

IUSTI

INTERNATIONAL UNION AGAINST
SEXUALLY TRANSMITTED INFECTIONS
AFRICA



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Message from the Regional Director



2007 has been a good year for IUSTI and there have been exciting new developments within all regional branches of the organisation. IUSTI-Latin America, IUSTI-North America and IUSTI-Asia Pacific now have new Regional Directors who are active in their respective regions, namely Roy Chan (Singapore), Patricia Garcia (Peru) and Charlotte Gaydos (USA).

The IUSTI world meeting was held in partnership with the International Society for STD Research (ISSTD) in Seattle at the end of July. The conference was very well attended and the quality of scientific presentations very high. I was pleased to be able to meet both existing IUSTI-AFRICA members as well as to meet other African delegates, some of whom have now joined the growing membership of the African Region.

The joint IUSTI-ISSTD meeting was an ideal venue in which to publicise the next IUSTI world meeting to be held in the African Region in 2009. There are more details about this meeting within this newsletter and also on the IUSTI website. I would like to see as many African delegates as possible at this world meeting and hope to meet many of you in South Africa's beautiful Western Cape in December 2009.

This second newsletter has **Syndromic Management** as its theme, which is the cornerstone of efforts to control STIs in Africa. My thanks go to Professor Ahmed Latif (WHO, formerly Zimbabwe) for his review of the syndromic management approach, Dr. Pierre Yassa, our Zambian IUSTI country lead, for his contribution to this edition's 'Country Focus', to Mr. Sakhile Mhlongo for his informative article on STI surveillance, to Mrs Aulette Goliath for putting it all together, and to Dr Ricky Ilunga (South Africa) and Professor Doctor Filomena Exposto (Portugal) for their assistance in translating the newsletter in French and Portuguese.

The on-going success of the IUSTI-AFRICA newsletter does rely, however, on contributions from our members. If you would like to write a country-focus report on STI-related matters within your country, please send your contributions to Mrs Aulette Goliath, our Administrative secretary. We have made a big effort this year to publish our newsletters in English, French and Portuguese – so please support your Region by sending us through your contributions in any of these languages.

With your support and involvement, I hope that the IUSTI-Africa Region will continue to grow from strength to strength in the year ahead.

Finally, it remains for me to wish you and your families a very happy New Year and lots of success for 2008.

David Lewis

Focus on African Countries: Zambia



Contribution by: Dr Pierre Yassa

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Introduction

Zambia is one of the countries hardest hit by the HIV epidemic, with one of the highest national HIV prevalence rates in sub-Saharan Africa (UNAIDS 2006 World AIDS Report).

The last situation analysis done in 2005 by Nkandu Luo showed a 10% prevalence of sexually transmitted infections (STIs).

In this newsletter, I will present current prevalence of STIs and describe on-going research on STIs in Zambia.

PREVALENCE OF STIs IN ZAMBIA

1. Common STIs identified in Zambia

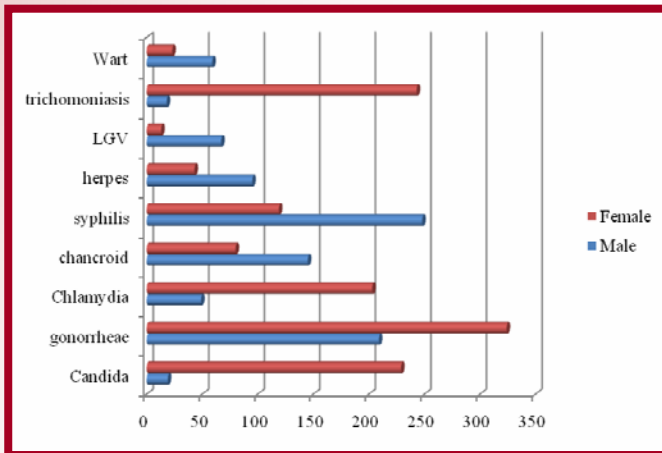


Figure 1: Frequency of STIs detected in Lusaka (Validation study 2004-2005, UTH).

Figure 1 above shows the relative frequency of detection of the common STIs found in Zambia, including gonorrhoea, syphilis, trichomoniasis, chlamydial infection, chancroid, genital herpes.

2. STI syndromes

Since 1995, the Zambian Ministry of Health has adopted the Syndromic Management approach. Figure 2 shows the occurrence of STI syndromes among patients who received treatment at the UTH STI clinic in Lusaka, from National STIs Reference Lab in Lusaka, Zambia.

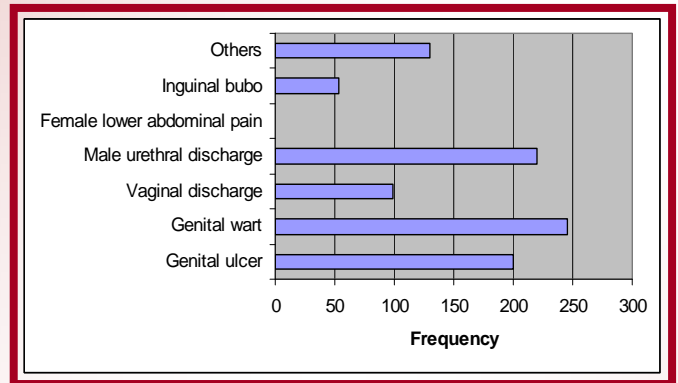


Figure 2: Frequency of STI Syndromes reported at the UTH/STIs Clinic (2007).

Vaginal discharge, genital ulcer, male urethral discharge and female lower abdomen pain syndromes are the commonest syndromes found in Zambia.

RESEARCH

1. Conference Presentations

The following research data has been presented at international conferences:

4th IAS Conference on HIV, Sydney, Australia (2007)

Routine counselling for HIV testing among STI clinic attendees: pilot study at University Teaching Hospital, Lusaka, Zambia [Abstract TUPEC018] Luhana C.F., Yassa P., Malibata C., Macuacua R., Kangwa L., Matembo T., Kimbinyi W., Mwila J.K., Chama G.C.

IUSTI - ISSTD joint meeting, Seattle, USA (2007)

Recent sensitivity patterns of *Neisseria gonorrhoeae* among men with dysuria and/or urethral discharge attending five urban clinics in Lusaka, Zambia [Poster - 443] Y.P. Yassa, C.Malibata, F.C. Luhana, F.C. Linda Kangwa.

2. On-going research

The National STI Reference Laboratory is currently undertaking collaborative research with the International Medical Centre of Japan. The following studies are underway:

- (1) Impact of the number of sexual partners on HIV infection in clients attending UTH Clinic 3/VCT Center in Lusaka.
- (2) An investigation of the psychosocial and contextual risk factors for HIV/AIDS among female STI clinic attendees at University Teaching Hospital, Lusaka.

Syndromic Management: 25 years on

Syndromic management of sexually transmitted infections twenty-five years on

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Introduction

The syndromic approach for the management of sexually transmitted infections (STIs) was developed in order to provide high quality care for persons with STIs at the first point of contact with a health facility without having to wait for laboratory results. Initiated in the early 1980's in Zimbabwe this approach to the management of STIs has become the standard of care for the management of symptomatic persons in many parts of the world.^{1,2,3} The approach has been promoted by the World Health Organization (WHO) as an effective method for the rapid treatment of infected persons to limit the development of complications and to reduce the possibility of transmission to others.⁴ Antimicrobial therapy is guided by local and regional epidemiology and patterns of antimicrobial susceptibility of organisms that cause the infections. In syndromic management patients are treated for all the common infectious causes of their symptoms and signs without waiting for results of laboratory tests. Even when laboratory diagnostic services are available there will be delays in results being reported and patients may not return, hence risking developing complications and transmitting the infection further. The approach does lead to a degree of over-treatment but the benefits of immediate treatment outweigh this disadvantage. Studies have demonstrated the difficulties of making a clinical diagnosis of infection by a specific pathogen based on the clinical picture.^{5,6,7,8,9}

Making a syndromic diagnosis

The syndromic approach to the diagnosis of STIs is based on the fact that a number of sexually transmissible pathogens produce a common pattern of easily recognisable symptoms and signs, hence is only applicable to those who present with symptoms and signs. The syndromic management of STI is based on the identification of the STI-related syndrome, and the provision of treatment that will deal with the majority of organisms responsible for producing the syndrome. The syndromes and their common causes are shown in Table 1.

Table 1: STI-related syndromes and their causes

STI Syndrome	Common causes of the syndrome
Urethral discharge syndrome	<i>Neisseria gonorrhoeae</i> , <i>Chlamydia trachomatis</i> , <i>Trichomonas vaginalis</i>
Genital ulcer syndrome	<i>Treponema pallidum</i> , <i>Haemophilus ducreyi</i> , Herpes simplex virus, <i>Klebsiella granulomatis</i> , <i>Chlamydia trachomatis</i> (types L1, 2 and 3)
Vaginal discharge syndrome	<i>N. gonorrhoeae</i> , <i>C. trachomatis</i> , <i>T. vaginalis</i> , <i>Candida albicans</i> and non-albicans yeasts, bacterial vaginosis
Syndrome of lower abdominal pain/tenderness in women	Pelvic inflammatory disease – caused by <i>N. gonorrhoeae</i> , <i>C. trachomatis</i> and other aerobic and anaerobic bacteria
Syndrome of acute scrotal pain and swelling	<i>N. gonorrhoeae</i> , <i>C. trachomatis</i> and other bacteria and viruses such as <i>Escherichia coli</i> and mumps virus
Suppurative inguinal lymphadenitis syndrome (Bubo)	<i>H. ducreyi</i> , <i>C. trachomatis</i>
Syndrome of neonatal purulent conjunctivitis (ophthalmia neonatorum)	<i>N. gonorrhoeae</i> , <i>C. trachomatis</i> and other pyogenic bacteria

A syndromic diagnosis is made after taking a history from the patient and carrying out a physical examination, which is essential to make a syndromic diagnosis. The diagnosis will, therefore, depend on the clinical findings, for example

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urethral discharge syndrome in a man, or a vaginal discharge syndrome in a woman is only made if a visible urethral or vaginal discharge is found on examination. Similarly, the diagnosis of the syndrome of lower abdominal pain/tenderness is made in a woman only when on examination it is noted that the woman has lower abdominal pain and tenderness. A diagnosis of genital ulcer syndrome and that of inguinal bubo depends on the visualization of the ulcer or the painful, swollen and tender lymph nodes in the groin. Likewise the diagnosis of acute scrotal pain and swelling is made on finding on clinical examination of an acutely swollen and painful testis and that of ophthalmia neonatorum on the finding of conjunctivitis with discharge in a neonate.

Once a syndromic diagnosis has been made it is important to exclude serious conditions that require immediate specialist attention. For this reason clinical management protocols, usually in the form of algorithms, include important steps that allow the clinician to recognise possible complications of STIs as well as to exclude conditions that require immediate specialist referral.

Managing STI syndromes

Clinical management algorithms have been developed for most STI-related syndromes and if followed they provide guidance for the adequate management of infections. However one common syndrome, vaginal discharge in women, is quite complex and needs to be adapted locally in response to local prevalence of infections that cause vaginal discharge. Vaginal discharge may be physiologic or pathologic. Physiologic vaginal discharge is a normal state and does not require treatment. It appears at various times during the menstrual cycle, before, during and after sexual intercourse, and during pregnancy and lactation. Therefore all women should be carefully evaluated if they present with a vaginal discharge. An abnormal or pathologic vaginal discharge may be caused by vaginitis, cervicitis and by infection of the genital tract above the cervix, i.e., pelvic inflammatory disease (PID). In women with symptomatic vaginal discharge it is important to attempt to distinguish whether the patient has vaginitis or cervicitis. From the clinical examination alone it may not be possible to differentiate between these. Vaginitis is generally caused by trichomoniasis and candidiasis, whereas bacterial vaginosis causes vaginal discharge in the absence of marked inflammation; though other, less common, causes of vaginitis should be kept in mind. Cervicitis is usually caused by gonococcal or chlamydial infection. Developing syndromic protocols for management of vaginal discharge that are sensitive and specific for STIs in a range of settings has proven particularly difficult.¹⁰

The WHO advises that in women with vaginal discharge a rapid behavioural and demographic screen should be carried out and has identified certain factors that are predictive of cervicitis.⁴ These risk factors are:

- The patient states that her partner has an STI
- The patient is aged less than 20 years
- The patient is unmarried
- The patient has had sex with a new partner in the last 3 months
- The patient has had sex with more than one partner in the last 3 months

WHO advises that a woman with vaginal discharge has a positive risk assessment for cervicitis if she states that her partner is symptomatic or if she has any two of the other risks listed.

Syndromic management algorithms for managing vaginal discharge when it is possible to perform a speculum examination and to carry out simple laboratory tests have also been developed.³

In men and women presenting with discharge, dual treatment for gonorrhoea and Chlamydia is now widely recommended since affordable single-dose therapy with minimal side effects is available to treat both infections adequately and also because the two infections often co-exist. Syndromic management protocols will vary according to local patterns of infection and antibiotic susceptibility of micro-organisms responsible for the symptoms and signs.

1. Management of urethral discharge in men

Common causes of urethral discharge in men include *N gonorrhoeae* and *C trachomatis*. In the syndromic management of men with urethral discharge treatment should adequately cover the two organisms. A history should be taken and the patient should be examined to determine whether urethral discharge is present or whether there is any other STI. If urethral discharge is found then the patient should be treated for gonorrhoea and Chlamydia. If any other STI is found the patient should be treated appropriately.

2. Management of persistent or recurrent urethral discharge in men

Urethral discharge in men may persist or recur. If a person has been treated adequately for urethral discharge and presents with a recurrence or persistent discharge the reasons may be that he has become re-infected, he has not taken his treatment as prescribed, he has a resistant infection, or that the cause of the infection may not have been gonococcal or chlamydial infection. Men with recurrent or persistent symptoms should be examined that they do have a discharge. If a urethral discharge is present the patient should be re-treated if it is likely that re-infection or poor treatment compliance

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has occurred or given treatment for trichomoniasis if re-infection is unlikely and treatment compliance has been adequate.

3. Management of vaginal discharge in women

Women presenting with a history of vaginal discharge should have a history taken, a risk assessment for cervicitis carried out and should be examined. If it is possible, a speculum examination should be performed. A spontaneous complaint of abnormal vaginal discharge, i.e., abnormal in terms of quantity, colour or odour, is most commonly due to a vaginal infection. Rarely, it may be the result of muco-purulent STI-related cervicitis. *Trichomonas vaginalis*, *Candida albicans* and bacterial vaginosis are the commonest causes of vaginal infection while *N. gonorrhoeae* and *C. trachomatis* cause cervical infection. The clinical detection of cervical infection is difficult because of the asymptomatic nature of gonococcal or chlamydial cervical infection. The symptom of abnormal vaginal discharge is poorly predictive for cervical infection.³ The World Health Organization recommends that all women presenting with vaginal discharge should receive treatment for trichomoniasis and bacterial vaginosis. However women with vaginal discharge who have a positive risk assessment for cervicitis should also be treated for gonococcal and chlamydial infection.

4. Management of genital ulcers in men and women

The prevalence of pathogens responsible for genital ulcer disease varies considerably according to geographic region. The clinical differentiation of cause of genital ulcers is inaccurate, hence management of genital ulcers is based on an understanding of the epidemiology and aetiology of genital ulcers locally and recommendations should be based on local patterns of disease prevalence. In areas where both syphilis and chancroid are prevalent it is advisable to treat all patients with genital ulcers for both conditions initially. In areas where granuloma inguinale is also prevalent, treatment for this condition should also be included. In many parts of the world, genital herpes is the most common cause of genital ulcers and in areas where HIV infection is prevalent an increasing portion of cases of genital ulcer disease is caused by herpes simplex virus.

It is therefore recommended that in the syndromic management of genital ulcer disease patients are treated for syphilis PLUS either treatment for chancroid if chancroid is prevalent, or treatment for granuloma inguinale if granuloma inguinale is prevalent, or treatment for lymphogranuloma venereum if lymphogranuloma venereum is prevalent.

There is no known cure for genital herpes; however the course of the illness and the symptoms may be modified with antiviral treatment. In patients with symptoms and signs suggestive of genital herpes, it is important to establish whether the episode is the first clinical episode. In up to one third of patients the first apparent clinical episode is actually a reactivation of an existing infection. Patients with a first clinical episode of genital herpes should be a course of anti herpes virus treatment. Most patients with a first-episode of genital herpes simplex virus (HSV) infection, particularly of HSV type 2, will have recurrent episodes of genital lesions. Episodic or suppressive antiviral therapy will shorten the duration of genital lesions. This needs to be discussed with patients who should be advised to start treatment as soon as symptoms of recurrence begin.

5. Management of pelvic inflammatory disease (PID)

Women with lower abdominal pain and/or tenderness should be examined carefully to exclude surgical or gynaecologic conditions requiring immediate referral for specialist care. If the patient needs to be resuscitated then resuscitatory measures should be applied before transfer and an intravenous line should be set up. The following women with lower abdominal pain and/or tenderness should be referred for specialist opinion:

- the diagnosis is uncertain;
- surgical emergencies such as appendicitis and ectopic pregnancy can not be excluded;
- a pelvic abscess is suspected;
- severe illness precludes management on an outpatient basis;
- the patient is pregnant;
- the patient is unable to follow or tolerate an outpatient regimen; or
- the patient has failed to respond to outpatient therapy.

Women who have acute PID and are not in any of the above categories should receive treatment for gonococcal, chlamydial and anaerobic bacterial infection.

6. Management of acute scrotal swelling

Acute epididymo-orchitis should be suspected in all men presenting with acute scrotal swelling and pain. However other causes, including surgical emergencies such as testicular torsion, traumatic haematocele and irreducible or strangulated inguinal herniae, should be excluded through careful history taking and examination. In men with acute epididymo-orchitis

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treatment for gonorrhoea and chlamydial infection should be given.

7. Management of suppurative inguinal lymphadenitis (Bubo)

Inguinal and femoral buboes are enlargements of the lymph nodes in the inguinal regions and the femoral triangles of the body. They are caused by inflammation of lymph nodes and may lead to the formation of unilocular or multilocular abscesses. Buboes are frequently associated with lymphogranuloma venereum and chancroid. However buboes may also occur in non-sexually transmitted infections, including infected lesions on the lower extremities and in some systemic infections as well. Patients with buboes should be managed for chancroid and lymphogranuloma venereum. Patients in whom buboes have become fluctuant require needle aspiration of the pus.

8. Management of the syndrome of purulent neonatal conjunctivitis

Purulent neonatal conjunctivitis, ophthalmia neonatorum, is defined as conjunctivitis with discharge occurring during the first month of life. Common causes include bacterial infection, and gonococcal or chlamydial infection. All neonates with purulent conjunctivitis should be treated for gonococcal and chlamydial infections.

Provision of comprehensive STI care

Regardless of the method used to make a diagnosis of STI, all patients with STIs and those that suspect they may have an STI should be offered comprehensive STI care. The simple provision of antibiotics for a sexually transmitted infection is not sufficient. The STI consultation provides an ideal opportunity to institute interventions to prevent future acquisition of infection and to prevent further transmission. The patient-clinician encounter should be used as an opportunity to provide education on the nature of infection, its mode of transmission and possible complications. In addition during the encounter the patient's perception of risk and reasons for engaging in un-safe activity should be assessed and then the patient should be counselled on risk reduction. The patient should also be educated on the correct use of condoms, and the association between STIs and HIV infection. Patients should also understand the importance of having partners treated and the procedure of partner notification and contact tracing and treatment should be initiated. Finally the patient should be educated on how to prevent becoming infected in future through modifying sexual behaviour, i.e., sexual abstinence, having sex only with a mutually faithful lifelong partner, or using condoms. It is important to bear in mind that patients with STI have put themselves at risk of becoming infected with HIV as well and all patients should offered voluntary confidential counselling and testing for HIV. It is important to remember that if the HIV test is negative then it should be repeated in 3 months time to allow for the seroconversion window period. Hence in post-test counselling of persons found to have a negative initial HIV test possibility of infection being present should be explained and the patient is advised to engage in protected sexual activity until the repeat HIV test has been carried out.

Concluding remarks

Twenty-five after its inception, the syndromic management of STIs is practiced widely throughout the world in developed and developing countries. The method does not rely on laboratory tests and patients with STIs may be managed adequately at the first point of care. The method is acceptable to patients as they are provided with treatment immediately and are rendered free of symptoms as quickly as possible. The approach does carry some over-treatment but in view of the seriousness of the infections this is considered acceptable. The success of implementing the approach depends on prior knowledge of the aetiology of STI syndromes and antimicrobial susceptibility of causative organisms. There is a need to train health care providers in using this approach and most undergraduate and post-graduate medical and nursing training curricula throughout the world have included this approach in their programmes. The syndromic approach requires that the patient is interviewed and is examined carefully. The approach is not without problems, the chief of which is treating a person for an STI when an STI is not present together with associated problems of treating contacts. In the management of vaginal discharge syndrome in women this poses a real problem especially when demographic characteristics are used as risk factors. Studies have shown that through the use of the syndromic approach in managing STIs incidence rates of syphilis and HIV infection may be reduced considerably .

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IUSTI World News

Key news points from the November 2007 edition of **STI Global Update** include:

IUSTI had two very successful meetings in 2007.

- Joint meeting of the **17th ISSSTD** – **10th IUSTI World Congress, July 29 to August 1**, held in Seattle, USA. An estimated 1200 participants from around the world attended this big global STI event, organized by Dr Hunter Handsfield and the local organizing committee in cooperation with IUSTI. Participants gathered to discuss aspects of STI-related science, clinical epidemiological topics as well as recent developments in STI research. IUSTI held a special symposium with interesting contributions from all 5 regional branches. Excellent scientific programmes were presented through-out, as well as an active social program. The Executive Committee (EC) had its annual meeting in Seattle. Discussions took place concerning the further strategy of IUSTI, the regional structures, change of the membership strategy, future world meetings and the members of the Executive Committee.
- The IUSTI European branch held its annual conference, the **23rd IUSTI-Europe Conference** on STIs and HIV/AIDS, in Cavtat/Dubrovnik, Croatia. The conference was organized by Prof. Mihael Skerlev and was well attended with an impressive scientific programme.

IUSTI website

- The IUSTI website now conforms to the new IUSTI visual identity.
- The main issue to be sorted out is the provision of a convenient on-line credit / debit card web-based facility with an encrypted link to a commercial secure payment system for membership applications and renewals.
- The secure payment systems will hopefully be in place by the middle of 2008.
- Plans are to develop a new privacy policy to ensure that all relevant data protection standards are being met and will lay the foundation for a secure membership services area on the IUSTI website.
- The views of African members are very important, so please send your suggestions to Prof. Michael Ward (webmaster) at webmaster@iusti.org



Challenges for Africa

Summary of address given by Professor David Lewis, IUSTI-Africa Regional Director, at the IUSTI Global Challenges Symposium (ISSTD 2007/10th IUSTI World Congress)

Africa is the continent most affected by HIV/AIDS with an estimated 24.7 million HIV-infected individuals in the Sub-Saharan Region (UNAIDS, 2006). In addition, in 1999 it was estimated by the World Health Organisation (WHO) that the African Sub-Saharan Region had 69 million cases of treatable bacterial and protozoan sexually transmitted infections (STIs), i.e. syphilis, gonorrhoea, chlamydial infection and trichomoniasis. This equates to 63% of global HIV cases and 20% of global treatable STI cases.

The WHO has now launched its 'Global Strategy for the Prevention and Control of STIs: 2006-2015'. This document has both technical and advocacy sections and provides a unique opportunity to try and improve the quality of STI services and STI strategic information on the African continent. The envisioned strategic goals outlined in this document will only become reality if advocacy is successful; there is a need to engage politicians, to mobilise funds, to utilise existing resources effectively and to deal with the lack of capacity and institutional knowledge often lacking in the African Region. Training of staff is a key pillar for improved quality of STI service delivery. The WHO-UNFPA Strategic Partnership Programme has created some very useful training manuals that are being evaluated in field trials in 8 African countries at the present time.



Prof. David Lewis talking at the World AIDS Day in Alexandra Township, South Africa

The African Region lacks effective and timely clinical and microbiological STI surveillance initiatives. South Africa has recently established a national STI microbiological surveillance programme. Initial data have confirmed the rapid spread of ciprofloxacin resistant gonococci within several South African cities as well as highlighted the high HIV co-infection rates in patients with common STI syndromes such as urethral discharge in men and vaginal discharge in women.

The syndromic management approach has contributed to the decline in chancroid and syphilis among men with genital ulcers within South Africa. Whilst this has been seen as a 'success', the replacement of easily treatable chancroid by recurrent genital herpes in the context of an HIV epidemic has created new challenges for the control of genital ulcer disease. At present, even in a middle-income country like South Africa, there is an absence of acyclovir in the genital ulcer syndromic management algorithm for the treatment of this syndrome in STI clinic attendees. A recent, as yet unpublished, randomised placebo-controlled trial of acyclovir in South Africa has shown an overall benefit of acyclovir in improving ulcer healing among all patients with genital ulcers by 2-3 days, as well as a decrease in the prevalence and quantity of HIV shedding from the sores.

The decline in maternal syphilis, as determined by antenatal RPR screening, has been observed as a success in many African countries. Again, this is likely due in the major part to effective screening and the use of the syndromic management approach, but other factors are also likely to have played a role, including improved access to healthcare in some communities and behaviour change and improved condom use in response to the HIV epidemic. However, healthcare staff and policy makers must not be complacent as there remains a need to improve prevention efforts for congenital syphilis, which still occurs at unacceptably high rates in Africa and for which a cost-effective intervention is available.

There are now data from Uganda that the abstinence approach alone is not working in terms of preventing new HIV infections. Whilst this was predictable to those of us who work with STI patients at the grass-roots level, it has taken clear research outcomes to convince funders that it is very important to include condom promotion in all STI interventions among sexually active individuals.

Many Africans are still without access to anti-retroviral (ARV) drugs despite 63% of the global burden being within the Sub-Saharan Africa Region. There is much work to be done in terms of negotiating cheaper prices for ARVs and providing African countries with cheap and affordable HIV medicines. In addition, there is a need for Governments within the Region to de-politicize HIV/AIDS and to discuss HIV issues more openly in an attempt to reduce stigma. Many believe that there is a need to move away from single dose nevirapine regimens within prevention of mother-to-child transmission programmes in order to avoid future non-nucleoside reverse transcriptase inhibitor drug resistance for the mother and baby.

Finally, the importance of gender-based approaches to HIV care and prevention and the human rights of sex workers, men who have sex with men, and adolescents should not be forgotten within the continent. These are important areas requiring attention within national sexual health programmes.



SURVEILLANCE OF SEXUALLY TRANSMITTED INFECTIONS

AN OVERVIEW

Contribution by:

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INTRODUCTION

In 2005, WHO estimated 2.7 million new cases of HIV with 2 million deaths. Currently, Sub-Saharan Africa has the greatest burden of disease with an estimated 24.5 million infected individuals¹. Transmission of HIV is predominantly by heterosexual contact in Sub-Saharan Africa, where sexually transmitted infections are also common². Epidemiological studies show evidence that STIs significantly increase the risk of acquiring HIV^{3,4,5}. In addition, some STIs have devastating effects particularly among women for example, pelvic inflammatory disease, mainly caused by gonorrhoea and chlamydial infections, have serious sequelae of chronic pelvic pain, infertility, ectopic pregnancy and potential death⁶. Surveillance of STIs especially in Africa, is therefore without doubt a key priority area in the management of STIs and HIV/AIDS.

In resource-limited countries syndromic case management remains the primary approach for the management of STIs. Some of the STI syndromes, particularly male urethritis syndrome (MUS) and genital ulcer syndrome (GUS), are strongly associated with a sexually transmitted aetiological agent. However, other syndromes like vaginal discharge syndrome (VDS) are poor indicators of STIs and are often caused by other pathogens which are not sexually transmitted. As a result it is important to perform microbiological laboratory testing to allow a better understanding of the STI burden represented by the various syndromes.

STI surveillance is therefore considered by WHO/UNAIDS to be a key component of second generation HIV/AIDS surveillance systems and surveillance data is essential for the formulation of disease policies and treatment guidelines⁷.

STI SURVEILLANCE COMPONENTS

The WHO Communicable Diseases Surveillance and Response provides comprehensive guidelines for STI surveillance and this is available in the WHO/CSR Web site.

As stated in the WHO guidelines, there are five components for effective surveillance:

Case reporting

STIs may be reported either syndromically or aetiologically, depending on the availability of laboratory facilities in clinical care settings. In most developing countries, syndromic case reporting is the only option.

Prevalence assessment and monitoring

The primary aim of prevalence assessment is to identify population subgroups with high prevalence of STIs and to monitor trends in STI prevalence among defined populations.

Assessment of syndrome aetiologies

Assessment of syndrome aetiologies complements syndromic case reporting using laboratory testing to identify specific pathogens that cause the syndromes. In women for example, in most cases discharge may occur as result of normal physiological discharge whereas in men it is most likely to be caused by an STI pathogen.

Antimicrobial resistance monitoring

With the increasing rates of resistance of gonococcal infections to drug treatment, it is important, especially in countries with high STI rates to monitor antimicrobial resistance so as to upgrade guidelines for treatment and detect newly emerging resistance.

Surveillance on STIs

Special studies as part of STI surveillance

In addition to routine STI surveillance there are other surveillance-related studies that can be useful in strengthening an STI surveillance programme. Depending on what questions need to be answered the need and frequency of these studies may vary⁷.

STI SURVEILLANCE IN SOUTH AFRICA

With nearly 2 million new episodes of STIs treated in the public sector between 2000 and 2002 annually, the STI/HIV Prevention Unit of the National Department of Health, STIRC (NICD) and the Reproductive Health and HIV Research Unit (RHRU) of the University of the Witwatersrand, in conjunction with provincial Health departments adopted the WHO guidelines for STI surveillance and established a National STI Surveillance Programme for South Africa. Currently, the comprehensive surveillance system for STIs in South Africa is made up of three components namely:

National Indicators Data Set (NIDS)

NIDS contain 5 data elements on STIs and these are collected routinely from all primary health care (PHC) facilities and level one hospitals in the country. The data elements are:

- Total STI episodes
- MUS
- STI partner notification rate
- STI partner treatment rate
- Condom distribution

Sentinel clinical surveillance

Detailed clinical STI data are collected from a selected number of PHC facilities (270 sentinel sites) in the country. These data are captured on the district health information system and are used to report:

- STI incidence rates in all provinces
- Relative prevalence of major STI syndromes
- Age distribution of total STI syndromes in men and women
- Patient referral patterns
- Partner tracing rates
- Stocks-out rates of major STI drugs used in PHC facilities across the country

Microbiological surveillance

Microbiological surveillance is composed of periodic surveys of syndrome aetiology and drug resistance monitoring.

MONITORING AND EVALUATION OF STI SURVEILLANCE SYSTEMS

Monitoring and evaluation is necessary for tracking information on reporting, promptness in data flow and for identifying problems within the STI surveillance programme. This is especially important for clinical surveillance which is based only on syndromic management of STIs. Key components in monitoring and evaluation of STI surveillance are:

- Data collection and reporting
- Data capture and management
- Data analyses and feedback
- Information utilization
- Data quality assurance

Although data obtained through routine public health surveillance activities need to be interpreted in view of their biases and limitations, they can provide valuable information on disease burden and aspects of programme services⁷. Collaborations between health care providers, governmental health departments and reference laboratories are therefore without doubt an important step towards strengthening STI surveillance in a country.

To access the Guidelines for STI surveillance document please visit the WHO Web site at <http://www.who.int/emc>

Surveillance on STIs

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IUSTI-AFRICA member wins best poster prize at the Seattle ISSTD-World IUSTI Meeting, July 2007



Congratulations to Mr. Frans Radebe, of the Sexually Transmitted Infections Reference Centre at the South African National Institute for Communicable Diseases, who won an IUSTI prize and medal for the best poster at the recent joint meeting of the International Society for Sexually Transmitted Diseases Research (ISSTD) and the International Union against Sexually Transmitted Infections (IUSTI) in Seattle. The conference attracted approximately 1,300 delegates, and over 600 abstracts were accepted for poster presentation. Frans Radebe's poster was entitled "Early detection of HIV-1 specific lymphocyte derived antibodies in a high risk population". The poster described results from a novel test, manufactured by PlasmAcute AS in Norway, to detect immature antibodies among miners and detected seroconversions at the same time, or in one subject, before detection of plasma HIV-1 RNA. **Well done, Frans!**



15th International Conference on AIDS and STIs in Africa

DAKAR, Senegal

December
3-7, 2008

IMPORTANT: Please note that the dates for this conference have been changed to December 3-7, 2008

Preparations are well underway for the 15th ICASA, to be held in Dakar, Senegal, between December 3-7, 2008. The secretariat has been working hard on fundraising and mobilisation of resources, as well as organisation and logistics for the conference.

The hotel Le Méridien Président has been chosen as the conference venue. The convention centre contains a 900 seat amphitheatre, a 450 seat conference room, two 300-seat conference rooms and several other rooms with capacity for more than 100 participants per room. For the plenary lectures, which may need to cater for up to 5,000 delegates, the local organising committee has contracted the services of a company specialising in the construction of temporary structures. The plan is to erect two large structures, each capable of housing a further 1,000 delegates. The plenary lectures will be held in the amphitheatre and broadcast live to all conference rooms and the two temporary structures.

For registrations and accommodation, state of the art conference management software has been chosen which will allow organisation of accommodations, abstract submissions and reviews, as well as communication with speakers in real time. The conference organisers report that they have set up a system of secure online payment via credit card which will be linked to the conference management software.

The Local Organising Committee has developed a conference website which is to be found at <http://www.icasadakar2008.org/>. Please look at the website for more information.

IUSTI-AFRICA will continue to keep members updated on the conference preparations.

We encourage you to attend this important conference for Africa at which both STIs and HIV/AIDS related issues will be discussed and debated.

Travel tip from the IUSTI-AFRICA Regional Director

For those of our members planning to attend the ICASA 2008 conference, consider placing a trip to Gorée Island (Île de Gorée) on your itinerary. There are several daily ferries to and from the island which can be visited as a day trip from Dakar. The island is a historical place that is today filled with a calm atmosphere as one strolls down tiny streets with quaintly painted houses covered with bougainvillea. However, the colonial splendour of the buildings bears witness to the island's less romantic past – a key role in the Atlantic slave trade. A trip to the island should not be missed – many famous visitors have also made the trip and some of their photographs can be seen in the curator's shop in the House of Slaves (Maison des Esclaves).



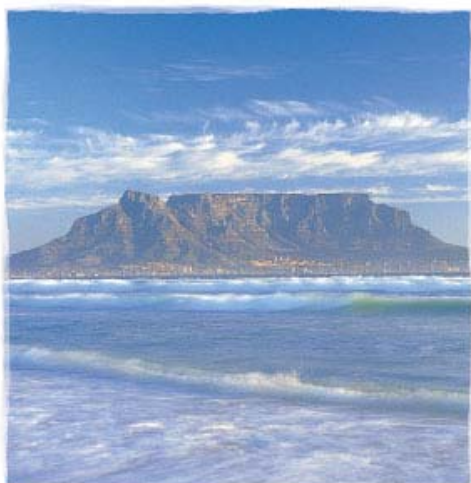
Street scene on Gorée Island



The House of Slaves (Maison des Esclaves) with the door onto the sea through which slaves were sent across the Atlantic.



The curator showing original chains put on slaves at the House of Slaves



**11th IUSTI
world
congress
Africa
2009**
**9-12 November
Cape Town
South Africa**

For further information contact

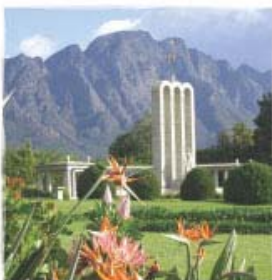
IUSTI Congress Office

Telephone: +27 (0)11 447 3876

Fax: +27 (0)11 442 8094

Email: suemc@icon.co.za

Website: www.iusti.org



Forthcoming Events

Conferences in Africa:

3rd Africa conference on Sexual Health and Rights - Sexuality, Poverty and Accountability in Africa:
Abuja, Nigeria: 4 - 7 February 2008: <http://africalsexuality.org>

15th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) 2008:
Dakar, Senegal: 3 - 7 December 2008: www.icasadakar2008.org

International AIDS Society Conference
Cape Town, South Africa, 19 - 22 July 2009: www.ias2009.org

11th IUSTI World Congress - Africa 2009:
Cape Town, South Africa: 9 - 11 November 2009: www.iusti.org

International conferences:

International Conference on Opportunistic Pathogens in AIDS:
New Delhi, India: 27 - 29 January 2008: www.icopa-india.org

15th IUSTI-Asia - Pacific Congress:
Dubai, UAE: 3 - 5 February 2008: www.iusti.ae

15th Conference on Retroviruses and Opportunistic Infections
Boston, USA: 3 - 6 February 2008: www.retroconference.org/2008/

STD Prevention Conference: Confronting Challenges, Applying Solutions-ASTDA/CDC
Chicago, USA: 10 - 13 March 2008: www.cdc.gov/stdconference/

IUSTI-N America - ASTDA-BASHH Joint Meeting
New York, USA: 7 - 10 May 2008: www.astda.org

6th meeting, European Society for Chlamydia Research
Aarhus, Denmark: 1 - 4 July 2008: www.chlamydia.au.dk/english

XVII International AIDS Conference:
Mexico City, Mexico: 3 - 8 August 2008: www.aids2008.org

24th IUSTI-Europe Conference:
Milan, Italy: 4 - 6 September 2008: www.oic.it/iusti-europe2008

17th EADV Congress:
Paris, France: 17 - 21 September 2008: www.eadv.org

25th International Papillomavirus Conference:
Malmo, Sweden: 8 - 14 May 2009: www.hpv2009.org

International Society for Sexually Transmitted Diseases Research:
London, United Kingdom: 28 June - 1 July 2009: www.isstdr.org/index.php?id=62

The Diagnosis and Management of Sexually Transmitted Infections in Southern Africa.

Authors:
Ron Ballard
Ye Htun
Glenda Fehler
Graham Nielsen



72 pages
Paperback

Price:
\$5 or ZAR 30
excluding postage

INTRODUCTION

- a rapid reference for health workers who may encounter diagnostic problems in this particular disease area;
- to emphasize the role which laboratory investigations can play in the establishment of a definitive diagnosis in cases of STI;
- to provide a rational basis for the treatment of these diseases in southern Africa.

FEATURES

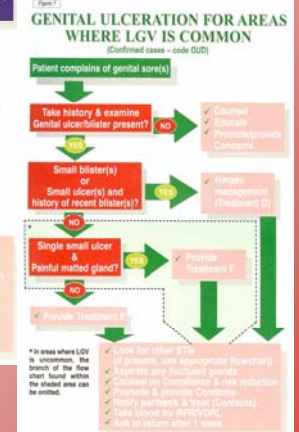
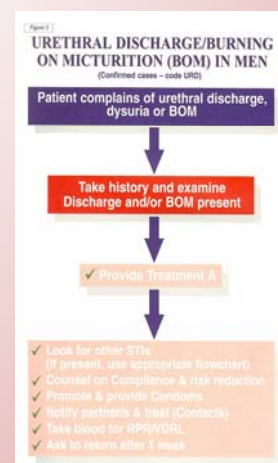
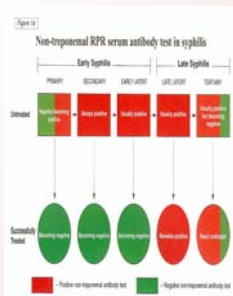
- 79 colour plates and 10 treatment flowcharts
- Suitable for the health worker, medical student, medical officer and/or post graduate student
- Use as a teaching/training guide

CONTENTS

- Disease specific management of STIs- *Gonorrhoea, Syphilis, Genital herpes, Chancroid, Genital warts, Pubic lice, etc.*
- Syndromic management of sexually transmitted infections - *Mixed infections, Syndromic management flowcharts, STIs in gay men, etc.*

For orders, please contact:

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 Email: iusti-africa@nicd.ac.za



Online membership registration on the website www.iusti.org is temporarily inaccessible due to on-going initiatives to improve the IUSTI website for members.

There are three types of membership for IUSTI- AFRICA:

- a) **Full Membership of IUSTI-AFRICA** is open to individuals who have a professional interest in the study, prevention and control of sexually transmitted infections. A medical qualification is not a requirement for full membership. Full membership of IUSTI requires a nominal fee of **40 EUROs every 2 years**. Full members of the union will be entitled to the privileges of membership, which include a reduction in registration fees at most IUSTI regional and world meetings. The membership fee has been set so that it will be attractive to anyone who participates regularly in IUSTI events. We anticipate that any member who attends at least one meeting every two years would re-coup their membership dues.

Full members will also receive a substantial discount of 40% on a subscription to the Union's official journal, the International Journal of STD and AIDS. Subscribers also benefit from free access to the online version of the journal and archive dating back to 1996. To find out more about the journal visit <http://www.rsmppress.co.uk/std.htm>. To subscribe at the special IUSTI rate visit <http://www.rsmppress.co.uk/specialoffers/iusti.htm> or call the journals subscriptions department on +44 (0) 207 2902927/8.

Moreover, the database of full members will be available in an edited form to the World Health Organization (WHO) and on the web for individuals seeking to recruit experts to assist as advisers etc. in specialist STI work.

There are two payment options for full membership:

1. An electronic bank deposit – for your currency conversion to South African Rand (ZAR) ,
please email: iusti-africa@nicd.ac.za

Payment can be done electronically or as a bank transfer into the following account;

IUSTI Africa, Standard Bank Ltd, Jan Smuts Avenue, Rosebank, South Africa

account number: 006988407 sort code: 004205 swiftcode: SBZAJJ.

Should you choose this option, please fax us a copy of deposit slip with your completed IUSTI-Africa application form.

2. Credit card payment (details to be completed on application form and faxed to us at Fax no: + 27 11 555 0470)
- b) **Associate membership of IUSTI-AFRICA** is open to individuals who would like to maintain a corresponding link with the IUSTI-Africa network. Associate membership is **FREE** and not linked to the payment of any membership dues. Associate members may participate in meetings of the Union without voting rights. As an **A s s o c i a t e** member of IUSTI-Africa, you will continue to receive the **IUSTI-Africa Newsletter**.
- c) **Organisational Membership of IUSTI-AFRICA** is also open to organizations, such as national organisations for the study of sexually transmitted diseases. The membership fee for organisations is **200 EUROs every two years**.

Suggestions, Comments, Feedback ...

We welcome your suggestions and feedback on the newsletter. Please direct your comments to the:

Administrative Secretary at iusti-africa@nicd.ac.za