD dispensary, Kyrgyzstan
KYRGYZSTAN
WHO initiated Projects on STD Control and Prevention

There has been a considerable increase in the incidence of syphilis in Kyrgyzstan and particularly in the country's capital, Bishkek, during the last five years (see table).

Incidence of syphilis (per 100,000 population) in Kyrgyzstan

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<tr>
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<td>22.4</td>
<td>73.1</td>
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The incidence of reported HIV-infections in the country remains at a low level. The cumulative total of 24 HIV cases diagnosed in the National AIDS Centre, 18 were diagnosed in non-residents (mostly African students studying in Bishkek). Of the remaining six patients, three contracted HIV as a result of intravenous drug usage, two further patients were assumed to have become infected through heterosexual transmission and in one case a mother-to-child infection was documented.

WHO Response
In January 1998 WHO initiated a project based on free confidential out-patient treatment of syphilis with benzathine benzylpenicillin by short regimen. The drugs were delivered to the National STD clinic and thereafter distributed among the regional STD clinics (there are 5 regional STD clinics in the country) in accordance with their actual needs. The National STD Clinic with its 230 person staff and the inpatient department with 300 beds performs approximately 1,000-1,500 blood screen-check-ups and treatment since the introduction of the new treatment practice. As a rule, almost everybody is now treated as an out-patient. Exceptions are made for pregnant women, children, difficult diagnostic cases, and those of social concern (homeless, etc.). At the time of our visit to the STD clinic in late 1998 there were four 14-17 year-old prostitutes who due to being homeless were receiving treatment for syphilis in wards.

The preliminary data on the incidence of syphilis for 1998 (144.4 per 100,000 inhabitants) show a decrease as compared to 1997. In absolute figures, this means 6,739 cases of which 748 were diagnosed by medical officers of the Ministry of Internal Affairs. Among patients diagnosed and treated by the short regimen at the National STD Clinic, 25 were male individuals who contracted syphilis through homosexual transmission.

Prostitution
The problems of prostitution exist on a large scale, particularly in Bishkek where sex workers of different age groups and different ethnic backgrounds are easily seen all over the city. As a rule, Asian and European sex workers do not work together. The outreach work amongst street sex workers has been initiated by members of the NGO "The life Tree" and workers from the AIDS centre. As a rule, sex workers are willing to communicate and to accept condoms distributed by the outreach workers. However, developing such contacts over a longer period is difficult because of the high mobility of sex workers. Unfortunately, due to other reasons, condoms are not used as widely as they should be.

According to the National STD Clinic and the Ministry of Internal Affairs the incidence of STDs amongst sex workers is very significant. There is a special police service working with the National STD Clinic dealing specifically with sex workers and focusing on child prostitution. Of the 15 prostitutes brought by the police to the STD clinic for a check-up during one evening, 13 were infected with syphilis.

The initiation of new forms of STD treatment services, particularly for sex workers, is a direct result of:
1) The high incidence of STDs in the population;
2) The growing number of sex workers and the high rate of STDs among them;
3) The problem of stigmatisation arising from visiting public STD clinics or AIDS centres.

Recommendations
A future project could be a first step in the creation of a support centre for sex workers consisting of both medical and psychosocial components. If successfully implemented the STD care unit could be included into a network of sentinel centres for STD surveillance in Kyrgyzstan and also serve as a best practice site for advocating WHO policy on STD surveillance and care in other countries of Central Asia.

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YUGOSLAVIA

Preventing the Spread of HIV and STDs

The last twenty years have witnessed the emergence of new infectious diseases, and among them HIV/AIDS has been identified as the most serious. In spite of regional variations, taking up the epidemiological and health problem associated with HIV and STDs is imperative for an organised multilevel prevention-oriented health protection programme.

In Yugoslavia nearly two years elapsed from the moment when HIV infection was first recognised and diagnosed in two cases reported in 1985 until the first organised response.

Based on the Global AIDS Strategy as defined in 1986, and the Global AIDS Programme from 1987, a satisfactory programme of work was established at the national level through well-thought-out strategies and goals.

Implementation of the measures for HIV prevention and control at the national level was successfully regulated through the appropriate provisions and by-laws. The first among them was the resolution on combating the AIDS.

This was followed by the Programme on AIDS Prevention, Control, Early Screening and Treatment in Serbia in 1987. This programme built on already initiated activities.

As a component of the strategy for the implementation of the global HIV/AIDS programme in our country, special attention was devoted to the prevention programme contents because the problem is marked by a multi-layered one. The programme design was based on three essential components: (1) prevention and control of risky behaviour, particularly among youth; (2) safe public health procedures; and (3) social tolerance. Like all other community programmes this one also called for a multidisciplinary approach and intersectoral collaboration.

The First Conference on AIDS held in Zagreb, in 1987, was one among the first major activities organised at the national level. A year later, in December 1988, the Second Conference on AIDS was held in Belgrade with nearly 150 papers registered on topics in the areas of epidemiology, transfusiology, health education and drug dependence. Public health institutes, as the promoters of certain HIV/AIDS related activities, had a special task in carrying out the health educational activities. By 1988 the Institute of Public Health of Serbia.

Programme Activities

The programme activities have resulted in the design of a number of projects focused on certain problems, groups and segments of the population. In chronological order these are the following: AIDS Information for Dentists: Health Education Programme for Elementary School Children and AIDS; Methodological Instruction for Implementation of Health Educational Programmes on AIDS Prevention and Control; Measures or AIDS Prevention in Health Facilities; Health Educational Work with Temporary Employees in Countries with a High Risk of AIDS; Prevention of HIV Infection Among Drug Users; Health Educational Work with College Students, and many other creative activities by non-governmental organisations.

Developed in response to the global societal challenge of HIV infection, the above-mentioned as well as many other programmes, though devised for AIDS, sought solutions to many problems associated with STDs (responsible sexual behaviour, promotion of condom use, use of non-shared syringes and needles among drug users, etc.).

In the course of developing HIV/AIDS prevention programmes, various associations, societies and non-governmental organisations have been formed or engaged, such as Jugoslavenska asocijacija za borbu protiv side (JAZAS Yugoslav Association for the Struggle Against AIDS), The JAZAS Youth, Yugoslav Family Planning Association, The Red Cross, Action Nord-Sud, Handicap and many others. Along with decision- and policy-makers, educational and public-health professionals, and the media, these associations play an important role, particularly in decentralisation of strategies designed to meet local needs, with a focus on conveying the messages to the audience in a way that makes them interesting and acceptable. This is especially relevant for youngsters in clubs and on the street.

Continued on page 16
The activities of JAZAS include forums, lectures in schools, mass media campaigns, demonstrations on World AIDS Day, promoting condom vending machines, humanitarian concerts, "anti-AIDS parties", and the like.

Since 1 December 1988 World AIDS Day has been marked as the day of a jointly coordinated action against AIDS. Topics and slogans have included Communications; Young People: Women and AIDS; Let’s Share the Challenges; One World, One Hope; and Children are Living with AIDS Worldwide. They are designed to arouse interest and set the stage for more intensive activities the following year.

Last year, World AIDS Day was marked by the one-month campaign Score Safely which was aimed to promote an AIDS-info hot line and to popularise condom use. The campaign was inspired by the World Football Championship in France, and is also a part of the world campaign Play Safely. The main motto of the Yugoslav campaign in December 1998 “Good in Offense, the Best in Defense” was intended to promote increased condom use in our country. For that purpose, 32 condom vending machines have been made accessible to its users in Belgrade, Novi Sad, and Niš; an AIDS Manual was printed, as well as an AIDS Informer, posters, labels and folders, and throughout the country seminars and forums were held where different aspects of AIDS were reviewed.

HIV Integration
With the emergence of HIV/AIDS, activities to protect the population in Yugoslavia from STDs (including gonorrhoea and syphilis) have been carried out by using the already existing model of STD Prevention and Control. Moreover, for AIDS Prevention and Control, organisational, methodological and educational activities are under way, as well as co-ordination of strategies, provision of media support and legislation. However, it still seems as if the problem of STD prevention is secondary.

The Resolution on Protecting the Population from STDs was passed in Serbia in 1994, and the new Programme of Protecting the Population from STDs by 2000 had been adopted. The programme has set forth tasks on the prevention and control of HIV/AIDS, gonorrhoea, syphilis and hepatitis B with pre-determined targets and measures for the implementing organisations. As of 1992, sexual diseases caused by chlamydial infections must be notified to the health authorities in our country. This has also been the case for the herpes virus anogenital infection since 1997.

By resolving the most severe problems associated with the prevention and control of HIV infection, and in view of the indisputable fact that HIV infection is primarily sexually transmitted, the comprehensive prevention activities in these two fields can be developed and realised. Since transmission of sexual diseases and HIV infections indicate the significance of risky behaviour, the basic strategic choices are concrete health educational activities and particularly the promotion of condoms and safe sex practices.

“The basic strategic choices are concrete health educational activities and particularly the promotion of condoms and safe sex practices.”

In future, HIV and STD prevention programmes in our country will develop following the experiences gained in both developed and developing countries provided that they have resulted in the following effective strategies: support of policymakers and their collaboration with WHO, UNAIDS and NGOs; co-ordination of agencies, primarily at the national level; dissemination of information and adequate messages; promotion and distribution of condoms; mass-media campaigns; community and school-based health educational activities; peer education; individual counselling; strategies for target groups; screening and surveillance programmes to combat the HIV epidemic; and screening, monitoring, and treatment of STDs.

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ARTICLES

“New Approaches to Early Abortion” in Outlook (Vol. 16, No. 2, PATH, UNFPA, October 1998) points out the need to do something about the 75 million unintended pregnancies worldwide each year and the 20 million unsafe abortions annually. Unsafe abortions result in the death of almost 80,000 women every year. The article describes a number of options for women who choose to terminate their pregnancy including manual vacuum aspiration and non-surgical methods.

CONFERENCE

Women's Health - The Nation's Gain: An International Conference with a Special Focus on Older Women in Asia will be held in Singapore, 5-7 July 1999. Keynote addresses will include “Global Perspective, Older Women's Health” by Dr Gro Harlem Brundtland, Director General, WHO. The conference will serve as a launch-pad for an Older Women's Health Network across Asia and it is open for policymakers, service providers, researchers and academics.

Available from:
Women's Health Project
PO Box 1038
Johannesburg 2000
South Africa
E-mail: womenhp@sn.apc.org

DOCUMENTS

Implementing the ICPD Programme of Action in Central and Eastern Europe: Lessons Learnt Post-Cairo (UNFPA, WHO 1998) was held at WHO Regional Office for Europe on 28-30 September 1998. Reproductive health (RH) and sexual health policies, adolescent RH, RH in emergency situations, the role of civil society and the private sector, and key actions for the next decade were the main themes.

Available from:
Women's and Reproductive Health
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen 0
Denmark

Reproductive Health of Young People in Central and Eastern Europe (UNFPA; WHO 1998, pp 132) is a collection of the background papers presented at the UNFPA/Government of Denmark/WHO workshop held in June 1997 in Copenhagen. Eleven countries highlight their most pressing RH issues for adolescents.

Available from:
Women's and Reproductive Health
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen 0
Denmark

Women's Health News (Women's Health Project, Nov. 1998) contains a number of articles on HIV/AIDS including prevention of mother-to-child transmission of HIV. The organisation also publishes documents on a range of women's health issues.

Available from:
International Planned Parenthood Federation
Regents College, Inner Circle, Regent's Park
London NW1 4NS, England
Fax: (+44) 711 487 7950
E-mail: info@ippf.org
www.ippf.org

Available from:
Women's Health Project
PO Box 1038
Johannesburg 2000
South Africa
E-mail: womenhp@sn.apc.org
European Strategies to Combat Violence against Women (WHO 1998, pp 88) is a report from a technical meeting held in Copenhagen, Denmark, in December 1997. The WHO Regional Office for Europe acted on its commitment to combating violence against women and sought to build on existing links between WHO and country-based networks and centres specialising in the issue of violence against women in an effort to draw up proposals for joint strategies at the European level.

Available from:
The WHO Regional Office for Europe Scherfisvej 8
DK-2100 Copenhagen 0
Denmark

Health Issues of Minority Women Living in Western Europe (WHO 1998, pp 20) is a report from a WHO meeting held on the subject in November 1997. Case studies are presented as well as a focus on female genital mutilation.

Available from:
Women's and Reproductive Health WHO Regional Office for Europe Scherfisvej 8
2100 Copenhagen 0
Denmark

Contraceptive Safety: Rumors and Realities (Population Reference Bureau 1998, 1998) is a resource guide on contraception for policymakers, programme managers, service providers and others needing accurate information on contraceptive methods. It answers questions such as: What are the advantages, disadvantages, risks and benefits of each method? and How do the potential risks compare with those associated with pregnancy and childbirth?

Available in English, French and Spanish from:
Population Reference Bureau
1875 Connecticut Ave., NW
Suite 520
Washington, DC 20009-5728 USA
Fax: (+1) 202 328-3937
E-mail: prborders@prb.org

Health Dimensions of Sex and Reproduction, edited by Christopher J.L. Murray and Alan D. Lopez (WHO, Harvard School of Public Health, World Bank 1998) shows that reproductive ill-health accounts for 5-15% of the global burden of disease. It attempts to calculate how much of the burden of disease is the consequence of unsafe sex.

Available from:
Harvard University Press
Customer Services Department
79 Garden Street
Cambridge, MA 02138 USA
Fax (+1) 617 496-2550
www.hup.harvard.edu

Female Genital Mutilation: An Overview (WHO 1998, pp 76) is not easy reading. At least 130 million women and girls alive today have undergone the procedure. This overview, which includes an extensive bibliography, describes this brutal and humiliating practice that has been condemned by international agreements and national governments. The authors present ample evidence why, for the sake of all the women at risk, female genital mutilation (FGM) must become a thing of the past.

Available from:
Distributions and Sales
World Health Organization
CH-1211 Geneva 27, Switzerland
Price: Sw.fr. 26.-
Price in developing countries: Sw.fr. 18.20

The Climacteric and its Treatment (Swedish Consensus of Obstetrics and Gynecology Series 1997, pp 128) contains 16 articles on issues such as sexuality menopause and estrogen replacement theory.

Available from:
The Parthenon Publishing Group Limited
Casterton Hall, Carnforth
Lancs. LA6 2LA, UK

Paying Their Fair Share? - Donor Countries and International Population Assistance (by Shanti R. Conly and Siyamini de Silva, 1998, pp 140) tracks advances the donor community has made since Cairo - financial commitments have risen in many countries and aid agencies are designing broadly defined and integrated RH programmes. Yet the report reveals serious deficiencies on the part of the donor com-

Available from:
The Secretariat of the Inter-Agency Group for Safe Motherhood
Family Care International
588 Broadway, suite 503
New York, NY 10012 USA
Fax: (+1) 212 941-5563
E-mail: sm10@familycareintl.org
www.safemotherhood.org

The Safe Motherhood Action Agenda: Priorities for the Next Decade (Family Care International in collaboration with Inter-Agency Group for Safe Motherhood, 1998, pp 100) is a report on the Safe Motherhood Technical Consultation held in October 1997 in Sri Lanka. "Safe Motherhood" is universally defined as one of the central components of reproductive health and this report looks at among other things strategies to reduce maternal mortality.


Available from:
Population Action International
1120 19th Street, NW suite 550
Washington, DC 20036 USA
www.populationaction.org

1996 Russia Women’s Reproductive Health Survey: A Study of Three Sites
(All-Russian Centre for Public Opinion and Market Research, Centers for Disease Control and Prevention, USA, USAID, 1998, pp 244) is a comprehensive report on women’s RH in Russia. It includes chapters on induced abortion, contraception, IEC, STDs and adolescent health among others.

Available from:
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road
Atlanta, Georgia 30333 USA

TRAINING

London School of Hygiene & Tropical Medicine
The Centre for Population Studies at the London School of Hygiene & Tropical Medicine offers a four-week short course in Reproductive Health Research. The course introduces participants to the principles and methods of effective social and demographic research in this field and concentrates on the design of policy-oriented research and methods of evaluating the impact of programmes. The course (21 June - 16 July 1999) is suitable for those with research interests in this field and for managers and others who wish to commission or use research results.

Available from:
WHO Regional Office for the Western Pacific
PO Box 2932
1099 Manila, Philippines

Cervical Cancer Alert
The US National Cancer Institute has issued an alert to doctors around the world to change the way they treat cervical cancer after studies showed survival rates could be improved by up to 500 per cent, potentially saving thousands of lives worldwide every year. Results from the five studies show that combining chemotherapy with radiotherapy for advanced cervical cancer cuts deaths by 30 to 50 per cent compared with the standard treatment, used in the US and the UK, of surgery or radiotherapy alone. Last year there were 5,000 cases of cervical cancer in the UK and 1,222 deaths.

- Jeremy Laurance, Health Editor

Abortion Rates Up in Russia
After years of dramatic decline, Russia’s high abortion rate is on the rise again as more women resort to abortion because of the country’s economic crisis. Falling living standards and substantial rises in the price of contraceptives such as the Pill are encouraging more women to risk becoming pregnant and use abortion as a last resort contraception. The new trend is a depressing development for health experts and anti-abortion campaigners who have watched the number of abortions carried out in Russia steadily drop in recent years.

- Marcus Warren, The Daily Telegraph
Hague Forum Has Proved That ICPD Programme of Action Works

"We have shown each other and the world that the ICPD Programme of Action is far more than a piece of paper. We have proved that it works," Dr Nafis Sadik, Executive Director of the United Nations Population Fund (UNFPA) told delegates to the Hague Forum. "In all of our countries, some steps have been taken to make it a reality; and in many countries implementation is moving ahead quite rapidly."

The forum, a review of progress in implementing the Programme of Action of the 1994 Cairo International Conference on Population and Development (ICPD), ended after adopting a report of findings and proposing actions to carry forward the Cairo agenda.

Delegates from 177 States approved the report in the final plenary session. The report's findings and proposals cover the forum's five themes: creating an enabling environment for population programmes; gender equality and the empowerment of women; reproductive rights and health, including family planning, and sexual health; the strengthening of partnerships; and financing.

Organized by the United Nations Population Fund (UNFPA), the Hague Forum was part of ICPD+5, a series of review activities leading up to a high-level special session of the United Nations General Assembly in New York from 30 June to 2 July. The meeting examined countries' achievements since the Cairo agreement, identifying successes, constraints to be overcome and priorities.

In a press conference, Dr Sadik highlighted some of the major findings:

- Little progress has been made in reducing high levels of maternal mortality in a number of countries; governments should promote safe motherhood as a human rights issue and give it greater priority;
- The HIV/AIDS situation is much worse than in 1993: benchmarks are needed for progress in preventing the spread of the disease;
- Unsafe abortion should be addressed as a public health issue, and reduced through the provision of family planning information and services, including emergency contraception;
- Refugees and others in emergency situations should be provided with reproductive health care;
- Countries should have "zero-tolerance" for all forms of violence, including rape, incest, sexual violence, sex trafficking, against women and children;

WHO

Excerpt from Reproductive Health: A Health Priority Statement by WHO Director-General Dr Gro Harlem Brundtland

"I am here today to pledge the commitment of the World Health Organization to reproductive health - a health priority in a new century.

I am here to lend our support to those committed women, men and constituencies who speak out for the right of all people to lead a healthy reproductive life.

I am here to share with you our impatience. Cairo was a crossroads. A lot has happened since 1994, but there is still a long way to go.

Today, a broader understanding of reproductive health is gaining ground. Reproductive health deals with intimate and highly valued aspects of our lives. It reflects health in childhood and adolescence. It sets the stage for health beyond the reproductive years for both men and women.

It is about relationships, with its positive dimensions - closeness, fulfilment, the opportunity to have a desired child. But there are the negative ones - disease, abuse, exploitation, unwanted pregnancy and even death.

Why did it take us so long to understand the full importance of reproductive health? Partly because these highly personal aspects of life are difficult to talk about openly. But also because there have been cultural taboos - and because women have been denied access to political, social and economic decision-shaping and decision-making.

Cairo was significant because it change a lot of that. Our discussions there resonated around the world. Since Cairo, a more open debate has been possible on adolescent sexuality, on HIV/AIDS and on unsafe abortion.

Unless we can talk about the real challenges that we face - pandemics of sexually transmitted disease, adolescent pregnancies, sexual abuse, rape, and pregnancy-related deaths and disabilities - we will never be able to address them, or to change the situation. Let there be no doubt. We will need decades of continued advocacy and action. WHO for its part will speak out more strongly.

- Every year, at least 120 million women who do not want to become pregnant do not have the means to prevent it.
- Every year, 20 million women put their health and lives at risk because they seek unsafe abortions.
- Every year, there are more than 330 million new cases of curable sexually transmitted diseases and one in 20 adolescents becomes infected.
- Every year, the HIV virus infects 5.2 million people, over half of them young people between 15 and 49 years old.
- Every year, there are 450,000 new cases of cancer of the cervix.

Between 5% and 15% of the global burden of disease is associated with failures to address reproductive health needs. This burden hits people particularly women in the prime of life, it hits when their potential, responsibilities, and productivity are at their highest. Globally, among women of reproductive age, more than 20% of total years of healthy life lost are due to three main groups of reproductive health conditions: sexually transmitted diseases including HIV/AIDS, maternal mortality and morbidity, and reproductive tract cancers. A further 10% of healthy years of life are lost due to conditions affecting the newborn."