sexually transmitted infections:
BREAKING THE CYCLE OF TRANSMISSION

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A growing consensus underscores the urgent need to give sexually transmitted and other reproductive tract infections (STI/RTI) greater prominence in reproductive health policies and programmes. In 1994, the ICPD Programme of Action stressed the importance of managing sexually transmitted infections within integrated, comprehensive reproductive health programmes. However, these infections continue to be a serious health problem, particularly among women. Where access to timely treatment is not available, sexually transmitted infections may result in pelvic inflammatory disease, infertility, cancer, neonatal complications or even death.

Moreover, mounting evidence suggests that people who have sexually transmitted infections are much more likely than others to contract and transmit the HIV virus. Thus, though prevention and treatment should be pursued for their own sake, the role of STI/RTI in fueling the HIV pandemic has made this an even more pressing human rights and public health issue.

Because ample literature is already available on the subject, this publication does not specifically address HIV/AIDS. Emphasis is given instead to the most common and treatable infections. However, because HIV is usually sexually transmitted, most of the information here about prevention applies equally to it. Moreover, programming should strive to avoid duplication of efforts and take advantage of possible synergies in providing services for those with any reproductive health concerns.

Managing STI/RTI is challenging in terms of diagnostic accuracy and appropriate treatment, especially in resource-poor settings. Integration of STI/RTI care within the reproductive health care infrastructure, as called for by ICPD, is a challenge as well. The discussion of these challenges and their implications for reproductive health policy form the core of this programming note.

We hope the information presented here will be useful to UNFPA staff, especially those in Country Offices, in deciding what programmes to support, and as background for their participation in health-policy discussions on health sector reform and sector-wide approaches.

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Issues and Programme Implications

Common sexually transmitted infections can have severe consequences for individuals and communities. Apart from being serious diseases on their own, the presence of untreated sexually transmitted and other reproductive tract infections (STI/RTI) can increase the risk of HIV infection and transmission by a factor of two to nine.

The most serious complications and long-term consequences of untreated sexually transmitted infections tend to be in women and newborn babies. Gonorrhoea and chlamydial infections can cause pelvic inflammatory disease, which can lead, in turn, to ectopic pregnancy and infertility. Almost all STI/RTI have been associated, for pregnant women, with premature delivery and low birth weight babies. Children can be born with congenital syphilis or herpes or with serious eye infections due to gonorrhoea or chlamydia.

PREVENTION

Creating community awareness of STI/RTI and how to prevent them should be central to reproductive health programming. Family planning settings present excellent opportunities to promote condoms for dual protection (from both unwanted pregnancy and infection).

Routine screening of pregnant women can result in better pregnancy outcomes and fewer neonatal complications. From a public-health perspective, special efforts should be made to target the high-risk groups that are disproportionately responsible for sustaining and spreading STI within a community. Early treatment of infected individuals is critical to breaking the chain of transmission. However, because STI are often asymptomatic, they often go untreated, and continue to be transmitted.

DIAGNOSIS AND TREATMENT

Diagnosis of STI/RTI is not straightforward. Simple tests using microscopy can detect certain vaginal infections, but laboratory tests to detect cervical infections caused by gonorrhoea and chlamydia are more expensive and complicated. Moreover, results are generally not available while the patient is still at the clinic, which often means a missed opportunity for treatment if infection is found. And in resource-poor settings, laboratory methods of diagnosis are often neither affordable nor available.

In many settings, therefore, treatment is

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based upon a patient's symptoms and clinically observed signs (the 'syndromic' approach). This approach uses standard flowcharts, adapted to the local epidemiological profile, to decide on a treatment that will be effective against all the organisms most commonly known to cause the particular syndrome in the particular setting. Although the syndromic approach has drawbacks, it is an essential component of STI/RTI management where resources are limited. The method is simple and does not require extensive training for health personnel. An important advantage is that this approach helps to ensure that the patients get effectively treated at their first – and probably only – contact with the health system. However, this also means treating for several possible infections even if the patient has only one.

Many studies have found that syndromic diagnosis of STI/RTI is generally reliable for men, but less so for women. Abnormal vaginal discharge is highly indicative of vaginal infections, but is a poor predictor of cervical infections, which are often asymptomatic.

Strategies have been developed to improve syndromic management of vaginal discharge and to detect more cases of cervical infection (the cervix is the most common site of infection for gonorrhoea and chlamydia). Syndromic management may be improved in populations with high prevalence of gonorrhoea and chlamydia by introducing speculum examinations to detect cervical mucopus (although where this is not possible, it is better to treat presumptively when cervical infection is suspected). Given the low rate of return by clients for follow-up, diagnosis and treatment in one visit is generally preferable. Diagnostic accuracy, however, is enhanced if the patient's condition can be reviewed a week or so after the initial treatment. Specific guidelines for diagnosis and treatment should be adapted to local conditions.

Integrating STI/RTI care into existing programmes

Prevention and treatment of STI/RTI must go together, and neither should be sacrificed for the other. While prevention is relatively easy to incorporate into health infrastructures, the urgent need to address the large health burden of STI requires that diagnosis and treatment also be integrated into reproductive health services, as ICPD has mandated.

Full integration does pose challenges in terms of overcoming barriers related to the stigma attached to STI and in terms of reaching higher risk groups. However, several programme examples show that with sufficient resources it *is* possible to surmount social barriers within clinics. For example, some programmes offer STI management at different hours than family planning or antenatal care, and offer services beyond the clinic confines to reach key target groups.

Implications for programming and policy

For STI management in resource-poor settings, a gradual approach is called for. All reproductive health programmes should undertake prevention and counselling (with a special emphasis on the dual protection that male and female condoms provide), and symptomatic clients should be treated as appropriate.

Married women tend to be the main users of reproductive health clinics. But wherever feasible, STI/RTI care also should be offered to men, unmarried women and adolescents. This may require separate entrances or areas, or clinic hours, or special 'youth-friendly' services to overcome social barriers. But if these key sectors of the population are ignored, community control of STI will be very difficult to achieve.

In areas where overall prevalence rates are low, targeting services to especially vulnerable groups – such as sex workers, long-distance truck drivers, prisoners, street children, refugees and the internally displaced – can be a cost-effective way to break the cycle of transmission and reduce rates of infection.

The following additional recommendations identify ways in which STI/RTI management can be more fully incorporated into reproductive health programming:

- Promote STI integration, as discussed above, in reproductive health care and address the issue in policy dialogues, such as those concerning health-sector reform and sector-wide approaches (SWAps).

- Ensure active support by training providers at the level of service appropriate to their reproductive health care settings (from STI prevention and counselling to diagnosis and treatment).

- Adopt a policy of promoting dual protection in all family planning programmes, especially in areas of high prevalence of STI (including HIV).

- Encourage screening and treatment for maternal syphilis as part of routine antenatal care.

- Support campaigns to sensitize policy makers in governments and donor agencies on STI/RTI not only as a public health issue, but also in terms of its links to poverty and gender.

- Link UNFPA activities with wider advocacy efforts and community-based education campaigns on the risks of STI and ways of preventing them. Potential partners in this effort include women's health advocates and organizations active in HIV/AIDS prevention, safe motherhood and adolescent reproductive health.

- Support projects on STI prevention and treatment for adolescents and youth.

continued

- Support research on the role of gender-based violence in increasing the spread of STI/RTI and appropriate interventions.

- Assist countries in gathering epidemiological data on STI/RTI to establish local prevalence rates for different populations.

- Support costing studies, on actual costs and cost-effectiveness, for various STI interventions.

- For all levels of integration, use the UNFPA Reproductive Health Commodity Security global strategy at the country level to provide necessary logistics and supplies such as posters, clinic supplies, diagnostic equipment, condoms and essential drugs.

- Ensure that STI management includes responding to the needs of people living with HIV/AIDS.

- Increase awareness of higher vulnerability to infection due to interactions between HIV/AIDS and other STI.

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The ICPD Programme of Action calls for safeguarding the reproductive health of women in a comprehensive and holistic manner.

There is wide agreement that STI prevention, such as awareness-raising and the promotion of dual protection, should be a part of family planning services, and that antenatal care/family planning (ANC/FP) clinics afford a natural setting for some degree of STI management. However, integrating the management of STI/RTI more fully into reproductive health-care settings is complicated by the challenges for proper diagnosis and treatment of these infections, social barriers, accessibility and cost.

Often, the treatment and care for sexually transmitted infections is confined to hospitals, private doctors, pharmacies and specialized STI clinics. Surveys show that integration usually requires antenatal/family-planning infrastructures to absorb the additional services of providing STI management. The degree of integration varies. In some cases, only STI prevention activities are added to family planning services. In other cases, STI diagnosis and treatment may be taken on as well. Integrated STI/FP programmes may include outreach to communities and schools in the form of educational campaigns, STI services for sex workers, for men in workplaces, and strategies to reach other groups at risk.

Advantages of full integration

Offering STI/RTI screening, diagnosis and treatment at ANC/FP clinics has many advantages. Millions of women access these clinics each year (surveys in several East African countries show that more than 90 per cent of women use these services). These visits are often their only interaction with the health-care system. Therefore, a visit to a family planning clinic offers an opportunity to learn about STI/RTI risks and prevention, and, if the facility is equipped to do so, to be screened, diagnosed and treated for infections.

> *All health-care providers, including family-planning providers, should be given specialized training in the prevention and detection of, and counselling on, sexually transmitted diseases, especially infections in women and youth, including HIV/AIDS.*
> (ICPD Programme of Action, para. 7.31)

Integration can provide a more holistic approach to health care, convenience to clients ('one-stop shopping') and cost efficiency – since the same health-care providers, if properly trained, can provide the range of services involved. Besides, family planning and STI/RTI services require overlapping supplies (condoms, for example) and equipment (such as speculums), similar knowledge (knowing, for instance, which contraceptive methods provide dual protection and what special precautions should be taken with IUDs) as well as similar counselling skills.

Challenges to Integration

Integrating STI/RTI care into reproductive health programmes can pose significant challenges from a sociocultural perspective and in terms of planning. First, the stigma attached to STI can create social barriers. Family planning and antenatal care facilities serve primarily – though not exclusively – married women and those in stable relationships. These women are not high transmitters of STI, and may, some argue, stay away from the health centres because of the stigma and the different clientele associated with STI/RTI services.

Moreover, prevention messages need to be directed to men and to other higher risk groups. When these messages are directed at women at antenatal care and family planning settings, they may have a limited impact, since women often have little power to influence their partners' sexual behaviour.

In addition, male partners of STI-infected patients may be reluctant to be treated in a family planning clinic where the providers are usually women. Thus, it may be useful to offer

in Bangladesh concluded that targeting populations with an elevated risk of sexually transmitted infection could prove more cost-effective than offering STI management at family planning clinics, where prevalence of these infections is likely to be lower.

Overcoming the challenges

Despite these concerns, the integration of STI management with reproductive health services has produced positive results in many settings, both in terms of treatment and cost-effectiveness. Various examples show that it is possible for an integrated programme to also reach out to vulnerable or at-risk groups.

In Indonesia, the integration of STI services, including a programme for female sex workers, began in 1995. The concerns that the family planning services would be stigmatized and that serving sex workers would tarnish the clinic's image were addressed by scheduling STI services outside regular clinic hours and by physically separating examination rooms for STI patients and regular clinic clients. The project demon-