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WHO

REGIONAL OFFICE FOR EUROPE

INTEGRATED APPROACH TO THE PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

Report on a WHO Meeting

St Petersburg, Russian Federation
12–14 May 1999

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1999 EUROPEAN HEALTH21 TARGET 7, 11

EUROPEAN HEALTH21 TARGET 7

REDUCING COMMUNICABLE DISEASES

By the year 2020, the adverse health effects of communicable diseases should be substantially diminished through systematically applied programmes to eradicate, eliminate or control infectious diseases of public health importance

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

EUROPEAN HEALTH21 TARGET 11

HEALTHIER LIVING

By the year 2015, people across society should have adopted healthier patterns of living

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

In previous decades, the WHO European Region has experienced a steady decline in the incidence of the main sexually transmitted infections (STIs) such as syphilis and gonorrhoea. Until about 1992 they represented a fairly minor part of the Region's health problems. More recently, serious new epidemics of STIs have occurred, mainly in the NIS. In order to assist the affected countries to cope with these epidemics, the WHO Regional Office for Europe convened a meeting in 1996 of senior officials responsible for STI control at the national level from the affected countries. The participants developed a plan of action which was implemented during the following years. A second intercountry meeting was held in 1997 at which the progress of and obstacles to the implementation of the plans were reviewed and assessed. Further measures were recommended. A third intercountry meeting was convened in May 1999 at which STI officials met senior officials responsible for reproductive health at national level. The aim was to strengthen collaboration between STI services and reproductive health services in providing more comprehensive care, prevention and control of STIs at national level. The meeting also reviewed the progress made in implementing the action plans, analysed obstacles and agreed on further action necessary to combat the epidemics of STIs in the affected countries. The report of the Meeting presents a brief summary of the situation in the affected countries, a discussion of the role and responsibilities of the STI services and the reproductive health services in the prevention and care of STIs, priorities for national efforts and for international assistance, and recommendations to be made to the national health authorities developed by the participants at the meeting.

Keywords

SEXUALLY TRANSMITTED DISEASES – prevention and control
REPRODUCTION
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Introduction and objectives of the Meeting

The newly independent states of eastern Europe (NIS) continue to experience major epidemics of sexually transmitted infections (STIs), especially syphilis, affecting in particular the young population. The rates of notified syphilis cases continue to remain at a very high level although signs of stabilization have been observed in a number of countries. Moreover, during the last two years the epidemic has started to spread increasingly among the rural population.

The WHO meeting on an Integrated Approach to the Prevention and Treatment of Sexually Transmitted Diseases was convened in St Petersburg, Russian Federation, from 12 to 14 May 1999. This meeting followed up two meetings initiated by the WHO Regional Office for Europe to promote the WHO-recommended policies in STI case management. The first meeting was held in Copenhagen in 1996 and the second in Riga in 1997, at which recommendations for appropriate STI prevention and control were developed and reviewed by the affected countries. During the last two years many countries have taken action to control the epidemics based on the recommendations of these meetings. Strong advocacy is, however, urgently required to promote wider acceptance and full implementation of the recommended polices and strategies. It is also imperative to identify constraints and obstacles hampering the progress and to formulate further actions to be taken to control the epidemic.

In order to ensure greater access by STI patients to the medical services, especially at district level and in rural areas where there are almost no STI clinics, the involvement of reproductive health services in STI care may provide substantial input to the control of the epidemic.

Two participants were invited from each country: the highest Ministry of Health official with full responsibility for STI control at national level, and the most senior responsible officer for the reproductive health infrastructure. The list of participants is in Annex 1.

The specific objectives of this Meeting were as follows:

- to assess the current epidemiological situation on STIs in the affected countries;
- to monitor progress made in implementing the recommendations of the meetings held in Copenhagen in 1996 and in Riga in 1997;
- to discuss the possible role and functions of the reproductive health sector in STI prevention and care;
- to reinforce cooperation between STI services and reproductive health services to curb the epidemic of STIs, and to develop a strategy for wider involvement of the reproductive health sector in STI prevention and care;
- to elaborate a plan of action including proposals for international assistance;
- to discuss the role of the Task Force for the Urgent Response to the Epidemics of Sexually Transmitted Diseases in Eastern Europe and Central Asia (TF/STI) in assisting the affected countries to control the STI epidemic.

Situation regarding sexually transmitted infections in the Region

Since the early 1990s, epidemiological data officially notified to WHO by national health authorities have shown an alarming epidemic of STIs in eastern European and central Asian countries (primarily the NIS). The surveillance data are based on mandatory universal notifications of newly identified cases reported by physicians. Because the reporting of syphilis cases is compulsory, this disease has become a benchmark for all STIs when looking at trends. Official notification of other diseases (except gonorrhoea) has also followed the increasing trends, as can be seen from the data submitted by the Russian Federation (Table 1).

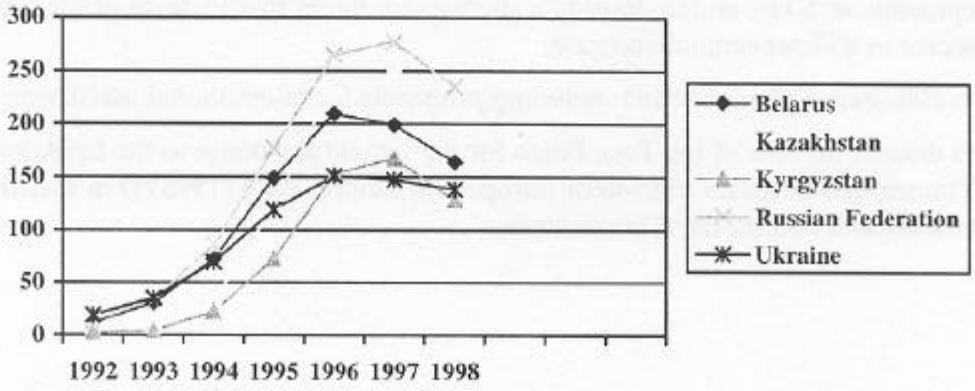
Table 1. Incidence of major sexually transmitted infections in the Russian Federation, 1993–1998 (per 100 000 population)

Disease	Year					
	1993	1994	1995	1996	1997	1998
Syphilis	33.9	85.8	177.0	264.6	277.3	234.8
Gonorrhoea	230.9	204.6	173.5	139.0	114.2	103.0
Trichomonias	327.9	335.0	343.9	341.5	328.4	317.2
Chlamydiosis	37.1	61.6	90.2	106.1	116.1	113.8
Ureaplasmosis	24.4	38.0	56.9	67.6	81.9	95.7
Gardnerellesis	45.0	102.2	139.3	153.0	183.0	215.7
Candidosis	77.1	122.9	153.4	185.0	213.7	243.2
Herpes genital	8.5	7.4	8.8	10.8	14.1	13.0
Condilomatosis	17.8	20.3	20.9	22.6	25.0	25.2

The extent of the epidemic varies between countries. Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova and the Russian Federation have been the most strongly affected, with national rates of notified syphilis cases reaching between 170 and 270 per 100 000 population. The reasons for the epidemic were extensively discussed at the meetings in Copenhagen in 1996 and in Riga in 1997.

Since 1996, however, most of the countries affected have reported a stabilization or even a decline in the incidence of syphilis rates (Fig. 1).

Fig.1. Notification rates of newly diagnosed syphilis cases in the most affected NIS, 1992–1998 (per 100 000 population).



The reasons for these trends are not yet quite clear. However, many countries report that this is a result of national efforts to control STIs and implementation of the WHO recommendations. At the same time, countries have also reported the spread of STIs to rural areas where the prevalence of syphilis is, in some cases, higher than among the urban population.

An alarming increase in the occurrence of congenital syphilis has been noted in many of the countries most affected by the STI epidemics. No declining trend in this disease has been reported during 1996–1998 (Table 2).

Table 2. Notifications of new congenital syphilis cases in the NIS, 1994–1998 (absolute numbers)

Country	Year				
	1994	1995	1996	1997	1998
Armenia	0	0	5	8	12
Azerbaijan				7	11
Belarus					23
Georgia	3	1	2	11	20
Kazakhstan	2	30	50	100	294
Kyrgyzstan	1	12	43	45	67
Latvia	2	15	25	22	16
Republic of Moldova	0	2	2	4	4
Russian Federation	118	222	47	714	
Tajikistan					4
Turkmenistan					5
Ukraine			71	83	79
Uzbekistan					3

Information gained from questionnaire

With the aim of ascertaining the progress made by countries and the obstacles to implementation of the WHO recommendations, a questionnaire was prepared and sent out to all participants before the meeting, so that the information and experience from all the NIS could be shared. The responses to the questionnaire were analysed and are listed below (Table 3).

Table 3. Analysis of responses to questionnaires circulated prior to the Meeting

Participation of public Sexually Transmitted Infections (STIs) services in the primary prevention of STIs		
Primary prevention unit is an integrated part of STI clinic	Limited participation with plans for extension in future	No primary prevention units in STI clinics
Azerbaijan Kyrgyzstan Uzbekistan	Belarus Republic of Moldova Russian Federation	Armenia Estonia Georgia Latvia Lithuania Kazakhstan Tajikistan Turkmenistan Uzbekistan

Participation of private venereologists in the management of STI patients

Same range of services as public STI clinics	All service range except syphilis treatment	All service range except treatment of syphilis and gonorrhoea	Diagnosis only	No licensed private sector
Estonia Latvia Lithuania	Armenia Kyrgyzstan Ukraine	Republic of Moldova Belarus	Uzbekistan	Azerbaijan Georgia Kazakhstan Russian Federation Tajikistan Turkmenistan

Participation of reproductive health service in the management of STI patients

Diagnosis and treatment (all STIs)	Diagnosis and treatment (except for syphilis)	Diagnosis and treatment (except for syphilis and gonorrhoea	Diagnosis only
Estonia Latvia	Armenia Azerbaijan Georgia Kyrgyzstan Lithuania Republic of Moldova Russian Federation Turkmenistan Ukraine	Belarus	Kazakhstan Tajikistan Uzbekistan

Syndromic approach to STI management

Introduced widely where appropriate	Introduced as experiment in few selected areas	Not introduced
Armenia Belarus	Azerbaijan Kyrgyzstan Kazakhstan Russian Federation Tajikistan	Etiological diagnosis is possible on the same day: Estonia Latvia Lithuania Republic of Moldova Resistance from specialists: Turkmenistan Uzbekistan Insufficient financing (drugs): Georgia Ukraine

Guarantee of confidentiality of STI diagnosis and treatment in public sector

No passport required throughout diagnosis and treatment in most STI clinics	Limited confidentiality (anonymity introduced as experiment in few places or some personal details are required)	No confidentiality throughout diagnosis and treatment
Armenia Estonia Georgia Kyrgyzstan Lithuania Republic of Moldova	Azerbaijan Belarus Kazakhstan Latvia Russian Federation Ukraine	Tajikistan Turkmenistan Uzbekistan

Free outpatient treatment of syphilis with parental penicillin G in public sector

Introduced widely		Not sustainable due to financial or/and administrative hurdles	Not introduced
Armenia Belarus Estonia Georgia Latvia	Lithuania Kyrgyzstan Russian Federation Tajikistan	Azerbaijan Kazakhstan Republic of Moldova Ukraine Uzbekistan	Turkmenistan

STI prevention and care in countries and implementation of WHO recommendations

Armenia

- Morbidity levels of syphilis and gonorrhoea reached their peak in 1996 with an incidence of 17.7 and 36.6, respectively.
- 1997 saw the start of a decline in syphilis morbidity. By 1998, incidence had fallen to 14.2.
- A similar tendency occurred in 1997 with gonorrhoea morbidity when the incidence fell to 28.4, although it increased again to 31.9 in 1998.
- Great emphasis has always been given to the testing of pregnant women for syphilis; 94% of pregnant women are screened in the capital and 90% in the rest of the country.
- In 1998, pregnant women who were treated for syphilis represented 16% of all female patients with syphilis.
- Owing to the continued decline in the socioeconomic situation, cases of congenital syphilis began to appear in 1996: 5 cases were registered in 1996, and by 1998 the figure had risen to 12 cases.
- Continuous efforts have been made to control STIs by detection of early syphilis through mandatory screening of:
  - patients in general hospitals
  - patients attending outpatient facilities
  - periodic examination of high-risk groups.

  These efforts have brought about an insignificant decrease in STI morbidity. One of the main reasons for this is the lack of coordination among such specialists as, for example, gynaecologists, urologists and laboratory workers.
- The WHO programme on women's reproductive health was introduced over two years ago. The STI component is carried out by the Centre of Dermatology and Sexually Transmitted Infections.
- The specialists in the STI control service support the implementation of the WHO-recommended policies concerning STI case management, development of coordination and collaboration between the STI control service and reproductive health service in the control and prevention of STI.

Azerbaijan

- The number of registered cases of syphilis increased by 37.4% in 1998 compared to 1997.
- There was also a noticeable increase in the number of congenital syphilis from 7 cases in 1997 to 11 cases in 1998.
- WHO-recommended methods of diagnosis and treatment of syphilis have been implemented.
- As a rule patients with syphilis receive treatment in outpatient departments free of charge. Inpatient treatment of syphilis and gonorrhoea cases may also be provided.
- The syndromic approach to STI case management was initially introduced in Imishli region in 1998. During 1999 it will be introduced in two further regions, Sumgait and Saatly, on a pilot basis.

Belarus

- In spite of a decline in syphilis morbidity in general and among pregnant women, the number of cases of congenital syphilis has increased to a record high number, with 23 cases being registered in 1998. The reason for this is that some pregnant women do not contact the medical service or are first examined late in their pregnancy.
- Gynaecologists have diagnosed 16% of their registered patients with syphilis, and 10% of these were pregnant women.
- Treatment of syphilis is only offered by STI facilities. 80% of patients receive outpatient treatment. There is no compulsory hospitalization. Treatment of patients with syphilis in day hospitals is free of charge.
- Modern long-acting drugs for syphilis treatment are widely used.
- Syndromic approach to STI case management is being implemented on a pilot basis.
- STI facilities provide anonymous STI examinations, testing for syphilis and HIV free of charge.
- Two facilities (one public and one commercial) have been given permission to conduct anonymous treatment of patients with syphilis. The anonymous treatment of patients with other STIs has begun in a large number of public facilities, some of which are commercially run.
- A new edition of the law on the health care system is currently being worked on.
- Forced examinations are only allowed with a prosecutor's approval, and forced treatment is only allowed following a court decision.
- There are hotlines in several facilities collaborating with UNAIDS.
- To increase the efficiency of the primary prevention of STIs, it is considered necessary to ensure the participation of HIV/AIDS centres and to create primary prevention departments in the large regional medical centres.
- STI specialists and, in particular, epidemiologists continue to be trained, although on a broader scale than before.
- It has been decided to create an STI control centre along the lines of the earlier Research Institute of Dermatology and Venereology.

Estonia

- The epidemiological situation has been alarming since 1991.
- The number of registered cases of syphilis rose from 53 cases in 1991 to 1101 in 1998, equal to an incidence rate of 72.6 per 100 000 population.
- Gonorrhoea morbidity has decreased from 3535 cases in 1993 to 1477 cases in 1998, to an incidence rate of 97.4 per 100 000 population.
- Among STIs, trichomoniasis morbidity is the highest. The highest number was registered in 1996. In 1998, 3882 cases of trichomoniasis were registered – equal to an incidence of 255.8.
- Registration of chlamydia and urogenital herpes began in 1991. In 1998, 3442 cases of chlamydia were registered, an incidence rate of 226.7 per 100 000 population.
- Anogenital papilloma and hepatitis A,B,C are also now registered. The highest number of STI patients (57%) are young people aged 20–30 years.

- Specialists believe that efficient STI control cannot be achieved without solving social problems. The priority issues are:
  - prostitution, alcoholism, control of drug use
  - the need for appropriate legislation
  - the need to promote healthy lifestyles
  - examination and treatment of sexual partners.

Georgia

- Syphilis morbidity among pregnant women is about 6%.
- 20 cases of congenital syphilis were registered in 1998. The trend is increasing and alarming.
- Compulsory hospitalization of patients with syphilis has ceased over the last 5 years. Outpatient treatment using mainly benzatyn benzylpenicillin has been implemented countrywide.
- WHO's recommended guidelines on diagnosis and treatment of STIs are used.
- The examination and treatment of STI patients is carried out without patients having to present identification documents (passport, for example).
- Notification of new cases of syphilis, gonorrhoea and chlamydia are obligatory and are made using anonymous forms.
- Contact tracing, screening and treatment is carried out on the initiative of patients themselves.
- The federal programme on control and prevention of STIs has been approved and includes provision of free treatment for patients with syphilis. Provision has also been made for each pregnant woman to have one serological examination for syphilis free of charge.
- Wide use of modern medicines is not possible owing to the relative poverty of the major part of population.
- There are currently no officially licensed commercial facilities for the treatment of STIs.
- With the current epidemiological situation and the preference of women to attend gynaecological facilities, the active participation of the gynaecological service in the control and prevention of STIs is considered necessary.
- Efforts have been made to coordinate the work of dermato-venereologists and gynaecologists. Over the past two years the federal programme has provided free examination of patients with inflammatory diseases of the urogenital tract attending gynaecological services. Gynaecologists have been trained to carry out these examinations.
- STI care for particular vulnerable groups is currently not optimal. The following data highlight the need for further improvements:
  - of 123 sex workers examined in 1998, 49 (40%) were found to have syphilis;
  - of 71 sex workers examined during the first 3 months of 1999, 24 (38%) had syphilis.
- Improvements in STI prevention might come about if more affordable STI screening and treatment are provided and wider use is made of free care, such as:
  - providing women with two serological screening tests for syphilis during pregnancy
  - providing appropriate and optimal STI care for vulnerable groups, particularly sex workers
  - optimizing methods of primary prevention
  - improving the quality of STI care – especially in gynaecological services
  - improving the effectiveness of STI surveillance.

Kazakhstan

- Syphilis morbidity and gonorrhoea morbidity declined in 1998.
- The number of cases of congenital syphilis increased in 1998.
- There have been a number of negative tendencies:
  - a decline in attendance at medical care facilities
  - a decline in early detection
  - a decline in partner examinations
  - epidemic nature of the morbidity
  - grave stigma attached to STIs
  - inability of the STI services to affect the trends.
- The above highlight the neeed to restructure medical services in line with social and economic realities, and to introduce more modern internationally supported methodologies (such as the syndromic approach) and a national programme on STI control and prevention.
- The following major strategies have been approved for a new approach to STI control and prevention:
  - health education should be provided by all public and social institutions and nongovernmental organizations (NGOs) to create awareness of safe sex and prevention;
  - the health care system, including primary health care services, should be restructured and decentralized, with an emphasis on outpatient treatment, flexibility and mobility in the health care system so as to ensure a closer affiliation with the affected population groups;
  - cost-effective technologies should be implemented with close international collaboration to respond to the conditions of a democratic society;
  - the new approach should be directed at reducing the causes of STIs and the heavy burden of treating STIs under the current system, increasingly activating the population in preventive activities, raising the level of accessibility and affordability of medical care for the whole population, and improving the efficiency of the health care system.

Kyrgyzstan

- Syphilis morbidity is declining but the number of cases of congenital syphilis is increasing. Gonorrhoea morbidity is increasing.
- The traditional methods of STI control used in the recent past are no longer effective, so the policy of STI prevention and control has been changed:
  - since 1995, STI patients have been treated on an outpatient basis;
  - since 1996, the anonymous treatment of syphilis patients has been permitted in national and regional STI facilities;
  - all public or private facilities with approved licenses are permitted to offer STI treatment (except for syphilis);
  - the syndromic approach has been approved as the priority form of treatment in those areas with poor laboratory systems;
  - there are still criminal sanctions against deliberate infection.

- Owing to the severe epidemiological situation, the government has declared a state of epidemic emergency and approved the national AIDS/STI prevention programme for 1997–2000.
- The Joint Project with WHO and UNAIDS works in three main areas:
  - creation of multisectoral approach to STI prevention
  - information, education, communication
  - work with vulnerable groups.
- A coordination committee has been established under the President of the Republic for policy formulation, preparing the orders of the Ministry of Health and developing guidelines for syphilis and gonorrhoea treatment. These guidelines have been prepared and published and distributed to all licensed specialists.
- Regional educational seminars are being held.
- Modern methods of STI treatment are assessed and monitored.
- Free and anonymous examination and treatment for STIs has been made available, with the support of WHO, to vulnerable groups such as commercial sex workers and their clients and men having sex with men.
- Seminars to enhance psychosocial consultations are taking place, and so is intensive work with the media.
- Outreach work with young people in the Bishkek area and around the city markets is going on.
- A programme has been initiated to promote healthy lifestyles.
- There is an educational programme for the staff of the Ministry of Internal Affairs, medical personnel and special groups.

Latvia

- Syphilis and gonorrhoea morbidity decreased further in 1998.There was also a continued decline in congenital syphilis cases.
- Over 80% of syphilis patients received outpatient treatment using modern medicines. Treatment of syphilis is free.
- New regulations concerning sex workers have been introduced; they should now possess a special card issued by the Ministry of Health enabling them to have a monthly STI examination.
- One private structure has been licensed to provide STI care to vulnerable groups.
- Specialists believe the following areas should be given particular attention:
  - the current lack of efficient STI education in schools;
  - the limited opportunities to work for high-risk behaviour groups, such as marginalized young people, sexual minorities, prostitutes, prisoners and drug users;
  - insufficient STI prevention at the primary health care level including family doctors, general practitioners, etc.;
  - the need to increase awareness of STI patients about their opportunities and rights with regard to medical care for STIs.

Lithuania

- The WHO recommendations are being successfully implemented.
- Work with vulnerable groups is given great attention.
- In accordance with the decision of the Vilnius City Council, a special place has been selected near the railway station for work with prostitutes. Dermato-venereologist consultations are provided regularly.
- Patients with syphilis receive free treatment.
- The AIDS Centre organized a mobile consultation, using a specially equipped bus, to enable workers from the city market to obtain free examinations. The majority of those tested were infected with syphilis. Later the same kind of activity was conducted by the AIDS Centre at the railway station.
- There is a limited overlap between STI prevention and control services and reproductive health service, because the dermato-venereologists consider that this would place some kind of limitation upon their areas of responsibility.

Republic of Moldova

- In 1998 the absolute number of registered cases of syphilis declined, although the incidence rate is still three times higher than it was 10 years ago. The incidence of gonorrhoea remains high, though 6 times lower than that of registered syphilis cases. Syphilis and gonorrhoea morbidity is higher among the urban population than the rural population.
- The national programme on AIDS/STI prevention has been in existence since 1995. It takes into account the recommendations worked out at the international meetings in Copenhagen and Riga. Some of the WHO recommendations are used in practice, as under:
  - anonymous outpatient treatment of patients with syphilis and gonorrhoea has been introduced widely (only patients from low social conditions, patients with complications and/or pregnant women and children are hospitalized for treatment);
  - strict confidentiality is observed: the former repressive methods of contact tracing are no longer practised;
  - efficient medicines are being widely used (syphilis treatment with benzathyn benzylpenicillin in all public facilities was free in 1998);
  - however, specialists rarely use the syndromic approach as they consider that this is an over-simplified approach;
  - licensed private doctors provide STI care, although where patients are found to have syphilis or gonorrhoea, they should be directed to the public sector facility.
- No separate places have been established for the treatment of vulnerable groups.
- The media are actively involved in primary prevention and there is considerable interest in the population in learning about STI.
- There is close cooperation among the relevant health services and NGOs regarding the prevention and treatment of STIs, i.e. dermato-venereologists work closely with specialists in the AIDS Centre, the reproductive health and family planning services, gynaecologists and urologists.
- Guidelines are being worked out and implemented and seminars are being conducted.

- Adequate financial support of the national programme on AIDS and STI prevention and control, the active participation of the media and schools in enhancing primary prevention, and the availability of cheap condoms are all essential for further improvements in STI prevention.

Russian Federation

- In 1998, syphilis morbidity declined among the rural population as well as the urban population. However, the decrease was three times greater among the urban population.
- In 1997, 6.5% of syphilis patients were pregnant women. 5.6 per 10 000 newborn babies have congenital syphilis although women can have three serological screenings during pregnancy.
- Modern medicines are used for treatment of syphilis.
- Specialists consider that the syndromic approach could be used in cases where etiological diagnosis and treatment are unaffordable and also in times of epidemic. At present, this approach is used in two regions – St Petersburg and Republic Tyva.
- About 300 clinics providing anonymous examination and treatment exist where a fee is payable. Free service is provided in the public sector and presentation of identification documents is not compulsory.
- In the field of STI prevention and control, there is integration between different services, primarily between the dermato-venereological and reproductive health services.
- Legislation against deliberate infection has been retained.
- With the aim of improving primary prevention, appropriate departments have been established in the STI dispensaries. These innovations are reflected in the new regulations concerning the status and responsibilities of the STI dispensaries and clinics.
- Recommendations have been worked out on the conditions for licensing STI specialists and criteria for private doctors.
- The first experience of working with risk groups, in close collaboration with the Russian Association against STIs (SANAM), in the provision of affordable, acceptable forms of STI care for prostitutes, has been established.
- The first centre for youth counselling was created in Novosibirsk. Social workers and psychologists work together with doctors and other specialists. Research has been conducted on the way the target population seeks STI health care. Protocols for STI case management have been worked out.
- A federal programme on STI prevention and control has been developed.

Tajikistan

- Since 1991 a steady increase has occurred in STI morbidity after a long period at a relatively low level. The incidence of syphilis has increased 16 fold to 20.0 per 100 000, although specialists consider that the actual rate is higher.
- The major problem areas are:
  - an increase in the number of cases of congenital syphilis and ophtalmia neonatorum;
  - STI morbidity among adolescents;

  - the number of cases of self-treatment and treatment outside medical facilities has increased;
  - since 1992 there has been a significant increase in the urban population due to the migration of huge numbers from rural areas, most of them with poor sanitary habits, which has contributed to an increase in STI morbidity.
- Prevention and control of STI is considered a national priority problem.
- There has been a national programme on HIV/AIDS and STI prevention and control since 1997.
- It has been decided to establish a national STI centre.
- A centralized laboratory has been established on the basis of republic and city STI clinics.
- The WHO recommendations are implemented in all STI clinics.
- Workshops on the syndromic approach are being held at the Institute of Postgraduate Education and at republic STI clinics.
- Clinics providing anonymous examination and treatment have existed since 1997.
- Hotlines are functioning.
- Primary prevention activities are limited to public discussions on STI prevention, sometimes with the active participation of church representatives. The mass media take an active part in primary prevention.
- Workshops and discussions with the staff of the Ministries of Internal Affairs and Education also take place.

Turkmenistan

- A national health reform programme has been developed.
- Modern medicines are used for treating syphilis; 70% of patients with syphilis have been treated in outpatient departments.
- Anonymous clinics exist and have hotlines.
- Active measures have been taken to prevent congenital syphilis by both dermato-venereologists and gynaecologists, with the active participation of family doctors. These include provision for serological examinations of women three times during pregnancy. Particular attention has been given to the development of guidelines for the reproductive health service, and to arrange meetings and workshops with gynaecologists.
- There is good cooperation with the Ministry of Education in primary prevention activities.

Ukraine

- Syphilis morbidity continues to decrease, from 150.9 per 100 000 in 1996 to 138.4 in 1998. The incidence of congenital syphilis has also started to drop from 83 cases in 1997 to 79 cases in 1998.
- Morbidity is 30% higher in the urban population than in the rural population.
- Patients with early syphilis are treated on an outpatient basis.
- Benzatyn benzylpenicillin is not used in the public health service due to its high cost.
- In the governmental sector patients are no longer required to provide identification documents.

- Anonymous clinics exist for diagnosis and treatment of STI.
- Partner tracing and treatment is recommended, except for patients with syphilis and gonorrhoea, where there is still a law requiring obligatory treatment.
- The syndromic approach is not being used yet. Specialists are considering this approach for use with high risk groups.
- The reproductive health services work actively with STI problems except for the treatment of syphilis. This is because the leading dermato-venereologists do not consider it reasonable that non-STI services should treat syphilis, because non-STI professionals are not trained in the treatment of syphilis and are not well trained in syphilis epidemiology. Besides, as the specialists believe, in the currently poor economic climate it would be inadvisable to spend funds on training.
- There are no special clinics for treating vulnerable groups in the public health service.
- Primary prevention activities are provided by health, family planning and young people's sex education centres, supported by NGOs with the participation of dermato-venereologists.
- Issues of primary prevention are included in the healthy lifestyle programmes.
- Regulations concerning the provision of free contraceptives (including condoms) for young people under 18 have been in force since 1998.
- Collaboration between the STI and reproductive health services with HIV/AIDS centres in the area of primary prevention is not satisfactory.
- The major obstacles for implementing the WHO recommendations are:
  - economic problems
  - poor professional skills of the specialists
  - unsatisfactory legislation.

Uzbekistan

- STI morbidity started to rise in 1991. In 1998, the incidence of syphilis was 45.5 per 100 000 which constitutes a 26-fold increase compared to 1990.
- STI prevention and control is a government priority. The Prime Minister has personal control over many related issues.
- According to current legislation, patients spreading STIs and avoiding treatment are subject to criminal justice. A joint order of the Ministry of Internal Affairs and Ministry of Health regulates the tracing of partners and contacts and forces them to be examined and treated. Regulations have been worked out concerning police-supported STI hospitals.
- Owing to the serious epidemiological situation, regular medical examinations of various population groups have been conducted on a continuing basis. Specialists consider that this has helped to avoid the increase in STI morbidity. Thus the majority of patients (85%) were actively detected.
- Different specialists work together with dermato-venereologists. Training of general practitioners and physicians from rural areas is offered by postgraduate institutions with the aim of involving them in STI detection. Quarterly intersectoral meetings are held in which representatives of the Ministries of Education and Internal Affairs as well as NGOs are obliged to participate.

- Guidelines have been prepared on the treatment of syphilis and gonorrhoea using modern medicines.
- Outpatient treatment of some affected groups is permitted.
- STI clinics and the AIDS Centre are providing anonymous services.
- Special sites for individual information on STI prevention and provision of care have been set up in major cities, regional centres, railway stations and areas with a high presence of migrant populations.
- A federal programme on STI control and prevention for 2000–2005 has been developed.

Syndromic approach to STI case management

St Petersburg Municipal Health Service presented its experience on the introduction, on a pilot basis, of a syndromic approach to STI care in two districts of the city. The approach has been successfully used in the following conditions:

- in cases of urgent care for patients with complications requiring emergency antibiotic therapy;
- for patients with no social status, i.e. individuals without a permanent home, prostitutes, drug users, criminals, etc.;
- in cases where further observation is not possible, i.e. if the patient leaves because of a number of circumstances;
- in cases where laboratory equipment for STI diagnosis is poor and/or a patient refuses to be examined by specialized facilities.

Obstacles which were encountered in implementation of the syndromic approach included:

- excessive utilization of antibacterial drugs and high risk of complications;
- a high number of patients were refusing treatment without etiological diagnosis;
- increasing risk of groundless family conflicts;
- decrease in efficiency of surveillance;
- possibility of conflict with patients due to their requirements of refund in case of inefficient treatment.

Reproductive health services and STI prevention and care

There is little tradition of separate family planning services in eastern Europe. Traditionally, abortion has been the most widely used form of birth control. The provision of family planning services has often been combined with general gynaecological services which in turn comprise some, although not all, STI prevention and care services. For this reason, the continuing international debate on the benefits of integrating family planning services with STI services may only be partially relevant to this region. Strong clinically-oriented STI control services have been in existence in eastern Europe as well as (since 1985) a separate vertical programme on the prevention and care of AIDS. It would, therefore, be more appropriate to consider integrating the services of reproductive health, STI control and AIDS control when dealing with STIs. This could lead to the abolition of one or two of the existing services, leaving only one to deal with the problems of reproductive health and STIs.

Benefits of involving/integrating the various services in STI prevention and care

There are benefits to be considered from providing an integrated approach to dealing with public health problems and, in particular, the prevention and control of STIs.

The benefits of involving *the reproductive health services* include the following:

- there are 3–4 times more staff in reproductive health services compared to the STI service;
- generally speaking, reproductive health service clinics (women's consultation clinics, gynaecological services) are more user-friendly and much more easily accessible to women than STI service clinics;
- staff in reproductive health services are capable of diagnosing and treating STIs;
- reproductive health services have more experience in and are devoted to counselling and educating women;
- patients usually feel more confident about sharing intimate personal information with a physician from the reproductive health services;
- there is no forced contact tracing practised in the reproductive health services;
- the reproductive health services have extensive experience in information dissemination and educating the population.

The benefits of involving *the STI services* include the following:

- their specialized competence in diagnosis and treatment of sexually transmitted infections;
- their possession of appropriate drugs for treatment;
- STI infections with complications or mixed infections have traditionally been treated by the STI service;
- they have accumulated experience in partner notification and contact tracing;
- STI clinics have epidemiological specialists for contact tracing;
- the population is conditioned to the tradition that STIs are treated in STI clinics.

The benefits of involving *the AIDS prevention service* include:

- it has accumulated knowledge and experience in primary prevention of AIDS as an STI;
- it is usually staffed with professionals experienced in working with the mass media and video production, and with specific vulnerable groups of the population who are involved in spreading STIs.

Opportunities for involving reproductive health services in STI prevention and care include the following:

- the current epidemiological situation requires common action from dermato-venereologists, gynaecologists and other reproductive health specialists;
- the network of facilities and staff already exists, but they should work in a coordinated way;
- there is considerable experience of cooperation between STI and reproductive health services but new methods of coordination need to be created in response to the current social and economic changes;

- international organizations might be more willing to provide appropriate support for an integrated approach.

The *advantages of integration* include the following:

- the involvement of gynaecologists in STI care will increase the number of specialists providing such care, thus making it more accessible;
- STI patients may be more inclined to visit gynaecological services due to the absence of stigmatization, again, making STI care accessible;
- the improved accessibility of STI care and increased attendance at the medical services by STI patients will lead to:
  - early STI detection
  - early treatment
  - more comprehensive care
  - increased opportunities for primary prevention
  - greater cost-effectiveness.

Issues for further consideration and implementation

1. There is a need to study the ways in which women (and men) seek reproductive health care in order to measure attitudes towards the STI clinics and the gynaecological and women's health clinics and their services. It would be valuable if such a study could document the attitudes of those who are unable or unwilling to use these services.

2. Training should be offered to as many reproductive health workers as possible in communication and counselling, especially sex counselling, risk assessments, contraceptive choice and partner dynamics. Gynaecologists specializing in young people should have priority for such training.

3. Gynaecological/family planning services are already testing for gonorrhoea and syphilis on a routine basis. These services should be licensed to treat these infections for the following reasons:
   - people who have been diagnosed with STI infection should be offered on-site (one stop) treatment, in accordance with WHO recommendations;
   - the specialized STI services are not broadly available, whereas the gynaecological services are considerably more accessible;
   - many women prefer the women's consultation centres where no contact tracing is enforced to the STI services where it is; active contact tracing is becoming increasingly difficult because of stigmatization, and passive partner notification could be conducted as well by gynaecologists as by venereologists.

4. The cost-effectiveness of all gynaecological/family planning services providing STI diagnosis and treatment services should be considered. Studies should be conducted on the prevalence of various STI pathogens among both symptomatic and asymptomatic gynaecological/family planning clients in different geographical settings and at different levels of care (urban, oblast, rayon). On the basis of these findings, those services where prevalence is higher should provide full services, while others should perhaps refer their

patients. Where prevalence is known to be sufficiently high but laboratory tests are not available, presumptive (syndromic) treatment should be considered.

5. Comprehensive user-friendly model services should be established at strategic locations where counselling, contraception and STI prevention and care are all provided at the same site, for example, where there are large groups of particularly vulnerable young people. These might comprise either upgraded public clinics or, in countries where they can be licensed, NGOs, associations or private firms that aim to provide high-quality reproductive health services.

Existing obstacles to possible integration

- A lack of understanding at the different levels of the current health system of the advantages to be gained from integration.
- Staff in the gynaecological services lack the professional skills for STI care.
- A lack of proper protocols and guidelines on treatment and management of STI patients and limited capacity in laboratory diagnostics.
- A lack of financial resources for training staff and supporting an appropriate laboratory system.
- A conflict of the interests between dermato-venereologists and gynaecologists.
- Reduced effectiveness of surveillance and monitoring of the STI epidemiological situation.

Priorities

Priorities in STI prevention and care

- The improvement of primary prevention and the education of the population, particularly vulnerable groups. Development of educational material for various groups of population and particularly for certain vulnerable groups.
- Training of staff in the primary prevention of STI and in counselling, and of teachers in educational methods and skills in STI prevention and sexual health issues.
- Provision of free medical care for the poorer layers of society and provision of anonymous testing and free treatment of STI for vulnerable groups in the population.
- Improved forms and methods of work with the vulnerable groups.
- Provision of equipment, diagnostic reagents for syphilis, gonorrhoea and chlamydia infections.
- Provision of drugs and condoms.
- Special attention to prevention and early diagnosis of congenital syphilis.
- Integration between STI and HIV/AIDS services.

Priorities for external support identified by sub-regions and countries

The priorities for external support identified by sub-regions and countries are set out in tabular form below (Table 4).

Table 4. Priorities for external support identified by sub-regions and countries

Group priorities	*Group A*	*Country priorities*
1. Population. Education 2. Training specialists (doctors and educationalists) 3. Free care to poor and high risk groups 4. Surveillance of risk groups and identification of programme and improvements 5. Support national programmes	Russian Federation	1. Implement syndromic approach in rural areas 2. Improvement of diagnostic tests for congenital syphilis
	Belarus	1. Improve diagnostics and treatment 2. Improve surveillance of risk groups
	Ukraine	1. Implement syndromic approach 2. Improve laboratory diagnostics
	Kazakhstan	1. Improve surveillance 2. Improve targeted health care to risk groups
	Republic of Moldova	1. Improve preventive approach to rural groups 2. Increase attention upon risk groups
Group priorities	*Group B*	*Country priorities*
1. Laboratory diagnostic equipment 2. Preparation and activation of health promotion media 3. Free drugs and condoms 4. Enhancing services for pregnant women to prevent congenital syphilis	Uzbekistan	1. Research to define scale of problem 2. Monitoring of GC resistance
	Tajikistan	1. Research to define scale of problem 2. To develop educational material for risk groups and the military
	Turkmenistan	1. Monitoring GC resistance 2. Research to define scale of the problem
	Azerbaijan	1. Education of risk groups 2. Research on attitudes to STI and behavioural modification
	Kyrgyzstan	1. Social research to identify area amenable to behavioural intervention 2. Monitoring of GC resistance
Group priorities	*Group C*	*Country priorities*
1. Development of concept and implementation of mass media campaign on primary prevention 2. Training of medical staff in primary prevention and counselling 3. Organization and financing of anonymous free STI service for vulnerable groups (prostitutes and homeless) 4. Support regional meetings to enhance exchange of information	Lithuania	1. HPV cervical screening 2. Preparation of STI register
	Latvia	1. Monitoring GC resistance 2. HPV cervical screening
	Armenia	1. Advance work with prostitutes (special services and condoms) 2. Improved screening and surveillance
	Estonia	1. HPV cervical screening 2. Support wider education of population. Re: STIs
	Georgia	1. Increase syphilis screening to x3 during pregnancy 2. Monitoring GC resistance

Priorities identified by the participating countries

The most important priorities identified by the participants from the participating countries are listed below:

Armenia

1. Advance work with vulnerable groups, particularly sex workers (special services and condoms).
2. Improve screening and surveillance.

Azerbaijan

1. Education of risk groups – drug users, sex workers, etc.
2. Research on attitudes to STI and behavioural modification.

Belarus

1. Improve diagnostics and treatment.
2. Improvement surveillance of risk groups.

Estonia

1. HPV cervical screening.
2. Support wider education of population regarding STI prevention.

Georgia

1. Increase syphilis screening to x3 during pregnancy.
2. Monitoring GC resistance.

Kazakhstan

1. Improve surveillance.
2. Improve targeted health care to risk groups.

Kyrgyzstan

1. Monitoring of GC resistance.
2. Social research to identify areas amenable to behavioural intervention.

Latvia

1. Monitoring of GC resistance.
2. HPV cervical screening.

Lithuania

1. HPV cervical screening.
2. Preparation of STI register.

Republic of Moldova

1. Increase attention to risk groups.
2. Improve preventive approach to rural groups.

Russian Federation

1. Implementation of syndromic approach in rural areas.
2. Improvement of diagnostic tests for congenital syphilis.

Tajikistan

1. Research to define scale of problem.
2. Develop educational material for risk groups and the military.

Turkmenistan

1. Monitoring GC resistance.
2. Research to define scale of the problem.

Ukraine

1. Implement syndromic approach.
2. Improve laboratory diagnostics.

Uzbekistan

1. Research to define scale of problem.
2. Monitoring of GC resistance.

Recommendations

1. Participants should bring to the attention of their ministries of health the issues concerning an integrated approach to STI prevention and care, to identify priorities and to define the appropriate actions to be taken at national level.

2. National health authorities should review and reformulate policy regarding the involvement of reproductive health services in STI diagnosis and treatment. Obsolete instructions, rules and orders banning or limiting such involvement should be abolished. Treatment of pregnant women infected with syphilis and/or with related complications should be carried out under the supervision of the dermato-venereological services.

3. Primary prevention of STIs needs to be vigorously promoted. Awareness of safe sex needs to be heightened, together with the importance of seeking early medical care, enabling any infection to be detected and treated earlier in its development rather than later. The establishment of an integrated approach to STI care among STI, reproductive health and HIV/AIDS services will enhance the primary prevention of STIs.

4. Appropriate methods/rationales need to be found for the screening of certain population groups for syphilis.

5. It is important that STI prevention and care among vulnerable groups is intensified. Knowledge and experience gained in other countries about successful diagnosis, treatment and care of these population groups should be shared between countries.

6. With the reform of the health services and the introduction of a system of family doctors, it is imperative that adequate training be given to the family physicians and general practitioners to ensure that they possess appropriate knowledge about the diagnosis and treatment of STIs.

7. Information about experience and lessons learned from adopting an integrated approach to STI prevention and care should be exchanged between the countries in the Region and with WHO.

8. A follow-up meeting should be held to discuss ways of improving STI surveillance in the light of the growing number of private practices in the field of STI diagnosis and care.

9. The actions recommended by the participants in this Meeting should be monitored and assessed.

Annex 1

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