Briefing of Consultants on sexually transmitted infection control

World Health Organisation Regional Office for Africa

Harare 24-26 April 02

Report by Dr Sunanda Ray, Director of SAfAIDS, who attended this meeting as a consultant for DfID

Summary

The objectives of this meeting were:

1. To update participants on the HIV/AIDS Regional Strategy, the priority areas for HIV implementation and the new WHO recommendations on STI prevention and management
2. To inform potential consultants on technical aspects of STI consultations and on WHO rules and procedures
3. To introduce networking in order to strengthen STI prevention and control in the Region

Key points that emerged from the updates and new recommendations were:

- Surveillance has moved from reliance on ANC sentinel surveillance to also considering "risk surveillance" using STI rates and behavioural surveillance especially in young people, and monitoring trends in indicator diseases such TB and hepatitis.
- The presentation of various models of Voluntary Counselling and Testing that include "opting in" or "opting out" of options for testing that may be used to incorporate VCT in STI settings.
- The need for quality assurance in laboratory support for STI programmes, in particular to validate guidelines for syndromic management of STIs.
- The opportunities and complications of offering dual protection methods for STI prevention and treatment in reproductive health settings
- Two draft manuals were presented – the programme guidance tool and essential care practice guide for reproductive tract infections, with experience of one programme manager from Ghana described.
- The new WHO recommendations for use of syndromic management of vaginal discharge and genital ulcer disease included the use of women's own perception of having a vaginal discharge as being the entry point into syndromic management in high prevalence areas, and promotion of use of acyclovir for genital herpes simplex [HSV2]. The links in epidemiology of concurrent epidemics of HIV and HSV2 in Africa were discussed in connection with synergistic effects of the two infections.
- A comparison of providing syndromic management of cervical infections versus no treatment is provided using decision tree analysis of costs of either strategy, in high prevalence areas.
- Technical aspects of consultancy with WHO with regard to rules and procedures were discussed with explanations for some common problems such as timescales, payments and medical fitness to travel requirements.
- The benefits of setting up an African network of STI consultants to strengthen STI prevention and control in the region were discussed, resulting in a steering committee set up at the end of the meeting to carry the process further. Training and capacity building for consultancy were identified as important components for the success of this initiative.

The WHO Regional Office for Africa organised this briefing session for potential consultants from the region with expertise in HIV and STIs who could potentially provide consultancy services for WHO in the future, to increase the technical resources available for STI control. An additional aim was to explore the possibility of setting up a network that could promote use of WHO guidelines and activities in STI control.

The meeting was scheduled to start on 22 April but started a day late because the West African delegates were delayed in their arrival.

Introduction and opening statements

Delegates were welcomed and the objectives of the meeting explained. Donors supporting the meeting such as DfID were thanked for their support.

Objectives

Overall objective

To strengthen the capacities of countries in the areas of STI prevention and management

Specific objectives

- To update participants on the HIV/AIDS Regional Strategy, the priority areas for HIV implementation and the new WHO recommendations on STI prevention and management
- To inform potential consultants on technical aspects of STI consultations and on WHO rules and procedures
- Strengthen the network of experts participating in STI control in the Region

Objective 1: To update participants on the HIV/AIDS Regional Strategy, the priority areas for HIV implementation and the new WHO recommendations on STI prevention and management.

1.1 The place of STIs in the HIV/AIDS Strategy in the African Region and its implementation framework

Dr Moeti presented the regional HIV/AIDS strategy and implementation framework [Overhead handout 1], guiding principles and priority interventions. Proper management of STIs is integral to control of the HIV epidemic, and most interventions targeting HIV are central to control of STIs in general, such as promotion of protective behaviours and voluntary counselling and testing.

1.2. Second generation surveillance: the place for STI surveillance

Dr Asamoah-Odei talked the audience through the key epidemiological questions related to HIV and STI surveillance [Overhead handout 2], including the biases related to using ANC sentinel surveillance data. Second generation surveillance improved on earlier methods by addressing the diversity of HIV epidemics in different areas, integrating biological surveillance of HIV and AIDS prevalence with "risk surveillance" that looks at STI rates and behavioural factors. Data collection methods are listed in the handout, but key points include use of repeated cross-sectional surveys in the general population as well as defined sub-populations such as

young people, to monitor trends and changes in risk behaviour. Monitoring trends of indicator diseases such as TB and hepatitis as well as STIs are essential components of improved second generation HIV surveillance, as well as valuable in their own right.

The key STI surveillance components are:

- Case reporting
  - → Universal case reporting provides a minimum estimate of population based STI incidence and is good for reporting ongoing information on the capacity of health care providers to report STIs
  - → Sentinel case reporting gives an indication of trends in disease burden in the community through distribution seen at clinic sites
  - → Syndromic case reporting – only urethral discharge and genital ulcer disease [GUD] are potentially useful for monitoring trends.
- Prevalence assessment and monitoring
  - → useful STIs are syphilis, gonorrhoea, chlamydia, trichomonas, GUD, and urethral discharge
  - → best done among high risk populations with high prevalence
  - → may be adjusted to reflect general population
  - → as a minimum must be done in major cities
- Assessment of STI syndrome aetiologies – can assist in assessment of disease burden due to specific pathogens
- Antimicrobial resistance monitoring
- Special STI surveillance- related studies
  - → Outbreak investigations
  - → Assessment of STI care seeking behaviour
  - → Estimation of economic costs of STIs

The advantages and disadvantages of STI surveillance components, how each type of surveillance can contribute to data on STI infection, laboratory requirements and sampling considerations are listed in the handouts. Surveillance of cases presenting to the private sector is difficult to co-ordinate but may be improved through site visits, training courses, and provision of written updates on STI diagnosis and treatment. The importance of disseminating and using STI surveillance data was stressed. Methods suggested for this were through annual reports, newsletters, press releases, and fact sheets.

Challenges include:

- How to integrate STI syndromic reporting into national disease surveillance systems
- How to set up sentinel sites for STI case reporting
- How to institutionalise the conduct of STI prevalence surveys, and surveys to determine the aetiologies of STI syndromes and anti-microbial sensitivity patterns.

Discussion points on above:

- STI management does not get submerged in HIV control, eg health workers have to remember to give education and advice on syphilis treatment during antenatal care.
- Integration of STI control into health service packages has been promoted for nearly ten years, but is rarely practised, and there is much geographical

variation. Staff may be trained to provide primary health care that includes STI management, but often do not ask patients about symptoms because of time restraints or due to stigma and prejudice about who gets STIs.

1.3. VCT and management of people infected with HIV; relation with STI prevention and control

Dr Isaacs highlighted the key interventions in HIV care and counselling that are supported by WHO/AFRO within the relationship between VCT and STI prevention and control [Overhead handout 3]:

- VCT
- Psychosocial support
- Clinical management (including medical, nursing and counselling care)
- Home and community based care
- Infection control
- Capacity building
- Assessment and development of interventions for orphan care

She then went on to discuss recommended linkages with STI for the delivery of quality care, based on continuum of care principles:

- In prevention, via VCT for STIs including HIV infection, and basic skills training in early detection and management of HIV related infections in STI patients
- During treatment, via timely identification and appropriate management of HIV related infections at the STI clinic
- By encouraging referral – encouraged STI practitioner to routinely refer clients for further medical care, community and peer support services, and HIV/AIDS management and counselling services.

The specific role of WHO consultants is to:

- Assist in the development of guidelines, training manuals, human resources
- Plan for provision of skills in early detection and case management
- Assist in estimating the essential drugs needed for treatment of HIV related infections that can be undertaken at STI clinics, as well as commodities such as condoms
- Participate in the development of basic counselling skills training for STI staff
- Assist with the development of referral systems for clients to VCT services, and monitoring systems for various interventions
- To review indicators for measuring quality, efficiency and acceptability of services with national counterparts, and to recommend refinement of indicators where necessary.

What are known as VCT sites [voluntary confidential counselling and testing sites] are often stand-alone centres set up by social marketing projects or NGOs. The challenges to broadening the scope of VCT in STI settings include;

- the increased demand for skilled personnel to provide comprehensive reproductive health services such as family planning, fertility management and intensive counselling for a range of problems;

- medical and psychosocial needs of HIV positive clients requiring treatment with ARVs and for opportunistic infections; how to improve uptake of VCT outside pilot projects;
- "opting out" of testing [eg in antenatal clinics for prevention of parent-to-child transmission] has higher uptake than "opting in"

Dr Isaacs provided flow charts of the various VCT models that could be adopted [please see handout for details]:

Model 1: Classic VCT model: individual decision to attend for VCT
Model 2: Group information, opt-in individual shortened pre-test counselling, individual post-test counselling
Model 3: Group information/written information, opt-out individual testing, individual post-test counselling for sero-positive and sero-negative client.
Model 4: Group information, opt-in couple/family pre-test counselling, individual/couple/family post-test counselling [shared confidentiality model]
Model 5: No pre-test information, screening/testing [with an option to opt-out], individual post-test counselling for those found sero-positive [classical for antenatal screening programmes].

Discussion points on above:

- safeguarding the voluntary nature of clients attending for VCT rather than diagnostic testing
- preserving the quality of VCT in scaling up from pilots and research projects to larger programmes
- the need for community education to support uptake of testing and knowledge of one's HIV status, particularly addressing stigma and rejection.
- Does use of "opting out" for testing still protect patient autonomy in high prevalence areas, ie are they adequately prepared for their results? [Consultant note: this model has arisen in rich countries where syphilis testing in antenatal care is provided through "opt out" services, but works mainly because so few women are positive that the greater majority will not face receiving a positive result when they have not been precounselled. In poorer countries, women are often treated for syphilis identified during antenatal care without receiving any counselling at all or knowing what they are being treated for, or by being scolded by the health worker for having the infection.]

1.4 Laboratory support for HIV/AIDS/STI prevention and care

Dr GM Gershy-Damet presented on laboratory support for HIV/AIDS/STI prevention and care and stated the mission at the outset, which was to "improve the quality and the capacity of laboratory diagnosis in the region".

Points made included:

- Highlighting previous WHO experience and capabilities in this area
- A description of the AFRO approach (adaptation to country need, country by country, concept of "priority countries", technology transfer and training
- The main strategic orientations, including networking exchange between countries, development of focussed support in priority countries, strengthening institutional and human capacity and resource mobilisation to implement priority programmes.

- Outlined the role of the laboratory in STI control as "to support decision making", both in clinical practice and in public health.
- In clinical practice, this includes improving diagnostic specificity of symptomatic STIs, and improving the diagnostic sensitivity of asymptomatic STIs.
- In public health, this includes validation of guidelines for syndromic management, defining appropriate STI treatment guidelines and advocating STI control interventions as well as assessing their impact.
- Highlighted the essential criteria for selecting a laboratory test as
    - Validity
    - Reliability
    - Feasibility
    - Acceptability

Resources available:

- Sufficient number of technical resources
- A small amount of "seed money" – if countries articulate requirements, then will try to mobilise funds for this activity

Activities planned for the future:

- To develop an HIV regional external quality assurance, and National QA
- Assist countries for implementation and monitoring of prevention of parent to child transmission [PPTCT] programmes
- Evaluate a simple alternative method for CD4/CD8 counts
- Provide ongoing technical support
- Advocacy
- Assist African Vaccine Initiative Programme
- Assist countries to access care
- Monitoring drug resistance

The important issue of sustainability was highlighted and the need to ensure government responsibility by integrating recurrent costs into national budget (even although WHO can assist with initial mobilisation of funds). Indicators for assessment of progress need to be established at regional level, with emphasis on periodic review. The presenter stressed the absolute importance of "writing things down" and maintaining written contact as a means of communicating information, to enable the identification of problems before submission of final reports.

1.5 Presentation on Improving Access to STI drugs, needs assessment did not take place

1.6 Strategic Planning: place of STI prevention and control in the health sector response against HIV/AIDS

Dr Kaluwa stated that many countries have strategic plans for responses to HIV and AIDS.

Highlighted characteristics of strategic plans as

- Medium term (3-5 years)
- Multisectoral

- Coordinated by National AIDS Councils
- To give broad overall guidance for the response
- Need to be linked to National Development plans, which are essential for resource mobilisation.

Stressed that, although the health sector is only one of several sectors to use the strategic plan, it is also a central one for the following reasons:

- Most interventions for HIV/AIDS are health based
- The health sector has the longest experience in dealing with the epidemic
- Already possesses a "bank" of professional expertise that other sectors will need to develop in order to effectively respond to the epidemic.

The presenter also stressed the problems with sustainability, the necessity for the health sector to have plans for HIV/AIDS that are linked to resource mobilisation. The development of strategic plans is not about *what* to do (as this is already well known), but *how to do it.* The focus of these plans must be *participatory.*

In summary, the presenter stated that:

- HIV/AIDS plan for the health sector should be linked to strategic AIDS framework
- Important to clarify objectives
- Define how the services will be delivered.

Discussion points: These mainly took the form of clarification of points by different country representatives, and a sharing of experiences from specific countries relative to the topic under discussion.

Day 2. Objective 1 continued

1.7 STI prevention in the context of reproductive health and dual protection

Dr Askew from the Population Council explained the need to integrate STI prevention into ANC and Family planning services [Overhead handout 7]:

- Existing STI information and services are not easily accessible for women
- Coverage - the majority of pregnant women attend ANC clinics; women using contraception visit FP clinics
- There could be efficiencies in using existing staff skills and service procedures

STI prevention in RH settings included discussion of risk and education to change behaviour, promoting consistent condom use, optimising opportunities for STI detection and treatment among FP clients and in MCH clinic settings. Limitations of this approach are that men and adolescents are often excluded; there is not enough time for adequate consultation to cover comprehensive reproductive health; staff are often not trained well enough or have the right attitudes to provide this level of care. Working with sex workers including their dual protection needs, requires more intensity and to be scaled up from pilot projects.

Opportunities outside clinic settings include community based distribution, peer education programmes, social marketing programmes and better use of pharmacies as places for getting advice.

Points on dual protection

- Emphasis in programmes varies depending on the key preoccupation in the area, ie unintended pregnancy vs infection:
  - → At least half of all pregnancies are unintended [this has considerable implications for parent to child transmission of HIV]
  - → 12% of persons aged 15-49 have a curable STI
- Need for good advice when using emergency contraception [EC] since women in Kenya switched to using oral contraception after using EC which compromised condom use;
- Monogamy failure: change of partner may need review of methods;
- May need special training for nurses on "Outercourse" – non intercourse sex eg during pregnancy or breastfeeding; or adolescents;
- Dual barriers – eg use of condom with diaphragm may be risky;
- Dual protection consultation – studies in Mexico and Nigeria showed that personal risk assessment training gave women more scope to choose for themselves compared to aggressive promotion of method by health workers.
- What can be done? – revise policy standards and service guidelines to explicitly promote counselling and service delivery that achieves dual protection during all FP or STI consultations.

M&E - Need for outcome measures rather than output – uptake of condoms often quoted rather than actual behaviour change [eg as measured by STI reduction]

Discussion points:

- Health needs to work with education and alternative services – youth friendly services. Students do not usually access clinics, mainly get information from friends.
- Challenge of reaching men since clinics mainly used by women. Men have to be involved in dual protection.

1.8 Integration of STI prevention and care into reproductive health: Dr Kassahun Kiros Brazzaville – WHO office Reproductive Health [Overhead handout 8]

Targets and strategies: Under the regional strategy for STI control 1998-2000, all national reproductive health programmes are to include STI control activities by the year 2002. The regional RH strategy 1998-2007 includes targets to treat pregnant women for syphilis, reduce the prevalence of curable STIs to less than 15% in all countries, and effectively manage at least 80% of curable cases of STIs brought for treatment.

The pace of organisational integration reflects the degree of political commitment to the process, and depends on pre-existing structures and service. The current status of this in many countries is not satisfactory. The syndromic approach is not widely used in RH structures, individuals do not seek treatment early and self-medication is common. Behavioural research is rarely available. There is urgent need for comprehensive integrated packages on prevention and care, simpler materials on STI management and strategies for overcoming resistance from staff to this process.

1.9 Programme guidance tool [PGT]and Essential care practice guide [ECPG] for RTIs: Dr Natalie Broutet WHO [overhead handout 9]

Dr Broutet presented these two draft manuals and discussed practical issues for their implementation. For the PGT, the steps include preparation and dissemination of the country background paper, followed by a stakeholder workshop, that would identify suitable sites and resources needed for the next step, the rapid assessment phase. After this a second workshop is held for consensus building, strategic recommendations and planning for policy and operational responses, including commitment to action from key players. The ECPG is intended to provide guidance for the integration of prevention and management of RTIs in primary health care settings or reproductive health care settings. A Health Care Providers'Guide is also currently in internal review at WHO.

Dr Agnes Dzokoto described her experience in implementing the above process in Ghana.

Discussion points:

- many of the recommendations already in place have not been implemented and need for tools to assist in this – so these guides will be useful for this.
- Difficulties with obtaining incidence data especially with short term infections like STIs. Have to refer to specific studies carried out in the region, cannot rely only on syndromic data.
- Integration has to have training as a priority. Manuals being developed will give guidance on training needs. Many health workers are giving advice but not necessarily good advice, so need training on how to do this.
- The advantages of integration outweigh the difficulties – emphasis on providing good care for each person. Local situation analysis needs resources – often brings resistance from health workers, therefore need to involve them in the process.

1.10 Vaginal Discharge Syndrome: new WHO recommendations.

Dr Francis Ndowa from WHO described how the global debate over use of syndromic management of vaginal discharge recently changed after the Matlab study in Bangladesh demonstrated that 31% of vaginal discharge was due to bacterial vaginosis and candida using laboratory verification, with concerns of over-diagnosis of STIs in women [see overhead handout 10]. A Brazil study on validation of different approaches for vaginal discharge showed that use of a syndromic approach increased ability to detect true infections [sensitivity] at the expense of some false positives [specificity]. Many women who do not have an STI will be 'labelled' as having an STI as a result. On the other side, costs of laboratory services are prohibitive for all women presenting with vaginal discharge, and reliance on this may mean that women with infections are not treated. The prevalence levels of gonorrhoea [GC] and chlamydia [CT] are the main deciding factors for the treatment of cervical infections. In high prevalence areas contact with health services still offers good opportunities for treatment against these STIs.

As a result there have been changes in WHO recommendations for management of vaginal discharge in high prevalence areas to include the use of self risk assessment ie women's own perception of having a vaginal discharge. The entry point to a flowchart method of management is the spontaneous [ie not elicited] complaint of vaginal

discharge. Prevalence of various pathogens as causative agents of discharge has to be assessed using laboratory services in that population to give background information. Tools need to be developed to ascertain cut-off points for high and low prevalence of STI prevalence in terms of cost-effectiveness of interventions.

Specific recommendations regarding management flowcharts also included:

- The speculum and bimanual flowcharts could be combined into one flowchart with microscopy.
- However, microscopy is only useful to detect candidiasis and in decisions to notify a sexual partner when *T.vaginalis* is suspected. For other STIs the sensitivity of microscopy is low.
- Cotrimoxazole should be removed from the list of recommended drugs for treatment of GC.
- In view of emerging resistance of *N. gonorrhoea* to azithromycin, this should not be used as a single dose drug for GC, but could still be used for *C. trachomatis*.

Flow chart 1 [see overhead 10]: Low prevalence; self-referral; no speculum.
Flow chart 2 [see overhead 10b]: High prevalence; self-referral;

Dr Ndowa demonstrated use of different parameters in a **decision tree cost analysis** of using syndromic management for treatment of cervical infections [presenting as vaginal discharge]. The different possibilities are shown in handout 10b. The endpoint is set at PID developing in 40%, which is what we are trying to prevent by using syndromic management. The cost of developing PID in women whose cervical infections are not treated is compared with the cost of syndromic treatment, accepting a high rate of false positives, depending on the overall prevalence of GC/CT in that community.

Discussion points:

- Emphasis is changing to accept that no one flow chart fits all. There are17 different algorithms based on different situations, trying to balance the consequences of over-diagnosis and stigma with those of PID. One setting will not have multiple flow charts. Services will have to decide on which algorithm to use depending on their clientele, for instance, sex workers or asymptomatic women need different algorithms. Whether or not cost effective analysis is used depends on priorities of country involved: labelling, stigma of STIs and so on. If other factors are taken into consideration the cut off prevalence level based on costs associated with PID goes up.
- Need for other strategies against STIs for instance, enhanced partner notification; special services for sex workers.
- psychological cost of being infertile in the African context.
- How to reach women who do not come to the clinic who need to be screened and treated, eg partners of men who are treated.
- There was some resistance to the idea of giving up using specula as part of the new algorithm. What about diagnosis of cervical cancer that is more common in high prevalence areas? Dr Ndowa felt that what was achieved by speculum examination was not always worth it. External examination is enough if you are going to treat anyway in high prevalence areas. Alternatively, in primary care settings where there is no cervical cancer screening, encourage repeat visits and referral if no improvement to a place where speculum examination can be done.

1.11 Genital ulcer disease [GUD] – new recommendations of WHO
Presentation by Dr Mamadou Ball: please also see overhead handout 11 and WHO report on HSV2.
In order to understand the patterns of GUD you need regular appraisal of pathogen microbiology through laboratory services. GUD plays important role in HIV transmission and the role of genital herpes simplex [HSV2] is now being explored.

Until the 1990s, 40% of GUD in Africa was due to Chancroid at the same time as 73% was due to HSV2 in US and Europe. Since then prevalence of HSV2 has been increasing – to 40% in Kenya and Durban, 20% in Rwanda and seems to correspond to the upsurge of HIV, the superimposition of 2 epidemics. On a country basis, the greater the HIV prevalence, the greater the prevalence of HSV2. HIV immune suppression leads to worsened HSV2 symptoms, more resistant to treatment, and also persistent carrier status. HSV2 infection may enhance HIV infectiousness and spread. Interventions that aim to reduce HSV2 therefore also aim to reduce HIV. HSV2 is more readily transmitted sexually than HIV, therefore HSV2 serology may be useful as a marker for changes in sexual behaviour.

Changes in the GUD algorithm [see overhead handout]
Patient presents with genital sore or ulcer; examine, if ulcers present, treat for syphilis or chancroid; if vesicular or recurrent; treat for HSV2 with acyclovir; educate, counsel, condoms, encourage HIV testing.
If difficult to differentiate, then provide mixed treatment.
If prevalence of HSV2 over 30%, use new algorithm; if low prevalence then use old regime as probably bacterial.
Work is currently progressing on a vaccine that may tackle herpes vaccine and HIV, but faster progress has been made on HSV than HIV.
RPR to test for syphilis was added in some cases, doxycycline for 14 days if positive.

The main constraint to use of acyclovir in developing countries is the cost of antiviral drugs. Cost of acyclovir depends on a country's ability to pay. There is also need to monitor emergence of resistance to acyclovir as a result of increasing use.
[*Consultant note: episodic and suppressive therapy shown on the charts were not discussed but can be found on page 16 of the WHO report on HSV2 attached in the folder*].

1.12 Specific aspects of STI management among women and adolescents
Dr Ndowa questioned why there was more anxiety about GC when in fact CT is more common and serious in infertility, causing significant morbidity in adolescents, yet we don't have a screening method for it in developing countries. [Overhead handout 12]

PID sequelae are frequent, often irreversible, and often the most serious of women reproductive health problems. In non-pregnant women infertility and chronic pelvic pain are common problems with PID. For pregnant women, ectopic pregnancy is a risk. There is also a danger of post abortion and puerperal sepsis, congenital infections, foetal wastage and low birth weight. Foetal loss due to infections may be the cause of high losses in HIV + pregnant women.

Discussion points on programmatic issues

- Solutions not adequately meeting needs.
- Special skills needed in providing services for adolescents who may have limited experience in talking to adults and using health services.
- Need for shared confidentiality;
- Role of religion: chaperones for young women having examinations may be a family member and cause inhibition;
- Disabled may have special reproductive health needs that are not being met
- Need for best practices on how to sustain drug supplies; WHO is using current interest in making ARVs accessible to lobby for other drugs to be made available.

Group work – evaluation and priorities

Dr F Kambugu gave an overview of evaluation of STI prevention and control programmes [see overhead handout 13]

Key points from group feedback:

- Specify data – situational analysis, economic and social situation, epidemiology, determinants, facility analysis, information sources;
- Relevance to target population
- Problems – may be seen as irrelevant, non-availability of key partners, travel problems, communications, attitude of assessors;
- Further use of audit – eg clinical audit of STI services.

Objective 2: To inform potential consultants on technical aspects of STI consultations and on WHO rules and procedures

In this session Dr Mamadou Ball explained and answered questions on the following:

- WHO protocols related to consultancies, who develops the TORs, duration of consultancies, consultancy fees, what to do in emergencies where work cannot be completed, insurance, etc.

- Contractual obligations. Need for medical examination to assess medical fitness to travel

- Public Health Package for STI consultancy: availability and prices of drugs and condoms, use of algorithms, vulnerable populations, linkages between public and private sectors, pharmacies. Most countries will be revising algorithms so there will be a lot of work in this field in the near future.

- Draft report needs to be sent immediately by email so findings can be discussed because final report has to go through several points like the country office before completion. Report has to be submitted by the end of the contractual period.

- Duration of consultancies; if extensions requested then have to be at the beginning of mission; if time is not considered sufficient, may decide to send 2 consultants with some overlap; have to ensure that objectives are met; the plan of work should predict length of time required, but depends on how much travel needed. Decisions have to come from regional office. Asking for extensions later shows poor planning.

- Payments: Temporary advisers – per diems + some amount of money added since easier and shorter. Salary depends on grade, first consultancy on lower grade while assessed. HQ pays more because in competition with other institutions but in line with other UN bodies. If consultant gets a 3-month contract then has to have a medical; longer process and then do not have a daily rate.

- Conflict – contracts may be cancelled, final payments only at completion of reports. Unacceptable reports – sometimes shows that briefing has not been done properly.

- Issue of training consultants in skills required – not done at present but necessary to build up network/database of local consultants. Was not previously considered.

- Institutions may carry out work on behalf of WHO, but independently without supervision, have an agreement of performance.

More detail is provided in handout 14 from WHO. Relations between WHO and consultants were explained further by AFRO staff.

Objective 3: To introduce networking in order to strengthen STI prevention and control in the Region

Dr Ndowa presented on technical resource networks [see overhead handout 15]. Technical Resource Networks [TRNs] include thematic networks such as MTCT, VCT, HIV/AIDS Care, Vulnerable groups, Training, and are made up of groups of individuals coming from communities, private institutions, governments that work together towards a shared objective in order to help achieve specified goals. The rationale for networking through TRNs can be for capacity building, sharing expertise, strengthening responses, sharing information and experiences, and for mobilising and effective utilisation of financial resources.

There are several networks already in existence working on STIs and HIV issues, such as the Regional AIDS Training Network (RATN), African Union Against STIs, Network of AIDS Researchers of Eastern and Southern Africa (NARESA). Others are listed in the handout.

Dr Moherdaui from STI-NET-LAC gave the PAHO experience of setting up their network. He is the current coordinator based in PAHO for sustainability and credibility. He is not paid or full time. They have a task force of 10 volunteers from countries in South America. PAHO offered a secretariat but the task force wanted to stay autonomous and independent. The network started functioning properly about six months ago. When they have meetings to discuss network activities, these are financed by PAHO. Other activities are financed by governments or organisations. The volunteers mainly contribute time commitment.

Lessons learnt:

- Territory, political issues: other networks may feel threatened. Other networks work preferentially on HIV even if STI is in their title and objectives.
- Fundraising not an issue as above. Therefore do not need to become registered as a separate organisation with a constitution.

- Work conducted by members of task force in each country so will not be commissioned out.
- Get more support from their universities and governments – eg maintaining website, information sharing.

PAHO is much richer than WHO AFRO so can afford to support these activities but AFRO may not be able to offer the same level of support. Need a framework to work within. Other networks were considered: NARESA is mainly for clinicians whereas the new network would need the skills of wider professionals to carry out these activities. Need to look for credible focal points in the countries concerned. Does there need to be a separate network per language? All communication at STI NET is in three languages, English, Portuguese and Spanish.

Group work
Participants were divided into small focus groups to discuss development of proposals to establish the AFRO STI prevention and control network, with facilitation from WHO.

Feedback from group discussions:

All groups came up with broadly similar answers to the questions posed:

1. Definition: "A technical network of experts": A formal or informal group of individuals/institutions in regular contact with each other and outside world on matters of interest (in this case STIs).
2. Is there a need for an STI technical network of experts in this region? Yes, there is a need for a technical network of experts in STI – due to the rapid changes in STI Epidemiology, and queries as to the effectiveness of existing "networks" to adequately address STI needs (e.g. African Union Against STIs, Gonococcal antimicrobial system). In addition a concern expressed was that much STI work had been swallowed up into HIV thereby losing its special emphasis.

3. Benefits and products expected from a technical network of STI experts:
    - Information sharing
    - Websites/newsletters
    - Linkages with other experts
    - Technical support to individual countries/organisations/programmes
    - Mobilisation of resources
    - Advocacy
    - Strengthening of existing capacity and skills
    - Sharing experience and resources – "best practices"

4. a. Enabling factors for networking
- Existing and willing expertise
- Potential technical and financial partners
- Improved communication technology
- Available information for sharing between and within countries
- Socio-economic and political factors that impact STI transmission on neighbouring countries
- Existing regional and sub-regional structures (e.g. SADC, ECOWAS etc)

b. Obstacles to networking:

- Communication difficulties
- Language to be used in setting up/operating network
- Funds
- Limited manpower to steer work

5. Mechanisms for sustainability and effectiveness of an STI network in the region?
    - Identification of existing institutions to "host" network
    - Potential partners (e.g. WHO)
    - Establish guidelines and principles
    - Regular communication (email/website/reports)
    - Regular meetings (minimum every two years, could utilise other regional and international conferences)
    - Resources
    - Training

Dr Ndowa then chaired the discussion following the presentations, to decide how to take the next step in setting up this network. A steering committee was set up and tasked with taking the process further, to develop Terms of Reference. All languages were represented on the committee. I was asked as director of SAfAIDS for advice regarding setting up databases and websites, also about information sharing. I stressed the need for training workshops in consultancy, especially around report writing and protocols. I offered assistance once the TORs for the committee/task force have been developed, in sending materials and papers on STIs from our resource centre, linkages with other databases such as SHARED that houses our bibliographies on STI research in Zimbabwe, and networks such as RATN that promote STI training such as through Harare City Health. The steering committee decided to approach WHO AFRO and other donors for funding and technical assistance. It was noted that a European network on STIs received funding from DfID and EU and could be approached to support a similar initiative for Africa.

The meeting closed on Friday afternoon followed by the first meeting of the new steering committee.

Dr Sunanda Ray