Together Alive Youth Link (TAYL)

Management Component

Goals:

- Deliver primary prevention activities (e.g. promotion of safer sexual behavior and condom provision) in conjunction with National AIDS Programs
- Promote accessible, acceptable, and effective case management of persons with STDs through public and private health care systems, including first-level health care, using simple algorithms based on diagnosis
- Include STD prevention and care services in maternal and child health, antenatal and family planning services
- Direct acceptable and effective STD care services to populations identified as being particularly vulnerable to infection with STDs, including HIV
- Promote early STD healthcare-seeking behavior together with education related to sexual behavior

1. STI Prevention in Mbarara Uganda

The determinants of STD epidemiology are as multifaceted as the approaches to prevention and care. The interventions for preventing the spread of STDs and HIV will take into consideration the role of human physiology, human behavioral patterns, and socio-cultural influences. STD and HIV prevention cannot be addressed by behavior and barrier methods alone. Other factors such as family units and values, housing, employment, education, religion, culture, age, gender, and so on need to be considered at all times. Although coverage of these determinants is beyond the scope of this document, governments and program managers need to address these issues during the planning and establishment of STD prevention and care programs.

1.1 Primary prevention

Since the primary mode of transmission for both classic STDs as for sexually transmitted HIV is sexual intercourse, the primary prevention activities and the audiences are the same. It is logical that there is close coordination between those responsible for HIV/AIDS prevention and those responsible for STD prevention activities. Indeed, full integration is recommended. In primary prevention the aim is to prevent the acquisition of infection and disease. This can be done by promoting:

- Safer sexual behaviour
- The use of condoms for penetrative sexual acts

Only primary prevention activities can have an effect on the spread of presently incurable STDs resulting from viral infections.

Primary prevention activities are therefore the responsibility of integrated or coordinated AIDS/STD programs. Providing STD clinical care offers an important opportunity for primary prevention by providing education, treatment, and effective cure to persons who are, by definition, at increased risk of infection and of transmitting infection. It is important to remember that one person's treatment and cure for an STD can act as prevention for a potential contact. In most countries the National AIDS Programme (NAP) is developing prevention strategies and has interventions already in place. It is important that these interventions include education on STDs. It is probable that this is therefore mutually beneficial; for instance, education on possible STD complications such as infertility may be persuasive in reducing risk activity for STDs, including HIV. In low AIDS/HIV settings, STDs may seem more relevant to people than HIV. In some places existing STD programs have developed expertise in primary prevention which can be shared with the NAP.

Most prevention messages are applicable to both HIV and conventional STDs, but the educational messages that specifically relate to conventional STDs will include:

- The knowledge that many STDs can be treated and cured
- The knowledge that early treatment is necessary to avoid complications and permanent squalor
- The knowledge that symptoms and signs may not be noticed, particularly in women, until complications appear
- A description of recognizable signs and symptoms
- A list of places where STD advice may be obtained (e.g. basic health care services) and, where available, categorical STD clinics and voluntary counseling centers
- The assurance that wherever services are obtained in the public sector privacy, confidentiality and respect are guaranteed
- Advice on assessing one's personal risk of having acquired an STD and the risk for one's sexual partner(s). (If the assessment suggests a possibility of STD, available channels of advice is indicated.)

In order to provide realistic, acceptable and culturally appropriate STD messages it is important to appreciate the knowledge, attitudes and practices of the audience. Simple research is therefore needed to obtain information from communities including:

- Knowledge and perceptions of the relevance of STDs
- Healthcare seeking behavior
- Constraints to seeking STD care

1.2 Secondary prevention

Secondary prevention entails the provision of treatment and care for infected and affected persons. The activities will include:

- Promotion of health care seeking behavior directed not only at those with symptoms of STDs, but also at those at increased risk of acquiring STDs, including HIV
- The provision of clinical services that are accessible, acceptable, and effective, and which offer diagnosis and effective treatment for both symptomatic and asymptomatic patients with STDs as well as their partners
- Support and counseling services for both STD and HIV patients

Knowledge and experience in promoting health care-seeking behavior for women, men, and young people in relation to STDs is limited. UNAIDS and WHO recognize as a priority the development of best methods for different settings in this area. Guidance will be provided as information is acquired. More operational research is needed in this area of STD care.

2. STD care services

The provision of accessible, acceptable and effective care services is a cornerstone of any program for the control of STDs.

2.1 Access to services

TAYL will seek all possible methods of inviting donors to contribute to the expansion of its own district and national STD care facility network. Patients will have a choice of services from which to seek STD care. TAYL has identified several primary potential sources of STD care in Mbarara.

The public sector:

- Specialized STD clinics or dermato-venereology clinics in Mbarara Hospital
- Outpatient departments of other specialties in hospitals
- First-level care, including emergency rooms, dispensaries, and health centers
- Reproductive health/maternal and child health clinics
- Family planning clinics

The private sector:

- Private STD clinics
- Outpatient departments of private hospitals
- Private physicians providing first-level health care and care in various specialties
- Pharmacists (where it is legal to dispense antibiotics without prescription)

The informal sector:

- Traditional healers (African Traditional Healers in Mbarara district.)
- Vendors of antibiotics

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By ensuring universal access to appropriate STD care programs, it is acknowledged that patients seek care from a mixture of public and private sources. In many countries most STD care is obtained outside the public sector. Planners of a balanced and comprehensive program will need to consider strengthening any health care providers that are able to provide a quality service.

2.2 Public services in Mbarara

STD services in the public sector are integrated into existing healthcare structures such as outpatient departments, first-level health care facilities, maternal and child health clinics, and family planning clinics. Attention is therefore paid to ensuring coverage for women, men, and young people.

2.3 Categorical STD clinics

Vertical service delivery through specialized STD or dermato-venereology clinics is often unsatisfactory in both industrialized and developing countries for reasons that include poor accessibility and acceptability. It has beenvirtually impossible to provide specialized clinics that are easily accessible to all populations in both rural and urban areas.

Attendance at such clinics may be stigmatizing, particularly for women. Thus, even when the public sector STD services are delivered through a vertical system, there will still be a requirement for STD care through general health care services. If this is not provided in the public sector, pressure to provide it transfers to private practitioners and the informal sector.

It is argued that high-quality STD care can be delivered by specialist clinical staff in categorical STD clinics, but inaccessibility, unacceptability, and the many human and economic resources required make this an impractical method of service provision for the general population. STD clinics can, however, serve as reference/referral centers (see below).

Although UNAIDS and WHO recommend that routine STD services be integrated into primary healthcare, clinics specializing in STDs (sometimes called categorical clinics) may be useful in providing primary care in urban settings for specific groups such as sex workers and their clients, migrant workers, truckers, and any other group with poor access to healthcare. Additionally, because of the concentration of STD expertise, these clinics can offer referral services for primary care services, hospital outpatient departments, private practitioners, etc. In a few selected cases the specialized clinics will also be reference centers that offer healthcare provider training in STDs, epidemiological information (e.g. prevalence of etiological agents within syndromes and antimicrobial susceptibility), and operational research (e.g. studies on the feasibility and validity of algorithmic approaches).

STD care is still provided through dermato-venereology clinics serving both skin and STD problems. To some extent this reduces the stigma associated with clinics that deal only with STDs. Such clinics often, however, concentrate on treatment of symptomatic, self-presenting patients and ignore public health issues, prevention, and case finding in asymptomatic patients. Dermato-venereology services are common, for example, in Asia and Latin America.

2.4 TAYL general healthcare structures

TAYL general healthcare services, with its planned potential to reach the whole community, will offer a major thrust of programmes focusing towards providing access to acceptable and effective routine STD care through general healthcare services. In many situations the public health sector is experiencing financial and personnel crises. It is therefore essential that efforts to integrate STD services put as little pressure as possible on existing structures. The recommendations on the provision of acceptable and effective STD care given below have been composed with this in mind.

2.5 TAYL referral services

Where routine STD care is provided by the general health services there is a proportion of patients, between 5% and 10%, who will require referral for specialist care. This secondary care can be provided by categorical STD clinics or dermato-venereology departments. It is recognized that, for the rural community, access to referral services is hampered by long distances, poor transport services, and travel costs. For this reason, decentralization of referral services to be provided in regional general health care facilities is important. Consideration is therefore given to strengthening referral services at intermediate health care levels, such as district hospitals or their equivalents.

2.6 TAYL and private services partnership

STD programmes usually concentrate on services provided by the public sector. It is important to recognize, however, that in many settings a substantial sector of the market in healthcare is captured by the private sector. This is unlikely to change significantly until the long-term goal of strengthening health systems' infrastructures overall is achieved. The influential private sector can provide more than 70% of STD treatment in many settings and must be taken into account. It is important to improve as far as possible case management at all sources of care. The provision of treatment guidelines, training of the respective health workers, availability of information on effective drugs, and information on condom provision and use will need to be addressed by STD programs.

3. Effective STD care

STD care must be of high quality at the first point of contact with a STD infected patient. The provision of high-quality care is not unattainable, even for programs with limited financial resources. Furthermore, assuring quality of care is more likely to result in a more efficient use of resources when the public and personal health benefits of interventions is given due consideration.

Whatever choice an individual makes for obtaining advice, whether in the public or private sector, the STD programme will ensure that appropriate and effective case management is available. STD care, whether being provided in a resource-rich or resource-poor country, will aim to provide the same comprehensive case management, which includes diagnosis (syndromic or laboratory-based), curative treatment, reduction of risk-taking behaviour, and the treatment of sexual partners.

3.1 TAYL national guidelines for case management

The objectives of case management of patients with STDs are:

- To make a correct diagnosis
- To provide effective treatment
- To reduce/prevent future risk-taking behavior
- o advise on treatment compliance
- To promote and provide condoms
- To ensure sexual partners are notified and appropriately treated

In order to promote consistent and quality case management, guidelines based on identified patterns of infection and disease are therefore developed and circulated to all health personnel offering STD care. The preparation of such guidelines may be a task for a National STD Technical Advisory Committee, while the adaptation to the circumstances and capabilities of different health care facilities and providers may be undertaken by program staff.

UNAIDS and WHO strongly recommend the adoption of the syndromic diagnosis and treatment of STDs. Syndromic case management is based on classifying the main causative agents giving rise to a particular clinical condition (syndrome). It then uses flowcharts that help the health service provider reach a diagnosis and decide on treatment. The treatment covers all the relevant causes of the syndrome.

National guidelines for the management of a STD infected patient must be produced and distributed. The guidelines must be comprehensive but easy to follow. They will address the issues of diagnosis, treatment protocols, partner notification, health education, and condom provision.

3.2 Training of healthcare providers

Guidelines alone are not enough to ensure successful changes. Training in STD case management for basic-level and other healthcare workers providing STD care is key to the success of an integrated service. Training activities may include:

- On-the-job training
- Training within basic courses
- Supplimentary courses utilizing venereology expertise concentrated in those specialized clinics selected as referral/reference centres
- Training of potential future trainers, to encourage health workers to train their colleagues (“cascade” principle)
- Distribution of national guidelines in form that can be understood and used without special additional training

3.3 Availability of means for consultation and examination

The feasibility of providing case management must be assured within any healthcare setting that offers STD care, whether in the public or private sector. An essential requirement will always be privacy for consultation. Depending on the source of care there may also be need for:

- Examination tables or couches with adequate lighting
- Consistent facility supplies as appropriate (e.g. gloves, syringes, specula, sterilization equipment and laboratory supplies where appropriate)

The UNAIDS and WHO recommendations on case management minimize requirements for the delivery of STD services so that effective care can be provided even in settings with modest resources.

3.4 Consistent availability of appropriate drugs

Therapeutic protocols for treatment of specific organisms responsible for STDs will form part of the guidelines on case management produced by the National STD Technical Advisory Committee. Having reviewed the antibiotic susceptibility of prevalent organisms, the committee will recommend drugs that are effective in that particular country to the national drug policy-making bodies.

The availability of effective treatment is a fundamental requirement in any STD control program. Coordination with the Essential Drugs Programme is necessary to ensure that the required drugs are included in the country’s essential drugs list and that there is timely and adequate delivery. Coordination must be ongoing so that the drug list can be modified as changes in the antibiotic sensitivity of STD organisms are recognized.

For effective treatment to be provided, the drugs selected as part of the national guidelines must be consistently available. This is therefore a major budget item in any public setting and responsible authorities at all levels are likely to be reluctant to commit large resources without any return. In many countries patients are accustomed to paying for drugs, or at least making some contribution, and a policy of cost recovery may be considered as an option. Drugs for effective treatment must also be available and used in the private sector. Training to encourage their use is therefore necessary.

3.5 Consistent supplies of condoms

The means by which national condom procurement and distribution is carried out in the public sector may differ from country to country. Condoms must be available through all regular healthcare

services and, therefore, to all patients with STDs. In its first year of implementation TAYL has achieved some impact in the marketing of condoms, but have also experienced setbacks, namely lack of enough funds to effectively implement our condom social marketing. Additionally, TAYL will need to ensure that condoms are available in categorical STD clinics and via any outreach services to target groups and the general population.

The STD programme will also facilitate the enhancement of social marketing mechanisms in order to supplement and increase the availability of quality condoms to the public.

3.6 Acceptable STD care

However accessible and effective services may be, they are useless unless potential patients are prepared to use them. The acceptability of services is likely to be greatest when care is integrated into routine health services. Care is less acceptable when provided through dermato-venereology departments and is poorest when delivered through specialized STD clinics.

Examples of constraints on acceptability, some of which overlap access and effectiveness, include:

- Inconvenience of opening times and long waiting periods
- Poorly maintained and unattractive physical facilities
- Judgmental staff attitudes
- Poor staff communication skills
- Stigmatization of those seeking advice about STDs
- Failure to relieve symptoms
- Unaffordable charges
- Lack of privacy and perceived lack of confidentiality

3.7 The role of the laboratory in STD services

Cost and inconsistent availability of supplies, support, and expertise severely limit the practicality and availability of laboratory investigations in low-resource settings. For some sexually transmitted organisms, even in the presence of good resources, laboratory diagnosis is unreliable. For instance, Haemophilus ducreyi, which causes chancroid, is a fastidious bacterium which cannot easily be cultured. Tests for Chlamydia trachomatis are expensive and the collection of specimens is invasive and unpleasant for both men and women. The diagnosis of primary syphilis requires a special microscope and special training — furthermore, even in the best hands the spirochete may not be visible.

For these reasons and others mentioned above, the case management guidelines recommended by UNAIDS and WHO (discussed in Annex 2) allow effective STD care with little or no recourse to laboratory support. Laboratory support is therefore confined to situations where it is essential for clinical or programmatic decisions, as in the following tasks:

TAYL programme management

- Training of health workers and laboratory personnel
- Epidemiological and microbiological survey
- Antimicrobial susceptibility monitoring
- Validating flowcharts
- Sentinel surveillance

Patient management:

- Syphilis case-finding in all pregnant women
- Diagnostic confirmation of selective cases at referral centers

Research:

- Development of new diagnostic tests
- Development of new drugs
- Clinical research

It is the responsibility of the STD program manager to assess the capacity and requirements for laboratory support in the area of STDs. Any surplus laboratory capacity is best directed towards diagnosis and case-finding of Gonorrhea and Chlamydia in women, for whom syndromic diagnosis is least sensitive and specific.

4. Partner notification

Partner notification should be considered whenever STD is diagnosed, regardless of setting. Partner notification comprises those public health activities in which sexual partners of individuals with STD are notified, informed of their exposure, and offered treatment and support services. To achieve success in limiting the transmission of STDs, partner notification will aim to:

- Treat all sexual partners (at least within three months) of the index patient
- Treat the partners for the same STD (and any that are additionally diagnosed) as in the index patient

Partner management must also observe the principles of confidentiality and non-compulsion. It is important to address the issue of gender in partner notification. The implications and impact of notifying a partner may be different if the index patient is male rather than female. The necessary support and counseling needs is provided.

4.1 Approaches to partner notification

There are two approaches to contacting sexual partners, which can be adapted to a particular setting. UNAIDS and WHO recommend patient referral after adequate education and counseling.

Patient referral

In this option the patient is given the responsibility, after adequate health education and counseling, to contact sexual partners and ask them to present themselves for treatment.

Provider referral

This is the situation where the patient is asked to provide the names and addresses of the partners to the health worker so that members of the health staff can contact the partners. The health worker then asks the partner to present themselves for treatment.

5. Additional activities for STD prevention and care

As with other communicable diseases, the prevention of STDs cannot be achieved solely by the provision of care to self-presenting individuals.

It is important to identify and provide treatment to infected individuals who do not spontaneously seek health care. Many of these are women in whom symptoms may be absent or minimal, who do not recognize the significance of the symptoms, or who ignore the symptoms for reasons of embarrassment, fear, or stigmatization. Additionally, in some countries men who have sex with men, particularly bisexual and non-identifying homosexual men, may fail to seek and obtain treatment for similar reasons.

5.1 Promotion of appropriate health care-seeking behaviour

Developing and strengthening the provision of STD care needs to be accompanied by the education of potential service users about the availability and advantages of the services. This education will take

into account the reasons why many individuals fail to seek early treatment. Some may not seek treatment at all until the disease is identified while they attend a medical service for an unrelated condition.

Some of the commonly encountered reasons for not seeking health care are:

- Ignorance of STDs and their potential consequences
- Absence of signs or symptoms (especially in women)
- Lack of knowledge about where to seek healthcare
- Reluctance to discuss sexual matters
- Fear that others will find out (especially in the case of adolescents)
- Fear of a judgmental approach by the healthcare provider
- Reluctance of women to be examined, particularly by a man
- Lack of confidence in public sector services
- Laws and restrictions on healthcare for minors

5.3 Case-finding

Case-finding is a term that refers to STD screening for individuals seeking healthcare for unrelated reasons. A very important application of case-finding is the provision of STD care in maternal, child health, and family planning services. Such services provide an opportunity to offer STD care in acceptable and non-judgmental circumstances, and also to enable healthcare providers to assess the probability of infection in women who are unaware of having been at risk of infection. Supplementing routine STD care provision by the integration of STD services in such gender-specific services should receive careful consideration by any STD control program.

An example of case-finding which will always receive high priority is the routine testing of pregnant women for syphilis at antenatal clinics and maternity units. Treatment of those with positive syphilis serology prevents long-term disease in the mother and congenital infection in the child. This control of maternal syphilis has been shown to be highly cost-effective. Sexual partners will also be offered treatment. Support and counseling services, where necessary, is also provided.

There is a particular potential for the infringement of individuals' rights in screening activities. Confidentiality must be preserved (e.g. information obtained at screening will not be passed to the administration or to employers) and employment will not be denied unfairly and unjustly. Provision is made for counseling and treatment, and advice given on the necessity of treatment and where it can be obtained. Apart from during antenatal care, case-finding and screening are optional services to be implemented where resources are available.

5.4 Screening

Screening is the testing for STDs in individuals not directly seeking any healthcare. Donors of blood, tissue, and semen are screened for at least syphilis, HIV, and Hepatitis B in order to protect the recipients and is the responsibility of the blood transfusion services rather than the STD program. However coordination is necessary in order to ensure that donors found to be infected are offered appropriate case management. Although the potential exists for the screening of curable STD within populations such as military personnel (during routine medical examinations) or employees (as part of occupational health schemes), UNAIDS and WHO recommend that it be done in confidentiality and with respect for human rights.

5.5 STD in children and adolescents

WHO has defined adolescents as people of ages 10-19, while youth has been defined as the 15-24 year age group. "Young people" is a combination of these groups and ranges 10-24 years.

Provision of care for STDs in sexually active adolescents and sexually abused children is on the agenda of a STD control program. There is increasing evidence to suggest that STDs are a serious problem among adolescents in both urban and rural environments. The magnitude of the problem is not fully realized, especially in developing countries, because of lack of sufficient studies within this population.

A recent WHO review of adolescent reproductive behavior showed that in many developing countries there are particularly high rates of sexual experience and childbearing among adolescents. These same behaviors are associated with the acquisition and transmission of STDs.

Age-specific data from many countries indicate that the peak incidence of STDs is seen in the 15-29 year group. Among sexually active adolescents, the incidence of infection is highest in the youngest edge of the age bracket. (Sexually transmitted diseases amongst adolescents in the developing world: A review of published data. Geneva: World Health Organization, 1993 - WHO/ADH/93.1). However, services for prevention and care of STDs are frequently not accessible, acceptable, or appropriate to this section of the population. This makes it imperative that adolescents are recognized as an important target group for STD prevention and care programs. STD programs will put in place mechanisms to address the issue of curable and non-curable STDs in children and adolescents, with particular attention to those below the legal age. Governments will have clear policies to guide program planning in the provision of STD care for individuals below the age of majority (as well as for sexually abused male and female children) and mechanisms for counseling will be explored and put in place.

Given the legal framework within which one has to work, differing cultural norms, different levels of infrastructure for health service provision between regions, and the diversity of adolescent populations, more local initiatives are needed to address the provision of STD services for this age group.

5.5.1 Child abuse, rape, and STDs

Child sexual abuse is becoming a serious social and medical problem requiring the attention of policymakers, educators, and other professionals who deliver social and health services. The treatment of child victims is an important aspect of child healthcare in both industrialized and developing countries.

Healthcare workers should be made aware of the possible link between sexual abuse and STDs in children and adolescents — children and adolescents with STDs will not be assumed to have acquired infection from nonsexual contact. In cases of rape, guidelines should be provided on the steps to take.

5.5.2 Strategies for control

Access to information:

- Information, skills, and services which can help children and adolescents understand their sexuality and protect themselves from unwanted pregnancies, STD/HIV and subsequent risk of infertility and untimely death are vital.
- Provision of sex education and negotiating skills before adolescence and puberty ensures that information is passed on before young people become sexually active. Mechanisms should be put in place to address groups both in and out of school. In some societies this is particularly important for girls.
- Information and skills have to be provided in different settings in order to reach different sets of young people and will take gender issues into consideration.

Access to services:

- Existing clinical services should be adapted in order to become more child-friendly and adolescent-friendly. This will involve retraining health workers to change their attitudes and modes of delivering health services. Health workers will need to be

provided with information and knowledge in order to refer young people to other setings that can assist in building up interpersonal skills.

- Existing treatment protocols will need to be evaluated to validate their efficacy in identifying infection, especially in female adolescents (up to 95% of which may be asymptomatic with Chlamydia infection). The questions currently recommended for risk assessment score are inappropriate and will not identify positive risk in adolescents. More research is necessary among adolescents to identify more sensitive methods of establishing positive risk for STD infection.
- Availability of drugs is important for the treatment of young people. If young people leave the clinic with a prescription to purchase medicines they are unlikely to obtain them because they may have to ask parents for the money. Furthermore, it is particularly important that education on compliance is given in full.
- Access to barrier methods (condoms) to protect from unwanted pregnancies and infection is therefore facilitated and funded. The provision of such methods encourages safer sex in those already sexually active and has not been shown to promote sexual promiscuity.
- In order for services to be trusted and used by young people, they must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent.

Policy on abused children:

- There should be clear policies or guidelines for health workers to follow on the management of children or adolescents who have been sexually abused. Such policies and guidelines should be drawn up in collaboration with the country's legal department and the Department of Social Services, or an equivalent entity.
- The guidelines will outline the role of the health care-giver, the role of the child's parent or guardian, counseling and follow-up services, and the legal aspects of child abuse.

5.6 Confinement and STD services

People in confinement (e.g. prisons, psychiatric hospitals, refugee shelters, and children's homes) will have access to health services and preventive medicine. The health services will provide prevention messages against STD/HIV and the means to protect against acquiring or transmitting infection. It must be kept in mind that people in confinement interact not only within their area of confinement but also, when later no longer confined, with the general population.