

View from the WHO

Task force for the urgent response to the epidemics of sexually transmitted diseases in eastern Europe and central Asia

The World Health Organisation (WHO) (Europe) has asked that International Union Against Sexually Transmitted Infections (IUSTI) publicises the urgent work of the task force. The first meeting was held in Copenhagen on 23-24 February 1998, the second meeting was held in Vilnius on 22-23 September 1998.

The unprecedented rise in syphilis and other sexually transmitted diseases (STDs) in large parts of eastern Europe and central Asia poses a significant threat of an immediate HIV epidemic in the region. International agencies and the most affected countries have joined forces to take action to curb the rapidly evolving STD epidemics. On the initiative of the WHO Regional Office for Europe and the Joint United Nations Programme on HIV/AIDS (UNAIDS), an international task force was created to mobilise an urgent and well coordinated multiagency response to the crisis. At the first meeting of the task force, the participants discussed the challenges facing STD control in the region and agreed on a strategic framework for a harmonised response. The response will address STD care and prevention, and will cover the newly independent states and the most vulnerable countries in central Europe. The participants agreed on the terms of reference for the task force and its secretariat, which will be located at the WHO Regional Office for Europe. The mission of the task force was defined as ensuring that:

- external support to the region is both timely and well coordinated
- international and national resources are mobilised, and
- the local capacity to respond to the STD epidemics enhanced.

Magnitude of the problem

STD TRENDS

In western Europe there has been a gradual decline in the incidence of STD over the past two decades and a levelling off of new HIV infections. The incidence of syphilis has dropped to below 5 per 100 000 and gonorrhoea to below 20 per 100 000. In contrast, the 1990s have witnessed a dramatic increase in reported cases of STD in eastern Europe and central Asia, despite a marked decline in mass screening and contact tracing activities and underreporting of cases. In other words, the reported data underestimate the true size of the epidemic.

The incidence of syphilis has reached epidemic levels, increasing 15-60-fold, from 5-15 per 100 000 population in 1990 to 200-500 per 100 000 by 1996, with proportionally larger increases occurring among young people.¹ The incidence of congenital syphilis has doubled since 1996 in many countries, reflecting an increase in the prevalence of untreated syphilis among pregnant women. Fewer women are seeking antenatal care and they are seeking care later, often during the third trimester.

THE PROBLEM OF UNDERREPORTING

Until recently, the incidence of reported syphilis has served as the most reliable indicator for STD trends in the region because it is the one STD that is still referred to government STD specialists and is reportable by law to health authorities. For other STDs, such as gonorrhoea, patients are more likely to avoid the stigma attached to the state service and to seek treatment in the growing private sector or, alternatively, to treat themselves. The rise in the ratio of syphilis to gonorrhoea is better explained by this shift in health seeking behaviour than by the absence of a gonorrhoea epidemic. Based on the proportion of gonorrhoea to syphilis cases reported, it is believed that only 1 in 20 cases of gonorrhoea is reported today.

Unless a more reliable surveillance system is put in place, underreporting can be expected to increase over the next few years. The STD epidemics will de facto disappear on paper. This will give governments a false impression that the STD epidemics are contained and resources allocated to STD control will also decline.

POTENTIAL FOR A WIDESPREAD HIV EPIDEMIC

Equally alarming are the recent outbreaks of HIV infection among injecting drug users in the region, particularly in Belarus, the Russian Federation, and Ukraine.² According to UNAIDS estimates, while there were 150 000 HIV infected individuals overall in western Europe by the end of 1997, in Ukraine alone there were 180 000 infections. Considering the high incidence of STDs in the region, the stage is now set for a potentially rapid spread of HIV infection particularly in the newly independent states (NIS), the Baltic states, Albania, and Bulgaria. Interventions are urgently needed to reduce the burden of STDs in the region rapidly and to abort a widespread HIV epidemic.

Challenges

In spite of important progress, there remain many inherent problems which slow or derail the reform process within the STD healthcare system.

Unfortunately, those who advocate strengthening and reforming STD care and policies are often not those who are influential in the policy making arena. As a result, they have trouble pushing their agendas forward and the prevention and control of STDs remain on the back burner in terms of health priorities.

Furthermore, decentralisation and privatisation of the medical sector has taken control partially out of the hands of the central government. While there may be a commitment among those at the national level to modernise the existing STD system, there is a big gap between conviction and will at the central level and the capacity to deliver services at the peripheral level.

As the STD problem grows among the marginalised segments of society (for exam-

ple, homeless, unemployed, sex workers, drug users, and street kids), it will become more and more difficult to mobilise political and social support for STD prevention and care.

The legal basis for working with sex workers, young people, and other vulnerable groups is a major barrier. STD specialists in particular have difficulty determining how they should proceed within the existing legal framework.

Anonymous or not, government STD services still carry a stigma. Prostitutes, homosexual men, drug users, and young people are unlikely to trust the government system because of a history of incrimination and persecution. Furthermore, the ideology of a police state still exists and the punitive element persists, especially at the peripheral level.

Central and regional governments are paying only a small fraction of the budgets necessary to run government health services. As a result, state clinics are poorly equipped and supplied. Staff morale is low because of low and unpaid salaries and because budgets cannot support in-service staff training.

Prevailing budgetary incentives are not conducive to reform. For example, since services are remunerated on the basis of hospital beds filled, STD specialists have an incentive to hospitalise patients rather than to treat them as outpatients.

In the face of the shortfall of money, services have responded by cost recovery schemes which have created major markets in STD care involving the pharmaceutical industry, STD specialists, and other professionals involved in reproductive health. The result is a two tier system in which high quality STD services are available to the minority who can pay, and low quality services are provided to the majority who cannot.

The sweeping introduction of users' fees and cost recovery schemes in the healthcare system has had a negative impact on STD clinic attendance, particularly among the most vulnerable groups. As a result, patients seek care later or not at all. This only fuels the epidemics.

The place for STD services and the role of STD specialists have yet to be defined in a reformed healthcare system which emphasises primary health care and family doctors.

Owing to underfinancing and inefficiency in the drug supply system, access to drugs in the region is precarious. National production of pharmaceuticals has severely diminished and is generally not competitive in terms of quality.

Although intentions are usually laudable, unsolicited donations of drugs can create more problems than they solve, often meaning inappropriate drugs, poor quality, products close to expiry dates, and the consumption of precious time and resources to sort and store the items.

Antibiotic resistance is a serious problem in the region owing to the widespread practice of self medication and the use of poor quality or counterfeit antibiotics.

An overall sexual health culture is absent and awareness about STDs and their consequences in the general population is low. Surveys conducted by UNFPA reveal a general lack of knowledge about sexual health, including the signs and symptoms of STDs. In many instances, the use of condoms is almost non-existent.

While governments are beginning to recognise the need for health promotion and primary prevention, they are reluctant to invest scarce resources in these activities. Governments are particularly unyielding when it comes to using loans for this purpose. Lack of cooperation between ministries of finance and ministries of health make negotiations more difficult.

In addition, there is resistance to sexual health promotion at almost any level on the part of conservative groups within society, other than the promotion of abstinence outside of marriage. There is a strongly held notion that the promotion of condoms corrupts young people.

While free or subsidised condoms are available through family planning programmes, they are quite expensive and of uncertain quality at retail outlets. Furthermore, as governments have not agreed to include condoms on their essential drug lists, the condoms are more likely to be taxed.

Despite their overlapping objectives, the STD and HIV/AIDS programmes in the region still function separately, competing for scarce resources.

Last but not least, with a few exceptions, there has been a woeful lack of cooperation and coordination between donor agencies at country level. This results in duplication of efforts and wastage of scarce international and national resources. For example, in the Baltic states seven different sexual health school education manuals have been developed by seven different donors.

Mission and tasks

Participants agreed that the mission of the TF/STD is threefold:

- (1) to ensure that external support to the region is both timely and well coordinated
- (2) to ensure that international and national resources are mobilised, and
- (3) to ensure that the local capacity to respond to the STD epidemics is enhanced.

The specific tasks are:

- (1) in consultation with governments and other stakeholders in affected countries, to elaborate a harmonised strategy for international assistance that will reduce the burden of STDs and their health consequences in the region;
- (2) to mobilise and advocate national and international resources for STD prevention and care in affected countries;
- (3) to ensure that external technical and financial support to affected countries is both timely and well coordinated in order to avoid duplication, address gaps, and maximise the impact of contributions;
- (4) to ensure that the local capacity to respond to epidemics of STDs is enhanced in the region;
- (5) to serve as a channel for the international exchange of epidemiological and programmatic information on the STD situation and needs of the region;
- (6) to develop and promote international best practices and policies while ensuring that conditions and issues particular to the region are taken into consideration; and
- (7) to advise UNAIDS, its cosponsors and other partners on policies and strategies related to STD prevention and care in the region.

Summary

In summary, members of the TF/STD:

- share the common goal of reducing the STD burden and slowing the spread of HIV in the most affected and vulnerable countries in eastern Europe and central Asia
- contribute financially, technically, or in kind to the implementation of a joint strategy which aims:
 - to create an enabling environment for STD prevention and control, and
 - to strengthen the local capacity for STD prevention and care
- engage in a continuous exchange of information, collaborative partnerships, and coordination of activities at regional as well as country level through the TF/STD and in-country interagency working groups, respectively
- concur with the priority areas for international support consisting of advocacy and policy, STD drugs, condoms, educational materials, training, applied research, and surveillance
- meet twice a year to review implementation progress and the need for additional assistance
- as advocates of TF/STD, call on partners and other organisations to join in this important new initiative.

Adapted from WHO document EUR/ICP/CMDS 06 02 06.

Published concurrently with the *International Journal of STD & AIDS*.

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1 World Health Organisation. *Epidemic of sexually transmitted diseases in eastern Europe*. Copenhagen: Report on a WHO meeting, 1996 (EUR/CMDS 08 01 01).

2 Hamers FF, Batter V, Downs AM, *et al.* The HIV epidemic associated with injecting drug use in Europe: geographic and time trends. *AIDS* 1997;11:1365-74.