TASK FORCE FOR THE URGENT RESPONSE TO THE EPIDEMICS OF SEXUALLY TRANSMITTED DISEASES IN EASTERN EUROPE AND CENTRAL ASIA

Report on the Second meeting of the Task Force
Supported by the WHO Regional Office for Europe (WHO/EURO) and the Joint United Nations Programme on AIDS (UNAIDS)

Vilnius, Lithuania
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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)

ABSTRACT

At this second meeting of the Task Force, the participants shared information on the situation concerning sexually transmitted diseases (STDs) and on partners’ activities in the Region, particularly in the Russian Federation. A discussion on the potential for national coordination of international assistance concluded that the government had ultimate responsibility for such coordination. The discussion brought to the participants’ attention the need for a national strategic plan that would rationalize international and national inputs and serve as a channel for the work of the Task Force at country level. The Task Force could assist by serving as a channel for the international exchange of information that would help identify gaps, overlapping and inconsistencies. The participants discussed the potential for better coordinating or integrating STD services with other health services, particularly those concerned with women’s reproductive health. It was agreed that introducing STD services into the primary health care package would help to place STD services on the health care reform agenda and offer better prospects of acceptability and sustainability in the long run.

Keywords
SEXUALLY TRANSMITTED DISEASES – prevention and control
ACQUIRED IMMUNODEFICIENCY SYNDROME – prevention and control
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INTRODUCTION

The second meeting of the Task Force for the Urgent Response to the Epidemics of Sexually Transmitted Diseases in Eastern Europe and Central Asia (TF/STD) was convened on 22–23 September 1998 in Vilnius, Lithuania. This meeting was a follow-up to the founding meeting which was held on 23–24 February 1998 in Copenhagen, Denmark, at which representatives established the terms of reference for TF/STD. The meeting, which received national press coverage, was hosted by the Lithuanian Ministry of Health. It was supported through voluntary contributions to the TF/STD Secretariat.

Mr Vitautas Kriaunza, Vice Minister of Health of Lithuania, welcomed representatives from international organizations and medical experts from Armenia, Bulgaria, Estonia, Georgia, Latvia, Lithuania and the Russian Federation.

The specific objectives of this meeting were:

- to continue the consultative process with host countries and bring members to a common factual point of departure on the scope of the problem;
- to learn what activities and programmes international organizations are supporting in the region in the area of STD care and prevention and the broader area of reproductive health;
- to develop a model for in-country collaboration and coordination;
- to develop a harmonized approach to the integration of STD services into existing health services for women, in particular women’s consultation centres.

This report highlights the discussions and recommendations of this meeting.

REPORT FROM THE SECRETARIAT

The Secretariat reported on its activities since the First Meeting.

Staffing

Efforts are underway to establish a time-limited post at WHO/EURO for a professional who will manage and oversee the activities of the Secretariat. Establishment of this post was contingent on securing the necessary funds. In view of this, WHO/EURO hired a part-time consultant to conduct advocacy and fund-raising activities on behalf of TF/STD, draft the report of the First Meeting, develop a plan of action for TF/STD, and plan and organize the Second Meeting of TF/STD with administrative assistance from WHO/EURO. In a decision independent but relevant to TF/STD, WHO/EURO and UNAIDS will jointly fund a two-year time-limited post for a medical officer located in WHO/EURO who will provide STD technical assistance to the region.

Fund-raising

A proposal was developed seeking US $570 000 to support the Secretariat and its activities for two years. In a first round of fund-raising, the proposal was submitted to the Know How Fund (DFID), UNFPA, UNICEF, USAID, the Open Society Institute, and the World Bank. The objective was to raise funds from multiple sources in order to maintain a broad base of support for the initiative. To date a total of US $360 000 have been pledged: the Know How Fund has
pledged US $160 000 over two years, USAID US $100 000 over two years, and the Open Society Institute US $100 000 in two annual instalments of US $50 000 each. A second round of fund-raising has been initiated to raise the outstanding balance of US $210 000. The proposal was submitted to a number of Nordic funding agencies many of which are already funding health sector projects in the Baltic states.

Membership
Members of TF/STD believe it is important to maintain a strategic mix of organizations to bring programmatic and geographic diversity to the initiative. The TF/STD membership includes five types of agency: multilateral, bilateral, implementing (nongovernmental organization), academic and research, and professional organizations.

With one exception, all international organizations present at the founding meeting were represented at this meeting. These included the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA), the Joint United Nations Programme on AIDS (UNAIDS), the World Bank, the World Health Organization (WHO), the International Federation of Red Cross and Red Crescent Societies (IFRC), Médecins sans Frontières (MSF), several Scandinavian research institutions (listed in Annex 4), and bilateral donors from Denmark (Danida), the United Kingdom (Know How Fund/DFID), and the United States of America (USAID) which was represented by the Centers for Disease Control and Prevention (CDC).

Several donor and implementing organizations joined TF/STD for the first time at this meeting. These included the Open Society Institute (OSI), the American International Health Alliance (AIHA), the International Planned Parenthood Federation (IPPF), the International Union against Sexually Transmitted Infections (IUSTI), the US Centers for Disease Control and Prevention (CDC/Atlanta), SANAM (a Russian NGO affiliated to IUSTI), and a number of distinguished academic and research institutions which are listed in Annex 4.

Establishing a network of academic and research institutions
TF/STD is helping to build a network of western academic and research institutions who are keen on collaborating with institutions in eastern Europe and central Asia with similar interests and priorities. Joining the National Institute of Public Health of Norway, the Statens Serum Institut of Denmark, the Institute of Clinical Bacteriology at the University of Uppsala in Sweden, the National Research and Development Centre for Welfare and Health of Finland, the National Public Health Institute of Finland, the Swedish Institute of Infectious Disease Control, and the US Centers for Disease Control (CDC/Atlanta). These institutions receive grants from their respective governments and other donors to conduct projects in this region. Several of these institutions were representing their government at the meeting including the Norwegian Health Board and the Ministries of Foreign Affairs of Denmark and Finland.

Information collection and dissemination
The Secretariat has begun to collect an inventory of activities in the region. TF/STD will require detailed project documents from all members so that TF/STD can collate and develop an inventory of what is happening in each country of the region, analyse this information and present it to members in a useful format that facilitates cooperation and coordination. The Secretariat has also compiled a registry for TF/STD which includes over 200 individuals and organizations.
Development of a strategic planning and monitoring tool

The Secretariat has been working on the development of a logical framework which will enable the Secretariat to prioritize and monitor activities and achievements over the next two years. A draft of the logical framework will be distributed to members and discussed at the next TF/STD meeting.

EPIDEMIOLOGICAL AND PROGRAMMATIC UPDATES

At the first meeting participants had an opportunity to get an overview of the STD situation in the region and to learn from local experts about the specific situation in Belarus, Kazakhstan, the Russian Federation and Ukraine. At this meeting participants heard about the situation in the Baltic states of Estonia, Latvia and Lithuania, Bulgaria, and the Caucasian states of Armenia and Georgia.

Epidemiological trends

Participants presented a large amount of STD data which is presented in Annex 1. The trends can be summarized as follows.

- STD are increasingly affecting youth – this is also reflected in an increasing trend in teenage pregnancies.

- Congenital syphilis is on the rise – this is partly attributed to a drop in antenatal care clinic attendance and breaks in the supply of syphilis screening test and drugs in some countries. In Armenia, for example, one fourth of all syphilis cases detected among pregnant women was not detected until the time of delivery. Trends in syphilis sero-prevalence among pregnant women in the region are not systematically analysed and monitored.

- In contrast, the reported incidence of syphilis has stabilized since 1996–1997. Experts are sceptical that this represents a true trend and rather attribute this apparent stabilization to under-reporting by both government and private providers and to changes in mass screening and active contact tracing policies and procedures. In Georgia, a study conducted in 10 oblasts revealed that only about 50% of syphilis and gonorrhoea cases diagnosed at government STD services were reported to the national surveillance centre.

- The later stages of syphilis make-up an increasing proportion of reported syphilis cases. In Latvia, for example, late syphilis represented 30% of reported syphilis cases in 1997, up from 19% in 1993.

- The reported incidence of gonorrhoea has declined since 1993–1994, this is attributed to gross under-reporting resulting from massive shifts in health care seeking behaviour and a breakdown of the government health infrastructure. STD among women are seriously under-reported because women with genital complaints prefer to seek care at women’s consultations and gynaecologists tend not to report the cases they manage. In Georgia, in order to encourage gynaecological services to report the STD cases they manage, the government allocated funds to the VD Institute allowing the Institute to reimburse Women’s Consultation services for the cost of every STD case they diagnose, treat and report to the Institute. This reimbursement incentive resulted in a significant increase in the number of gonorrhoea cases reported from 863 in 1996, to 1075 in 1997 and 1443 in 1998 (Khotenashvili, personal communication).

- The capacity to test for Chlamydia trachomatis is being strengthened in the region, particularly in the Baltic states with assistance from Nordic research institutions. Reliable
data on the extent of genital chlamydial infections in various population groups should be forthcoming.

- More data are becoming available on the prevalence of STD among sex workers. In Lithuania, for example, among 35 female sex workers who visited an HIV/AIDS drop-in centre in Vilnius in 1998, 13% had active syphilis, 16% had serologic evidence of a past syphilis infection, 11% had a genital chlamydial infection and 3% had gonorrhoea. In Armenia, roughly half the female sex workers who underwent a mandatory STD check-up between 1993 and 1995, were diagnosed with an STD.

Trends in STD service delivery
Many reforms are under way to improve access to and use of STD services in the Armenia, the Baltic states, Bulgaria and Georgia. Some examples are the following.

- A more confidential reporting system has been introduced in a few countries. In Georgia, for example, the Dermato-Venereology Institute has introduced a new STD reporting form which replaces the patient’s name with a record number.
- Contact tracing methodologies have been liberalized.
- STD management has become more comprehensive in several countries to include prevention education and condom distribution.
- Ambulatory treatment of primary and secondary syphilis has increasingly replaced compulsory inpatient treatment in all participating countries. However, there remain special instances, such as pregnancy, that still require for a patient to be hospitalized. In addition, sex workers in Armenia are still admitted to the hospital for the treatment of syphilis. The argument put forth is that time spent at the hospital can be used for safer sex education.
- The syndromic approach to STD case management has been introduced in several countries in order to provide same-day treatment. In Georgia, for example, the syndromic approach has been introduced at peripheral level STD clinics.
- The provision of STD care for STD (other than syphilis) is increasingly de-specialized with gynaecologists playing a greater role. Gynaecologists in Armenia and Georgia have also been trained in the syndromic management of RTI through the Reproductive Health Projects which UNFPA and WHO/EURO are jointly supporting in these countries.
- Interventions are beginning to address the special needs of sex workers. In Lithuania, for instance, a drop-in centre and clinic for sex workers has been established in downtown Vilnius.
- Free STD services are available in several countries such as Georgia and Latvia but are limited to the diagnosis and treatment of syphilis.
- Authorities are beginning to recognize the special needs of youth including the need for sexual health education. In Georgia, the Zhordania Institute offers free and confidential reproductive health services including STD services to adolescents and youth.

Challenges
There remain many inherent problems in implementing an effective response to the STD epidemics. The following are a few examples.

- STD and HIV/AIDS programmes continue to function as separate programmes competing for scarce resources. As a result there is little cooperation or collaboration between them.
• Similarly, there is little cooperation among different medical specialists who compete for the same clients. Amidst the sweeping wave of primary health care reforms, medical specialists are fighting for their professional and economic survival.

• Clinics are under-funded and experience frequent shortages of screening tests for syphilis, drugs, syringes and gloves.

INTERNATIONAL ASSISTANCE UPDATES

Representatives of international organizations which were not officially represented at the first TF/STD meeting, were given precedence over others to give an overview of the STD activities they are supporting, or planning to support, in the region. These included AIHA, IPPF, IUSTI, OSI, SANAM, the National Research and Development Centre for Welfare and Health of Finland, the National Public Health Institute of Finland, the Swedish Institute of Infectious Disease Control, and CDC/Atlanta. IFRC and MSF, which were represented by IFRC/Russia and MSF-Belgium/Azerbaijan at the first meeting, had an opportunity to present their regional portfolios. As a first step in building an inventory of STD-related activities sponsored by members in the region, the Secretariat has compiled a list of reports and other documents which have been submitted to date by members and other participants. This list is available upon request.

COORDINATION AT THE COUNTRY LEVEL

While TF/STD is not responsible for in-country coordination, participants recognized the need to create a conduit between the work of TF/STD at the regional level and in-country activities. Participants selected the Russian Federation as an example to discuss the potential for coordination of national and international inputs and activities at the country level. The Russian Federation proved to be a challenging case study because of its size and complexity.

The need for coordination at the country level

Participants heard about a wide range of activities which are being supported by TF/STD member organizations in the Russian Federation, ranging from the national to the local level (Annex 3). The meeting was a good opportunity to identify duplication in the response and to seek collaboration among member agencies. The following examples are illustrative.

• Several organizations are supporting, or planning to support, activities in the same thematic area. For example, UNAIDS and its co-sponsors, the Know How Fund, USAID, IFRC and MSF are all engaged in advocacy and the development of national STD policy. Several organizations, including IUSTI, are assisting with the development of national STD case management guidelines. UNAIDS, WHO, several Nordic institutions, CDC/Atlanta and the Open Society Foundation are committed to building the national capacity in epidemiology with the ultimate objective of strengthening national surveillance. UNICEF and IFRC are engaged in the development of curricula for school health education. Members recognized that they need to work together in these areas and streamline their efforts in order to achieve these common objectives.

• Two international organizations from neighbouring European countries were surprised to discover that they were working on the same problem, in the same city, with the same local partner in the Russian Federation. After this meeting they will sit together and combine their efforts.
• Participants from countries in the region were surprised to learn about internationally-funded projects taking place in their country which were relevant to their work and which they were hitherto not aware of. In the same token, international agencies were pleased to identify new potential collaborators in the host country at the meeting.

The need for an operational framework
The discussion raised many questions. Among them were the following.

• Can current international activities be rationalized? Are there geographic or programmatic gaps or duplication in the response? Will the sum of national and international activities add up to a comprehensive programme that is likely to have an impact on the current STD and future HIV/AIDS epidemics?

• Can experience gained in one oblast be transferred to other regions of the country? Is there more to be gained by working at the central level, at the oblast level or at both levels? If so, what should be the balance of those activities?

• Despite many overlapping objectives and activities, STD, HIV/AIDS and MCH/FP programmes continue to function as separate programmes in the Russian Federation as in most countries in the region. How should international agencies approach these individual programmes without creating more division?

Participants agreed that it is difficult to rationalize the international response in the absence of a national strategy. Duplication is easy enough to spot, but how can gaps in the response be identified unless there is a clear vision of what we are trying to achieve collectively with our limited resources? Clearly there is a need for a national strategic plan which prioritizes activities according to need, impact and feasibility, and helps to integrate (or at the very least, coordinate) relevant activities within the STD, HIV/AIDS and MCH/FP programmes.

Developing the local capacity for national coordination
Participants agreed that the responsibility for in-country coordination should be with the national government and that building the local capacity for national coordination should be a priority within the region. Since the national strategic plan constitutes the basis for a coordinated response, as a first step, international agencies could assist governments in the development of such a plan.

International agencies should encourage local governments to designate a governmental focal point which would be responsible for coordination of international assistance. In countries inexperienced in this area, the government could, as an interim measure, be encouraged to invite a third party to assist with coordination. This might be the UN Theme Group, a subgroup thereof, or a separate interagency working group (an STD Theme Group of sorts). Such a body would be responsible for bringing together a group of government officials, representatives of international organizations and NGOs, and other stakeholders, on a regular basis to share information and experience, and coordinate activities. Participants recognized that the creation of such an in-country coordination mechanism requires a lot of organization, hard work, leadership, and considerable openness to sharing detailed information about projects including both successes and failures.

Role of TF/STD
The challenge before TF/STD is to determine how it can best channel its activities as “value added” at the country level. The depth and breadth of communications required by international
organizations to coordinate their activities at the implementation level is clearly beyond the capacity of TF/STD. Such close coordination can only take place in-country, in close consultation with national counterparts and partners. Participants suggested that the primary role of TF/STD in this regard, should be to serve as a channel for the international exchange and dissemination of country project information, experience, material etc and to facilitate the sharing of knowledge and the building of contacts/networks. This will help to identify gaps, overlaps, inconsistencies in programme or project activities and serve as a basis for coordination.

INTEGRATION OF STD SERVICES INTO BROADER HEALTH SERVICES

TF/STD facilitated a discussion on the integration of STD services into existing health services, particularly into women’s reproductive health services.

Positioning STD services on the health care reform agenda

Health care reforms are being introduced across the region to improve the quality and coverage of health services. Much effort is being directed toward the introduction of basic services. The World Bank emphasized that the challenge at hand is to find ways to accomplish this within the confines of existing health budgets. Decision-makers are looking to find ways to restructure health services to make them more efficient, to find a mix of services that represents the best value with regards to the health needs of the population. Introducing STD care into other basic reproductive health services provided in women’s consultation centres and maternity centres, constitutes an important strategy to introduce STD services into the primary care package and ensure that they are funded in the future. In addition to influencing how services are structured, another way to introduce STD services into the primary care package is to develop clinical protocols that influence how STD are managed. Again, these protocols should improve outcomes without necessarily increasing the cost of services.

The regional context of integration

Integration is taking place during a difficult period of economic transition and health care reforms. A shift to the primary health care model and the emergence of an anarchistic private sector create a fiercely competitive environment. There is an uneasiness, a distrust and a sense of insecurity among providers. Each specialty is fighting for its economic survival.

Furthermore, there has been a general breakdown in the public health infrastructure resulting in under-utilization of services. For instance, country participants reported a rise in congenital syphilis resulting from a breakdown in antenatal syphilis screening programmes. Countries reported a decline in antenatal clinic attendance, that women are attending clinic later in their pregnancy, and, in some cases, a shortage of syphilis test kits. In Armenia, between 1992 and 1997, as many as one third of the syphilis cases among pregnant women were detected during the third trimester and a quarter at the time of delivery.

Status of integration in the region

Thus far, experience among participants with integration of STD services in the region is limited and can be summarized as follows.

- Policies and practices regarding who can provide STD services are changing in some countries. In Armenia, legislation was passed in 1996 allowing gynaecologists to manage any STD other than syphilis. Similarly in Georgia, gynaecologists have been diagnosing and treating genital discharges for years but are still required to refer syphilis cases.
• In pilot projects jointly supported by UNFPA and WHO/EURO, gynaecologists in Armenia and Georgia are being trained to screen, diagnose and treat STD as an integral component of the reproductive health training curriculum.

• STD prevention education and counselling is a focal component of the STD training programme which AVSC International is implementing for physicians in the Russian Federation with funding from USAID.

• STD services are part of the sexual health services offered at the Women’s Wellness centres which are being established in six countries in the region with funding from USAID and technical assistance from AIHA. STD patients constitute 15% of the client population at the Women’s Wellness clinic in St Petersburg.

**Overall objectives and approaches**

A strong view was put forward that the objectives of integration in the region should be two-fold: (i) coordination of STD services with other health services, and (ii) introduction of STD care into women’s health services. There was general agreement that gynaecologists and general practitioners providing reproductive health services should become actively involved in STD case management and that integration needs to move beyond diagnosis and treatment to include the larger areas of prevention and health promotion.

In order to reach these objectives, participants agreed the following.

• A lot more can be accomplished by taking the time to reach consensus among national stakeholders regarding the best mode of action for integration. There are many actors involved in the delivery of reproductive health, STD and HIV/AIDS services in the region. It is therefore important to keep in mind what constraints each of these players might face.

• As a strategy for STD control, integration should be assessed vis-à-vis the long-term objective of having a maximum impact on sexual health. For instance, we need to recognize that integrating STD services into family planning and other reproductive health services may not have significant impact on STD in the short term because FP clients are not necessarily at high-risk for STD.

• A model of integration which may be feasible in one setting may not be feasible in another because there is a lot of diversity within and among countries in the region. It is therefore necessary to work within existing systems and to gradually put into place a framework of public health regulations and policies which are conducive to establishing what might be an ideal model of integration for that setting.

• There is a need for an accurate surveillance system in order to evaluate and compare the impact of different approaches and programmes.

**Role of the STD specialist in an integrated system**

Participants explored the role of the dermato-venerologist in a fully integrated system. His role becomes one of mentoring, advice-giving, training, supervision, quality assurance, monitoring, evaluation and research. Responsibilities would generally include surveillance, monitoring of antibiotic sensitivity patterns (participation in WHO’s regional Gonococcal Antibiotic Resistance Programme or GASP), development and update of clinical management protocols. Responsibilities may also include: clinical and outreach services to vulnerable segments of the community such as sex workers, men who have sex with men, and drug users; and, mass media
campaigns to increase the population's awareness of STD and their complications and the importance of early and effective treatment.

**The bottom line: client-centred services**

In developing a model for integration, participants agreed that the basic point of departure should be the client and the client's perspective rather than the provider's or the system's perspective. The focus of integration should be to improve the quality, accessibility and desirability of services to the end-users. The end-user wants her sexual health improved be it through STD, family planning, fertility, sexuality, gynaecological or other sexual health services.

**Role of TF/STD**

Participants suggested the following role of TF/STD in the area of integration.

- TF/STD can facilitate the sharing of information and experience regarding integration among international organizations and countries in the region.
- TF/STD can facilitate a process of consensus building among national stakeholders. For instance, TF/STD can encourage members to support regional networking meetings where key constituents can reach a consensus on how to move the integration process forward.
- Finally, TF/STD can assist in formulating guidelines to improve existing surveillance systems in the region. Strengthening surveillance systems has been suggested as a possible discussion topic for a future meeting.

**CONCLUSIONS, RECOMMENDATIONS AND NEXT STEPS**

**State of the epidemics**

Since syphilis is considered the "indicator disease" for all STD in the region, experts are concerned that official reports of a levelling-off of syphilis rates will lead to complacency in the region. There is a strong view point that this trend is largely due to under-reporting and that the epidemics are only "resolving on paper". Supporting this view is the alarming rise in congenital syphilis. Surveillance systems must be strengthened to ensure that reported STD data are reliable and predictive of the future HIV epidemic. On the positive side, more data have become available on the prevalence of STD among sex workers.

**Role of TF/STD**

- Encourage members to support activities to strengthen and innovate STD surveillance systems in the region. TF/STD can assist in formulating guidelines to improve existing surveillance systems in the region and strengthening surveillance systems has been suggested as a possible discussion topic for a future meeting.
- TF/STD needs to rely more on trends in congenital syphilis and HIV/AIDS data to build a better case for strengthening STD control programmes in the region.
- TF/STD should continue to assist UNAIDS in compiling country profiles and Epi Fact Sheets which summarize the STD data country by country.

**State of STD programmes and interventions**

While many reforms are underway to improve STD services in the Armenia, the Baltic states, Bulgaria and Georgia, the long list of challenges described in the first meeting report remains valid. In particular:
• STD and HIV/AIDS programmes continue to function as separate programmes competing for scarce resources;
• STD specialists, gynaecologists and other medical specialists compete for clients under the stress of health care reforms and privatization;
• clinics are under-funded and experience frequent shortages of drugs and other essential supplies.

On the positive side:
• access to STD services has improved in several countries thanks to the introduction of more confidential reporting systems, a liberalization of contact tracing methods, free treatment for syphilis, the outpatient management of syphilis, and STD training for gynaecologists;
• the quality of STD services has also improved with the introduction of the syndromic approach to STD case management and the introduction of prevention education and condom promotion at clinics;
• STD services and interventions are becoming more responsive to the special needs of sex workers and other marginalized groups;
• authorities are beginning to recognize the special needs of youth including the need for sexual health education.

*Role of TF/STD*
• Promote an integrated approach to STD and HIV/AIDS prevention and care.
• Promote UNAIDS best practices, particularly with regards to the most vulnerable population subgroups such as sex workers, men who have sex with men, injecting drug users (IDU) and youth.

*Activities of international organizations*
Organizations present at the first meeting of TF/STD returned and the number of new partners in TF/STD is growing. Partners include five types of organization: multilateral, bilateral, implementing (NGO), academic and research institutions, and professional agencies. This mix reflects a broad base of support for TF/STD. Partner organizations are providing support to a large and diverse range of activities, both geographic and programmatic. This information needs to be compiled, analysed and structured in such a way as to facilitate coordination tasks.

*In-country coordination*
Participants agreed that coordination is ultimately the responsibility of the government and that a national strategic plan should be the basis for coordination, rationalizing international and national inputs, and channelling the activities of TF/STD at the country level.

*Role of TF/STD*
• Encourage members to assist governments in the development of a national strategic plan and establishing a focal point for coordination of international assistance.
• TF/STD should explore options for in-country coordination with governments and other local stakeholders for discussion at future meetings.
• TF/STD should serve as a channel for the international exchange of country project information, experience and materials.
Integration of STD services into broader health services

Participants agreed that integrating STD services into the primary health care package is going to be an important way to position STD services on the health care reform agenda.

It was agreed that the focus should be to improve the quality, accessibility and desirability of services to the end-users, be it through STD, family planning, fertility, sexuality, gynaecological or other sexual health services.

**Role of TF/STD**

- TF/STD can facilitate the sharing of information and experience regarding integration among international organizations and countries in the region.
- TF/STD can facilitate a process of consensus building among national stakeholders.

**Next steps**

TF/STD is still evolving in terms of deciding on its priorities and on the limits of its responsibilities. The discussions at this meeting brought new insights and a better understanding of these priorities and responsibilities.

There was consensus that the:

- TF/STD Secretariat should do more in the way of information gathering, analysis and dissemination in order to inform its members more thoroughly on regional activities, gaps, overlaps and inconsistencies;
- TF/STD members will provide accurate, complete and timely reports on their activities and programmes to the Secretariat;
- TF/STD Secretariat will resume the development of a logical framework and workplan for TF/STD and present at the next meeting;
- TF/STD Secretariat will continue fund-raising activities in order to finance Secretariat staff and activities for two years;
- TF/STD Secretariat and partners should further explore models for in-country coordination with host country counterparts and report back to TF/STD at the next meeting;
- TF/STD Secretariat to plan third meeting in consultation with members.
Annex 1

EPIDEMIOLOGICAL TRENDS

Extract from a report prepared by Dr Gabriele Riedner,
Department of Tropical Hygiene and Public Health,
University of Heidelberg, Germany, for UNAIDS/WHO

Gonorrhoea trends
During recent years, rates of reported gonorrhoea decreased in all countries represented at the meeting. Fig. 1 shows data from Armenia, Bulgaria, Latvia and Lithuania:

![Graph showing gonorrhoea cases in selected Caucasian and Baltic countries, 1993-1997.]

Source: WHO/EURO.

Reported gonorrhoea data are unlikely to reflect the true magnitude of the problem. According to the representative from Latvia, gonorrhoea may be increasingly underreported because of shifts in health care seeking from the public to the private sector during the 1990s. Private providers do often not report cases. Self treatment is practised too, as people can buy drugs without prescription.

Syphilis trends
Rates of reported syphilis incidence have been rising until 1996, in all countries represented at the meeting, though at a different pace and at different levels. Russia has been most affected, with rates of up to 275/100 000 nationwide, followed by the Baltics, the Caucasus and Bulgaria. Since 1996 rates seem to stabilize, as shown in Fig. 2.

Rates differ significantly between regions: in the Russian Federation syphilis rates are especially high in Transural (1300/100 000) and Kaliningrad (500/100 000) oblasts. Officially, approximately 70% of syphilis cases are estimated to be reported in the Russian Federation; the real number of cases in 1997 would therefore have exceeded 500 000.
The validity of STD surveillance data

How valid are STD surveillance data in the region? Country representatives pointed out that syphilis case reports are considered the most reliable indicator of STD trends in their countries. As compared to case reports of other STD, reporting of syphilis is thought to be relatively more complete, as regulations remain strict and still largely re-enforced through government controls.

In Georgia, however, where the completeness of syphilis and gonorrhoea case reporting of public health facilities was recently assessed in several oblasts, no significant difference was found (Fig. 3).

The completeness of reporting varied between oblasts (data not shown). Overall approximately only 50% of syphilis cases and gonorrhoea cases diagnosed by public STD services were reported to the national surveillance institution. In addition, many patients with primary symptoms might not be treated at public STD clinics and not reported at all. Therefore true syphilis rates in Georgia are likely to be much higher than reported surveillance data suggest.

The completeness of STD case reporting should be assessed in other countries as well, in order to get better estimates of the true case load.
In this context, the validity of reported syphilis trends was discussed. Most STD rates had been presented as incidence rates per 100 000 population without indicating possible changes in the denominator (e.g. how many individuals have been tested for syphilis during each year?). Therefore the question arose, whether changes in case finding policies may have been the reason why rising trends had not continued. The observed stabilization of reported syphilis incidence in 1997 might well have been due to a reduction in screening.

Generally, little information on the sources of syphilis case reports (screening among pregnant women, screening among occupational groups, symptomatic case treated at a STD Centre, referral and/or treatment by gynaecologists/urologists, etc.) and of trends over time was provided at the meeting. In Lithuania in 1997, approx. 50% of syphilis patients seemed to have presented themselves at a venereologist or gynaecologist, while active case finding and screening programmes appeared to have contributed almost another 50% to the overall number of cases treated and reported. Nevertheless, there was no clear distinction between the various categories, and double reporting might have blurred the picture (Fig. 4).

Another observation indicates that either people do not seek treatment early when they have symptoms, that fewer early stages are detected through screening programmes, or a combination of both. The proportion of late stages of syphilis (late latent and tertiary) among all reported cases has increased in several countries. In Latvia late stages made up 19% in 1993 and 30% in 1997. In Armenia the proportion of late stages appeared to have risen from 44% to 68% during the same period.

Fig. 4. Sources of syphilis case reports in Lithuania (by sex)

Finally, congenital syphilis has become a major concern and trends are clearly rising. For example Estonia reported 10 new cases of congenital syphilis in 1997, after there had been none for many years. Armenia reported 5 cases in 1996 and 8 cases in 1997. In Russia, 471 cases of congenital syphilis were recorded in 1997, an alarming figure. Several factors were discussed that might have contributed to this trend: the rising number of adult syphilis cases, the low quality of STD services (e.g. lack of syphilis test reagents and drugs in peripheral health facilities), and the low utilization of antenatal care, and in particular, the increase in the proportion of unattended teenage pregnancies.

The two parallel trends, away from public health services towards care seeking at private providers, self-treatment or no treatment at all, and towards the reduction of screening and testing programmes, are likely to significantly affect the overall number of STDs and their trends reported by national STD programmes throughout the region. All countries represented at the meeting reported a shift from the public to the private sector during recent years, and policy changes concerning active STD case finding were also
reported from several countries. In Latvia, routine syphilis screening among several low-prevalence populations such as school teachers and other occupational groups, has been abandoned. In Russia and Latvia, among other countries, contact tracing is no longer being strictly enforced, resulting in a reduction in the number of contacts identified and reported.

In summary therefore, although reported syphilis rates might well have constituted the best indicator of the spread of STDs during the early and mid-1990s, the observed stabilization of reported syphilis incidence in the region in 1997 is unlikely to reflect the real development of the epidemic. Further studies on STD care seeking behaviours are required to determine the relative importance of different service providers for STD case management and to conclude on the proportion of STD cases that are actually reported. In addition prevalence studies using clearly defined denominators are needed.

**Adolescents**

Several countries, Armenia, Georgia, Latvia and Russia, reported that the number of syphilis cases among adolescents had over-proportionally increased. For example in Russia, syphilis in 15–17-year-old girls increased 120-fold between 1985 and 1997.

More than 26,000 cases of syphilis among adolescents were recorded alone in 1997. The rate in children of 1–14 years which includes congenital syphilis was 7.5 per 100,000.

The Russian participant gave some background information on the social conditions and factors that are associated with increased vulnerability and risk behaviour of adolescents. Teenage pregnancies are on the increase in Russia, but more than 50% of teenage pregnancies are not registered by ANC clinics. Of (registered) pregnant women aged 18–20 years, 95% had no permanent occupation, 70% were not married and the source of infection was in 50% a casual partner.

**Sex workers**

STD prevalence data from among sex workers in Lithuania and Armenia were presented. In Lithuania, 35 sex workers were examined in a drop-in-centre in Vilnius in 1998. 97% had an STL. 13% had active syphilis, additional 16% had serological markers of a past syphilis infection. 3% had gonorrhoea and 11% had a chlamydial infection.

Trends in the prevalence of STD in sex workers in Armenia from 1993 to 1997 are shown in Fig. 5. Roughly 50% of sex workers who underwent obligatory STD check-ups were infected with STDs during that time period.

**Fig. 5. Prevalence of STD in sex workers, Armenia, 1993–1997**

![Bar chart showing prevalence of STDs in sex workers.]

Source: Professor Karen R. Babayan, Ministry of Health, Armenia.
Annex 2

RESPONSE OF PARTICIPATING INTERNATIONAL ORGANIZATIONS

IMPLEMENTING AGENCIES

American International Health Alliance

The American International Health Alliance (AIHA) is a not-for-profit corporation, established by leading US health care organizations and hospital associations to enable America’s health care professionals to respond to requests for international technical assistance. In cooperation with the US Agency for International Development (USAID), AIHA has been able to provide technical assistance to key health care institutions in the newly independent states (NIS) and in central and eastern Europe (CEE). AIHA relies upon a partnership model, incorporating a peer-to-peer approach in order to identify problems and develop practical solutions.

In June 1996, AIHA convened a Women’s Health Task Force, comprising women’s health clinicians and educators associated with the partnership programme to develop a model for the creation of comprehensive Women’s Wellness Centres in 14 of its NIS partnerships.

The Women’s Wellness Centres provide clinical and educational services in an ambulatory care facility. They offer services in maternal health, primary care, and family planning. They address health promotion, disease prevention and other health and social issues that affect a woman’s health in her lifetime.

The goals of the centres are to prevent: (i) unintended pregnancies and abortions; (ii) poor pregnancy outcomes; (iii) sexually transmitted diseases and infertility; and (iv) unhealthy lifestyles across the continuum.

Centres have now been established in Moscow, Dubna, St Petersburg and Stavropol in the Russian Federation; Kiev, L’viv, Odessa, Chisinau, and Minsk in CEE as well as in Almaty, Tashkent and Yerevan. Each AIHA partnership implemented the model through a series of professional exchanges, with the aim of making these Women’s Wellness Centres self-sustaining within one year. A new Women’s Wellness Centre will open in Iasi, Romania, during the Autumn of 1999.

Centers for Disease Control (CDC)

The CDC Foundation is a private, not-for-profit corporation, dedicated to helping the Centers for Disease Control and Prevention (CDC) achieve its vision of “Healthy People in a healthy World, through Prevention”.

In relation to the STD epidemics in eastern Europe and central Asia, CDC is very actively involved in the Joint Russia/US health Committee of the Joint Commission on the Economic and Technological Cooperation – Priority Area of STD Control and Prevention. Major objectives of the Joint US/Russia Health Committee’s Priority Area of STD/HIV Control and Prevention are:

- to improve STD case management and increase consistent condom use in order to prevent HIV infection;
- to facilitate the shift from expensive inpatient treatment of STDs to outpatient treatment with cost-effective single dose therapies;
- to provide the epidemiological tools to effectively monitor the STD/HIV epidemics; specifically, to facilitate a shift from current STD and HIV surveillance approaches (frequent screening of large
occupational groups at low risk) to more cost-effective approaches (screening both high-risk groups and sentinel populations); and

- to strengthen the STD/HIV laboratory capacity.

Starting in spring 1997, activities have included:

- The translation of the materials, such as the CDC’s 1998 STD TREATMENT GUIDelines and STD Case Definitions for Public Health Surveillance, into Russian. These materials were disseminated throughout the Russian Federation in 1998.

- Considerable team- and knowledge-building culminating in a Joint Russia/US Workshop on STD and HIV Prevention in the Spring of 1998. The meeting was held as a way to collaboratively identify priority issues and propose appropriate actions for STD/HIV prevention. At this workshop there were four working groups: 1. Epidemiology and Surveillance, 2. Clinical Management and Reproductive Health, 3. Laboratory issues and 4. Prevention. The recommendations of these working groups have been adhered to, resulting in:

- A Training Workshop on Epidemiological approach to STD/HIV Prevention and Reproductive Health. The objectives of the workshop were to forge city-specific, multidisciplinary teams that could identify local issues/needs for HIV/STD intervention, and continue to work together;

- Conducting of a major analysis of factors influencing health risks, prevalence of STD/HIV, and health seeking behaviour among female sex workers and their clients. In January–February 1999, in order to identify groups at increased risk of STD/HIV infection and transmission, the initial phase of this study, describing the types, locations, and risk behaviour of sex workers in Moscow, was completed.

- In May, the Associate Director for International HIV/AIDS Prevention from CDC participated in a 2-week planning trip in Russia, to identify priority needs and to assist USAID in developing their HIV/STD strategy.

- In November, at the request of the Russian MOH, CDC’s DSTD co-sponsored and participated in the Russian National Dermato-venereology Conference.

- In November–December, together with Russian colleagues, 3000 school children (grades 8–11) were interviewed about their health risk behaviour, including sexual risks.

Planned activities in 1999–2000:

- CDC will conduct the next phases of the FSW study in Moscow and Saratov. Both CDC and USAID will fund this activity.

- Through a public-private partnership between CDC and the Becton-Dickinson Foundation, new laboratory diagnostic methods will be used to evaluate the prevalence of two common and curable STDs among important risk groups. Series of laboratory training courses will be provided to the Russian colleagues in the US and Russia.

- CDC will fund a study of risk factors for syphilis and congenital syphilis, in order to strengthen prevention efforts.

Ministry for Foreign Affairs, Finland, Department for International Development Cooperation (HEDEC) at National Research and Development for welfare and health (STAKES)

Finland’s principal position in cooperation policy was defined in 1996, in relation to its neighbouring areas, i.e. the Baltic republics and north-western Russia. Finland aims to (i) support welfare, including social welfare and public health; (ii) support democracy, and (iii) support social stability and security. The following projects are being implemented in this area.
Reduction of Infectious Diseases and their Disadvantages 1997–1999 in St Petersburg and Leningrad Oblast, Russian Federation

The long-term project objectives are to reduce infectious diseases as well as prevent and decrease the premature deaths, complications and costs of treatment and care. The financing and management of the prevention, diagnosis and treatment of infectious diseases follow the health care reform in Russian Federation. The project is prepared, planned and implemented in cooperation with the St Petersburg Pasteur Institute, Russian Federation and HEDEC close collaboration with the expert organizations in both countries.

With a team of specialists from Finland and St Petersburg, the project is currently evaluating a pilot programme on health education that has been run in four St Petersburg schools in the Frunzenski district aimed at influencing pupils knowledge and attitudes to sexuality, health behaviour and sexually transmitted diseases.

The project is financed by the Ministry for Foreign Affairs of Finland, Department of External Economic Relations (3.5 million FIM (60 000 ECU)).


This EU Tacis programme aims to create sustainable solutions to the problems of increased morbidity and mortality due to major communicable and noncommunicable, preventable diseases, poor hygiene and insufficient awareness of health promotion among the population. Epidemiological situation analysis will be performed and an assessment of the demographic implications for Russian preventive health care will be made. The project supports the planning and implementation of pilot preventive health action programmes in selected areas. HEDEC is a member of the implementing consortium providing technical assistance to the project (3.96 million ECU).

International Planned Parenthood Federation (IPPF)

The International Planned Parenthood Federation links national autonomous family planning associations (FPAs) in over 150 countries worldwide. It is the largest voluntary organization in the world to be concerned with family planning and sexual and reproductive health.

IPPF and its member associations are committed to promoting the right of women and men to decide freely the number and spacing of their children and the right to the highest possible level of sexual and reproductive health. They believe that the balance between the world’s population and its natural resources and productivity is a necessary condition for improving the quality of life on the planet.

IPPF works closely with other voluntary, intergovernmental and UN agencies which share its concerns for reproductive health in general, the health and wellbeing of women and children and the role of population in socioeconomic development.

IPPF's main strength is that it is a unique federation of voluntary and autonomous FPAs who, while operating within their own cultural, social and legal setting, are linked to the Federation through common standards and objectives. Each FPA is run by local staff and volunteers. IPPF and its members can, therefore, tackle issues which governments may be unwilling or unable to deal with, such as the distribution of new methods of contraception, sexuality education, individual counselling, the prevention of unsafe abortion and services for disadvantaged groups and for young people.

FPAs help to raise standards of reproductive health by promoting model protocols of care, running model clinics and insisting upon the rights of the client, and providing a choice to users.
Some programmes implemented by FPAs to raise awareness about STDs include the following:

- Promotion of safer sex awareness and condom use among students, sex workers and men who have sex with men (Ukraine)
- Safer sex education (Russian Federation)
- Youth counselling/telephone hotline (Republic of Moldova, Latvia)
- Condom promotion/outreach (Cyprus, Romania)
- “Summer Bus” campaign. Promotion of syndromic approach to diagnosis and treatment of STDs using a bus that travels the country, following experience in Sweden and the United Kingdom (Albania)
- Peer education (Bulgaria)
- Youth services integrated into youth and leisure services (Albania)

**International Federation of Red Cross and Red Crescent Societies**

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the biggest international humanitarian organization with an extensive network in 175 countries in the world. It is supported by its 175 member national societies, 297 000 permanent employees and over 105 381 000 volunteers. Its mission is to improve the situation of the most vulnerable people in the world.

IFRC has the capacity to immediately respond to natural and man-made calamities in any part of the world. In the area of health it is actively involved in the control of epidemics and emergency medical care. In developmental health programmes, being auxiliary to line ministries of respective countries, the Federation supports governments’ efforts in the control and prevention of prevalent diseases by targeting the most vulnerable segment of the population in particular.

Since the onset of the HIV/AIDS pandemic, IFRC has joined the international communities in different part of the world in their efforts to curb the pandemic. Youth peer education, promotion of human rights and dignity and there-by preventing discrimination against PWHAs and their families. Psychosocial support, home care and the screening of blood for blood-transfusions are the programme components being implemented by the national societies.

With the objective of enforcing collaborative efforts, networks on HIV/AIDS and other STDs have been established and are operational in Asia, Africa and Europe.

In eastern Europe an integrated project on TB, HIV/AIDS and other STDs is under way in Belarus, the Republic of Moldova, the Russian Federation and Ukraine. The European national societies’ network on HIV/AIDS and other STDs (ERNA), which was established by 12 national societies, has now increased its members to 18 national societies and facilitates exchange of information, best practices and expertise and promotes capacity-building for effective implementation of planned programmes.

**Médecins Sans Frontières (MSF)**

Médecins Sans Frontières is a private international organization which offers assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict, without discrimination and irrespective of race, religion, creed or political affiliation.

Country projects involving STD-related activities are as follows.
Armenia

An extended family planning programme covering three northern districts was launched in February 1998 by MSF Greece. Contraceptive methods are proposed to women of reproductive age in preference to the previous Soviet-style response: abortion. In Yerevan and in Gyumri, Shirak region, teams are involved in STD/AIDS activities including STD detection, updating treatment techniques in a specialized hospital, blood screening and information.

Azerbaijan

MSF Belgium works in eastern and central Azerbaijan. A number of dispensaries are being run in the eastern region, where basic health care is available free of charge. Integrated reproductive health care assistance, including family planning, prenatal care, MCH and STD management is also provided to a number of governmental health structures. As part of a pilot project in the central region, STD syndromic approach was started in two clinics in February 1998. Laboratory technicians are now being trained on STD smear identification.

Bulgaria

MSF Switzerland has donated Benzathine Penicillin to health structures in Bulgaria to promote the introduction of the WHO protocol on the treatment of syphilis, as a replacement of the inpatient treatment which was required under the old system. An STD clinic has been set up in Sofia introducing the WHO syndromic approach. Staff training in counselling techniques is taking place enabling the clinic to offer improved patient confidentiality.

Georgia

MSF Greece has a reproductive health project in Tbilisi, Georgia. Focused around the IDO centre the project aims to increase public awareness with regard to the prevention of STD/HIV and unintended pregnancies, increase accessibility to quality and confidential reproductive health services and encourage community participation in raising awareness. In addition the project aims to provide health providers with counselling skills on STD/HIV issues, as well as creating a library of relevant literature in the centre. The quality of services will be ensured through improved and standardized STD management, quality control of STD Laboratories, and the availability of drugs and contraceptives.

Kyrgyzstan

MSF-F continues to implement a programme, integrated into the MANAS plan, responding to the alarming increase in STDs, particularly syphilis. There was a recorded rise of 700% between 1993 and 1996 in the Osh region alone. The programme includes a training programme directed towards dermatovenereological specialists in order to improve syndromic STD diagnosis, to implement treatment according to WHO protocols and to ensure the availability of drugs. New RPR-TPHA tests and other laboratory material have been supplied to improve the diagnosis of STDs. Prevention and information activities focusing on STDs and AIDS are targeted at high risk groups (drug addicts, prostitutes, prisoners, young people) and the population in general. The programme is being carried out in collaboration with 16 health structures dealing with STDs in the Osh region. The future plan is to organize training for a broader category of doctors – obstetricians/gynaecologists, urologists and general practitioners.

Russian Federation

There continues to be a decline in overall level of health care, including a steady rise in HIV/AIDS/STD rates. The numbers of homeless already excluded from the minimal social welfare system continues to swell.

MSF Holland is implementing an HIV/AIDS/STD prevention programme in Moscow together with other international and local organizations. This programme includes: a mass media campaign to raise awareness of HIV/AIDS/STD prevention among Moscow youth and to inform journalists on these issues;
an HIV/AIDS prevention programme among injecting drug users using outreach and peer education. Advocacy for reform on HIV/AIDS prevention and other policy issues is also undertaken.

Open Society Institute/Soros Foundations

The Soros Foundations are a network of foundations, programmes and institutes established to support the creation and development of open societies, especially in the former communist countries of central and eastern Europe.

National foundations operate in more than 30 countries, and in all the countries covered by the TF/STD except Belarus and Turkmenistan. Each foundation has its own executive board and carries out its own programmes.

The Open Society Institutes in New York and Budapest also operate network programmes, which initiate and support new projects and assist with coordination of work of the National Foundations.

Projects to date in the region carried out by the National Foundations and the Network Medical Programmes which relate directly to the work of the STD task force, include: public health training, prevention and control of HIV among intravenous drug users (harm reduction), school based health education, and reproductive health. OSI also provides support to WHO and UNAIDS for work in STD and HIV prevention.

NATIONAL PUBLIC HEALTH INSTITUTES

The Swedish Institute for Infectious Disease Control, SIIDC

The Swedish Institute for Infectious Disease Control, SIIDC (Smittskyddsinstitutet – SMI) has been assigned by the Swedish government to monitor the epidemiology of communicable diseases in humans and to promote the control of such diseases. The SIIDC has to survey and analyse the epidemiology of infectious diseases on the national and international arena, to provide information on the epidemiological situation to the National Board on Health and Welfare and to other national authorities and suggest appropriate measures on prevention and control. The SIIDC shall propose actions for preparedness to meet critical situations and warfare.

The Department of Epidemiology at the SIIDC is the epidemiological surveillance centre in the country. The Institute is part of an EU network for surveillance of infectious diseases.

The SIIDC provides diagnostic analyses of rare infectious diseases or when specially high containment is needed. Epidemiological investigations are carried out and epidemiological typing of microorganisms are performed to support these investigations.

Research, a large part of which is funded externally, and development are among the tasks of the SIIDC and often takes place as international collaborations. The SIIDC participates in WHO and EU collaborative projects, surveillance systems and networks, e.g. as focal point for an EU programme on AIDS and other communicable diseases and with reference function in the EU Fifth Framework Programme.

The Swedish Government has funded a programme through the SIIDC for Infectious Disease Control in the Baltic States and St Petersburg, Russian Federation. Projects have been initiated on epidemiological surveillance, antibiotic resistance, MDRTB, Helicobacter, STD control, hepatitis, TBE and nosocomial infection control and bio-safety.
As part of a programme on infectious disease control in the Baltic region, the Swedish Institute for Infectious Disease Control, SIIDC, has initiated a project on STD Control in Lithuania. The main aims are to improve laboratory capacity, surveillance and management of STDs at the primary health care level, especially in gynaecology services and with Kaunas as the focal point. A similar project, with the University of Uppsala as coordinator and funded by the Swedish East European Committee, is in the planning phase in Leningradskii Oblast.

*Other Swedish activities in the region*

In St Petersburg the Stockholm County Council supports a project on sexual health education in schools with the aim to reach half the number of schools in two districts in the city. In addition youth clinics are being established in the same districts. The Swedish Association for Sex Education (NGO) runs a project on information and education on STD control for key policy makers and administrators in five areas in the Russian Federation.

*National Public Health Institute of Finland*

The Department of Infectious Diseases Epidemiology at the National Public Health Institute has developed a surveillance network for STDs in Finland. The network consists of STD clinics which collect data on visiting patients. Together with the National Research and Development Centre for Welfare and Health (STAKES), within the framework of the project of Infectious Diseases and their Disadvantages, the department has established a STD surveillance centre in St Petersburg.

The diseases surveyed include Chlamydia, Gonorrhoea, HIV, Syphilis, Condyloma and Herpes simplex. Also data on sexual behaviour is collected. The aim is to provide information on STDs that help to target prevention, enable informed strategic decisions to be made, assist in prioritizing of resources as well as in strengthening existing national surveillance systems.
Annex 3

INTERNATIONAL ASSISTANCE TO THE RUSSIAN FEDERATION

At the national level, the World Bank is providing a loan for a national health care reform project. UNAIDS, with support from six other organizations (UNDP, UNICEF, WHO, UNFPA, MSF-Holland and USAID), will assist the government with the development of a national HIV/AIDS strategic plan. Pending resolution of the economic crisis, the Open Society Foundation is moving forward with its new Russian Public Health Initiative which is its first year of operation with focus on the health of women and children including STD.

At the oblast level, international assistance is currently concentrating on the western part of the country. TF/STD member organizations are active in Kaliningrad, St Petersburg, Moscow and Kaluga. The Know How Fund is active in Samara, Sverdlovsk and Kemerovo, three oblasts which are located more centrally closer to the Kazakhstan border. They are launching a pilot STD control project in Samara which is also aimed to influence national policy. USAID support pilot HIV/AIDS project in six oblasts and is planning an expanded HIV/AIDS/STI project but has not yet determined which oblasts will serve as demonstration sites.

A high STD burden does not appear to be the principal criterion used by international organizations to select their project sites. Indeed there are many regions which report higher incidence of syphilis than those which have been selected for international assistance. Other factors come into play. For the Nordic organizations there is obvious interest to become involved in STD control activities across their borders. With limited resources, international organizations prefer to work in oblasts where there is an opportunity to demonstrate something meaningful which can be replicated elsewhere. They often prefer to work in oblasts in which they have had successful projects in the past, a good foundation to build on. In addition, international agencies prefer to work in oblasts which are open to reform and experimentation. At the same time, they recognize that they need to work in different geographic areas because of cultural diversity.
Annex 4

PARTICIPANTS

Temporary Advisers

Professor Karen R. Babayan
Chief STD Expert at the Ministry of Health, Director, Medico-Scientific Centre of Dermatology and STD, Yerevan, Armenia

Professor K.K. Borisenko
Central Institute of Dermato-Venereology, Director-General, Russian Association Against STD (SANAM), Moscow, Russian Federation

Dr Saulius Chaplinskas
Director, AIDS Centre of Lithuania, Vilnius, Lithuania

Dr Ilze Jakobsone
Chief STD Expert at the Ministry of Health, Director, State Centre of STD, Riga, Latvia

Dr Lali Khotenashvili, Chief STD Expert at the Ministry of Health, Deputy Director, Research Institute of Skin and Venereal Diseases, Tbilisi, Georgia

Dr Genovaitė Lapinskaitė
Director, Central Hospital of STD, Vilnius, Lithuania

Dr Mati Majass
Chief STD Expert at the Ministry of Health, Chief Doctor, Tallinn Dermatological Hospital, Estonia

Professor André Z. Meheus (Co-chairperson)
Epidemiology & Community Medicine, University of Antwerp, Belgium

Dr Arunas Petkevičius
Chief STD Expert at the Ministry of Health, Lecturer, Department of Dermato-venereology, Kaunas Medical University, Lithuania

Dr Adrian Renton (Co-chairperson)
Reader in Social Medicine, Imperial College School of Medicine, The Centre for Research on Drugs and Health Behaviour, London, United Kingdom

Dr Rima Vaitkiene
Chief Specialist, Department of Medical Care, Ministry of Health, Vilnius, Lithuania

Dr Tonka Varleva
National AIDS Coordinator and Chief STD Expert at the Ministry of Health, Sofia, Bulgaria
Representatives of International Organizations

American International Health Alliance
Ms Bernice E. Bennett
   Director, Community Based Programs, Washington, D.C., USA

Centers for Disease Control and Prevention, Atlanta
Dr Anna Shakarishvili
   Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Atlanta, USA

Danish International Development Assistance (DANIDA)
Ms Lise Kaalund-Joergensen
   HIV/AIDS Adviser, Copenhagen, Denmark

International Federation of Red Cross and Red Crescent Societies (IFRC)
Dr Getachew Gizaw
   Senior Officer, Communicable Diseases, HIV/AIDS, Community Health and Social Welfare Department, Geneva, Switzerland

International Planned Parenthood Federation (IPPF)
Dr Esmeralda Kuliesyte
   Executive Director, Lithuanian Family Planning and Sexual Health Association, Vilnius, Lithuania

International Union against Sexually Transmitted Infections (IUSTI)
Dr Michael Waugh
   President, Leeds, United Kingdom

Know How Fund, Department for International Development (DFID)
Dr Fay Hutchinson
   Consultant, London, United Kingdom

Ms Julia South
   Health Sector Field Manager – Russia, Sheffield, United Kingdom

Médecins Sans Frontières
Dr Wilma Doedens
   Geneva, Switzerland

National Public Health Institute, Finland
Dr Olli Haikala
   Senior Medical Officer, Department of Infectious Disease Epidemiology, Helsinki, Finland

National Institute of Public Health, Norway
Dr Viggo Hasseltevdt
   Senior Physician, Section for Infectious Disease Control, Oslo, Norway
National Research and Development Centre for Welfare and Health, Finland

Dr Esa Tulkki
Project Director, International Development Collaboration Unit, Helsinki, Finland

Open Society Institute

Ms Nina Schwalbe
Acting Director, Russian Public Health Program, Moscow, Russian Federation

Statens Serum Institut, Denmark

Dr Inga S. Lind
Director, Neisseria Department, Copenhagen, Denmark

Swedish Institute of Infectious Diseases Control

Dr Ingegerd E. Kallings
Chief Medical Officer, Stockholm, Sweden

United Nations Development Programme (UNDP) and United Nations Population Fund (UNFPA)

Mr Cornelis Klein
UNDP and UNFPA Resident Representative, Vilnius, Lithuania

UNAIDS

Mr Ross Noble
Programme Development Officer, Department of Country Planning and Programme Development, Geneva, Switzerland

Dr Gabriele Riedner (Co-chairperson)
Epidemiologist, Department of Tropical Hygiene and Public Health, Heidelberg, Germany

UNICEF

Dr Alexander Malyavin
Health Adviser for Eastern Europe and Central Asia, Geneva, Switzerland

University of Uppsala, Sweden

Dr Marius Domeika (Co-chairperson)
Senior Researcher, Coordinator of the STD group, Institute of Clinical Bacteriology, Uppsala, Sweden

World Bank

Ms Teresa J. Ho
Principal Health Specialist, Human Resources Sector, Operations Division, Central and Eastern Europe Department, Washington, D.C., USA

World Health Organization

Regional Office for Europe

Dr Alexander Gromyko
Acting Regional Adviser on HIV/AIDS and Sexually Transmitted Diseases, Communicable Diseases and Immunization
Dr Doris S. Mugrditchian (Rapporteur)
Consultant, TF/STD Secretariat, HIV/AIDS and Sexually Transmitted Diseases, Communicable Diseases and Immunization

Ms Alice Schaumburg
Programme Assistant, HIV/AIDS and Sexually Transmitted Diseases, Communicable Diseases and Immunization

Ms Janchen de la Cour
Secretary, HIV/AIDS and Sexually Transmitted Diseases, Communicable Diseases and Immunization

Headquarters
Dr Kevin O’Reilly (Co-chairperson)
Acting Chief, Reproductive Tract Infections, Division of Reproductive Health
Annex 5

STATEMENT CONCERNING THE ESTABLISHMENT OF THE TASK FORCE FOR THE URGENT RESPONSE TO THE EPIDEMICS OF SEXUALLY TRANSMITTED DISEASES IN EASTERN EUROPE AND CENTRAL ASIA

COPENHAGEN, 24 FEBRUARY, 1998

In response to the alarming rise in sexually transmitted diseases (STD) and the associated increase in the potential for a substantial and immediate HIV epidemic, the WHO Regional Office for Europe (WHO/EURO), WHO headquarters and the Joint United Nations Programme on HIV/AIDS (UNAIDS) organized a series of consultative meetings with affected countries and international organizations in the region.\(^1\)\(^2\)\(^3\) These consultations led to the establishment of the Task Force for the Urgent Response to the STD Epidemics in Eastern Europe and Central Asia (TF/STD), which is an interim mechanism to mobilize a well coordinated international response to the rapidly evolving STD crisis in this region, and mitigate the potential for an explosive and far-reaching HIV epidemic.

Current STD prevention and care activities in the region are too few and fragmented to effectively curb the STD epidemics. TF/STD was conceived jointly by UNAIDS, its co-sponsors and other partners to provide urgent reinforcement to the STD prevention and care component of the UNAIDS strategy in the region. TF/STD will not operate as a new vertical structure. Rather, it will take every opportunity to integrate STD care and prevention into existing services and programmes and interface with other components of the UNAIDS strategy. In order to achieve maximum impact, TF/STD will remain highly focused on its purpose to improve the accessibility, acceptability and cost-effectiveness of STD prevention and care services in the region.

The objectives of TF/STD are to:

- elaborate, in consultation with host country governments and other stakeholders, a harmonized strategy for international assistance that will reduce the burden of STD and their health consequences in the region;
- mobilize and advocate for national and international resources for STD prevention and care in affected countries;
- ensure that external technical and financial support to affected countries is both timely and well coordinated in order to avoid duplication, address gaps and maximize impact of the contributions;
- enhance the local capacity of countries in the region to respond to the STD epidemics;
- serve as a channel for the international exchange of epidemiological and programmatic information on the STD situation and needs of the region;
- develop and promote international best practices and policies while ensuring that conditions and issues particular to this region are taken into consideration;
- advise UNAIDS, its co-sponsors and other partners on policy and strategies related to STD prevention and care in the region.

1. WHO Regional Office for Europe. Epidemic of sexually transmitted diseases in eastern Europe: report on a WHO meeting (document EUR/CMDS 08 01 01).
Membership in TF/STD is guided by the recognition that no single agency possesses the full range of technical capabilities and resources required to support the region. Therefore, TF/STD draws on the abilities and comparative advantages of a strategic mix of member organizations, country representatives and technical advisers in order to construct a viable assistance partnership. In order to achieve a critical mass of technical, financial, political and institutional resources, membership is open to any international organization that (i) subscribes to the objectives of TF/STD, and (ii) makes a financial, technical or in-kind commitment toward the implementation of the collaborative work plan. The Secretariat of TF/STD is located at WHO/EURO.

This statement was elaborated by the participants of the first meeting of TF/STD, which was held in Copenhagen, 23–24 February 1998. The countries and organizations represented are listed in Annex 1. The participants of this founding meeting:

- share the common goal of reducing the STD burden and slowing the spread of HIV in the most affected and vulnerable countries in eastern Europe and central Asia;
- recognize the need for coordination of international assistance through TF/STD at the international level and interagency working groups at the country level;
- agree to a joint strategy which assists countries to create an enabling policy environment, develop national STD case management guidelines, build the national capacity for STD prevention and care, and strengthen STD surveillance;
- concur with the priority areas for possible technical assistance delineated in Annex 2 consisting of advocacy and policy, STD drugs, condoms, educational materials, training, applied research and surveillance;
- are advocates of TF/STD and will call on their own and partner organizations to join in this important new initiative.

For further information please contact:

Secretariat for the TF/STD
Communicable Disease and Immunization
WHO Regional Office for Europe
8 Scherfigsvej
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 15 12
Telefax: +45 39 17 18 75