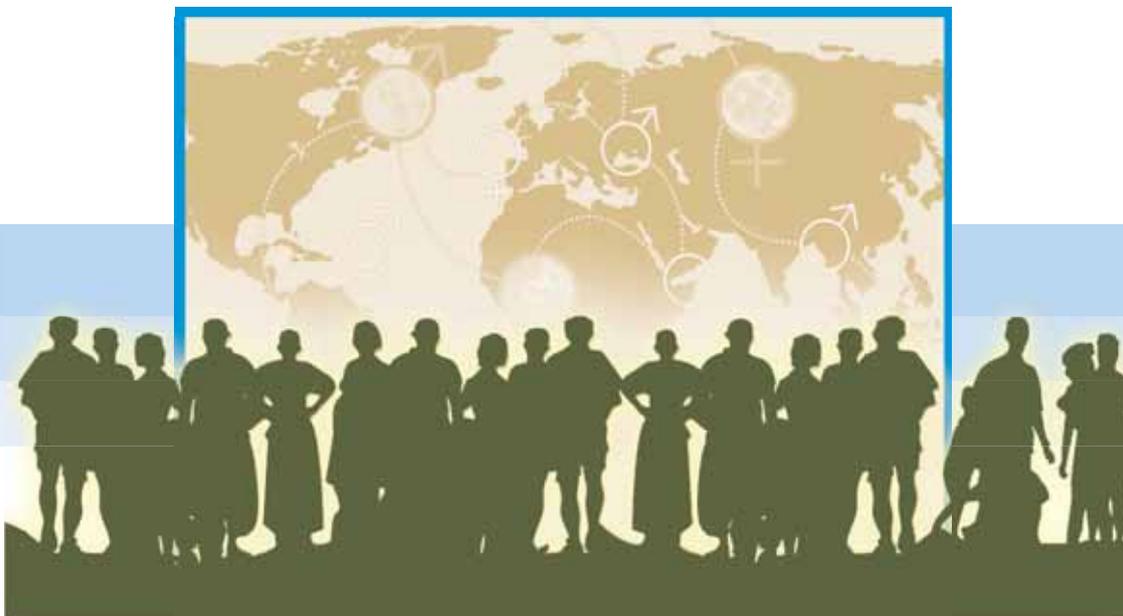


Meeting Report

Mid-term Review of the Regional Strategic Action Plan for STI Prevention and Control (2008–2012)



18–20 October 2010
Ulaanbaatar, Mongolia

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**REPORT OF THE MEETING ON THE MID-TERM REVIEW
OF THE REGIONAL STRATEGIC ACTION PLAN FOR
STI PREVENTION AND CONTROL (2008–2012)**

**18-20 October 2010
Ulaanbaatar, Mongolia**

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NOTE

The views expressed in this report are those of the participants at the meeting on the Mid-term review of the Regional Strategic Plan for STI Prevention and Control (2008–2012) and does not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the meeting on the Mid-term review of the Regional Strategic Plan for STI Prevention and Control (2008–2012), which was held in Ulaanbaatar, Mongolia from 18 to 20 October 2010.

CONTENTS

ABBREVIATIONS

SUMMARY

1. INTRODUCTION	1
1.1 Objectives.....	1
1.2 Meeting participants.....	2
1.3 Opening remarks.....	2
2. PROCEEDINGS	3
2.1 STI situation and control strategies.....	3
2.2 Progress according to the five main objectives.....	10
2.3 Field visit.....	31
2.4 Group work.....	34
3. CONCLUSIONS AND NEXT STEPS	41
3.1 Conclusions.....	41
3.2 Next steps.....	42
ANNEX 1 – PROGRAMME OF ACTIVITIES	45
ANNEX 2 – LIST OF PARTICIPANTS	49

Keywords:

Sexually transmitted diseases – prevention and control / Syphilis, Congenital – prevention and control / Program review

ABBREVIATIONS

ADB	Asian Development Bank
AIDS	acquired immune deficiency syndrome
AMR	antimicrobial resistance
ANC	antenatal care
ASRH	adolescent sexual and reproductive health
ART	antiretroviral therapy
ARV	antiretroviral (drug)
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CoC	continuum of care
COMBI	communication for behavioural impact
CoPCT	continuum of prevention to care and treatment
CT	<i>Chlamydia trachomatis</i>
CUP	condom use programme
DHS	demographic and health surveillance
DIC	drop-in centre
ECS	elimination of congenital syphilis
EQAS	external quality assurance scheme
FGP	family general practice
FHI	Family Health International
FSW	female sex worker
GASP	Gonococcal Antimicrobial Surveillance Programme
GC	gonococcus
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
GUD	genital ulcer disease
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HPV	human papillomavirus
HR	harm reduction
HSS	health systems strengthening
HSV	herpes simplex virus
IDU	injecting drug user
IHBSS	integrated HIV behavioural and serological surveillance
LR	linked response
MARP	most-at-risk population
MCH	maternal and child health
MDG	Millennium Development Goal
MDR	multidrug resistance
M & E	monitoring and evaluation
MOH	Ministry of Health
MSM	men who have sex with men
NCCA	National Committee for the Control of AIDS/STDs
NGO	nongovernmental organization

PAHO	Pan American Health Organization
PIC	Pacific island country
PITC	provider-initiated testing and counselling
PMTCT	prevention of mother-to-child transmission
PoC	point-of-care
PPT	periodic presumptive treatment
PSM	procurement and supply management
PWID	people who inject drugs
RH	reproductive health
RPR	rapid plasma reagin (test)
SGS	second generation surveillance
SHC	strategic health communication
SRH	sexual and reproductive health
STI	sexually transmitted infection
STI CB	sexually transmitted infection capacity building
TB	tuberculosis
TPHA	<i>Treponema pallidum</i> haemagglutination (test)
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRC	UN Resident Coordinator
WHA	World Health Assembly
WHO	World Health Organization
WPRO	Regional Office for the Western Pacific

SUMMARY

A meeting on the Mid-term review of the Regional Strategic Plan for STI Prevention and Control (2008–2012) was held in Ulaanbaatar, Mongolia from 18 to 20 October 2010. This meeting was attended by 17 participants from 10 countries in the Western Pacific Region, one consultant, 10 WHO staff from headquarters, regional and country offices, and 19 observers from Family Health International, Bill and Melinda Gates Foundation, London School of Hygiene and Tropical Medicine, Save the Children, United Nations Population Fund, United Nations Educational, Scientific and Cultural Organization, Joint United Nations Programme on HIV/AIDS and the United Nations Resident Coordinator, all collaborating in the domain of STI.

The objectives of the meeting were:

- (1) to review country progress and challenges in implementing the Regional Strategic Action Plan for Sexually Transmitted Infections (STI) Prevention and Control, and in contributing to Millennium Development Goals (MDGs) 4, 5 and 6;
- (2) to discuss the latest developments in STI prevention and control; and
- (3) to identify next steps in achieving the targets of the STI Regional Strategic Action Plan, specifically accelerating the elimination of congenital syphilis (ECS) and strengthening STI surveillance including gonococcal antimicrobial surveillance.

The meeting was structured to provide technical updates by consultants and WHO staff, share country experiences through plenary and gallery sessions, and participatory discussions through group work.

After the three-day meeting, participants agreed on the following conclusions and next steps:

- There has been overall good progress in implementation of the regional plan, with some countries reporting remarkable achievements.
- Challenges and difficulties persist, especially in:
 - the quality of STI services;
 - the high burden of chlamydial infections and complexities of responses, including point-of-care testing;
 - emerging infections among key populations;
 - low implementation of screening for maternal syphilis;
 - surveillance and reporting of STIs;
 - emerging patterns of antimicrobial resistance (AMR); and
 - funding for STI interventions.
- The consultation served as a good forum for exchange of experiences, technical updates and a stimulating field visit.

- Linkages between STI–HIV–sexual and reproductive health (SRH) services have resulted in increased coverage and access for key populations (Cambodia, Lao People's Democratic Republic and Malaysia).
- Interventions for key populations can be scaled up through community involvement, by developing clear objectives and milestones with a defined organizational and management framework, ensured supervision and a robust monitoring system (as in the Avahan project).
- Encouraging experiences are under way in providing STI services for men who have sex with men (MSM), but the scale of interventions is still inadequate, capacity limited, and acceptance needs to be improved.
- STI services offer an interface between HIV and SRH programmes. ECS could be speeded up when linked with elimination of parent-to-child transmission of HIV as a twinned campaign.
- Where STI has become part of second generation surveillance, data on STI are increasingly available and of good quality (Cambodia, Lao People's Democratic Republic, Papua New Guinea, Viet Nam).
- STI indicators have been successfully included in Universal Access (UA) reporting mechanisms.
- The Gonococcal Antimicrobial Surveillance Programme (GASP) has informed treatment guidelines for gonorrhoea in the Region over several years, and has now reached a high level of participation.
- There is high appreciation of the one-stop services model observed in Ulaanbaatar districts. Visiting groups unanimously recognized the value of this service delivery model.
- One-stop services were at first geared towards ECS and designed for rural settings, but are actually suitable for urban facilities and include several SRH services.
- The pillars of the model are high levels of commitment and support, decentralization of services, and highly efficient monitoring and referral mechanisms.
- The role and use of the treponemal rapid test needs to be clarified, as well as the need for other tests such as rapid plasma reagin (RPR)/*Treponema pallidum* haemagglutination (TPHA). Terminology also needs to be standardized (screening, confirmatory, etc.).
- It is expected that the new generation of rapid tests for STI will soon become available, including the dual rapid test (treponemal and non-treponemal).

Next steps

- Participants recognized the need for and opportunity to move STI prevention, care and condom programming, especially among sex workers, into a new phase.
- There is a need to capitalize on the achievements and lessons learned from the 100% condom use programme (CUP), and engage sex workers and community-based organizations more consistently.
- The health sector must contribute with comprehensive interventions (STI, HIV and SRH) to complement other sectors' efforts and adopt a human rights-based approach.
- WHO/UNFPA/FHI programme managers and partners should compile the evidence available in the Region and provide a regional reference through a document on "Health sector's key interventions for HIV, STI and SRH services among sex workers".
- Investment must be made in capacity building to implement partner notification.

- Information and awareness campaigns are needed to support expansion of the one-stop services model.
- The one-stop services model implemented at family group practice (FGP), antenatal care (ANC) and STI clinics for the prevention of congenital syphilis in Mongolia should be documented and a publication disseminated by WHO.
- Implementation of the *Chlamydia* control campaign should be accelerated through various options that are available and through a combination of interventions.
- An elimination campaign should be started towards a “generation free from HIV and congenital syphilis”.
- Investment should be made in surveillance (STI surveillance plan), capitalizing on second generation surveillance (SGS) opportunities, maintaining case reporting (balance between syndromic and etiological), triangulation of data and periodic studies.
- WHO Country Offices should assist in the review of recording forms to improve the availability of data and information.
- Support should be provided to GASP. The use of reference laboratories should be increased; sites expanded to improve representativeness; circulation of strains and material facilitated; capacity building provided; and linkages maintained with the global network.

1. INTRODUCTION

*"Sexually transmitted infections (STIs) are of public health concern because of their high prevalence, their ability to cause serious complications, and their role in facilitating the transmission of HIV. Complications of infection include: infertility in men and women; infection being transmitted to the fetus and infant causing blindness and permanent damage to organs and tissues; and serious generalized infection and deaths. STIs result in considerable family and social problems. The socioeconomic costs of these infections and their complications are substantial, ranking among the top 10 reasons for health-care visits in most developing countries, and substantially drain both national and household incomes. The social cost includes conflict between sexual partners and domestic violence. The costs increase further when the cofactor effect of STI on HIV transmission is taken into consideration."*¹

In order to address these concerns, WHO Headquarters developed a Global Strategy for the Prevention and Control of STI for 2006–2015, following a wide consultation. This was launched in August 2006, after it was adopted by 192 Member States in May of the same year. Based on this Global Strategy, the Regional Office developed the Regional Strategic Action Plan for 2008–2012, following consultation with countries in the Region. The main goal is to reduce STI-related morbidity and mortality in the Western Pacific Region.

This year marks the mid-term of implementing the Regional Strategic Action Plan. A meeting on the Mid-term review of the Regional Strategic Plan for STI Prevention and Control (2008–2012) was held in Ulaanbaatar, Mongolia from 18 to 20 October 2010. The meeting was organized to review progress made according to the five priority objectives: (i) to improve STI case management; (ii) to expand access to STI care; (iii) to eliminate congenital syphilis; (iv) to reduce STI transmission; and (v) to improve the recording and reporting of STI data.

This meeting served as a forum to share country experiences and technical updates from experts on the response to STI. The meeting's programme of activities is attached as Annex 1.

1.1 Objectives

(1) To review country progress and challenges in implementing the Regional Strategic Action Plan for STI Prevention and Control and in contributing to the Millennium Development Goals (MDGs) 4, 5 and 6;

¹ *Regional Strategic Action Plan for the Prevention and Control of Sexually Transmitted Infections, 2008–2012*. Manila, WHO Western Pacific Region, 2008.

- (2) To discuss the latest developments in STI prevention and control; and
- (3) To identify next steps for achieving the targets of the STI Regional Strategic Action Plan in:
- accelerating the elimination of congenital syphilis (ECS), and
 - strengthening STI surveillance including gonococcal antimicrobial surveillance.

1.2 Meeting participants

The meeting was attended by 17 participants from 10 Western Pacific countries, one consultant, 10 WHO staff from Headquarters, regional and country offices and 19 observers from Family Health International (FHI), Bill and Melinda Gates Foundation, London School of Hygiene and Tropical Medicine, Save the Children, United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO), Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Resident Coordinator (UNRC), all collaborating in the domain of STI.

The list of participants is attached as Annex 2.

1.3 Opening remarks

Dr Wiwat Rojanapithayakorn, the WHO Representative in Mongolia, delivered the opening remarks on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific. In October 2007, a meeting was convened in Penang, Malaysia, to develop a regional action plan for controlling STIs in the Western Pacific Region. Since then, several countries in the Western Pacific Region have been successful in decreasing STI prevalence as well as the rates of HIV incidence and/or maintaining low levels of HIV prevalence. Mongolia, for example, has reduced maternal and congenital syphilis by providing syphilis screening and treatment as part of antenatal care (ANC).

Despite this progress, much remains to be done. The incidence of STI among men who have sex with men (MSM) and sex workers continues to escalate in some countries. The majority of countries still have limited data to assess the magnitude of the STI problem and inform programmatic interventions; screening for asymptomatic STIs is often constrained by the lack of point-of-care (PoC) testing and affordable laboratory tests and, despite the declaration of commitment by several countries, responses towards ECS remains slow in some countries.

Dr Rojanapithayakorn encouraged the participants to deliberate on how to strengthen the existing Western Pacific Gonococcal Antimicrobial Surveillance Programme (GASP) to respond to the threat of untreatable gonorrhoea.

This year marked a critical junction for the HIV and STI community as it moves towards the achievement of universal access to HIV prevention including STI control, care and treatment services. A new strategic cycle has started, characterized by the pursuit of

synergies and efficiencies among public health programmes for strengthening health systems aimed at achieving all health-related MDGs, especially MDGs 4, 5 and 6.

2. PROCEEDINGS

After the opening ceremony, participants were introduced, a chairperson was selected and the objectives and expected outcomes of the meeting were presented. These were followed by thematic presentations, group work and field visits.

The meeting was structured to provide technical updates and country experiences through plenary sessions, gallery/poster presentations, participatory discussions by countries through group work and an actual programme site visit.

2.1 STI situation and control strategies

2.1.1 Global perspective

WHO staff from Headquarters provided technical updates on the epidemic picture of STI, its public health importance, especially the complications and sequelae; its transmission dynamics; burden of the disease, which disproportionately affects women; pursuing a policy of integrated service delivery in the context of bringing together common functions within and between organizations; and programmatic decisions affecting treatment options.

STI estimates have been provided since 1990, when WHO estimated that over 250 million new cases of STIs had occurred that year. The estimation was based on a modified Delphi technique, which was chosen due the limited information on incidence and prevalence of STI available at that time from many regions, including sub-Saharan Africa and some parts of Asia. The estimation for 1999 was made using the same 1995 methodology. Data for the estimation were collected by searching published and unpublished information on prevalence and incidence, both in the literature and in the WHO country files on STIs. New estimates to be released by December 2010 still follow similar methods as in the past. However, since more actual country data are available, the new STI estimates will more closely mirror the real figures.

The 2005 global estimates on the incidence of STI generated a figure of 448 million STI cases, up from 340 million in 1999. Males outnumbered females. Again, sub-Saharan Africa and the Western Pacific lead in incidence. Surprisingly, despite its reasonably well-developed health-care systems, data from Latin America have consistently shown a higher prevalence than expected. There is regional complexity and the differences possibly represent differences in regional epidemiology. The global estimated totals of selected STI incidences in 2005 are as follows: chlamydia 101 500 000, gonorrhoea 87 650 000, syphilis 106 000 000 and trichomoniasis 248 500 000. A summary of the data available in WHO Western Pacific Region on four bacterial causes of STI was presented. These are

based on data that met the study criteria for male and female populations on syphilis, gonorrhoea, chlamydial infection and trichomoniasis.

In order to generate timely and more realistic estimates, countries were encouraged to enhance STI surveillance. This could come about through phased strengthening of the surveillance systems, initially within second generation HIV surveillance (SGS), and eventually as an STI surveillance programme itself.

WHO and UNAIDS recommended the public health approach to STI control in 1997, primarily focusing on prevention efforts. Prevention efforts should take note of the social and cultural environment, promote safer sexual behaviour and the use of condoms for penetrative sexual acts, delay sexual debut (especially for young adolescents), encourage engagement in non-penetrative sexual practices, promote abstinence (especially during treatment for STIs), make vaccines available such as for hepatitis B and human papillomavirus (HPV), and in the future for herpes simplex virus (HSV) and HIV, and explore other barrier/chemical methods (e.g. microbicides – 39% reduction in HIV infection and 60% for HSV-2 infection with tenofovir gel).

Issues of stigma, discrimination and violation of human rights still pose major constraints and obstacles that hamper a supportive and energetic response to STI. Despite the challenges faced, countries were reminded to continue implementing what is embodied in the Global Strategy for the Prevention and Control of STI 2006-2015, which was presented to the World Health Assembly and adopted by all 192 Member States in May 2006.

Countries need to improve access to services for STI care at all levels and outlets of the health-care system. This should translate into improved quality of care for STIs. There are three important factors that influence patients' access and utilization of the facility of their choice. These are accessibility (proximity and affordability), acceptability (non-stigmatizing, non-judgmental staff attitudes, convenient opening hours and affordable fees), and quality of services (efficiency of service delivery, competence of staff, effectiveness of therapy and availability of drugs).

2.1.2 Regional perspective

2.1.2.1 *STI status and perspectives in the Western Pacific Region*

The status of the four bacterial causes of STI in the Western Pacific Region was presented based on various sources such as the SGS, recent research, and mapping exercises done among most-at-risk populations (MARPs) and antenatal women.

The package of STI services proven to be effective and implemented in selected countries was shared as follows:

Sex workers	MSM
<ul style="list-style-type: none"> • Outreach and peer education – minimal sex worker involvement • 100% CUP <ul style="list-style-type: none"> – Policy – Engagement of brothel/ establishment owners – Increased condom access – Monitoring • STI services – drop-in services <ul style="list-style-type: none"> – Initial presumptive treatment – STI syndromic treatment – Regular check-ups for STI • HIV testing and counselling 	<ul style="list-style-type: none"> • Behaviour change communication <ul style="list-style-type: none"> – Outreach and peer education – Web-based education – Condoms and lubricants • Community involvement • Drop-in centres • Counselling and testing • STI services

A quick mapping of country status on the implementation of the five main objectives of the Regional Strategic Plan was done. There has been major progress. However, several key issues were identified.

(1) Improve STI case management

Issues

- There is a need to enhance standardization and quality of STI services.
- STI guidelines for sex workers and MSM need to be developed.
- There is difficulty in diagnosing asymptomatic STIs and limited access to laboratory diagnosis and screening programmes.
- There is a lack of capacity to provide regular STI services with sufficient coverage to have a population-based impact.
- In selecting tests, their validity for the local epidemiology, effectiveness and value for money should be considered.
- Epidemiological or presumptive treatment should be provided.
- There is limited access to laboratory tests and these are often unaffordable.
- Syndromic case management should be enhanced to include syphilis test.
- Screening should be done for chlamydial infection and gonorrhoea.
- The use of nucleic acid amplification tests (NAAT) is limited due to their cost and inadequate laboratory capacity.
- The rapid test for chlamydia is not a PoC test; thus, it does not facilitate same-day diagnosis and treatment.
- STI drugs are unavailable.
- The quality of and access to services are limited.
- Provider-initiated testing and counselling (PITC) should be scaled up.
- Partner notification remains elusive.
- Training for capacity building is needed.

- There is a need for a formal national STI programme structure.
- The management of STIs must be integrated into the medical curriculum.

(2) *Expand access to STI care*

Issues

- The availability of services for MSM and youth as well as the capacity to provide such services is limited.
- Sustainable and effective models of service delivery should be developed by involving the private sector/pharmacy.
- Regular STI services should be provided for MARPs.
 - Operational linkages between HIV and reproductive health (RH) services should be strengthened and expanded, and national policies and functional referral mechanisms developed.

(3) *Eliminate congenital syphilis*

Issues

- There is low coverage of services for eliminating congenital syphilis in the majority of countries.
- Prevention of mother-to-child transmission (PMTCT) of HIV would lead to elimination of paediatric HIV and congenital syphilis.
- Reporting and monitoring need to be improved and harmonized with current reporting mechanisms.
- For the diagnosis of syphilis, the use of a rapid test versus RPR/TPHA should be examined.

(4) *Reduce STI transmission*

Issues

- Targeted interventions should be implemented to elicit a comprehensive and sustained response. Scaling up coverage and quality is needed.
- *The 100% CUP should be repackaged.*
- Condom programming is an integral component of HIV prevention.
- Behaviour change communication with the general population is essential but how to prioritize this has to be worked out. The following are some approaches to behaviour change communication:
 - communication campaigns
 - advocacy
 - sexual health education
 - clinic-based education.
- High-risk groups should be vaccinated for HPV and hepatitis B but implementation is limited due to the cost. In addition, the available HPV vaccination does not cover all strains.

(5) *Improve recording and reporting of STI data*

Issues

- STI reporting
 - There is no systematic data collection from the national to the regional level.
 - There is difficulty in strengthening and harmonizing STI reporting.

- Data on STI are limited as it is a neglected disease.
 - Systematic STI surveys are not conducted due to limited funding/high cost of surveys.
 - Recent prevalence data are limited.
 - Documentation of the complications of chlamydial infection is limited (conditions caused by other infections) e.g. PID which is a complication of chlamydia may also be due to other conditions.
 - STI data are not being used for programming.
- Surveillance for STI should be integrated with HIV surveillance.
- The GASP needs to be sustained and strengthened.

2.1.3 Country perspectives

Country progress according to the five main objectives of the Regional Strategic Plan was shared through gallery presentations. During the plenary session, each country was also given the opportunity to share the lessons learned and challenges faced. These are summarized below.

2.1.3.1 *Cambodia*

Issues

- Multiple stakeholders and partners are involved in implementing STI initiatives.
- The workload of health-care providers is increasing.
- The number of health-care providers at the operational level (health centres, referral hospitals, STI clinics, etc.) is inadequate.
- Numerous indicators are used to measure referral outcomes at different levels of the health services.
- Motivation of health-care providers to commit themselves to this approach is poor, especially those for RH.
- Expansion to new sites is constrained due to financial barriers.

2.1.3.2 *China*

Issues

- There is insufficient policy and financial support for STI management.
- Coordination between departments is inadequate (vertical system).
- Capacity to respond to STIs at various levels is inadequate.
- The quality of STI services in health-care settings needs to be improved.
- Control of congenital syphilis is poor.
- Stigma and discrimination are faced by those with STI

- Data collection for surveillance is poor, as well as interpretation and utilization of data.
- There is low coverage and lack of an integrated package of STI services for MARPs.

2.1.3.3 *Fiji*

Issues

- The availability of drugs and condoms in health centres and nursing stations needs to be ensured (access to island and remote sites).
- PITC for STI/HIV should be implemented.
- Partner notification and contact tracing should be strengthened.
- STI care-seeking behaviour of different population groups should be assessed, including its relation with stigma, cost of services and appropriate human resources.
- Linkages should be developed with other services (the RH policy is integrated but implementation is a challenge).
- Pregnant women access ANC services during the later part of pregnancy.
- Access in remote locations needs to be improved.
- The long turnaround time of laboratory results leads to low treatment coverage.
- Providers need to be trained in testing for syphilis (e.g. laboratory tests).
- Availability of tests should be ensured.
- Stigma faced by STI patients should be minimized.
- The public should be informed about STI prevalence and its complications.
- Female condoms should be promoted and provided.
- Coverage of HPV immunization should be improved.
- The reporting system needs updating.
- A system should be developed for data management, analysis and dissemination.

2.1.3.4 *The Lao People's Democratic Republic*

Issues

- The National Committee for the Control of AIDS/STDs (NCCA) needs to meet as planned (twice a year).
- Additional support is needed to strengthen the NCCA's Secretariat.
- Comprehensive provincial strategic and action plans need to be developed.
- An annual work plan needs to be developed based on the national strategic action plan.
- Prevention efforts do not reach most remote communities.
- Information on some key vulnerable groups such as MSM, youth and migrants is limited.
- Financial commitment to prevention interventions should be made on a yearly basis.
- HIV services are not yet linked with maternal and child health (MCH) services. This will be discussed soon between the Centre for HIV/AIDS and STDs (CHAS) and Maternal and Child Health Centre (MCHC) to strengthen the PMTCT package.
- More human resources are needed.
- There is a need to ensure access to drugs for opportunistic infections, and first- and second-line antiretroviral (ARV) drugs.

2.1.3.5 *Malaysia*

Issues

- MARPs are hard to reach; they have risky sexual practices and little knowledge of STI prevention and condom use.
- MARPs are often stigmatized and discriminated against in the current government system.
- Availability of rapid test kits is limited.

2.1.3.6 *Mongolia*

Issues

- The programme depends on external funding.
- There is a need to strengthen partner notification and contact tracing.
- Capacity of staff at the national and local levels is limited.
- There is limited laboratory capacity at the national and local levels.
- Research capacity is lacking.
- There is duplication of STI data.

2.1.3.7 *Papua New Guinea*

Issues

- The quality of service delivery needs to be improved.
- Current achievements should be sustained.
- Human resources (quantity and quality) should be developed.
- Logistics and distribution, and communication and information need improvement.
- Linkages and integration should be improved among programmes such as tuberculosis, MCH and sexual and reproductive health (SRH).
- Health financing is limited.
- Information on health should be improved (surveillance and monitoring and evaluation [M&E]).

2.1.3.8 *The Philippines*

Issues

- The programme should be implemented in a decentralized governance setting.
- Related ordinances/resolutions should be passed.
- Technical capacity should be strengthened to intensify focused/targeted interventions including for MSM and people who inject drugs (PWID).
- There is strong opposition to condoms by Catholic groups.
- Implementing the programme becomes difficult in the face of growing globalization, mobility of the population and the increasing number of tourists.
- Local governments have financial constraints due to competing programmes and health is generally not a concern.

2.1.3.9 Samoa

Issues

- Standard treatment guidelines should be developed/updated.
- Systems for data management, analysis and dissemination of information need to be developed.
- A national SRH programme (umbrella programme) should be established and strengthened.

2.1.3.10 Viet Nam

Issues

- Knowledge and understanding of STI among the community is limited.
- Those with STI face stigmatization and discrimination.
- There is a propensity for self-treatment or taking inadequate treatment doses.
- Some STIs are asymptomatic and go undiagnosed.
- Partner management is difficult.
- People are reluctant to follow safe sex practices.
- The quality of treatment is poor, especially in the private sector.

2.2 Progress according to the five main objectives

2.2.1 Improving STI case management

2.2.1.1 *STI case management in Pacific island countries*

The Pacific island countries (PICs) are composed of many smaller islands and small numbers of scattered populations. Access to care is complicated and costly.

The PICs, excluding Papua New Guinea, registered 1419 HIV cases between 1982 and 2009. No pregnant women has tested positive for HIV during the SGS held between 2004 and 2008.

STI data from SGS in asymptomatic, antenatal women showed a prevalence ranging from 10% to 29% for chlamydial infection; 1%–10% for syphilis; and 1%–7.9% for gonorrhoea in PICs with the lowest and highest prevalence.

Several issues compound STI control in PICs, ranging from social, economical, geographical and cultural issues to those of the health sector.

The PICs developed two strategies since 2003 as a response to HIV prevention and care. The Pacific Regional Strategic Implementation Plan (PRSIP) I: 2004–2008 focused on HIV. However, due to the high STI prevalence in the SGS, there was a felt need to address not only HIV but also other STIs. The PRSIP II: 2008–2013 strategy jointly addresses STI/HIV, putting more emphasis on STI within the six main thematic areas of prevention, diagnosis, treatment, enabling environment, surveillance and coordination.

Because of the high prevalence of STI, especially chlamydia, several guidelines were developed to address symptomatic and asymptomatic STI and vertical transmission of HIV/STI.

From 2010 onwards, PICs are gearing up towards further improving STI management. It was decided to adopt an enhanced approach to STI control and prevention, a strategy recommended by the STI Technical Working Group in 2010, which includes the following strategic components:

- i. Strategic health communication (SHC/communication for behavioural impact [COMBI]) to integrate STI with HIV prevention and SRH, to increase awareness about STIs and their consequences and to increase condom acceptance;
- ii. Provision of quality comprehensive syndromic management for symptomatic STIs;
- iii. Counselling, testing and treatment for asymptomatic STIs, including proactive screening for chlamydial infection, syphilis and HIV among vulnerable and at-risk populations, including mobile men with money (MMM), MSM, sex workers and seafarers;
- iv. Improving partner management and coverage;
- v. Epidemiological treatment for chlamydial infection in antenatal couples in high STI burden countries as well as increased screening and treatment of antenatal women, youth, STI patients and people with high-risk behaviour in all PICs;
- vi. Prophylaxis for neonatal conjunctivitis in newborns;
- vii. Provision of STI drugs free of charge at all levels of the health-care system;
- viii. Documentation of the complications of chlamydial infection and neonatal STI, and monitoring of STI prevalence in high- and low-risk populations through SGS (2012).

2.2.1.2 Improving the quality of STI services

China has made big strides in terms of government commitment and policy to align the national guidelines with the WHO guidelines on STI. These included updating the following:

- Regulations on the prevention and control of STIs, issued in 1991 and updated in 2010;
- National AIDS mid- and long-term strategy plan, five years' action plan (2001–2005, 2006–2010, 2011–2015 [ongoing]); integrating HIV/STI/hepatitis into one plan is one of the important changes in the ongoing development of the 2011–2015 action plan;
- National strategy plan for prevention and control of syphilis (2011–2015) issued by the Ministry of Health in 2010;
- National implementation plan for PMTCT of HIV, syphilis and hepatitis B has been developed and submitted to the Ministry of Health for endorsement. It will be issued by 2011.

Moreover, the country has ensured that there is funding to implement the STI programme. For HIV/STI, about 2.1 billion RMB has been provided every year since 2007, and 800 million RMB is approved for implementing PMTCT strategies and activities.

Technical guidelines to continuously improve the quality of STI services at all levels and sites were developed and distributed nationwide to guide practice. These include the following:

- Standardized case reporting in the national STI sentinel surveillance;
- Standardized criteria for diagnosis, treatment and reporting of STI;

- Capacity-building activities embodied in the training programme;
- Promotion of standardized services, with emphasis on quality clinical management, quality control for laboratory diagnosis of common STIs; integrated preventive services (providing at least “health education prescription” and condoms) to patients at STI service settings, accurate and timely recording and reporting of new STI cases to the National Information System of China Centers for Disease Control and Prevention (CDC).

Despite progress and commitment of the government, the country still faces several challenges. These include:

- insufficient investment for management of STIs;
- inadequate collaboration and coordination due to a vertical system;
- non-standardized STI care – feasibility of implementation, e.g. burden for doctors, balance between public health and clinical approach; compromise between quality of and access to STIs services;
- diversity in capacity – *infrastructure and personnel*;
- stigma and discrimination – *care-seeking and partner services*;
- lack of efficient supply of drugs and kits; and
- technical issues – *poor sensitivity/specificity of tests, diagnosis of congenital syphilis*.

2.2.1.3 STI screening for MARPs – use of rapid tests

The presentation focused on the importance of performing rapid tests for STIs; the rapid tests used for screening of MARPs, specifically *genital chlamydial and gonococcal infections*, as well as syphilis; and the promises and challenges of using rapid tests.

The purposes of using rapid tests are as follows: provide evidence for appropriate management at the point of care, especially in populations with low return rates; prevent progression to long-term sequelae; interrupt onward transmission to sexual partners, especially among MARPs; prevent syphilis transmission to the fetus resulting in congenital syphilis (MDG 4); prevent adverse pregnancy outcomes, including miscarriages and stillbirths (MDG 5); and reduce empirical use of antibiotics.

A comparison of the advantages and disadvantages of laboratory tests versus rapid tests was also discussed.

However, it was noted that despite the progress made in making rapid tests for STI available, countries still carry out syndromic management. This was attributed to three main challenges; quality of the test (lack of regulatory oversight for diagnostics); too many steps and the cost.

Challenges to the use of rapid tests in MARPs

	What can be offered	Challenges
Outreach	Acceptance (education, condoms) Syphilis screening CT, Ng screening	Suspicion-links to public security - Do not want results on site - Can not give penicillin on site Tests not ASSURED
Referral to Clinic	Incentives (health care, beauty tx/creams)	Clinic staff attitudes Need to return for results

2.2.2 Expanding access to STI care for MARPs

2.2.2.1 Linking STI services in Cambodia

The background of the HIV/STI programme in Cambodia was presented, followed by sharing of the national response to the epidemic, the principles of the continuum of prevention to care and treatment (CoPCT) and linked response (LR) approaches (linking STI services to HIV and RH services). The challenges and next steps in improving linkages with STI services were also presented.

HIV and STI prevalence among female sex workers (also called entertainment workers in Cambodia) showed a clear decline between 1996 and 2006. This is the outcome of a national response that put in place CoPCT and harmonized linkage of SRH services for MARPs, which is being scaled up and sustained.

The main purpose of linking STI services to HIV/AIDS and RH services is to define the procedures to link already existing health services to improve access of MARPs to the continuum of care (CoC) services of HIV/AIDS. This optimizes internal referrals between key services such as STI, voluntary counselling and testing (VCT), ANC, birth spacing, and safe abortion and post-abortion care in harmony with the existing LR and CoPCT approaches.

Access to services for entertainment workers and MSM was improved through the District Prevention to Care team (NGO peer educators and referral) to linked and integrated STI and RH services provided in government and NGO clinics.

In ANC services, dual rapid testing (HIV and syphilis) was piloted as part of the standard operating procedures (2008), and is now being rolled out countrywide.

Challenges that remain in linking health-care services include:

- Multiple partnerships in implementation
- Increasing workload of health-care providers
- Limited number of health-care providers at operational levels (health centres, referral hospitals, STI clinics)
- Numerous indicators of referral outputs between each health-care service

- Limited motivation of health-care providers to commit themselves to this approach, especially RH care providers
- Financial barriers to expanding to new sites.

Priorities that will be implemented in the next steps:

- Strengthening the CoPCT of HIV/STI for MARPs (especially entertainment workers and MSM) to increase their access to linked health-care services
- Improving referral mechanisms and systems between health-care services within the linked approach
- Expanding implementation of the ECS programme in newborns to other operational districts that apply the LR approach
- Improving indicators and data collection at linked health-care services.

2.2.2.2 *STI control for MARPs in the Lao People's Democratic Republic*

The National STI Programme in the Lao People's Democratic Republic was set up in 1998 with the assistance of WHO and Lao-MOH/EU/STD Project, 1997–2002, in two pilot sites. National guidelines for STI management, training manuals, laboratory support and surveillance including for resistance to gonorrhoea were developed. Between 1999 and 2001, an assessment of the STI/HIV situation was done through an SGS with the support from FHI. These results were used for further action planning. Control of STI in the country focuses on MARPs such as the sex workers. The main goal in increasing both the quality and the coverage of interventions targeting sex workers is to address the drivers of the epidemic and reduce transmission of HIV.

Development partners that provided support include FHI: from 1999 till date in five provinces; the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund): from May 2003 till date in all 17 provinces (nationwide); and Asian Development Bank (ADB): from 2002 to 2005, in three provinces.

The main components or interventions for the control of STI among sex workers from 2002 up to the present are: periodic presumptive treatment (PPT), supported by FHI, ADB, Global Fund; drop-in centres (DICs) or wellness centres, supported by FHI; peer education for female sex workers and MSM/ transgenders funded by the Global Fund; and the 100% CUP supported by ADB and WHO.

Repeated SGS done in 2001, 2004 and 2008 demonstrated the ability of these combined interventions to decrease chlamydia, gonorrhoea and HIV prevalence among female sex workers.

Lessons learned:

- Special consideration is necessary for new female sex workers because they are more likely to be infected with STI and less likely to use condoms. Reaching them early is critical.
- A more enabling environment should be fostered for female sex workers, in part through increased advocacy efforts directed towards venue owners and managers.

- Prevention communication themes and messages must be based on, and respond to, the needs of female sex workers and MSM.
- Full and continuous coverage of female sex workers/MSM is essential to effect change and foster impact.
- Intensive mentoring of the outreach team and peers is crucial for ensuring high-quality interventions.
- Prevention communication strategies must be adapted to fit with the changing situations and needs of female sex workers and MSM.
- Monitoring the quality of communication and audience response is essential. This requires planning and adequate resources for monitoring activities and reprogramming.

The **expected outcome of the national STI/HIV action plan for 2011–2015** aims that for **sex workers by 2015**:

- HIV prevalence among high-frequency sex workers will be below 2%.
- Eighty per cent of the estimated 15 344 high- and low-frequency sex workers will be reached through interventions.
- Seventy-five per cent of sex workers will report consistent condom use with clients.
- The prevalence of chlamydiasis/gonorrhoea among sex workers will be less than 10%.

For **MSM**, the expected outcome by 2015 will be:

- HIV prevalence among high-risk MSM and transgenders will be less than 3%.
- Eighty per cent of the estimated 18 813 high-risk MSM and transgenders will be reached.
- Seventy-five per cent of high-risk MSM and transgenders will report consistent condom use.
- Seventy-five per cent of male sex workers will report consistent condom use with clients.
- The prevalence of chlamydial infection/gonorrhoea among high-risk MSM and transgenders will be less than 10%.

2.2.2.3 Scaling-up STI services for MARPs: lessons learned from Avahan

The Avahan programme started in 2004 in six states (600 towns) focusing on MARPs with nine lead partners, FHI and WHO.

It had to deal with a lot of challenges in the beginning such as:

- how to implement an HIV prevention programme at scale
- limited STI data for high-risk groups
- targeted interventions did not have a component of STIs
- low health-seeking behaviour among MARPs
- high levels of stigma and discrimination
- prescription behaviour of health-care provider not in line with national treatment guidelines
- Minimal treatment compliance.

- The design for scaling up was done through establishing a common minimum programme. This allowed fast scale up and served as a glue to bind all the partners together. Key elements of the STI delivery component of the common minimum programme included a standardized STI essential services package, a clinic operating guidelines and standards, project milestones (time bound), capacity-building support for all partners, and a common programme management framework. Prepackaged STI drugs ensured both health provider and patient compliance with the treatment regimens. The focus on screening for asymptomatic STIs helped bring down the prevalence of STI over time.
- Avahan organized virtually for scale and ensured management for scale up through simultaneous creation of a service delivery footprint, customizing services to high-risk population needs and maintaining execution focus while managing all levels of the intervention. The organizational structure was designed to enable rapid and simultaneous scale up across different geographical areas; facilitate standardization of key elements and share best practices across programmes including STI services.
- Programme data showed that 80% of all STI clinics in phase I were established within three years of programme start-up and that there was a steady increase in the percentage of sex workers, MSM and transgenders who attended the clinics on a monthly basis.
- Regular monitoring ensured standardized and quality of STI services by using a **clinic quality** monitoring tool developed by the STI capacity building (STI CB) team. Monthly STI technical support visits were done by STI coordinators of State lead partners (SLPs) to NGO clinics; quarterly STI CB visits by the STI CB team using the standard supervisory tool for quality monitoring of STI services.
- The improvement in scale and quality of clinic services between 2005 and 2009 was measured. It demonstrated an increase in the frequency of visits by MARPs in AVAHAN clinics; a decreasing trend in symptomatic visits; a reduction in visit delay time when sex workers experienced vaginal or cervical discharge and an increase in the proportion of sex workers undergoing speculum examinations.
- Comparison of baseline and follow-up surveys in five districts of Karnataka showed a significant decline in STIs among MARPs.²

The Avahan programme demonstrated that interventions for MARPs can be scaled up through:

- clear objectives and milestones
- clearly defined organization and management frameworks
- strong supportive supervision
- strong monitoring system, and
- an intervention package that ensures community involvement and engagement.

A centralized STI CB group is important for ensuring standardized and high-quality implementation in a large-scale effort. An appropriate mix of STI service delivery methods

² Ramesh BM. IBBA two rounds analysis with FSWs in Karnataka, 5 districts. *Sexually Transmitted Infections*, 2010, 86 (Suppl 1): i17.

can maximize programme utilization in a cost-effective manner. Active involvement of MARPs results in clinic services that are more acceptable to that population.

2.2.3 Exchange of experiences and discussion on the current practices and challenges

Many interventions highlighted in the previous presentation are complementary and cost-benefit evaluations are useful. In Cambodia, an impressive decrease in prevalence has been noted; however, improving the quality of care as well as data collection is a challenge. Incentives are used to improve quality.

Reaching partners of sex workers is particularly difficult. In Avahan, this is being addressed through peer educators and the mid-media. Avahan has started handing over the management of this programme to the government in a gradual manner: 2008: 20%, 2009: 10%, thereby confirming that it will be sustainable as structures are rationalized to adhere to government criteria. In the Lao People's Democratic Republic, NGOs are required to abide by government regulations. NGOs provide technical assistance; they do not have separate clinics.

2.2.4 Reducing STI transmission

2.2.4.1 *Condom promotion in sex work*

Targeting sex workers for HIV/STI prevention is effective and feasible. In countries with excellent STI services, STIs and HIV are not declining significantly without effective condom promotion programmes because reinfection occurs so rapidly that the impact of reducing transmission may not be observed.³

It is imperative to provide information, education and communication on the necessity and importance of condom use as well as an adequate supply of condoms. Other key areas include quality control of condoms, promotion of additional water-soluble lubricants, promotion of acceptance of condoms in the society, appropriate local nomenclature for condoms, government policy to promote condoms, availability of condoms in the market, good logistic network and effective interventions, such as the 100% CUP in the entertainment sector.

The 100% CUP is a programme to prevent sexual transmission of HIV in the general population by ensuring a high level of condom use among sex workers and their clients. Its main objective is to achieve universal condom use in 100% of sexual relations associated with all types of sex work. In other words, “100% CUP” is NOT “promotion of 100% condom availability”. It goes beyond that.

This programme was developed in Thailand in 1989 as a pilot project and expanded nationwide in 1991. Expansion to other countries began in 1998. The PRINCIPLE is to

³ Bonhomme MG et al. Incidence of sexually transmitted diseases among massage parlour employees in Bangkok, Thailand. *International Journal of STD and AIDS*, 1994, 5:214–217.

create an enabling environment to empower ALL sex workers to refuse sex services if customers do not want to use condoms (monopolizing the sex business regarding universal use of condoms). This universal approach is similar to the promotion of seatbelts, helmets and smoke-free initiatives. Customers are no longer in control of sex services with regard to the use of condoms: customers have no choice but to use condoms. Local authorities and owners of sex businesses are responsible for promoting and maintaining such an enabling environment.

The STRATEGY is to gain the cooperation of government authorities and all owners/managers of the sex business to require condom use in all sexual encounters. The measure must cover all sex business sectors (all places of all types) so that customers will not be able to purchase sex services without using condoms. Some forms of sanction need to be placed on non-cooperative sex business owners.

The implementation process includes:

- getting the local HIV/AIDS committee to obtain a consensus on 100% CUP implementation and preparation to start the programme;
- holding a meeting between the HIV/AIDS committee and owners of sex businesses and senior sex workers to get their cooperation in implementing the 100% CUP;
- educating sex workers on the programme;
- ensuring logistic support (condoms, STI services, education material, water-soluble lubricants); and
- monitoring and evaluating the programme as well as managing uncooperative sex business owners/managers.

As a result of the 100 % CUP, at least 5 million HIV infections were averted in Thailand⁴ and the incidence of STIs dropped dramatically from over 400 000 cases before 1991 to less than 14 000 cases last year.⁴

The 100% CUP has been found to be one of the most effective STI and HIV prevention interventions. In all countries where sex work exists or where sexual transmission is a major mode of spread of HIV and STI, this approach needs to be promoted. In the South-East Asia and Western Pacific Regions, it is currently implemented in Cambodia, China, the Lao People's Democratic Republic, Mongolia, Myanmar, the Philippines, Thailand and Viet Nam.

2.2.4.2 *STI control with sex workers*

STI transmission dynamics demonstrate that both upstream as well as downstream transmission is important. In Thailand, Cambodia and Sri Lanka, multiple components, including outreach and peer interventions, barrier protection and good clinical services were used to reduce the STI burden and address sex workers' needs. All had measurable public-health effects.

⁴ Patterson K et al. *Influencer, the power to change anything*. New York, McGraw-Hill, 2008.

Although the differences between such interventions are many, all have found ways to reach sex workers with relevant, effective services, and to involve and empower them as part of the solution.

Direct health interventions can greatly reduce morbidity and have frequently served as an impetus for broader social change. WHO and partners are exploring new approaches to scaling up interventions that reduce the incidence of HIV while supporting marginalized populations such as sex workers to improve their lives.⁵

New WHO evidence-based guidelines are being developed through a rigorous process of evidence review and grading; PICO (Population, Intervention, Comparison, Outcome) questions guide the recommendations. Components of the guidelines include:

- based on existing guidelines/evidence: condom use, syndromic case management; HIV testing and counselling, and provision of antiretroviral therapy (ART)
- based on new systematic reviews: STI screening, presumptive treatment, sex worker empowerment.

UNFPA is the coordinating United Nations agency on HIV and sex work; UNAIDS' guidance note promotes a multisectoral response.⁶

Unresolved issues in the guidelines are: STI control, condom access, family planning, sexual violence, responses to trafficking and community mobilization.

There are opportunities to avert most large-scale epidemics by focusing on sex work through a cost-effective package of scaling up second generation condom programming, which consists of existing condom programmes, enhancing sex worker empowerment, providing broader SRH services and creating an enabling environment. There are opportunities for Global Fund support to scale up interventions for sex workers.

2.2.4.3 *STI services for MSM*

STI programming for MSM is based on high STI prevalence, high rates of asymptomatic STIs and lack of screening tests for anorectal infections. Communication, health-seeking behaviour and clinical management are symptom related. Partner management is based on community mobilization.

Basic issues such as the language and capacity of health-care workers to manage STI in MSM and transgenders need to be addressed.

⁶ Jana S, Rojanapithayakorn W, Steen R. Harm reduction for sex workers. *The Lancet*, 2006, 367: 814.

The rates of syphilis and anorectal chlamydial infections are extremely high in Pakistan. Clinical guidelines on syndromic management of anorectal infections need further validation.

Issues in managing STI among MSM

- High prevalence of asymptomatic infections
- High prevalence of anorectal symptoms (e.g. burning, itching, bleeding and discharge), but poor correlation between symptoms and STIs. Management is syndromic though it is often compromised due to incomplete history-taking and lack of anorectal examination (poor training, negative attitudes) as well as lack of testing for gonococci (GC) and *Chlamydia trachomatis* (CT).
- Some conditions are already covered by existing guidelines (e.g. urethral discharge, genital ulcer disease [GUD]).
- The cut-off for the number of polymorphs (pus cells) in Gram staining is arbitrary.
- The role of treatment for HSV infection is unclear.
- Other sexual health issues (e.g. hormone use for feminization among transgenders) may pose problems.

In summary, there is a variable prevalence rate of STIs, which has implications for presumptive treatment. The highest rates are seen in transgenders. There are no data on neovaginal STIs. There is a clear need for more comprehensive services to manage other sexual health issues in MSM and transgenders.

2.2.4.4 Exchange of experiences and discussion on the current practices and challenges

Integration of the 100% CUP into wider packages of services for sex workers is the way forward. Each country needs to adapt their approaches and packages to their settings, but targeting sex workers as well as youth is important, especially for the 100 % CUP.

Guidelines are currently being developed for adaptation to the local situation and for decision-making on syndromic management of STIs among transgenders and MSM. At the Beijing meeting in September 2010, 19 recommendations were made concerning STI management in MSM. These will provide guidance to ministries of health for the management of STI in these populations, especially for this Region, where a strong alliance of response exists in MSM communities.

2.2.5 Improving recording and reporting

2.2.5.1 Second generation STI surveillance in Papua New Guinea

The surveillance unit was created in 2006 and equipped with staff and resources from partners and the government. Syphilis surveillance is linked to the HIV SGS. Both were moved to the National Department of Health from the National AIDS Council Secretariat in 2006. A five-year HIV/syphilis surveillance plan was drawn up and endorsed by the government, and initial surveillance started in 2008. With support from WHO and CDC, surveillance protocols as well as reporting tools were developed. All were field-tested. A

surveillance training module was developed and staff from selected ANC sites were trained for two months before surveillance started.

A sample size of 300 was taken in each site, and seven urban and six rural sites were selected. Syphilis testing is done among ANC attendees as part of routine service delivery. While HIV testing was done for all pregnant mothers attending ANC, testing for syphilis was done in only three sites due to logistical challenges in accessing the syphilis test kits in 2008.

In 2009, ANC sites were increased to 35: 19 urban and 16 rural sites. Of the 35 sites, 23 (66%) could test all pregnant women for both HIV and syphilis. Routine ANC HIV data show an increasing prevalence since 1995. Surveillance data of 2008 and 2009 have shown a slightly lower level of prevalence than routine data.

Syphilis prevalence in rural ANC sites varies between 0.3% and 10.9% (with the exception of Tearouki: 28.4%); and in urban sites between 1% and 8%, with one site of Buka GH having an exceptionally high prevalence: 39% (same province as the rural site of Tearouki).

Achievements include:

- an expansion of sentinel sites
- health-care workers are equipped with knowledge and commitment
- data generated provide an understanding into what is happening in ANC populations regarding HIV and syphilis
- HIV and syphilis surveillance are well integrated into ANC services.

Remaining challenges:

- Further expansion of sites is needed.
- Logistical challenges have resulted in some ANC sites not conducting syphilis testing.
- External quality assurance is not well built into the process.
- There is a shortage of human resources at the central level (the surveillance unit currently has no staff).
- Supervision and mentoring are limited.
- Data are not linked to monitoring of congenital syphilis.
- The data on the targeted population are limited (integrated biological and behavioural survey [IBBS] to be done in 2011 does not include syphilis).
- There has been disengagement of the family health services.

The way forward is to mobilize resources to expand syphilis surveillance; improve logistics and quality assurance mechanisms; link syphilis testing with efforts to eliminate congenital syphilis; increase dialogue with the family health services; and develop the next plan for 2011–2015.

2.2.5.2 *STI surveillance*

The global strategy 2006–2015 stipulates that to upgrade STI surveillance within the context of second generation HIV surveillance, at least two rounds of prevalence surveys

should be conducted by 2015 and that routine STI reporting should be sustained over at least five consecutive years by 2015.

Collaborative implementation of HIV and STI prevention and control interventions calls for SGS with STI indicators and surveillance for STI in HIV, STI and RH programmes.

Criteria for the selection of diseases and syndromes for surveillance as of January 2008 need to be updated as there is a need to rationalize surveillance. Criteria relevant for STI which can be scored to set priorities include:

- Current burden of disease
- Case fatality ratio
- Epidemic potential
- Potential threats or changing pattern of disease
- Preventability
- Social and economic impact
- International regulations or programmes for surveillance
- Public perception

Core components of STI surveillance are:

- Antimicrobial resistance studies
- Etiologies of the STI syndromes, leading to improvement in patient care
- Case reporting, and
- Prevalence assessments leading to improvement in programme management.

Strengthening STI surveillance is necessary among key populations such as sex workers, MSM, migrant workers and displaced people; pregnant women and women attending RH and other sexual health services; and focusing on key STIs, such as treatable genital ulcers, other curable STIs and surveillance for AMR. This can be achieved by strengthening components within the SGS: laboratory (good quality to ensure that the etiology of STI syndromes is determined; AMR surveillance, prevalence assessment studies and screening programmes are conducted), data use and management, STI and behavioural surveillance.

Specific guidelines need to be developed and used at the country level, with estimation of the morbidity due to STI in health facilities through a tiered surveillance system. This includes microbiological surveillance, sentinel syndromic STI surveillance and universal integrated morbidity surveillance, giving estimates of etiological STI case distribution by age, gender and selective quality of care indicators.

Advocacy both by countries and by WHO is very important.

Antimicrobial resistance of *Neisseria gonorrhoeae* is growing worldwide, hence the importance of the worldwide GASP network.

Screening programmes for *Chlamydia* have important implications; at the individual level to prevent reinfection and late sequelae in women, and at the population level to prevent transmission of infection.

Between 1990 and 2007, there have only been five randomized control trials in this subject, all of moderate-to-poor quality. The largest study in Sweden (1989–2005) on chlamydial surveillance shows:

- secular change resulting in an open attitude towards sexual health and changes in sexual behaviour
- test volume is important: increased testing generates more cases; need for denominator data
- diagnostic performance needs to be evaluated:
 - increased sensitivity generates more cases
 - need to establish the clinical significance of chlamydial infection
- changing risk profile:
 - expanded screening in lower-risk groups
 - positivity declines irrespective of programme effectiveness
 - *Chlamydia* surveillance needs to be linked with behavioural surveillance.

Issues in the evaluation of Chlamydia screening programmes:

- Natural history: progression to upper genital tract disease and association between *Chlamydia* load and progression of disease
- Organization of the screening programme: coverage and uptake of regular screening for *Chlamydia*
- Target population
 - Young, sexually active persons
 - Those undergoing termination of pregnancy
 - Pregnant women
- Monitoring: repeated prevalence surveys and combined microbiological and behavioural surveillance.

Important observations from the current data:

- *Chlamydia* screening programmes might reduce morbidity and transmission.
- Existing *Chlamydia* control activities are not controlling *Chlamydia* transmission.
- Consistent high coverage and frequency of screening are needed to control transmission.
- The effectiveness of existing *Chlamydia* control strategies on primary screening end-points has not been evaluated rigorously.
- Data from *Chlamydia* surveillance and screening programmes need denominators and behavioural data for interpretation.

2.2.5.3 STI reporting

STI reporting is a basic building block and surveys every two to three years help to confirm trends.

Incidences by place and over time of STI and, in particular, discharge and ulcers, show clear trends and allow for triangulation. This in turn can demonstrate the consistent effects of an intervention on the outcome (example: the 100 % CUP and the fall in incidence of STI in Thailand between 1984 and 2003). They help validate prevalence data. National managers can use data to assess the response to epidemics, and to identify poor-performing clinics/provincial sites.

2.2.5.4 *Gonococcal Antimicrobial Surveillance Programme (GASP) and the threat of untreatable gonorrhoea*

The objectives of AMR surveillance are to ensure

- systematic collection of data on antimicrobial susceptibility patterns of *N. gonorrhoeae* to guide treatment recommendations
- optimal antibiotic treatment for gonorrhoea (95% cure rate in a community setting).

Since 1992, GASP has been active in the WHO Western Pacific and South-East Asia Region. Its activities include:

- Susceptibility testing incorporating quality control and participating in an external quality assurance scheme (EQAS)
- Laboratories send AMR data to the WHO Collaborating Centre for STI in Sydney for data analysis and dissemination.

In 2007 and 2008, 17 553 *N. gonorrhoeae* isolates were tested for their susceptibility to one or more antibiotics used for the treatment of gonorrhoea by EQAS-controlled methods:

- 24 reporting centres; 20 countries and jurisdictions; 16 in WHO Western Pacific Region and four in WHO South-East Region
- *In vitro* susceptibility testing by either
 - Minimum inhibitory concentration (MIC) methodology (in well-resourced laboratories) or
 - Disc-testing procedures (more common and practical in laboratories with resource limitations).

High rates of penicillin, tetracycline and quinolone resistance were detected. These medicines are not recommended for treatment in most countries.

N. gonorrhoeae resistant to oral third-generation cephalosporins, with accompanying treatment failure, are increasingly being found in WHO WPR.

Injectable ceftriaxone, to which no resistance has been reported, is commonly preferred in higher-dose regimens than oral equivalents especially in the public sector. Wider issues of general antibiotic misuse, which impinges significantly on gonococcal resistance, and those of gonococcal disease control require urgent and sustained attention.

Current challenges:

- Obtaining sufficient numbers of viable and representative isolates due to diminishing capacity for performing culture and antimicrobial susceptibility – syndromic management, Gram stain and shift to NAAT testing
- Comparability and quality of AMR data
- Difficulties with reliable detection and reporting of decreased susceptibility of GC to cephalosporins:
 - variations in the interpretative values of MICs – poor standardization of methods and EQAS

- definition of cephalosporin resistance – correlate between treatment failure and MIC breakpoints
- Lack of early warning system for emergence of antibiotic resistance
- No systematic monitoring of cephalosporin treatment failure
- Establishing an optimal signal-to-response trigger in ongoing surveillance
 - rapid response approach
 - evidence-based approach.

Response:

- Expanding and strengthening global GASP
- Standardizing AMR data: this can be done by developing WHO surveillance guidelines and a WHO reference panel of *N. gonorrhoeae* strains in quality procedures (consistent phenotypic/qualitative categorization – sensitive, less sensitive and resistant, which should be consistent between different methods)
- Clarifying laboratory issues – multidrug-resistant (MDR) *N. gonorrhoeae* and resistance to extended-spectrum cephalosporins (ESC)
 - global technical working group to address definitional issues
 - develop simple quality-assured disc diffusion-based screening method
- Action plan to address the threat of untreatable GC: situational assessment – mapping of AMR data; enhanced surveillance; early warning system; share information and strains; web-based reporting system; monitor drifts in MICs and treatment failures; increase awareness of clinicians and laboratory staff; STI surveillance – STI reporting; epidemiological support: systematic monitoring of treatment failures (test of cure), collection of essential epidemiological data linked to AMR data, outbreak response, rapid epidemiological assessment survey, laboratory capacity strengthening; clinical support: identify alternative effective treatment and rational drug use; enhance gonorrhoea control (improve surveillance, scale up GC/STI control, assure potency and quality of essential drugs); advocacy, programme coordination and collaboration (dissemination of information; coordinate activities; bulk procurement – drugs and laboratory support materials).

What are we hoping to achieve? Containment or mitigation?

Reducing the burden of gonorrhoea prior to the emergence of multiple resistance/ “untreatable” disease is vital.

2.2.6 Elimination of congenital syphilis

2.2.6.1 Global initiative

- Elimination of congenital syphilis is everyone’s business: it supports MDGs 4 and 5.
- Prevention of congenital syphilis reduces neonatal mortality.
- Early antenatal care and fewer spontaneous abortions and stillbirths improve maternal health.
- Women with syphilis are at greater risk of acquiring and transmitting HIV.

Clinically manifest infection is just the tip of the iceberg: 69% of infected women have an adverse outcome of pregnancy. Diagnosis and treatment early in pregnancy, before 20–24 weeks of gestation, is key to avoiding adverse outcomes of pregnancy. Eighty per cent of these (50% at 24 weeks) can be avoided through early treatment. Congenital syphilis is preventable and avoidable:

- Inexpensive tests (both RPR and rapid tests) are available, *and* rapid tests *do not require a laboratory*.
- Inexpensive and effective treatment is available: penicillin is widely available and
 - One dose prevents bad outcomes for infants.
 - Three doses treat syphilis in the mother (and reinfection is avoided).
- Universal screening is cost-effective even in low-prevalence settings.
- If all women are tested and treated early enough, then congenital syphilis will not occur.

The objective of the global initiative is to eliminate congenital syphilis as a public health problem through PMTCT of syphilis.

Targets by 2015

- *Screen* >90% of first ANC attendees for syphilis.
- *Treat* >90% of syphilis-seropositive ANC attendees.
- Note: there is no global target for congenital syphilis cases/rates – very hard to do well! Current definitions make it either difficult to diagnose or are not specific for congenital syphilis.

Guiding principles

- The process should be **country-driven**.
- **An integrated** approach should be adopted.
- **A rights-based** approach should be applied.
- **Partnership** and **collaboration** is necessary to optimize use of available resources.

Four pillars of congenital syphilis elimination

- (1) Ensure sustained political commitment and advocacy:

Current tools:

- Partner brief: *Advancing MDGs 4, 5 and 6: impact of congenital syphilis elimination*.⁷ This is a brief advocacy document to raise awareness of the ECS initiative.
- Draft an in-depth advocacy document outlining why investment in ECS strengthens MCH services (public health impact, economic rationale); strategy for reducing congenital syphilis in 10 high-burden countries through improved ANC (includes China and Papua New Guinea).

⁷ WHO. *Advancing MDGs 4, 5 and 6: impact of congenital syphilis elimination*. Available at: http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.01_eng.pdf (accessed on 01 March 2011).

- (2) Increase **access** to MCH services.
- (3) Screen all pregnant women.
 - Conduct a *needs assessment* to define the country situation (include assessment of linkages with HIV and MCH).
 - Review/develop *guidelines* for syphilis screening and treatment in pregnant women.
 - *Train providers* to test for syphilis, interpret results and treat infected persons (include strategies for partner management).
 - Ensure the *availability of drugs* used for treating the infection in pregnant women.
 - Create *public awareness* of syphilis in pregnancy.
 - Promote *early* attendance for ANC.
- (4) Surveillance, monitoring and evaluation

Global activities: Draft *global strategy* for M&E of ECS.

Conduct *global monitoring* of ECS based on existing systems

- Two core indicators in HIV Universal Access (UA) reporting
- Indicators added by the Pan American Health Organization (PAHO) to HIV UA reporting

Routine global reporting (UA report and ECS specific)

- *Technical support* for country and regional efforts: development and piloting of M&E tools
- Country assessments
- Operational research design

Country activities: Develop a strategy for M&E *within* existing systems.

- Select *simple indicators*
 - Three *core* indicators (coverage, positivity, treatment), consider additional indicators as appropriate
 - Distinguish how these are to be obtained – routine health systems or sentinel sites or special studies (SGS, Demographic and Health Surveys [DHS], STI in ANC, RH surveys, etc.).
- Select feasible and useful *targets*.
- Document *roles and responsibilities* clearly at ALL levels.
- *Train* staff at ALL levels.
- *Monitor quality* of data collection.
- *Report routinely* (feedback to provincial and local level).
- *Use data* for advocacy, planning, etc.

Key indicators for ECS:

- Core indicators
 - % of pregnant women *tested* for syphilis at first ANC visit
 - % of pregnant women *positive* for syphilis
 - % of infected pregnant women *treated*

- Impact indicators
 - *Congenital syphilis* cases and rates (*NOT a global indicator*)
 - % of *stillbirths attributable to syphilis*
- Process indicators
 - Does the country have a *strategy/guideline* for congenital syphilis?
 - % of pregnant women with *at least one ANC visit*
 - % of women with *early first ANC visit* (first or second trimester)
 - % in whom at least one *partner* is treated
 - % of ANC *clinics routinely testing* for syphilis
 - % of ANC clinics with a *stock-out of syphilis tests* in the last quarter
 - % of ANC clinics with a *stock-out of benzathine penicillin* in the last quarter
 - % of exposed *infants treated* with penicillin
 - *Estimated percentage* of all pregnant women with syphilis *treated by 24 weeks.*

Regional indicators and targets:

- Needs assessment conducted and findings distributed by December 2008
- *Guidelines* for syphilis screening and treatment in pregnant women updated and revised by December 2008
 - Guidelines produced
 - Number of providers trained
- > 90% of pregnant women attending ANC *tested* by December 2012
 - Number of centres experiencing shortages of syphilis test kits
- 100% of seropositive pregnant women *treated* adequately by December 2012
- No new cases of *congenital syphilis* reported by December 2012
- 75% of pregnant women attending *at least one ANC visit* by December 2012
- *Drugs* for the treatment of maternal syphilis available at PoC sites at all levels by December 2008
 - Number of centres experiencing shortages of recommended drugs.

For the future there is a need to explore interest in *certification of elimination* for countries with strong ANC and syphilis screening coverage, motivate to improve the quality of data and to reach even the hardest-to-reach populations.

Discussion issues:

- (1) Is there a need for a regional M&E system? If so, how should it be structured?
 - a. Indicator selection
 - b. Flow of information (linkages?)
- (2) Are countries ready to establish a baseline?
- (3) What are the specific next steps to improve regional M&E?
- (4) Is the Region interested in certification of elimination?

2.2.6.2 *One-stop shop in Mongolia*

Integration of SRH and STI services allows clients to receive multiple services in a single visit. This increases their benefit from the health system and reduces associated transport and opportunity costs. Both SRH and STI services address sensitive issues of human sexuality.

- Both have overlapping target groups and prevention methods.
- There is medical justification in having the two services at one site (increased risk of HIV transmission due to STI, PMTCT).
- Specialized advice can be offered on family planning and maternal, neonatal and child health for people living with HIV.

This also reduces duplication and overheads, targets distinct populations with a comprehensive set of services, and allows for a more client-centred approach to health care.

Links at a policy level:

- National Programme to Combat Communicable Diseases (2002–2010)
- National Strategic Plan on HIV/AIDS and STI Prevention (2010–2015)
- National Strategy on ECS (2011–2015).

Links between different services at the same facility and between different levels of the health-care system are known as “one-stop services”. These help in the early detection and treatment of syphilis among pregnant women and their partners, and prevent transmission of syphilis from mother to child. This is currently implemented in eight provinces and Ulaanbaatar city.

Activities in this programme include diagnosis with rapid syphilis tests and, if positive, the following are provided:

- Free treatment for STIs
- Partner notification and contact tracing
- Specimen transportation (from *soums* to *aimag* centre for confirmation)
- Counselling
- Behaviour change communication targeting pregnant women and their partners
- Training of health-care providers (primary health care, ANC, STI providers)
- Monitoring visits to sites.

Achievements:

- Improved access to care for pregnant women
- Larger number of women tested for syphilis
- Client satisfaction due to reduced waiting time
- Receiving multiple services in a single visit makes it more likely that patients will follow through with treatment
- Reduced stigma
- Improved coordination of service delivery: reduced load on secondary and tertiary services
- Increased STI outreach activities of family group practice (FGP) – partner notification, high-risk groups
- Improved community respect for FGP services

- Sense of self-fulfilment in being able to respond to client needs
- Improved linkages between STI, ANC and FGP services.

Challenges that remain:

- Provider-related:
 - increased workload of FGPs
 - difficulties in contact tracing and reaching partners
 - limited systematic data analysis and presentation
- Service delivery:
 - transport of specimens – protocols not uniform
 - no transportation boxes for districts
 - additional costs not always covered by Global Fund-supported projects
 - Cost and availability of laboratory services
- Lack of consistent processes for quality assurance and quality control.

Lessons learnt:

- One-stop services are an effective strategy to eliminate congenital syphilis in Mongolia.
- On-site training of health-care providers with a focus on practical skills such as counselling and correct use of tests is essential.
- Regular monitoring of progress by the local monitoring team and Ministry of Health is important for addressing challenges and providing technical support to the local team.
- Strong collaboration and partnerships with local governmental entities such as FGP doctors and nurses and local managers are key to the success of the project.
- Advocacy efforts and raising public awareness about one-stop services need to be strengthened.

Further actions:

- Finalize the national strategy on ECS.
- Expand one-stop services nationwide.
- Mobilize resources from government and other sources.
- Provide continuous training of health-care providers (high turnover of health staff).
- Improve contact tracing.
- Strengthen supervision and monitoring.
- Improve quality assurance and control.

2.2.6.3 *Exchange of experiences and discussion on the current practices and challenges*

Several countries have signed a declaration of commitment for ECS in this Region.

Twinning the ECS and HIV programmes and ensuring the commitment of other partners such as UNICEF and UNFPA is important.

In Mongolia, a one-time screening initiative for STI was done of the whole population in the context of a "Healthy Mongolian Population". According to official reports, 85% of the population was screened and all detected cases were treated. No further evaluations were done.

In the Lao People's Democratic Republic, most women who test positive on a rapid test get a quantitative RPR test done (96% in 2009).

China has a large problem of follow up of infants. In Mongolia, this problem has been solved by the incentive for early registration of pregnancy, which entitles the child to free health care in its first year of life.

2.3 Field visit

The participants were divided into three groups. Each group visited a district and had an opportunity to observe clinic activities in the FGP, ANC clinic at a district outpatient department (OPD) and the STI cabinet at the district OPD. The following were observed by each group.

2.3.1 Group 1: (Sukhbaatar District)

Family Group Practice

- A model of a one-stop service at a primary health-care service, especially for RH.
- One-stop services are being provided since July 2009 and 100% of ANC attendees were screened for syphilis in 2010.
- The percentage of syphilis detected increased from 2005 (2+/198= 1.01%) to 2010 (9+/208=4.32%).
- Partners of infected women received syphilis testing and presumptive treatment. However, few partners have been notified.
- Syphilis testing is provided with other ANC packages but an HIV test is not available.
- According to the national protocol, pregnant women should be tested before 28 weeks of pregnancy and at least twice during pregnancy.
- A rapid syphilis test is performed by health-care providers at the clinic. Women who test positive get a single dose of benzathine penicillin at the clinic and the patient's blood specimen is sent to the district OPD for confirmation by the RPR and TPHA tests.
- If the RPR test is positive (result available with 24 hours), the patient is referred to the STI cabinet at the district OPD for further diagnosis, treatment and follow up.
- A small referral card is used as a tool to refer infected women to the STI cabinet at the district OPD.
- A medical record book for the mother is a tool to provide information on syphilis infection at the delivery service of a referral hospital, especially for treatment of the newborn.
- An emergency box for treating anaphylactic shock is available with the syphilis testing kit.
- Syphilis testing is free of charge (supported by the Global Fund).

Other health-care services that are available at the one-stop health service include ANC, family planning, Expanded Programme on Immunization (EPI).

ANC clinic at a district outpatient department

- This centre plays an important role as the referral ANC clinic (secondary health-care service). Cases of abnormal pregnancy are referred from the primary health-care centre for complementary diagnosis and treatment.
- Rapid syphilis testing provided by physicians is available in four ANC rooms. The process is the same as at the primary health-care service. The charges were reduced when one-stop services were introduced at primary health-care settings.
- Approximately 50% of infected women have been notified and have received treatment (more than in primary health-care settings).
- Even though syphilis testing can be done by physicians at the ANC rooms, HIV testing is not available at the same place. Pregnant women are informed about HIV testing (national policy is based on voluntary testing) through PITC and then they are referred to the VCT. All pregnant women are screened for HIV.

STI cabinet at the district OPD

- Four medical doctors are responsible for providing STI care and treatment as well as HIV testing (VCT).
- A small laboratory is set up to perform HIV testing and syphilis rapid testing, wet mounts and Gram staining. However, blood samples are sent to the district laboratory for RPR testing.
- All patients with STI as well as pregnant women with syphilis receive care and treatment at the STI cabinet.
- Record-keeping of patient information is good.

Lessons learnt

- Syphilis testing is available at the primary health centre, which reduces the burden on the district OPD (earlier, pregnant women had to get syphilis testing done at the district OPD by RPR test only). It is a good example of expanding access to syphilis testing among pregnant women.
- There is good record-keeping at the primary health centre and district OPD, and a good mechanism for sharing information between the primary health centre, district OPD and STI cabinet.
- There is strong commitment from policy-makers, stakeholders, health-care providers, and good participation by the community. Syphilis testing is integrated into the routine activities of ANC services at all levels of health-care settings.
- There is a good structure and mechanism to link relevant health-care services from the primary to the secondary level and vice versa for implementing activities towards ECS.

Recommendations

- Initial HIV testing should be done at the same time as syphilis testing (dual testing) by health-care providers. The confirmatory test (if the first HIV test is positive) should be performed at the district laboratory (same process as syphilis testing).
- The Mongolian experience should be a model of best practice, and should be published for distribution.

2.3.2 Group 2: Bayangol district

Family Group Practice

- Integration of STI services into ANC is limited to syphilis screening.
- The ANC package is limited.
- There are strong linkages with secondary- and tertiary-level services.
- Record-keeping is good.

District hospital

- This provides specialist care with nine specialists in obstetrics and gynaecology and six in STI.
- The hospital receives referrals from the FGP.
- It provides counselling.
- Obstetric and gynaecology services provide ANC to patients with co-morbidities.
- STI services include the following:
 - HIV (VCT)
 - Confirmatory testing for HIV
 - Treatment for confirmed cases of STI.

Lessons learnt

- One-stop shop in the FGP provides a comprehensive package for ANC.
- It provides specialist care.
- It has good linkage with the FGP.
- STI and ANC services are well integrated.
- Specialists are well trained and staff is dedicated.
- Good IEC material is available.
- There are dedicated cabinets for STI/HIV services.

Recommendation

- STI services at the FGP should not be limited only to syphilis but should also include services for other STIs including syndromic case management and HIV testing.

2.3.3 Group 3: Khan Uul district

Family Group Practice

- The district has a population of around 120 000.
- The FGP serves 7000–20 000 people.
- There are 10 staff with five doctors.
- The service is well organized and equipped, and has good documentation.
- It provides ANC, RH, family planning and other general services.
- All pregnant mothers are registered and screened for syphilis with a rapid test.
- In 2009, 420 were screened; 10 positive cases were confirmed, two partners were tested and, of them, one was confirmed.
- Pregnant women testing positive for syphilis are referred for confirmation and treated at the clinic.
- The number of partners being tested is increasing.

- Women are also referred to the district health centre for other tests such as blood sugar, protein, haemoglobin and HIV screening.
- A weekly meeting is held at the health centre to review progress and confirm referrals.
- Quality assurance visits to the site are conducted.
- Syndromic management of STI is not done at the FGP.
- The team observed a rapid test being performed.

District health centre

- It has qualified staff and 67 doctors.
- Tests are done for confirmation of syphilis as well as other tests that cannot be done at the FGP.
- All pregnant women are screened for HIV.
- It provides a range of RH and STI services, and the full range of ANC services.
- It is supported by multiple agencies (Global Fund, GTZ, US CDC) and the government.
- Around 2500 deliveries and 1–2 caesarean sections are conducted every year.
- Children of pregnant women who are treated for syphilis in late pregnancy are followed up for two years, quarterly in the first year and biannually in the second year.
- No HIV case has been identified for the past three years.

Lessons learnt

- The district health centre is a real one-stop service. Most services are available and offered in an organized manner.

Recommendation

- The FGP can be strengthened and turned into a one-stop service by:
 - training health-care providers in syndromic case management
 - using the opportunity for rapid HIV testing at the same time as rapid testing for syphilis
 - expanding the range of services for ANC including haemoglobin, sugar and protein determination; conducting normal deliveries and post-partum follow up
 - minimizing referrals and loss to follow up.

2.4 Group work

2.4.1 Achieving the objectives of the Regional Strategic Action Plan

2.4.1.1 *Group 1 (Reducing STI transmission)*

The working group was asked to consider two issues that received considerable attention during the meeting.

- Condom programming for and SRH needs of sex workers
- Control of chlamydia in hyperendemic countries (mainly PICs).

a. SRH services

The discussions were opened by reminding participants that WHO Western Pacific Region has been an active promoter of the 100% CUP for fifteen years. There have been remarkable achievements but conditions surrounding sex work have changed in many countries. It is now time to open the discussion, revisit strategies and add new elements. Based on the UNFPA consultation on HIV and sex work in Pattaya in October 2010, it is in the interest of the Western Pacific Region to change. The intervention among MSM can be used as an example of the possibility and importance of incremental change in sex worker interventions.

At the Pattaya meeting, there were more community representatives than government officials, and deliberations were held in a bottom-up manner. STIs received little attention, and discrimination and human rights were major issues. The participants called for recognition of sex workers as people, and of sex work as work. There are opportunities to improve services, access and environments to make them more enabling.

Mongolia noted that sex workers were bored with HIV and condom messages only, and needed family planning, partner services and programmes to reduce economic vulnerability. The work of FHI in the Region has highlighted the importance of broader SRH needs including safe abortion services.

Data from an FHI study in Cambodia, Indonesia and the Lao People's Democratic Republic showed that one in four sex workers had an unintended pregnancy and one in three had experienced sexual violence. There are arguments that the "dual protection" messages (that condoms can protect against pregnancy as well as infection) are not sufficient. Sex workers also need effective contraceptive back-up methods to condoms.

Cambodia argued strongly for a change in focus from STI to SRH services for sex workers. This should address the real health needs of sex workers including unintended pregnancy and unsafe abortion, and include links to other SRH services.

The Lao People's Democratic Republic cautioned that many governments have not yet accepted sex work as a form of work. Yet, programmes can still focus on sex workers' rights to health services. Experience with DICs is an interim solution.

Samoa added that parliamentarians should be brought on board, but one needs to be realistic about what is possible.

WHO Western Pacific Region pointed out that human rights and public health arguments cannot be separated, and their complementarity must be emphasized. Addressing the broader SRH needs of sex workers is part of the answer.

Among specific services, screening for cervical cancer and prevention of gender-based violence should be included as these are important services. Additional comments addressed operational aspects (how to), possible economic benefits of health services, and STI services for HIV-positive sex workers. WHO is in the process of developing evidence-based guidelines and opportunities should be sought to take these to countries with Global Fund support for implementation.

b. Sex worker involvement

WHO Western Pacific Region pointed out that development of the guidelines includes sex worker involvement and regional input into the process.

There is a need to support capacity building of sex worker organizations. This was taken up by Mongolia, which stressed the importance of bringing services close to sex workers by developing the capacity of community-based and nongovernmental organizations (CBOs/NGOs). DICs were also mentioned as a way to bring health and other services closer to sex workers.

Malaysia mentioned that their National AIDS Commission (NAC) promotes NGO participation as a mechanism for improving communication and collaboration between sex workers and the health services.

India pointed out that NGOs need capacity strengthening, particularly in areas of financial and organizational management. Tools to assess organizational capacity over time have been developed by Avahan.

The importance of peer interventions was mentioned and Mongolia noted how they facilitated empowerment of sex workers.

Fiji mentioned that research and support would be needed on how to implement services – as stand-alone or integrated services – particularly in countries with relatively low levels of sex work. Samoa mentioned the health sector as a catalyst for change.

It was suggested that a technical working group be established and tools for capacity building developed, with attention to increasing sex worker participation in implementation of SRH services. Capacity-building challenges can be summed up as follows:

- capacity of health-care workers to provide respectful services
- capacity of sex workers to access services (and extend them to peers)
- capacity-building of CBOs/NGOs.

Cambodia pointed out that the original “condom use working groups” formed in Cambodia under the 100% CUP did not include sex workers. The strategy was strengthened by including both sex workers and their organizations. Peer educators are now active in promoting better health-seeking behaviour and many volunteer in clinics.

c. Enabling environment

Work to create more enabling environments needs to be done at both the national and local levels. Conditions and “safety nets” vary from country to country.

The group introduced the term “disabling environment” where sex workers are “disabled” by the actions of the police. In response, Avahan has promoted work with senior police officials.

WHO Western Pacific Region asked about the role of the health sector. UNFPA responded by citing good examples of working with the police from the 100% CUP experience. Good examples were also cited from SWING (Thailand) on recruiting police cadets to spend some time working with sex workers on outreach activities.

Samoa pointed out that it is necessary to get high-level police buy-in.

It was suggested that WHO Western Pacific Regional Office invite a larger group to address this issue, to identify health sector responsibilities and those of other partners. This idea was supported by Cambodia and others.

d. Effect of anti-trafficking

Work is in progress to document the impact of anti-trafficking legislation (closing brothels, arrests, effects on sex worker clinic attendance and STI rates). It has been suggested that any negative impacts on previous achievements should also be documented to push the public health agenda to limit anti-trafficking abuses. It will also be necessary to educate and argue against the conflation of trafficking and sex work. Some of this can be done by building on the 100% CUP mechanisms for high-level political advocacy. Cambodia pointed out that this should also address discrimination and abuse at the local level.

A participant raised the issue of conflation and its definition. Mongolia noted that many sex workers migrate and work across borders. Improved cross-border collaboration will be needed to work with sex workers in border areas.

Cambodia suggested mechanisms such as rapid response teams (RRT) to work at the local level to reduce the conflation of sex work and trafficking.

The several points discussed on strengthening condom programming and targeted interventions with sex workers in the Region are summarized below.

- To broaden the spectrum of services there is a need to document available evidence on this.
- To continue the UNFPA Pattaya meeting with the health sector becoming more proactive in investing in capacity building and promoting the use of existing tools.
- To improve safety nets through a regional process to develop the health sector strategy, both technical and packaging, and compile current responses and evidence as a basis for development of the strategy.

- To document “disabling environments” and potential responses.
- To highlight the effects of anti-trafficking legislation, using condom possession as evidence of prostitution, etc.

2.4.1.2 Group 2 (Improving STI surveillance)

The group started their discussions on the components of STI surveillance that should be linked with SGS for HIV. The following were suggested:

- Countries should review available resources (human and financial) and then decide which STI can be included in the SGS.
- The challenges that may be faced include the following:
 - lack of human resources to perform tests
 - discomfort in collecting specimens other than blood;
 - important to identify which samples are to be collected for which test (e.g. urine for gonococci and *Chlamydia*) and ensure the presence of a polymerase chain reaction (PCR) machine and other reagents
 - availability of drugs for those who test positive; financial capacity of countries to provide drugs
 - patient follow up
- Countries should identify sentinel sites that will give a holistic picture
 - balance between high-risk and low-risk sites
 - selection criteria should well thought of
 - quality assurance must be ensured
 - STI surveillance should be done consistently to detect trends.
- Consider low-risk sites as an “early warning system”, which signal the emergence of new infections.

The group suggested the following for more efficient STI surveillance:

- It is important to have an STI surveillance plan in place.
- Systems should be strengthened by reviewing what is available at the country level.
- Use methods that will give the STI picture at the country level
 - balance between syndromic and etiological reporting.
- If etiological reporting is well established, this is fine.
- If syndromic reporting is being done; analyse the data further by triangulating them with etiological sentinel surveillance data. This will give the percentage of specific STIs among the different presenting syndromes.
- If etiological reporting is well established, this is fine.
- Link reporting with other programmes that have established reporting systems such as MCH services.
- Analyse the burden of STI among the different health conditions reported in specific areas
 - important to have a denominator
 - important to show the true picture of whether cases are increasing or decreasing.
- Expand data collection points, specifically from private clinics:

- Look for motivated private clinics and include them as part of the sentinel surveillance (can learn from the Belgium experience).
- Check whether data generated from private clinics mirror those from the public sector.
- Define country-specific timelines/frequency of surveillance, as well as the number and sites selected:
 - for routine surveillance – monthly
 - for sentinel surveillance/periodic reporting – two to three years depending on available human and financial resources at the country level
 - important to do prevalence studies every two to three years.
- Choose appropriate MARPs, ANC for BSS.
- Gives a snapshot of the STI picture
 - ensure consistency of case definitions for all clinics, denominators.

The group suggested the following elements of STI case reporting:

Priority syndrome	STI etiological reporting	Data utilization	Strengthening STI case reporting
<ul style="list-style-type: none"> • Urethral discharge • Genital ulcer 	<ul style="list-style-type: none"> • Gonorrhoea • Chlamydia • Syphilis • Trichomoniasis 	<ul style="list-style-type: none"> • Advocacy tool for resource mobilization • Document sequelae and complications • Triangulation of data to give true picture of STIs 	<ul style="list-style-type: none"> • Expansion of data collecting/reporting sites to include private clinics • Address issues of duplicate reporting • Improve data quality • Enhance computer-based recording • Review existing reporting forms to include the priority syndromes; four curable STIs; incorporate in other programmes such as MCH • Use standardized definitions

Challenges in implementing the Gonococcal Antimicrobial Surveillance Programme (GASP)

The main challenge is the limited number of sites that can conduct gonococcal antimicrobial susceptibility monitoring. Usually, this is outsourced to laboratories that can perform the test. This often results in low representation of samples. There is also limited capacity of staff to perform the tests, coupled with limited funding sources. Transporting specimens across borders and cities is a big challenge.

The following have been suggested to support the re-establishment of GC cultures.

- Sample collection process – establish country reference laboratories that can monitor what is happening.
- Collecting representative samples needs different sites because if samples are collected from only a few sites, it becomes hard to provide evidence to change guidelines.
- It is feasible to re-establish GC culture, but there is a need to identify potential for training and retraining of staff.
- It is essential to identify mechanisms to develop an environment that will permit regular conduct of and participation in the GASP.

2.4.1.3 Group 3 (Elimination of congenital syphilis)

The discussions started with a review of the four pillars of ECS:

- Ensure sustained political commitment and advocacy.
- Increase access to, and quality of, maternal and newborn health services.
- Screen and treat all pregnant women.
- Establish surveillance and M&E systems.

The main opportunity for linking PMTCT of HIV with ECS is advocacy through the following:

- Strong government commitment and support for PMTCT of HIV and syphilis to support a generation free from HIV and syphilis and to leverage support for MCH
- Advocacy for policy development (all countries)
- Advocacy for resource mobilization
- Global and regional actions towards linking PMTCT of HIV to ECS (framework, strategic plan)
- Strengthening MCH services and linkages with STI/RTI services
- Community-based advocacy using NGOs and CBOs
- Branding and marketing strategies using celebrities, slogans and logos.

There is strong agreement on the need for a regional M&E system through integrating existing global and regional reporting systems, including the use of UA reporting.

The group agreed on the following core indicators:

- % of pregnant women *tested* for syphilis at the first ANC visit
- % of pregnant women *positive* for syphilis
- % of infected pregnant women *treated*

Countries have agreed to establish baselines and WPRO will contact each country to establish baseline information.

Countries have expressed their interest in certification of elimination. The suggested elimination impact indicator is a congenital syphilis rate of <0.5 per 10 000 live births. This

could best be defined through a regional working group that will discuss the definition of certification into possible, probable and confirmed elimination.

The group suggested the following criteria to achieve ECS:

- >90% of pregnant women with at least one ANC visit (before 24 weeks, second trimester)
- >90% of pregnant women tested for syphilis at the first ANC visit
- >90% of infected pregnant women *treated*

The above levels should be maintained for at least 3–5 years.

The group suggested the following next steps to accelerate ECS:

- Development and dissemination of tools
 - Assessment tool
 - M&E tool
 - Advocacy tool
 - Operational research tool
 - Regional guidelines on diagnosis and patient management (includes service package, laboratory quality control)
 - Adopting tools in countries
- Training for capacity building including M&E
- Systematic review and documenting of existing best practices
- Harmonizing vertical systems including for MCH, RH, HIV and STI.

3. CONCLUSIONS AND NEXT STEPS

3.1 Conclusions

Participants noted the following conclusions:

- (1) There has been overall good progress in implementation of the Regional plan, with some countries reporting remarkable achievements.
- (2) Challenges and difficulties persist, especially in:
 - quality of STI services;
 - high burden of chlamydial infections and complexities of responses, including PoC testing;
 - emerging infections among key populations;
 - low implementation of screening for maternal syphilis;
 - surveillance and reporting of STI;
 - emerging patterns of AMR; and
 - funding for STI interventions.
- (3) The Consultation served as a good forum for exchange of experiences, technical updates and a stimulating field visit.
- (4) Linkages between STI–HIV–SRH services have resulted in increased coverage and access for key populations (Cambodia, Lao People's Democratic Republic, Malaysia).

- (5) Interventions for key populations can be scaled up through community involvement, by developing clear objectives and milestones with a defined organizational and management framework, ensured supervision, and a robust monitoring system (Avahan project).
- (6) Encouraging experiences are under way in providing STI services for MSM, but the scale of interventions still low, capacity limited, and acceptance needs to be improved.
- (7) STI services offer an interface between HIV and SRH programmes; ECS could be accelerated when linked with virtual elimination of PMTCT as twinned campaigns.
- (8) Where STI has become part of SGS, data on STI are increasingly available and of good quality (Cambodia, Lao People's Democratic Republic, Papua New Guinea, Viet Nam).
- (9) STI indicators have been successfully included in UA reporting mechanisms.
- (10) The GASP has informed treatment guidelines for gonorrhoea in the Region over several years, and has now reached a high level of participation.
- (11) There was high appreciation of the one-stop services model observed in Ulaanbaatar district. Visiting groups unanimously recognized the value of this service delivery model.
- (12) One-stop services were at first geared towards ECS and designed for rural settings, but are actually suitable for urban facilities and include several SRH services.
- (13) Pillars of the model are high levels of commitment and support, decentralization of services, and highly efficient monitoring and referral mechanisms.
- (14) The treponemal rapid test has a role, but its use needs to be clarified as well as the need for RPR/TPHA. Terminology also needs to be standardized (screening, confirmatory testing, etc.).
- (15) It is expected that the new generation of rapid tests for STI will soon be available, including the dual rapid test (treponemal and non-treponemal).

3.2 Next steps

- (1) Participants recognized the need for and opportunity to move STI prevention, care and condom programming, especially among sex workers, into a new phase.
- (2) There is a need to capitalize on the achievements of and lessons learned from the 100% CUP, and engage sex workers and CBOs more consistently.
- (3) The health sector must contribute with comprehensive interventions (STI, HIV, and SRH) to complement other sectors' efforts and realize a human rights-based approach.
- (4) WHO/UNFPA/FHI programme managers and partners should compile evidence available in the Region and provide a regional reference through a document on "Health sector's key interventions for HIV, STI and SRH services among sex workers".
- (5) Capacity for implementing partner notification should be developed.
- (6) Information and awareness campaigns are needed to support expansion of the one-stop services model.
- (7) An account of the one-stop services model implemented at the FGP, ANC and STI clinics for the prevention of congenital syphilis in Mongolia should be documented and a publication disseminated by WHO.
- (8) Implementation of the Chlamydia control campaign should be accelerated. Various options such as combination interventions are available.
- (9) An elimination campaign should be conducted towards a "generation free of HIV and congenital syphilis".

- (10) Investment in surveillance (STI surveillance plan) should continue, SGS opportunities should be capitalized, case reporting should maintain a balance between syndromic and etiological reporting, data triangulated and periodic studies conducted.
- (11) WHO Country Offices need to assist in reviewing the recording forms to improve availability of data and information.
- (12) The GASP should be supported, and the use of reference laboratories increased; sites need to be expanded to improve representativeness; circulation of strains and material facilitated; capacity strengthened; and linkages with the global network maintained.

PROGRAMME OF ACTIVITIES

<u>Activity/Agenda item /Subject of presentation</u>	<u>Facilitator/Presenter</u>
<i>Day 1 – Monday, 18 October 2010</i>	
08:00–08:30	Registration
08:30–09:30	Opening session <ul style="list-style-type: none"> • Opening remarks – WHO Dr Wiwat Rojanapithayakorn • Opening remarks – Host Government Dr J. Tsolmon, Vice Minister • Selection of Chairs and Rapporteurs • Introduction of participants and objectives Dr Massimo Ghidinelli • Administrative announcements Dr Teodora Wi Group photo
09:30–10:00	<i>Coffee break</i>
10:00–11:00	Global and regional STI situation and control strategies <ul style="list-style-type: none"> • Global perspective Dr Francis Ndowa • Regional perspective Dr Teodora Wi
11:00–11:30	Open forum
11:30–12:30	Poster presentation (per country): Country status (epidemiology and progress) <ul style="list-style-type: none"> • Cambodia • China • Lao People's Democratic Republic • Fiji • Malaysia • Mongolia • Philippines • Papua New Guinea • Samoa • Viet Nam
12:30–13:30	<i>Lunch break</i>
13:30–14:30	Country summary
14:30–15:00	Country highlights and updates: Improving STI case management <ul style="list-style-type: none"> • STI case management in Pacific Island Countries Dr Dennie Iniakwala/ Dr Brigitte De Hulsters • Improving quality of STI services Dr Chen Xiang-Sheng

<u>Activity/Agenda item /Subject of presentation</u>	<u>Facilitator/Presenter</u>
15:00–15:30	<i>Coffee break</i>
15:30–16:30	Improving STI case management (continuation)
	<ul style="list-style-type: none"> • STI screening for MARPs – use of rapid tests • Exchange of experiences and discussion on the current practices and challenges
	Dr Rosanna Peeling Dr Massimo Ghidinelli
16:30–17:30	Expand access to STI care
	<ul style="list-style-type: none"> • Linking STI services in Cambodia • STI control for MARPs in Lao People's Democratic Republic
	Dr Phal Sano Dr K. Sayabounthavong
18:30	<i>Welcome reception</i>
Day 2 – Tuesday, 19 October 2010	
08:30–09:30	Expand access to STI care (continuation)
	<ul style="list-style-type: none"> • Scaling up STI services for KPs, lessons learned from Avahan • Discussions
	Dr Sameer Kumta Dr Teodora Wi
09:30–10:00	Reduce STI transmission
	<ul style="list-style-type: none"> • Condom promotion in sex work • STI control with sex workers
	Dr Wiwat Rojanapithayakorn Dr Richard Steen
10:00–10:30	<i>Coffee break</i>
10:30–11:00	Reduce STI transmission (continuation)
	<ul style="list-style-type: none"> • STI services for MSM • Discussions
	Dr Graham Neilsen
11:00–12:30	Improving recording and reporting
	<ul style="list-style-type: none"> • Second generation STI surveillance in Papua New Guinea • STI surveillance • STI reporting • Gonococcal Antimicrobial Surveillance Programme • Discussion
	Dr Peniel Boas Dr Francis Ndowa Dr Richard Steen Dr Massimo Ghidinelli
12:30–13:30	<i>Lunch break</i>
13:30–14:30	Elimination of congenital syphilis
	<ul style="list-style-type: none"> • Global initiative • One-stop services in Mongolia
	Dr Lori Newman Dr Tugsdelger Sovd
14:30–17:30	Field visit (three groups) – One-stop shop

<u>Activity/Agenda item /Subject of presentation</u>	<u>Facilitator/Presenter</u>
<i>Day 3 – Wednesday, 20 October 2010</i>	
08:30–09:30	Group feedback on the field visit
09:30–10:00	<p>Workshop – Achieving the regional strategic action plan objectives</p> <ul style="list-style-type: none"> • Introduction to the workshop • Group discussion: Identify accomplishments, gaps and next steps including targets of the five priority objectives <ul style="list-style-type: none"> ▪ Improving STI case management ▪ Expanding access to STI care ▪ Eliminating congenital syphilis ▪ Reducing STI transmission ▪ Improving recording and reporting of STI
10:00–10:30	<i>Coffee break</i>
10:30–12:00	<p>Workshop – Achieving the regional strategic action plan objectives (continuation)</p>
12:00–13:00	<i>Lunch break</i>
13:00–15:00	Plenary session
15:00–15:30	<i>Coffee break</i>
15:30–16:00	Conclusions and recommendations
16:00–16:30	Closing session

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**PARTICIPANTS OF THE MEETING ON THE MID-TERM REVIEW OF THE
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CONTROL (2008–2012)**

