WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

REPORT
WORKSHOP ON PREVENTION AND CONTROL
OF SEXUALLY TRANSMITTED DISEASES
IN PACIFIC ISLAND COUNTRIES

Suva, Fiji
3-11 July 1997

Manila, Philippines
December 1997
REPORT

WORKSHOP ON PREVENTION AND CONTROL
OF SEXUALLY TRANSMITTED DISEASES
IN PACIFIC ISLAND COUNTRIES

Convened by the

REGIONAL OFFICE FOR THE WESTERN PACIFIC
OF THE
WORLD HEALTH ORGANIZATION

Suva, Fiji
3-11 July 1997

Not for sale

Printed and distributed

by the

Regional Office for the Western Pacific of the
World Health Organization
Manila, Philippines

December 1997
NOTE

The views expressed in this report are those of the participants in the Workshop on Prevention and Control of Sexually Transmitted Diseases in South Pacific Island Countries and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the Regional Office for the Western Pacific of the World Health Organization for governments of Member States of the Western Pacific Region and for the participants in the Workshop on Prevention and Control of Sexually Transmitted Diseases in Pacific Island Countries, which was held from 3 to 11 July 1997, in Suva, Fiji.
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**Keywords:** Sexually transmitted diseases - prevention and control / Pacific Islands / Fiji
SUMMARY

The control of sexually transmitted diseases (STDs) is a major strategy in the prevention of HIV transmission. STDs are highly prevalent in most countries/areas in the Pacific. On average, STD prevalence rates are 5%-10% in general adult population and 20%-40% among commercial sex workers. The widescale utilization of STD syndromic case management by community health care workers and the reinforcement of STD programmes would significantly increase the efficiency and effectiveness of STD and HIV control and prevention efforts.

In view of the above, it was proposed to hold the first of a two seven-day workshops on prevention and control of sexually transmitted diseases in the Pacific Island countries. Fifteen participants from eleven countries participated in the workshop.
1. INTRODUCTION

1.1 Objectives

The course was designed to develop skills in advocating for and organizing sexually transmitted disease (STD) prevention and control in the participants' countries or areas. These include:

- promoting STD syndromic case management;
- improving STD epidemiological surveillance; and
- reinforcing STD programme management.

1.2 Participants and resource persons

There were 15 participants representing 11 countries. One observer was representing the "AIDS Task Force", a local nongovernmental organization (NGO) which works with commercial sex workers and men who have sex with men. A venereologist attached to the Fiji Medical School also attended much of the course, as did the local representative of UNICEF. The Country Programme Adviser for UNAIDS was able to attend part of the course.

The secretariat was made up of staff from the Western Pacific Regional Office, the Office of the WHO Representative in the South Pacific and WHO Headquarters. The workshop was held at the Regional Training and Research Centre for Reproductive Health which also provided logistical support for the course.

The list of participants is attached as Annex 1.

1.3 Organization of the training course

The seven-day course was held from 3 to 11 July 1997 in Suva, Fiji.

There were three components to the course:

- surveillance and monitoring of HIV/AIDS, STDs and related behaviour;
- the syndromic approach to the management of STDs; and
- STD programme management.

During the first two days, one of the Consultants gave presentations and led seminars on surveillance and monitoring. During the next two days the Regional Adviser in Sexually Transmitted Diseases and AIDS gave presentations and led discussions on the syndromic approach. The final three days were devoted to STD programme management, concentrating on the improvement of existing STD services and the expansion of STD services to district level and primary health care level clinics.
The course concluded with a session during which lessons learned and priorities for the future were discussed.

The workshop schedule is attached as Annex 2.

1.4 Opening and closing ceremonies

The course was opened by Dr Lepani Waqatakirewa, Assistant Director, Primary and Preventive Health Services, Fiji Ministry of Health and Social Welfare. The WHO Representative in the South Pacific, Dr S.K. Ahn, replied on behalf of the Regional Director of the WHO Regional Office for the Western Pacific.

2. PROCEEDINGS

2.1 Summary of the first day

2.1.1 One of the Consultants, Professor J. Kaldor, covered the following topics:

- transmission of STDs;
- general principles of disease surveillance; and
- STD surveillance.

2.1.2 Summary of presentation

- Factors which influence the patterns of STDs in a population include the extent of active infections in the population, the disease stages or infectiousness, immunity or susceptibility of uninfected people, the presence of co-factors, the types of sexual activity, and sexual dynamics (frequency and patterns of partner change).

- Intervention targets were identified for each of these.

- Surveillance has a particular important function which is to identify the problem and plan interventions, but this function does not directly affect individual health.

- Careful thought is required to determine whether surveillance is best done routinely and continuously, in selected populations, or through periodic surveys.

- Advantages and disadvantages of each of these were discussed.

- Surveillance is not research, but it does provide data.

- Anonymous unlinked surveillance is an important way of gathering population information, but is completely unrelated to case finding, as no way exists to link names and results.
- 3 -

• Cumulative incidence, a common term in early HIV/AIDS work, should probably be abandoned.

2.1.3 Conclusions

• STDs have been shown to be very important co-factors in HIV transmission;
• reduction of STDs protects from HIV transmission;
• surveillance information provides a guide for actions and decisions;
• surveillance requires interpretation, this step is sometimes neglected.

In a group exercise, participants designed surveillance systems to gather specific data in particular groups, such as STDs among commercial sex workers, or HIV prevalence in the general population. This included defining the target population and the information required, and specifying who collects the data, what data is collected and how, and to whom it must be disseminated. This planning is critical in designing any surveillance system.

2.2 Summary of the second day

2.2.1 At the beginning of the second day Professor Kaldor led a plenary session on issues in STD surveillance and then gave presentations on:

• global patterns and trends in the transmission of HIV and STDs;
• behavioural surveillance; and
• the role of surveillance in programme planning, management and evaluation.

2.2.2 Plenary session

During the plenary session the groups reported on their first activity - designing an STD surveillance system for commercial sex workers, pregnant women, mobile workers, and estimating incidence and prevalence of HIV in the general population.

In all countries (except Niue, for financial reasons) antenatal testing for syphilis is carried out. However, some cases of congenital syphilis still occur, mainly when testing is done in the last few month of the pregnancy. In Suva, 7%-8% of pregnant women tested positive for syphilis. During discussion a number of issues linked to syphilis testing were raised:

• Few countries carry out epidemiological analysis of the results.
• In the Solomon Islands and Vanuatu, the high prevalence of yaws is as a problem in the interpretation of the results.
• The women most exposed to infection are often not tested.
• An algorithm for the diagnosis of syphilis should be developed.
• Each case of congenital syphilis should be investigated.
Prostitution is illegal in all countries. STD screening among sex workers is sometimes better performed by NGOs. The choice of place for screening of commercial sex workers is also important. It was reported that ad hoc STD surveys among sex workers have been made in Fiji and Tonga.

HIV surveys conducted among groups representing the general population have been considered in French Polynesia and New Caledonia. It was pointed out that anonymous unlinked testing raises ethical and confidentiality issues.

Specific sampling procedures might have to be considered in countries with small populations.

2.2.3 Global patterns and trends in the transmission of HIV and STD

Professor Kaldor outlined the HIV situation globally and in Asia. He emphasized that the HIV epidemic varies a lot between countries, both in its size and in modes of transmission. It is now expected that by the year 2000, the greatest incidence of HIV infection will be observed in Asia.

2.2.4 Behavioural surveillance

Professor Kaldor explained that the presence of an infectious agent is not the only element to consider in STD transmission. Sexual behaviours, which are themselves influenced by knowledge and attitudes, play an important role in the transmission of these infectious agents.

The participants were asked to draw up outlines of behavioural surveillance protocols among sex workers, young people (already done in Fiji and Solomon), men who have sex with men, and travellers. The sensitivity of disclosing information to the general population, in particular information on small population groups, was raised.

2.2.5 The role of surveillance in programme planning, management and evaluation

In his final session Professor Kaldor reminded the participants that disease surveillance does not prevent disease. He pointed out, however, that it can substantially help design and follow up health programme implementation. He emphasized that the design of a surveillance system should start from programme goals. Surveillance should be carried out by age group, gender, geographical area and time. He recommended that detailed analysis should not be carried out more than once a year.

2.3 Summary of the third day

2.3.1 The Regional Adviser gave presentations on the syndromic approach to managing sexually transmitted disease and the training package on the syndromic approach published by the Western Pacific Regional Office. During the presentation he:

- explained the rationale for adopting the syndromic approach and its use;
- discussed the limitations of the approach;
- acquainted participants with the contents of the training package.
2.3.2 Outline of points made:

- STDs are common and increasing (due to mobility, social and behavioural changes, antibiotic resistance).

- STDs are closely linked to HIV.

- STDs are now known to be co-factors for HIV transmission in both directions. HIV transmission is facilitated between an HIV-infected and an HIV-uninfected person if either one has another STD at the time. Similarly, it is also known that treating symptomatic STDs reduces HIV transmission.

- Current STD care often fails to reduce the problem because of limited access to treatment, delays in treatment, incorrect regimens, patient dissatisfaction, and other factors.

- The syndromic approach is not perfect, but it has advantages in primary care settings over the status quo for ensuring that the most people are treated correctly, and no better alternatives have been proposed.

- The syndromic approach only addresses symptomatic patients; however this is where the most serious problems are, both in transmission and in complications.

- The syndromic approach is a total package, and includes not only treatment regimens, but health education, partner notification, and condom promotion.

- Many concerns have been raised over the limitations of the syndromic approach. While the syndromic approach is not ideal for every setting, good responses exist to address each of these concerns.

- The urgent need is to get the most people treated in the most efficient and effective way.

2.3.3 Discussion

- Flow charts and treatment regimens need adaptation to the local setting.

- Some flow charts may need further work to address inconsistencies, or to acknowledge the range of real-life situations, e.g. the male urethral discharge flow chart includes a genital exam, while that for vaginal discharge does not; the “refer” box in the lower abdominal pain flow chart may need re-evaluation; there may need to be more direction provided when a patient complains of a discharge but none is seen on exam.

- While HIV is not a major problem yet in the Pacific, there are changes in sexual behaviour, prostitution, and trends in STDs which cause considerable concern.

- Reporting of STDs should be consistent with the diagnostic protocols in use.

- Other strategies are still necessary to address asymptomatic patients, and those with STD symptoms in other than the genital area.
• The genital ulcer flow chart may need adaptation to the Pacific setting: chancroid is not a problem; syphilis is generally asymptomatic and must be approached in other ways as well as those outlined in the flow chart.

• At least five of the countries represented have officially adopted the syndromic approach since 1995, developed local flow charts, trained workers, and are addressing such issues as ensuring adequate drug supplies, and especially the difficult problem of ensuring partner notification and treatment. The group shared their experiences in introducing the syndromic approach.

2.4 Summary of the fourth day

2.4.1 During the fourth day, the Medical Officer in the WHO Representative Office in the South Pacific gave a presentation on the need for policy development, training and technical endorsement when implementing the syndromic approach to STD management.

2.4.2 Outline of points covered

Rationale for considering the syndromic approach:

STDs are under-diagnosed and under-treated and a lot of individuals miss opportunities for treatment. A variety of treatment regimens are in use, patient compliance is often poor and antibiotic resistance is now more common.

The syndromic approach is intended to: expand the opportunities for treatment; err on the side of over-treatment; standardize treatment regimens; reduce defaulting; and provide a package which includes partner treatment, education, etc.

To establish the syndromic approach, the following are needed: technical endorsement of national protocols; policy statements and political support; training, implementation, and supervision and evaluation.

Technical endorsement

Success depends on addressing the following concerns which have been expressed about the syndromic approach. It is not scientifically based or sound; its efficacy is unproved; it fails to address problem of asymptomatics; it is a “shotgun” approach; it results in over-treatment and is wasteful; and it reduces the authority and value of clinical expertise.

To build a technical consensus it is necessary to gather local data, prepare draft technical documents and determine the key players. Then it is useful to conduct an initial workshop that will discuss the rationale, review drafts, address concerns and achieve consensus.

The following questions need to be resolved:

- How can we ensure that the curricula of medical and nursing schools are consistent with national technical guidelines or protocols?
- When and how should private practitioners be involved?
- What do we do if the technical consensus is opposed to the syndromic approach?
Policies

Policy consensus should be agreed by the health sector, other government sectors (political support), NGOs and the private sector. Consensus should be achieved through advocacy: meetings, documents, publicity, discussion.

Protocols

Protocols should include: standard treatment regimens and case management procedures and protocols adapted to local realities. It should also be made clear to whom the protocols apply.

2.4.3 Group work

Following the presentation, each country was asked to complete a grid indicating: (1) how many of each kind of health facility there are in the country; (2) what approach should be the standard for each facility; and (3) what approach is currently used.

To fully implement the syndromic approach, technical endorsement must be achieved. It will be important to list those who must be included in achieving technical consensus.

The participants were then asked to describe how they could bring these technical resource people to an initial meeting or workshop.

2.4.4 Outcomes of group work

In most countries, STDs are treated in clinics other than specialized STD clinics. Few countries offered diagnosis and treatment for STDs in family planning (FP) and maternal and child health (MCH) clinics. Most countries were already planning to expand STD services to outpatient, health centre and primary health care clinics. Where there are no plans to introduce STD services in FP and MCH clinics this was because it was felt that patients could easily be referred to clinics where the services were available.

Where countries had introduced the syndromic approach, this almost always included vaginal speculum examination. In many clinics, some form of laboratory support was offered although the patients were usually given what was thought to be the appropriate treatment while results were awaited. In some cases, the diagnosis would be based on the syndromic approach, in others a clinical diagnosis would be made followed by treatment for the most likely STD.

The participants agreed that even where there are facilities for vaginal speculum examination and where laboratory support is available, it was still desirable to introduce the syndromic approach when making the initial diagnosis. They also recognized the need for advocacy when promoting the syndromic approach and the need to involve many sectors when developing policies on introducing the approach in an expanded STD service.

2.5. Summary of the fifth day

During the first session of the day Dr P. Exon, Consultant, gave a brief presentation on STD programme goals and objectives. He pointed out that to achieve a national STD
programme of reducing the prevalence and transmission of STD in the country STD services must have the following objectives:

(1) to make sure that everyone with an STD is given the right treatment;

(2) to find and treat people with an STD who know that they are infected;

(3) to encourage people who think they may have an STD to seek the correct treatment; and

(4) to stop people from getting a new STD including HIV.

The following challenges were identified; it is difficult to stop people from getting STDs or HIV; many people have STDs but do not know it; getting them to seek treatment is difficult, as is providing correct treatment.

Worldwide experience has shown that controlling HIV transmission (itself largely sexually transmitted) needs broad collaboration. It is best if STD control and AIDS control are part of the same programme.

Comprehensive STD care includes information and education about not infecting someone with the current infection, avoiding infections in the future, partner management and condom promotion and use.

Expanding clinics delivering STD services and improving them so that they provided comprehensive care should be a priority for every STD programme manager. The remainder of the course concentrated on how this might be done.

2.5.2 Group work

Participants were asked to complete a grid showing what is happening in their countries to improve and expand STD services and, in particular, what measures had been taken to introduce the syndromic approach.

2.5.2 Plenary session

The results were discussed in a plenary session. It was noted that some of the activities selected under each objective were already in place and many were under development in a number of countries.

2.5.3 During the second session of the day Dr Exon gave a presentation of the current STD services in most countries and suggested ways that these might be improved and expanded.

The advantages and disadvantages of “vertical STD care system” and “horizontal and integrated STD care system” were discussed. It was emphasized that specialized STD clinics, although useful, are not sufficient to provide care accessible to all patients.

Family planning clinics and maternal and child health clinics should also play an important role in STD service delivery. The role played by pharmacists, traditional healers and private physicians was discussed.
Finally, detecting people with asymptomatic STDs can be made through partner notification, case finding and screening.

2.5.4 Group work and plenary

Participants were invited to list settings where any sort of care for STDs is available at present in their country, to list their strengths and weaknesses and to indicate where STD services could be provided. The results were discussed in a plenary session.

2.5.5 Finally, the concepts of vulnerable and core groups for STD were introduced by the Consultant. Participants were invited to identify these groups in their countries and suggest ways in which they might be reached.

2.6. Summary of the sixth day

2.6.1 During the first half of the day, presentations were given on STD policy development, advocacy and development of technical guidelines.

On policy development, the four issues that policy makers need to consider were emphasized:

- how to make sure people can get to clinics treating STDs;
- how to make sure that the services are attractive to the patients;
- how to make sure that patients with symptoms of STDs are managed correctly; and
- how to make sure that clinic staff know the importance of looking for STDs in patients not complaining of symptoms of STDs.

Dr Exon emphasized that when developing policies on improving, expanding and integrating STD services it is essential to involve all relevant sectors. Only if this is done will the different sectors feel part of the new service and understand their role and that of others.

2.6.2 Group work

The participants were asked to discuss what policies and regulations should be considered in their countries for different aspects of providing comprehensive care through an expanded STD service. They were also asked to discuss who they thought should be involved in developing these policies. The outcomes of their discussions were discussed in a plenary session.

The group that discussed drug policies brought up issues of free distribution of drugs in the health centres and of the right of nurses to prescribe (this right has already been introduced in a number of countries).

Most countries have partner referral policies but in the majority it is not possible to contact a high percentage of partners (except in Tonga where education programmes have been implemented) because many patients claim they do not know the names of the partners.
2.7 Summary of the seventh day

The Regional Adviser conducted a plenary session on issues around drug selection, procurement and funding and on operational management and devising workplans for STD programme management.

2.7.1 Points arising during discussion on drugs

Ordering drugs

Most countries base their orders on their previous year's use. Drugs ordered depend on the total needs of the country (i.e. drugs are not ordered by speciality). In other countries, some clinics run out of drugs or use these up before the end of the year, although they can order more.

Selection of drugs is usually based on price (this can be negotiated with supplier or manufacturer and done by the health ministries). No country had purchased drugs through non-profit organizations. Joint purchase has been tried in the past in one country but had been unsuccessful.

Other issues which were raised included drug availability on the market, toxicity or side effects and shelf life.

Many patients and some health care workers prefer to administer drugs by injection rather than orally (partly to ensure compliance and partly because patients believe that injections are more effective). Disposable needles and syringes are widely available.

At present penicillin resistance is not a problem for most of the countries.

Transport and Storage

Participants were aware of the danger of the effect of sunlight on some drugs and the need for drugs to be stored in a cool environment.

Some were aware that attention needs to be paid to the conditions in which drugs are transported. It was suggested that storage conditions in some government warehouses were inadequate.

Distribution

Ensuring regular and reliable delivery to remote islands is a problem.

In many countries there may be considerable (and unpredictable) delays between ordering and delivery due to administrative constraints.

Funding

Funding is a major problem. Some countries charge patients US$2-$5 for consultation and drugs (all conditions). The participants from these countries did not believe that the charges deterred patients with STDs from seeking treatment.
Conclusion

It was agreed that effective drug supply is essential when introducing the syndromic approach and it is essential to ensure a secure drug supply before introducing the syndromic approach.

2.7.2 Points arising during discussions on operational management and devising the Workplan

Operational Management

During the discussion many of the day-to-day operational activities for the programme managers were considered. These are shown in the table below:
<table>
<thead>
<tr>
<th>Elements</th>
<th>Processes / Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Management style</strong></td>
<td>Autocratic/delegating</td>
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<tr>
<td></td>
<td>Proactive/reactive</td>
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<tr>
<td></td>
<td>Facilitating initiative from staff or not</td>
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<tr>
<td></td>
<td>Decision-making process</td>
</tr>
<tr>
<td></td>
<td>Regular consultation with staff</td>
</tr>
<tr>
<td></td>
<td>Allocation of responsibilities</td>
</tr>
<tr>
<td><strong>Field supervision</strong></td>
<td>Site visits to discuss with staff their views on the new working arrangements, their training needs, their beliefs about client/patient satisfaction etc.</td>
</tr>
<tr>
<td><strong>Supplies and materials</strong></td>
<td>Assessment of requirements for clinic equipment, drugs and condoms, their availability and their cost.</td>
</tr>
<tr>
<td></td>
<td>Assessment of the efficiency of the supply process.</td>
</tr>
<tr>
<td><strong>Management information</strong></td>
<td>• Analysis and diffusion of latest scientific and administrative data directly benefiting the implementation of the programme.</td>
</tr>
<tr>
<td></td>
<td>• Flow in both directions, i.e. clinicians and other clinic staff who provide data should be shown how it is used and what it means. This will help them understand why it is important that they collect the data and learn from the evaluation results.</td>
</tr>
<tr>
<td></td>
<td>• Regular newsletter</td>
</tr>
<tr>
<td><strong>Public relations</strong></td>
<td>Regular contacts with;</td>
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<tr>
<td></td>
<td>the media</td>
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<td></td>
<td>leaders (politicians, religious)</td>
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<td></td>
<td>donors</td>
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<td>WHO</td>
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<tr>
<td><strong>Relation with other programmes</strong></td>
<td>Regular contacts regular meeting with;</td>
</tr>
<tr>
<td></td>
<td>Maternal and child health, family planning, tuberculosis programme</td>
</tr>
<tr>
<td></td>
<td>Other ministries involved, NGOs, Churches, etc.</td>
</tr>
</tbody>
</table>

**What to include in the workplan?**

The points discussed include objectives, strategies, activities, interaction with other programmes, person responsible, time frame (every three months), budget/source of funding, evaluation, results/indicators, process, outputs and outcomes as well as research.
One of the participants recommended the use of Gant charts to aid planning. Most participants identified delay in releasing funds as a major problem. The facilitators emphasized, however, that workplans should be both realistic and flexible.

2.8 Review of the course

In the final session of the course participants were asked to list the elements within the three components of the course (Epidemiology, Syndromic Approach, Programme Management) which they considered important. The following elements were identified:

| Drug sensitivity                      | Co-ordination between governments and NGOs |
| Treatment protocols and flowcharts    | Confidentiality                           |
| Training                              | Drug availability                         |
| STD surveillance and reporting        | Expanding STD services                    |
| Health care worker education          | Adoption of syndromic approach            |
| General population education          | Condom promotion                          |
| Patient education                     | Condom availability                       |
| Follow-up information on syndromic approach | Sharing experience/networking        |
| Monitoring                            | Partner management                        |
| Relationship STD/AIDS programmes     | Funding                                   |
| Policy on STDs                        | Working with core groups                  |
| Management                            | Designing workplan                        |

The participants were asked to identify five priority areas. Of these, training issues, STD surveillance, policy formulation and the syndromic approach were identified as the major concerns of 50%-66% of participants.

3. CONCLUSIONS

A decade and a half after the recognition of AIDS the incidence of reported AIDS cases in the Pacific Island countries remains low. So does the prevalence of HIV infection. Nevertheless incidence of other STDs in these countries shows that risky sexual behaviours are widespread.
Because of the morbidity and even mortality associated with sexually transmitted diseases, governments should make STD control programmes a public health priority. The recent confirmation of the links between the presence of other STDs and the transmission of HIV emphasizes the importance of this. In the Pacific Island countries, with their low incidence of AIDS but high prevalence of other STDs, there is an urgent need to improve and expand services for people with STDs, including HIV infection.

This STD programme management course was the first of its kind in the Region. It set out to ensure that participants appreciated that in their countries, as in many others, many cases of STDs are undiagnosed and untreated or are inadequately treated. In view of this there is an urgent need to improve existing STD services and to expand STD services with existing district and primary level services, often by introducing the syndromic approach to the management of sexually transmitted diseases.

The course also emphasized that STD services have an important role to play in limiting the spread of STDs, but to do so, they must do more than provide effective diagnostic and treatments services. Patient education and counselling, partner referral and condom promotion are essential parts of the comprehensive care of a person with an STD.

Formal and informal discussion with the participants and their evaluation of the course showed that the objectives of the course were achieved. Participants particularly liked the participatory nature of the course, with its opportunities to share and discuss their experiences, their successes and the challenges they face.

It was apparent that in general STD services and programme management are already well advanced in all the countries. Most are based on laboratory-supported specialist STD clinics although some countries have introduced the syndromic approach in some settings.

It was apparent too that the participants recognized the appropriateness, in their countries, of improving and expanding services for all STDs, including HIV, rather than concentrating solely on HIV/AIDS prevention.

They identified as priorities:

- Development of policies (and, where appropriate, laws and regulations) on the provision of comprehensive care services for people with STDs (including HIV) and for prevention programmes.

- Development of technical guidelines.

- The need to improve surveillance of STDs.

- Training of health care workers in the syndromic approach to ensure its adoption in appropriate settings.
# LIST OF PARTICIPANTS

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Position/Title</th>
<th>Organization/Location</th>
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</thead>
<tbody>
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<tr>
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<td>Principal Nursing Officer</td>
<td>Health Department Alofi</td>
</tr>
</tbody>
</table>
Annex 1

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Registered Nurse
FWC & STD Clinic
Department of Health
Apia

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Ministry of Health and Medical Services
Honiara

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TUVALU
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Ministry of Health and Human Resources
Development
Funafuti

VANUATU
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Health Department
Port Vila

2. CONSULTANTS

1. Dr John Kaldor
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Level 2, St Vincent's Hospital Medical Centre
376 Victoria Street
Sydney, NSW 2010
Australia
2. Dr Peter Exon  
10a Duke Humphrey Road  
Blackheath, London SE3 0TY  
United Kingdom

3. OBSERVERS/REPRESENTATIVES

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person</th>
<th>Address 1</th>
<th>Address 2</th>
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<tbody>
<tr>
<td>JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS</td>
<td>Mr Stephen Vete</td>
<td>Country Programme Advisor/UNAIDS</td>
<td>c/o UNDP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3rd Floor, ANZ Bldg.</td>
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<td>Fiji</td>
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<tr>
<td>UNITED NATIONS POPULATION FUND</td>
<td>Dr Salesi Katoanga</td>
<td>Officer-in-Charge</td>
<td>UNFPA</td>
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<tr>
<td>UNITED NATIONS CHILDRENS FUND</td>
<td>Ms Benedicte Darras</td>
<td>c/o UNDP</td>
<td>Private Mail Bag</td>
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<td></td>
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<td>Suva</td>
<td>Fiji</td>
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4. SECRETARIAT

Dr G. Poumerol  
Regional Adviser in Sexually Transmitted Diseases and AIDS  
WHO Regional Office for the Western Pacific  
Manila

Dr M. O'Leary  
Medical Officer  
Office of the WHO Representative in the South Pacific  
Suva  
Fiji
Annex I

Ms K. Fritcsh
Nurse Educator
Office of the WHO Representative
in the South Pacific
Suva
Fiji

Dr P.J. Rowe
Special Programme of Research Development
and Research Training in Human Reproduction
World Health Organization
Geneva
Switzerland
## TIMETABLE

<table>
<thead>
<tr>
<th>Time</th>
<th>Thursday, 3 July</th>
<th>Friday, 4 July</th>
<th>Monday, 7 July</th>
<th>Tuesday, 8 July</th>
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<tbody>
<tr>
<td>0700-0800</td>
<td>Facilitators' meeting</td>
<td>Subgroup presentations</td>
<td>9. Objectives of syndromic approach for STD case management: Why it is recommended</td>
<td>WPRO training package: - content</td>
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<td>1015-1045</td>
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<td>7. Issues in behavioural surveillance:</td>
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<td>1400-1600</td>
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<td>13. Review and summary of key issues in STD syndromic case management Evaluation Presentation by RTRC</td>
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<td>1700-1800</td>
<td>Facilitators' Meeting</td>
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## TIMETABLE

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<tr>
<td>0800-1015</td>
<td>14. STD programme management goals</td>
<td>17. Improving and expanding STD care services:</td>
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<td>1015-1045</td>
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<td>1045-1245</td>
<td>15. STD service delivery</td>
<td>Improving and expanding STD care services:</td>
<td>20. STD drug management</td>
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<td>1245-1400</td>
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<td>22. Workshop evaluation</td>
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*Note: TIMETABLE is subject to change and may be updated as necessary.*