

**Ministry of Health
Romania**

**National Strategy for the Prevention
and Control of
Sexually Transmitted Infections**

2003

The purpose of this national strategy is to contribute to the improvement of the health status of the population and in particular to the improvement of the reproductive health in Romania by preventing and controlling sexually transmitted infections, as well as by providing infected and affected people with equitable access to complex, integrated quality health care services.

Through the national strategy for the prevention and control of sexually transmitted infections, the Ministry of Health answers to a public health priority in Romania. Over the last ten years, the incidence of sexually transmitted infections has risen constantly, and in order to control this phenomenon, it is necessary to develop a complex inter-sector approach. The strategy provides the framework for the development and coordination of programs and interventions in prevention, epidemiological surveillance and health care provision for sexually transmitted infections by defining general and specific objectives and the main priority action areas to be undertaken between 2004 and 2006. The strategy also provides the necessary framework for the development and adjustment of existing Romanian regulations to correspond to European ones, as a step toward joining the European Union.

This national strategy follows the principles and recommendations of the World Health Organization and conforms to the Strategy of the Ministry of Health for Reproductive Health, to the HIV/AIDS National Strategy 2001-2003, and to other initiatives in this sector supported by the Ministry of Health.

In order to achieve these objectives, the Ministry of Health will promote and support collaboration with other Ministries, with the representatives of civil society, and with international organizations that provide technical and financial support for the development of the health care system in Romania. We believe that by working together we will succeed in achieving our goal to the benefit of the public health in Romania.

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List of the abbreviations used in the text

BCC	Behavior Change Communication
CHCSMDC	Computing, Health Care Statistics and Medical Documentation Center
CDC	Center for Diseases Control and Prevention Atlanta
CEE	Central and East Europe
CIS	Community of Independent States
CS	Congenital Syphilis
CSW	Commercial sex workers
EC	European Community
EU	European Union
DPHA	District Public Health Authority
DV	dermato-venereologist
FTA	Abs Fluorescent Treponemic Antibody Absorption (treponemic test)
GDPHSSI	General Directorate for Public Health and State Sanitary Inspection, MOH
HIV	Human Immunodeficiency Virus
IEC	Information-Education-Communication
JSI	JSI Research & Training Institute
MSM	Man having sex with man
MOH	Ministry of Health
NHIH	National Health Insurance House
WHO	World Health Organization
NGOs	Non-governmental organizations
RPR	Rapid Plasma Reagin test (non-treponemic test)
STI	Sexually Transmitted Infections
TPHA	Treponema Pallidum Hemmaglutination Assay (treponemic test)
UNAIDS	United Nations Fund for AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDRL	Venereal Diseases Research Laboratories (non-treponemic test)

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INTRODUCTION

The incidence of sexually transmitted infections is constantly rising in Romania, STI representing now a public health priority. Therefore, the strategy of the Ministry of Health aims to contribute to the improvement of the health status of the population by preventing and controlling sexually transmitted infections, as well as by providing equitable access to complex, integrated quality health care services to infected and affected people.

The following principles lie at the basis of the strategy of preventing and confronting sexually transmitted infections:

- Sexually transmitted infections represent a priority in public health. Not only are they a major cause of morbidity in the adult population, with potential complications ranging from infertility to cervical cancer, serious health problems in newborns, and premature death, but they also have significant social and economic consequences.
- There is a close connection between sexually transmitted infections and the transmission of the HIV virus through sexual intercourse. Therefore, the treatment of sexually transmitted infections is a component of the strategy of HIV infection prevention.
- To approach this issue only from the health care point of view has proved to be ineffective, as sexually transmitted infections continue to represent a public health care issue in both developed countries and transitioning countries. It is necessary to develop an integrated inter-sector approach to the services provided to infected and affected people, and special attention should be paid to primary prevention.
- The state guarantees the right to health to all its citizens, as well as fair universal access to health care. Medical services provided to people affected by sexually transmitted infections must be accessible, acceptable and effective. This can be achieved only through increased involvement of family physicians. Special attention must be paid to pregnant women and young people.
- Various international surveys show that the maximum incidence of sexually transmitted infections is found in the population group aged between 14 and 29. Special programs of prevention and access to specialized services need to be developed for teenagers / young people, as well as for vulnerable or marginalized groups (convicts, soldiers, commercial sex workers, man having sex with man, Roma population) after conducting studies to identify the most appropriate methods to reach these target groups.
- This strategy follows the principles and recommendations of the WHO and conforms to the Strategy of the MOH for Reproductive Health, the HIV/AIDS National Strategy 2001-2003, the UNFPA program “Support for Reproductive Health and Sexuality in Romania”, “The Romanian Family Health Initiative” financed by USAID and implemented by JSI Research and Training Institute (JSI), the STI component of the World Bank program for health in Romania, and other initiatives in this field supported by the Ministry of Health.

Therefore, the guidelines included in the “public health module” recommended by WHO and UNAIDS are adopted as priority strategic actions for the prevention and control of sexually transmitted infections:

- To promote low-risk sexual behavior;
- To encourage infected and affected people to use integrated health care services to a greater extent
- To integrate the fight against sexually transmitted infections into primary health care as well as into other health care services
- To develop and tailor services to the needs of high-risk population groups
- To approach the health care provided to infected and affected persons in a comprehensive and complex manner
- To prevent and treat congenital syphilis and neonatal conjunctivitis
- To detect symptomatic and asymptomatic infections in an early phase.

Here are the key elements for successful implementation of this strategy:

- To reach consensus on the present strategy and the Priority action areas and subsequent activities, especially among the healthcare providers.
- To develop and implement an action plan for the next three years to include the necessary activities to achieve the proposed goal, responsibilities for each level of action, resources necessary for the implementation of the activities at the set deadlines
- To provide the necessary (human and financial) resources. Financial resources should come from both the MOH (as part of the current national public health care programs 1.1 and 1.5) and the health insurance fund. It is necessary for the other Ministries (Ministry of Education, Research and Youth, Ministry of Justice, Ministry of National Defense, Ministry of Administration and Interior) to financially support programs designed to prevent and control sexually transmitted infections through their specialized departments. It is also necessary to raise funding from the private sector and from international organizations that carry out activities in this field
- To introduce the issue of sexually transmitted infections to the agenda of the Inter-ministerial and inter-sectoral Commission for Fighting against HIV/AIDS
- To coordinate the use of resources by establishing a Management Unit for the National Program of Prevention of Sexually Transmitted Infections with dedicated staff that will coordinate, monitor, and report on the effective and efficient use of resources for program activities
- To amend existing laws and regulations, if necessary
- To promote inter-sector collaboration, especially with the Ministry of Education, Research and Youth, Ministry of Justice, Ministry of National Defense and Ministry of Administration and Interior
- To acknowledge, support, and integrate civil society activities into programs related to the prevention and control of sexually transmitted infections

INTERNATIONAL AND EUROPEAN CONTEXT

Sexually transmitted infections affect more than 400 million adults in the world each year. STIs represent a public health problem in both developed and developing countries (see appendix no. 1). The impact of these infections on individual and social health is significant, and has determined the World Health Organization and the World Bank to concentrate on evaluating the seriousness of this problem.

The existence and impact of STIs on families and communities were formally acknowledged for the first time in 1994 during the International Conference on Population and Development organized by the United Nations in Cairo. On that occasion, political decision-makers decided to focus on reproductive health, including on the screening and treatment of STIs. In many countries, national prevention campaigns using messages tailored for high-risk target groups have proved to be effective and determine sound behavior. The general messages of these campaigns are: the importance of reducing the number of sexual partners; and the effectiveness of using condoms to protect against sexually transmitted infections, as well as the benefits of using a double method – a condom to prevent STI transmission and another contraceptive method to prevent unwanted pregnancy.

After the signing of the Amsterdam treaty, the European Commission adopted guidelines that aim at improving the surveillance system for infections including STIs in EU countries. The guidelines ensure the proper coordination of activities in the European countries. They refer to: Decision 2119/98/EC, which stipulates the creation of a network of epidemiological surveillance and infectious disease control; Decision 2000/57/EC, regarding a rapid signal and response system for the prevention and control of infections; and Decision 2000/96/EC, which describes the response to such infections in the EC countries. As a result, they have established an EU network for the surveillance and control of infectious diseases that is now operational.

The WHO/EURO regional strategy “Health 21 – Health for All in the 21st Century” states that there has been a constant decrease in the incidence of STIs such as syphilis and gonorrhea in European countries over the last few decades. Such STIs represented a minor problem in this region until 1993. There has been an epidemic evolution of syphilis recently, especially in some CIS countries, but also in some EEC countries. Here are some possible causes: a lack of sexual education in schools; the acceptability and quality of health care centers that deal with STIs; insufficient supply or high prices of condoms; the dramatic increase of population migration; cultural changes and changes in the value system, especially among young people; and an increase in prostitution. In these countries, the incidences of congenital syphilis and of mixed cases of STIs and HIV have increased dramatically. The WHO strategy suggests the development of programs for these countries to address the current situation which include prevention,

treatment, and monitoring of STIs, including congenital syphilis. These programs should target the entire population with particular attention to high-risk groups, and they should focus on observing human rights and protecting the dignity of affected persons.

The United Nations organizations WHO, UNFPA, UNAIDS and UNICEF, as well as the European Union, USAID, and other governments and international organizations, provide financial and technical assistance to countries in need throughout the world, including in Europe, in order to implement STI prevention programs for the entire population and for vulnerable groups. The health care sector has the role of leading political decision-makers in the affected countries to an understanding of the seriousness of these health problems.

In 1997, a World Bank report highlighted the fact that STI prevention efforts are critical and should be a priority for political decision-makers. The report emphasized that special attention should be paid to the development of prevention programs targeting high-risk groups including prostitutes, their clients, and young people. Thus, these programs should have the greatest impact in reducing infection rates in the population.

CURRENT SITUATION IN ROMANIA

1. Epidemiological Trends of Sexually Transmitted Infections

As far as reporting cases of sexually transmitted infections is concerned, the international requirements (EU decision) stipulate that it is compulsory to report cases of syphilis (including congenital syphilis), gonorrhoea, Chlamydia, and HIV/AIDS infection.

In Romania, it is currently mandatory to report only cases of syphilis, gonorrhoea, and HIV infection. Of these diseases, the incidence of syphilis can be considered an indicator of the evolution of all STIs. According to the data provided by the Ministry of Health¹, morbidity by syphilis in the population has increased constantly. In 2002, the number of cases (56.68/100,000 inhabitants) was almost three times more than in 1989 (19.8/100,000 inhabitants) (see appendix no. 2). However, general opinion is that the official data is affected by underreporting, especially because people tend not to see a specialized doctor when they have lesions in the genital area. Also, most cases of syphilis are diagnosed in the second or third phase of infection, and not in the primary phase. The incidence of syphilis is higher in urban areas, in men, and in the age groups 20-24 and 25-29. According to the World Health Organization's Health for All 2002, the average incidence of syphilis in 2000 in the European Union was 1.07/100,000 inhabitants and 13.14/100,000 inhabitants in the Central and East European

¹ Computing, Health Care Statistics and Medical Documentation Centre of the Ministry of Health

countries, versus 45.17/100,000 inhabitants in Romania (see appendix no. 2). Only a few other countries reported a greater incidence of syphilis: Kazakhstan (161.38/100,000 inhabitants), Belarus (104.86/100,000 inhabitants), Ukraine (91.64/100,000 inhabitants) and Kyrgyzstan (73.35/100,000 inhabitants).

The number of congenital syphilis cases recorded every year between 1989 and 2002 (taking into consideration the fact that there is no case definition at a national level for confirmed cases of infection) has increased significantly, from 22 in 1989 to 423 in 2002. Starting on July 1, 2002, a national-level system was established to monitor congenital syphilis in live newborns (based on a definition of suspected case and on reports of cases whose confirmation tests are positive). During the six months of monitoring, 59 confirmed cases of congenital syphilis in live newborns were reported in 20 counties. In the other counties, there were reports on suspected cases, but they have not met the minimum criteria necessary to be included in this category.

As far as the HIV/AIDS infection is concerned, the number of new cases remains relatively the same, but the nature of HIV epidemic had changed. In the early 1990s, cases of infection were most prevalent in children, due mainly to nosocomial transmission in health care centers; at present, “new” cases in children are represented by cases diagnosed in persons born before 1990 and children born to HIV positive mothers. The number of AIDS cases diagnosed in children under the age of fourteen has decreased, from 400-500 new cases between 1991-1998 to 65 new cases in 2002, whereas the number of adult diagnoses has increased relatively. Transmission of the virus primarily occurs through heterosexual activity (60%). At the end of 2002, the records showed 13,675 cases of HIV/AIDS (5,676 cases of HIV and 7,999 cases of AIDS) of which 10,125 patients were still alive. Of these patients, 7,279 (71.89%) were children.

The evolution of morbidity of gonorrhea has decreased significantly (almost by half) in 2002 (16.98/100,000 inhabitants) in comparison with 1989 (35.7/100,000 inhabitants). This trend is the opposite of that of syphilis (see appendix no. 2). There is an obvious underreporting of these cases, given the epidemiological data from international literature and current conditions in Romania. There may be two explanations for this phenomenon: underreporting by the health care system; and the general disinclination among the population to see a doctor. The main reasons for the latter situation may include the shame associated with this type of infection, lack of information about STI symptoms, and self-treatment with antibiotics.

As for genital Chlamydia, in 2002 a sero-prevalence and sero-incidence survey was conducted in eight Romanian counties (Constanta, Calarasi, Olt, Hunedoara, Alba, Cluj, Iasi, and Suceava); the participants were women aged 15 to 45. The goal of the survey was to assess the incidence of Chlamydia in women aged 15 to 45 by serologic tests for the antibodies IgG and IgM. Of the 6,067 tests, 3,147 (52%) were positive. Of the positive tests, 35% showed recent infection (IgG). The preliminary data of this survey indicate that genital Chlamydia represents a public health care problem requiring further investigation and treatment efforts. It is also necessary to develop surveillance and reporting system for genital Chlamydia.

As for other sexually transmitted infections of interest to public health care, it is necessary to take infections with the herpes simplex virus and / or with Papilloma viruses into account as well. There are no statistical data from a national-level reporting system in Romania regarding the morbidity of genital infection with Papilloma viruses, even if the technical and professional

capacity to diagnose and treat such infections regionally in University medical centers exists. It would be beneficial to coordinate these activities in order to make the most of the resources of various programs evaluating the incidence of human Papilloma virus infections. The very high percentage (43.4%) of women aged 15 to 45 stating that they had fertility problems in the Romanian Reproductive Health Survey 1999² can be considered indirect evidence of the potential existence of many untreated cases of STIs in Romania.

2. Sexual Knowledge, Attitudes, and Behaviors, of the Population Regarding Sexually Transmitted Infections

Teenagers and young adults under 25 are the most vulnerable age groups in the population as a whole. The age of first sexual intercourse is going down while the number of sex partners is going up. The rate of utilization of modern contraceptive methods is relatively low among young people in this age group (only 39% of young women report having used a modern contraceptive method during their last sexual intercourse, and half of them used a condom). The incidence of syphilis and other sexually transmitted infections, including HIV/AIDS, is higher in this age group than in other age groups. At the same time, according to the data provided by surveys conducted in Romania over the last decade, young people are not fully aware of the risks STIs pose to their health.

The following data, provided by the above-mentioned survey³, is useful for understanding the main characteristics of preventive sexual behavior of young people in Romania:

- **Sexual activity is intensifying and diversifying in Romania:** The Romanian Reproductive Health Survey (1999) showed that the average age of first sexual intercourse dropped from 20.5 in 1993 to 19.5 in 1999. In 1999, 56.3% of the women under the age of 20 and 80.5% of the men of the same age had begun their sexual life. 34% of sexually active women and 86% of sexually active men reported having had sexual relations with more than one partner. Most young men (62%) said they had sexual intercourse with more than four partners and 27% reported more than ten partners.
- **Lack of correct and complete information regarding STIs and condom use:** Although in 1999 almost all the respondents were aware of the existence of the condom, only 78% of women knew how to use it. This proves that there is a significant difference between being aware of the method and knowing how to use it – let alone actually using it at all. Surveys showed that about 97-98% of the population had heard of HIV/AIDS, about the same percentage of people were aware that transmission can occur during sexual activity, and 90% of them knew that AIDS is a lethal disease. Even so, about a third of women participating in the survey believed that HIV can be transmitted by touching the same objects, public toilets, kissing, mosquito bites, and handshakes. Also, 38% of the women who had heard about HIV/AIDS did not know that HIV infection can be asymptomatic and that an infected person may look no different from an uninfected one. Only 55% of women and 65% of men agreed that HIV can be contracted even from

² Romanian Health Reproductive Survey, Romanian Public Health and Health Management Association, 2000

³ Romanian Health Reproductive Survey, Romanian Public Health and Health Management Association, 2000

a stable partner. As regards other STIs, two-thirds of respondents had not heard of other such diseases, with the exceptions of syphilis (85% of the respondents had heard of it) and gonorrhoea (53% of the respondents had heard of it).

- **Lack of correct and consistent use of condom:** In 1998, 90% of young women and 93% of young men agreed that using a condom protects against HIV/AIDS. However, a survey conducted in 1999 showed that only 21.5% of women and 38.5% of men used a condom during their first sexual intercourse. 18.9% of young women and 33.9% of young men said they had used this contraceptive method during their most recent sexual intercourse.
- **Lack of awareness regarding the personal risk of infection:** In 1998, 75% of young women and 69% of men aged 15 to 25 believed that their risk of contracting HIV was very low or nonexistent. As for other sexually transmitted infections, even young people who were aware of their existence believed that these diseases were extremely easy to cure and that they therefore did not need to worry about them.

3. Surveillance and Control of Sexually Transmitted Infections

A surveillance system is intended to quickly detect infectious diseases and epidemics, to monitor the evolution of infectious diseases, and to develop public health care strategies and control measures in order to reduce the incidence of such diseases. At present, the STI surveillance system is a vertical, rigid system, focused almost entirely on effective case control. An effective STI surveillance system should include complex activities that have been carried out in Romania only partially or not been carried out at all, such as: sentinel surveillance (nonexistent for STIs at present); gathering prevalence data (activities carried out within the reporting system); development of screening activities (carried out partially in Romania – only in the case of pregnant women); behavior monitoring (nonexistent for STIs at present); and syndrome surveillance (also nonexistent for STIs at present).

In Romania it is mandatory to report diseases such as syphilis and gonorrhoea, and, starting on July 1, 2002, a reporting system for congenital syphilis in live newborns was established at a national level. At present, there is no reporting system in place for genital Chlamydia, human Papilloma virus or herpes simplex virus.

To comply with European Union standards, it is necessary to include infection with Chlamydia trachomatis in the STI surveillance system. This will require the development of: a reporting system for confirmed cases, a case definition, and a sentinel surveillance methodology.

In order to improve STI surveillance, it is also essential to develop and implement systems for syndrome and behavior surveillance in certain areas of Romania.

In the past, cases of STIs were actively detected and hospital treatment was compulsory, without taking the patient and his / her right to confidentiality into consideration. Currently no such control of STI surveillance by the authorities exists. This is due to the significant changes in the health care system. Decentralization was not followed by coherent regulations in this field, nor by measures and programs for confronting sexually transmitted infections.

At present, a draft of the Minister's order regarding sexually transmitted infections control is under consideration.

Deficiencies of the surveillance system include:

- Legislative and regulatory deficiencies: the surveillance system of sexually transmitted infections is regulated by the Order of Ministry of Health no. 544/1995 – “Measures of prevention and control of sexually transmitted infections”. The regulations of the MOH are not consistent with the provisions of the health insurance system. A more effective coordination between the MOH and NHIH is necessary in order to harmonize all decisions related to STIs. On the other hand, not all the provisions of the above-mentioned order are observed, and some of them are obsolete.

1. Early Detection

STIs are usually detected in their later phases, and employers are not required to ensure that employees are tested when hired. The stipulation that a patient with a recent history of syphilis can be hired only with the approval of a dermato-venereologist is impossible to enforce, and there are no means to monitor its implementation.

The regular medical examination of pregnant women (which should be conducted monthly) and serologic testing (in the third and eighth months) are no longer an effective measure of the prevention of congenital syphilis, because there are many pregnant women who do not see a family physician, and the physician may not recommend a serologic test. It is absolutely necessary to develop coherent measures for serologic testing for syphilis in pregnant women during their first medical examination.

Follow-up serologic testing for syphilis in patients with gonorrhea and other STIs is only conducted in a small number of cases, as many patients do not see their doctors after treatment to ensure that their infections have been cured.

The regular medical examination of some categories of people (staff in restaurants and canteens, cleaning staff in hotels and motels, child-care staff, etc.) is difficult to monitor, and such examinations (both clinical and serologic) are not cost-effective. Furthermore, there are no logical reasons why many of the categories of people included in the Ministry Order should undergo such examinations.

The regular medical examination of people who represent a potential source of sexually transmitted infection is stipulated in the 1995 Order, which requires police officers to report people who are considered sources of venereal diseases to appropriate medical authorities. At present, these regulations are inconsistent and impossible to enforce.

Specifications regarding the evaluation of services provided by family physicians for prophylactic treatment of contacts, epidemiological investigations, and monitoring of former STI patients should be included in the framework contract with the NHIH.

2. Treatment

Isolation and hospitalization of syphilis patients during the contagious phase of the disease or according to the recommendations of dermato-venereologists in non-contagious cases are not medically necessary. They are costly, and they are not in accordance with the recommendations of the World Health Organization.

The sexual contacts of syphilis patients do not receive complete chemo-prophylactic treatment (although it is specifically mentioned that this is mandatory for all identified contacts).

There are no precise regulations for case management and no alternative solutions for situations when patients and their contacts refuse treatment for syphilis.

The Order stipulates that information should be obtained from neighbors, friends, and work colleagues in order to identify sexual contacts not mentioned by the patient – a serious infringement of the patient's right to confidentiality.

Current epidemiological data is incomplete because family physicians are not involved in data gathering activities in spite of their work in detecting and treating some STIs (such as candidiasis, scabies, pediculosis, and genital herpes) and in referring other STI patients (syphilis, gonorrhea, Chlamydia, etc.) to specialists for definitive diagnosis and treatment.

3. Reporting

A mechanism allowing the reporting of STIs throughout the health care system (including the private health care system and the family planning network) should be developed and implemented.

The compulsory reporting flow for syphilis and gonorrhea is complicated and therefore ineffective. In theory, the specialist in dermato-venereology (who makes the diagnosis and decides the appropriate treatment) reports the cases every month to the DPHA and to the district dermato-venereology coordinator. Every six months, the DPHA and the district coordinator report the confirmed cases to the CHCSMDC and the Scarlat Longhin Hospital, who report in their turn to the Ministry of Health. At the same time, family physicians are also required to report suspected and confirmed STI cases to the DPHA. This double reporting leads not only to a waste of resources, but also to different data, depending on the source. The main "link" is the dermato-venereologist, who unfortunately cannot provide information either quickly or coherently. There is also a lack of unitary and logical information support. The only role currently played by the District Public Health Authorities is to pass on information, but they do not have a role in controlling it.

The reporting system of STI cases from the primary health care level to the Ministry of Health is not well coordinated, and the lack of a management information system leads to significant differences between various counties, creating difficulties in data interpretation at the central level.

There is no unitary method of case reporting at the various levels of health care. It is obvious that transmission of information among the various hierarchical levels involved in STI control is precarious and lacks IT support.

Before July 1, 2002, there was no clinical case definition of congenital syphilis. On that date, the national surveillance system of congenital syphilis in live newborns was introduced.

The health insurance system does not motivate health care service providers to contribute to STI surveillance and control. Neither independent family physicians nor private health care service providers observe the compulsory regulations to report cases of STIs. In certain cases, the cost of examination represents a barrier for potential patients or their contacts. In many counties, specialized STI ambulatory care clinics in health centers have been closed down. The number of nurses from STI ambulatory departments or doctors' offices who were previously involved in collecting the necessary data for epidemiological investigation has decreased dramatically. At present, epidemiological investigation is conducted by specialized dermato-venereological staff – doctors in 40% of the cases and nurses in 60% of the cases.

The population is unaware of their individual responsibility, and communities do not get involved in the resolution of such cases.

4. Provision of Medical Services for STI Patients

Health care for STI cases should be provided in compliance with the provisions of the Sexually Transmitted Infections Diagnosis and Treatment Guide promoted through an Order of the Minister of Health and Family⁴. This guide became operational in December, 2001 and was developed through consultation with the dermato-venereology commissions of the MOH and the College of Physicians in Romania. It follows the recommendations of the World Health Organization and the Center for Diseases Control (CDC Atlanta). It replaced the recommendations in Order no. 544/1995 and was distributed to dermato-venereologists, neonatologists, pediatricians, gynecologists, urologists, and physicians from family planning offices.

A formal evaluation of how the provisions in this guide are observed has not been conducted, but indirect evidence indicates that the dissemination of the guide in the country and the training of medical staff to use it are far from complete. Therefore, other types of diagnosis and therapy that are not cost-effective or scientific are often used.

In addition to the etiological treatment section, the STI Diagnosis and Treatment Guide include a section on syndromic treatment. Although etiological treatment is ideal and should be used whenever possible, its use has also some disadvantages: delay of treatment initiation (because of the period of time necessary for investigations); additional costs related to investigations; impossibility of using it when access to investigations is difficult or nonexistent. When it is impossible to have etiological diagnosis and treatment, the syndromic approach has some obvious advantages, including the immediate provision of a cost-effective treatment and the absence of additional investigation costs. But for the time being, the syndromic approach is seldom utilized even in areas with limited resources where etiological treatment is not possible. This is probably because few people are familiar with the algorithms of syndromic treatment, which were introduced about a year ago.

⁴ Order MOH no. 385 on May 31, 2002

4.1. Health Services Provided at Different Levels of the Health Care System

Family Physician's Office

Family physicians are in a privileged position with regard to the relationship they can build with their patients. They could provide counseling and health care for STI patients. Family physicians are in a position to identify patients with STIs by recommending that they be screened for such infections, especially in the following four cases:

- For confirmed STI patients who present themselves for examination by the dermatovenereologist, and for the sexual contacts of these patients;
- For pregnant women, when registered and during regular check-ups (in theory they should have two VDRL/RPR tests and a HIV test during pregnancy);
- For people requesting general medical examinations in order to obtain a new job or a pre-nuptial certificate (a VDRL test is performed and in some case a HIV test as well)
- For all people over 18 who have health insurance and therefore must have annual medical check-ups.

The framework contract⁵ motivates family physicians to get involved into STI detection. They receive 20 points for each confirmed case they detect. However, no points are awarded for testing suspected patients who prove not to be sick, so physicians are not motivated to investigate the sexual contacts of those with STIs. In addition, according to the same contract, family physicians cannot recommend investigations for clarification of STI diagnosis except for VDRL/RPR, nor are they authorized to recommend investigations of urethral / vaginal discharge or for the detection of Chlamydia. Family physicians are generally overworked and face many medical and bureaucratic challenges, which significantly reduce the time they could devote to STI patients.

Specialized Ambulatory Health Care

The modification of ambulatory health care in Romania through the establishment of family physicians' offices and individual doctors' offices providing ambulatory specialized health care has led to the closing of local health care centers with dermatovenereology departments. It also annulled the provisions of the MOH Order no. 544/1995 on this issue. Ambulatory dermatovenereology health care centers organized in compliance with Ordinance no. 124/1998 replaced these local health care centers. But these ambulatory health care centers did not assume all the responsibilities of the previous ones. The specialist in the outpatient department focuses on confirmation of STI diagnosis and treatment rather than on prevention, counseling, and STI detection / prevention. This led to a decrease in the number of cases of STIs actively detected and to a significant decrease of prevention and counseling services. According to the existing regulations, the dermatovenereological examination may be performed only by referral from a family physician or another dermatovenereologist, which delays STI patients' access to a specialist. (see appendix no. 3)

Hospital

The main STIs that are diagnosed / treated in hospitals are: syphilis, gonorrhea, acuminated condylomas, Chlamydia, and genital herpes. Patients with syphilis are usually hospitalized, but the therapeutic regime varies greatly, as in the case of ambulatory medical care. Even when the STI Diagnosis and Treatment Guide is available, many hospitals still use treatment plans including large doses of penicillin over a long period of time for syphilis treatment. This is

⁵ Order no. 20/December 2003 for approval of the Methodological Norms of Implementation of the Framework contract regarding the conditions for providing health care within the social health insurance system

because, traditionally, patients with syphilis were treated only in hospitals, which artificially increased the costs. The simplification of treatment plans and their adjustment to international standards on the one hand and optional hospitalization on the other have led to a decrease in the number of hospitalizations, but there are still situations when patients who could be treated on an out-patient basis are placed in hospitals. There are few dermato-venereology departments with trained nurses to carry out such activities as counseling, STI detection, and education of the sexual contacts of STI patients. This is due in part to the current nursing shortage.

Private Sector

The deficiencies of the public health care system lead many patients to seek private health care, for reasons including:

- a) a greater degree of confidentiality (due to a shorter information flow which, in the public health care system, is compromised by the inclusion of many health care providers – physicians and other medical or auxiliary staff);
- b) quick access to medical services;
- c) ambulatory treatment; and
- d) the hope that private workers will not require patients to state the names of all sexual contacts as mandated by the current system of compulsory notification of all contacts.

Although the increase in utilization of medical services, whether public or private, is beneficial, those who have scarce financial resources (the poor, other vulnerable population groups, young people) have limited access to diagnosis and treatment in the private system, and these are the groups that are the most vulnerable to STIs.

Laboratory

There is no coordination between the activities of laboratories involved in STI diagnosis, and quality control measures are nonexistent. This leads to medical and ethical problems. For instance, some patients may have positive test results for an STI in one laboratory and negative test results in another, causing increased diagnostic costs (multiple tests with uncertain results instead of one test with a valid result) for both the health care system and for patients who must cover the costs of the tests. Increases in treatment costs also occur when unnecessary medical care is provided to patients with false positive results due to technical / human errors, or when there are difficulties in post-therapy surveillance. Additionally, there is a negative medical and social impact when STI cases go untreated because they are not diagnosed after false negative test results due to technical / human errors. Laboratories are not distributed equally in the country and, in most cases, laboratory analyses require the patient to travel to a location other than the one where an STI diagnosis was first suspected. In certain regions, access to such analyses is limited.

4.2. Patient Flow

STI Patient Examination / Diagnosis

At present, STI patient flow is slow, which has negative repercussions both on the disease's evolution and on the community (there is the risk of passing the STI to other people). This slow flow is largely due to the legislation in effect, and its duration (several days) is often discouraging for people who would like to request medical care for STIs (see appendix no. 3). STI patients (or those who would like to have an examination in order to exclude an STI suspicion) have to see a family physician, usually by registration on a waiting list. After an examination, physicians can

confirm or reject the STI suspicion. Family physicians can prescribe necessary treatment for some STIs (such as scabies, pediculosis, and candidiasis), whereas for other STIs (syphilis, gonorrhea, Chlamydia, and acuminated condylomas) it is necessary to see a specialist from the ambulatory dermato-venereology department, which means another waiting list. If the dermato-venereologist deems it necessary, he / she will give a referral for hospitalization for the dermato-venereologist in the hospital (after another few days) or for a specialized (hospital or ambulatory) laboratory for additional investigations.

STI Patient Treatment

According to the regulations in effect, drugs that are free of charge, based on medical prescription, can only be distributed through closed-circuit hospital pharmacies. This regulation was introduced in order to reduce treatment costs (as drugs distributed through this system would be cheaper than those distributed in an open circuit) and to promote a better control of treatment fund management. Unfortunately for the particular case of STIs, this regulation brings bureaucratic obstacles that cause additional delays to the examination / diagnosis process that have significant negative repercussions on the patient and the community. The syndromic approach proposed by the STI Diagnosis and Treatment Guide cannot be supported with free-of-charge medication, as free drugs are distributed only for confirmed STI cases.

As for the dermato-venereologists' cooperation on STIs with physicians from other departments (obstetrics-gynecology, pediatricians), it usually works well. Some disconnects seem to be related to the fear shown by some physicians from other departments to treat STI patients. Although it is recommended that STIs such as syphilis be diagnosed and treated by dermato-venereologists, there are cases when the patient could be better treated in other departments (with surveillance by a dermato-venereologist). For instance, hospitalized pregnant women could be treated in the obstetrics-gynecology department, and early congenital syphilis in premature babies or babies who need specialized pediatric health care could be treated in the pediatric department when the respective patients have medical / surgery problems more severe than STIs.

4.3. Costs of Diagnosis and Treatment of STI Cases

Syphilis

Diagnosis: Direct examination with an ultra-microscope is not very expensive (US \$3.53)⁶, but it requires proper equipment and trained medical staff. Because of the lack of material and human resources, very few laboratories can perform an ultra-microscopy. Congenital syphilis diagnosis is not based on *T. pallidum* identification in newborns, although according to the case definition this is the most important diagnosis element. Serologic diagnosis is much more widely used and it costs about US \$2.8 per qualitative non-treponemic test (VDRL or RPR). Quantitative non-treponemic tests are performed in very few laboratories in Romania, which represents a problem because these are the best way of monitoring post-therapy evolution. Treponemic tests (FTA-Abs,

⁶ This investigation cost is the average cost of investigations based on the fees of three medical services providers (both public and private) in Bucharest in March 2003. The calculation was based on an average exchange rate of 34,000 ROL/USD.

TPHA) are available in few laboratories, although at present their cost (US \$3.6/test) is comparable to that of non-treponemic tests.

Treatment: The preferred drug for syphilis treatment is quite inexpensive (one vial containing 2.4 million benzathin penicillin units cost about US \$0.8). Treatment with this medicine should be administered to all patients and their sexual contacts whether or not they have medical insurance. (According to the agreement between MOH and NHIH, syphilis patients who do not contribute to the health insurance fund may be treated with penicillin-derived drugs). But in many cases, besides the low treatment cost, there is also a hospitalization cost (US \$20-\$25/day). Although the current treatment plans in the STI Treatment Guide no longer require compulsory hospitalization, there are still many syphilis cases that are treated in hospital for various reasons (tradition, social cases, and difficulties in providing free treatment in outpatient centers). Due to bureaucratic obstacles, it is currently easier to place a social case in a hospital and provide free treatment than to provide immediate access to medication and free treatment in outpatient centers.

Gonorrhea:

Diagnosis: A direct examination for gonorrhea costs US \$3.82. For cases when there is a suspicion of antibiotic-resistant gonococci, a microorganism culture and sensitivity test through an antibiogram should be performed. These are more expensive methods and they are available only in specialized laboratories.

Treatment: There are several antibiotics that allow for one-dose treatment of gonorrhea under strict surveillance. The antibiotics mentioned in the STI Treatment Guide cost between US \$2.1 and US \$6.5.

Chlamydia

Diagnosis: The cost per diagnostic test for Chlamydia antigens is about US \$8.1. In order to confirm the diagnosis, CDC and WHO recommend direct identification of antigens in pathological products (such as urethral discharge, vaginal discharge, urine). Although these recommendations are also included in the MOH Guide, there are still health care centers that use serological tests for Chlamydia for diagnosis purposes. This is not a specific method and it is not recommended by any of the international diagnosis and treatment guides. Also, it is quite expensive (US \$5.88 per serological test).

Treatment: The two main drugs used in Romania, as well as in many countries in the world, for Chlamydia treatment are doxycycline and azithromycin. The treatment cost varies between US \$0. USD per case treated with doxycycline (200 mg/day for 7 days) and about US \$16 per case treated with azithromycin (1g/day, single dose). According to the regulations in effect, Chlamydia treatment is free of charge only if the diagnosis is confirmed by laboratory tests. This is an important recommendation and it should be maintained. However, it should be mentioned that for this disease, the diagnosis cost is about nine times higher than the cost of doxycycline treatment. Therefore, doxycycline could be recommended as free syndromic treatment without compulsory para-clinical confirmation of diagnosis.

5. Available Resources

Physical Resources⁷

At present, there is no systematic planning process of resources at a national, regional, and district level based on the current needs. There are discrepancies in the geographical distribution of staff and facilities. The number of staff in the health care promotion system and epidemiologists in the public system is small.

Dermato-venereology departments network: There are two dermato-venereology hospitals in Bucharest and in the country there are dermato-venereology departments as follows: one department in each of the following sixteen counties (38.1%): Covasna, Vrancea, Salaj, Gorj, Mehedinti, Calarasi, Iasi, Valcea, Dambovita, Prahova, Arges, Satu Mare, Bistrita Nasaud, Arad, Braila, and Giurgiu; two departments in each of the following twelve districts (28.6%): Olt, Teleorman, Buzau, Vaslui, Galati, Tulcea, Ialomita, Botosani, Neamt, Dolj, Timis, and Constanta; three departments in each of the following eight counties (19%): Sibiu, Cluj, Alba, Brasov, Harghita, Bacau, Caras Severin, and Bihor; and four departments in four counties (9.5%): Maramures, Hunedoara, Mures, and Suceava (see appendix no.4).

The number of hospital beds within the network was 3,205 in 1999, ranging between 18 beds in Giurgiu District and 387 in Bucharest.

The number of physicians who were employed within the network in 1999 was 417 and the average number per district was 9.9, ranging between 1 person in Ilfov district and 80 persons in Bucharest. There are approximately 600 medical staff specialized in dermato-venereology who are currently working in the health care system. Appendix no. 4 shows the distribution of dermato-venereologists per 100,000 inhabitants. The number of nurses employed by the former epidemiological departments and outpatient centers (involved in epidemiological investigation) decreased constantly, leading to a showdown in specific activities. It would be useful to consider the possibility of paying their salary from the state budget (the subprogram for STI control – transfers) or the NHH.

Family Physicians. The primary health care system currently includes about 16,000 family physicians, plus about 250 family planning offices and 13 family planning clinics coordinated by NGOs. UNFPA and JSI/USAID provide support on primary health care providers' basic training in reproductive health, STIs being one component of this training. UNFPA has also been involved in the provision of continuing medical education for the family doctors, which includes a one-week module on sexually transmitted infections.

Epidemiologists. Within each district and in the Bucharest Department of Public Health, an epidemiologist is responsible for coordinating the STI control program at the local level. In most cases these persons are also involved in many other activities of their institutions. It is obvious that these 42 persons cannot effectively carry out their activities at the district level without a coherent and effective reporting system and a structured coordination system.

Health promotion network. As for the health promotion and education for health sections within the Departments of Public Health, there is not enough staff in general and specialized staff in dermato-venereology in particular, which does not give hope for improvement of their activities.

⁷ The data source is the Computing, Health Care Statistics and Medical Documentation Centre of the Ministry of Health

Financial Resources

Financial resources derive from two main sources: the budget of the Ministry of Health through the national public health programs for STI prevention and surveillance activities; and from the health insurance funds for diagnosis, treatment, and medical services.

International agencies and / or organizations provide significant funding, in particular the United Nations organizations and USAID, by supporting programs that are implemented by both governmental and non-governmental organizations.

6. Regulatory Framework: STI-Related Legislation

The structural changes that took place in the health care system after 1989 have been regulated by a great number of legislative documents. In many cases, these documents were issued as emergency ordinances / decisions in order to regulate a particular issue or domain. Therefore, the legislative documents in effect are not always consistent; they contain contradictory provisions or overlook certain issues and domains of the health care system. These legislative or regulatory issues are sometimes relevant to the STI domain.

STI prevention, surveillance, control and medical care in Romania are regulated through several legislative documents: the Constitution, emergency laws and ordinances, government decisions, and Minister's decisions, many of which were issued after 1989 (see appendix no.5). The Constitution of Romania guarantees the right to health care (art. 33) and the state has to take measures to provide public hygiene and health care. The law on health insurances (law 145/1997) specifies that persons who hold health insurance and members of their families have the right to indiscriminate medical services, in compliance with existing laws. Every year they develop the methodology norms of implementation of the framework contract with the NHIH regarding terms of health care services within the health insurance system. These norms also refer to STIs. The Public Health Law (no. 100/1998) stipulates that the District Public Health Authorities must organize and monitor the prevention activities within the counties and Bucharest through organizing, guiding and controlling the way in which STI detection, treatment, and prevention are performed, in compliance with MOH regulations.

STI prevention and control represent two of the objectives of the subprogram for surveillance and control of infectious diseases that is part of the EU public health program. This subprogram includes a description of proposed activities, as well as indicators for evaluation of the results obtained during the implementation process. Funding for this subprogram comes from both the state budget through the budget of the MOH and the budget of the National Health Insurance House, and the amounts allotted for each year are mentioned there.

The MOH also issued several orders regulating the organization and responsibilities of the health care centers and staff in the field of STI prevention and control, the list of diseases that must be reported, and the procedures to be used for monthly reporting.

Representatives of the College of Physicians, MOH, and NHIH are involved in monitoring the quality of the services provided to patients and observation of their rights. Given the particular nature of STIs, they deal with matters of confidentiality and keeping the professional trust, aspects that are stipulated in the deontological code and the Law on patients' rights that has recently been issued.

GOAL, OBJECTIVES AND PRIORITY ACTION AREAS

GOAL

The goal of the national strategy is to contribute to the improvement of the health status of the population by preventing and controlling sexually transmitted infections, as well as by providing equitable access to complex, integrated quality health care services to infected and affected people.

In order to achieve the proposed goal, general objectives for 2004-2006 were defined to correspond to the priority domains that must be included in a complex strategy of prevention, controlling and treatment of sexually transmitted infections in Romania:

- the domain of the promotion of healthier sexual behaviors among the sexually active population in general, and teenagers and young people aged 14 to 29 in particular
- the domain of vulnerable and disadvantaged population groups
- the domain of epidemiological surveillance which is important for STI control, as well as for using the information in health care decision-making in this field
- the domain of health care services
- the domain of health care public policy.

For each general objective, several specific objectives were defined. In order to define them, the following criteria were used:

- To be specific and to correspond to a certain component of the general objective it matches
- To be measurable and to allow for the development of indicators to measure the achievement of the specific objective
- To be adequate, given the existing health care system
- To be realistic. It should be achievable with the existing resources and in compliance with the general health care policies in Romania.
- To be time defined.

Main priority action areas to be taken in order to achieve each specific objective were also developed. These priority action areas are not exhaustive, but they represent the priority domains in which the Ministry of Health proposes to act in order to achieve the objectives of this strategy and to reach the proposed goal.

In order to implement the strategy, an action plan will be developed later on. The plan will define activities for each domain, as well as necessary and available resources, funding sources, deadlines, and responsibilities for each party involved, cooperation for implementation with international agencies or organizations and non-governmental organizations. In order to achieve

the proposed goal and to satisfy the objectives of this strategy, the action plans will, starting from 2004, be called the National Program for Prevention and Control of Sexually Transmitted Infections, which will be part of the national programs of public health care developed and coordinated by the Ministry of Health.

GENERAL OBJECTIVES. SPECIFIC OBJECTIVES. PRIORITY ACTION AREAS

The general and specific objectives of the National Strategy for Prevention and Control of Sexually Transmitted Infections comply with the Strategy of the Ministry of Health for Sexual and Reproductive Health and the HIV/AIDS National Strategy. Although the HIV/AIDS component can be considered part of a national strategy for sexually transmitted infection prevention and control, HIV/AIDS has become a priority for the Government of Romania, leading to the development of an HIV/AIDS governmental strategy that is under implementation. Because the incidence of sexually transmitted infections is constantly rising, it is necessary to develop a national strategy for STIs that will complement the HIV/AIDS strategy and that is based upon the same principles.

GENERAL OBJECTIVES

GO 1. To reduce the incidence of sexually transmitted infections among the sexually active population, especially among young people, through the sustained promotion of low-risk sexual behavior and an increase in the use and accessibility of specific services

GO 2. To reduce the incidence of sexually transmitted infections in vulnerable population groups through the sustained promotion of low-risk sexual behavior and an increase in the use and accessibility of specific services

GO 3. To develop a national system for the epidemiological surveillance of sexually transmitted infections in compliance with European Union norms

GO 4. To develop and improve the health care system in order to plan and provide complex and complete medical services for infected and affected persons

GO 5. To develop new services and tailor the existing ones to meet the needs of vulnerable population groups or people who require special care (pregnant women)

GO 6. To develop health care policies and a regulatory framework to address problems related to sexually transmitted infections at a sector (health care system) and multi-sector level

At present, there is no scientific evidence or structured information regarding the composition of the population groups affected by STIs in Romania. The existing statistical information on the number of syphilis or gonorrhea patients is insufficient. The framework of this strategy is intended to be flexible enough to be revised and adjusted based on data provided by subsequent surveys, as research is a priority for this strategy. Therefore, the entire sexually active population of Romania is considered to be a priority population group. The main reason for this is to be found in the Survey of Reproductive Health in Romania (1999) that shows that all population groups have high-risk sexual behavior.

Vulnerable population groups: Although there are no thorough surveys that define vulnerable populations, the international literature and national context allow us to define the following vulnerable groups for whom specific objectives and priority action areas must be developed:

- ❑ Persons who are not involved in a stable relationship, especially young persons and divorced persons, who reside in or commute to an urban area;
- ❑ Soldiers and gendarmes;
- ❑ Prisoners;
- ❑ Commercial sex workers and their clients;
- ❑ Man having sex with man ;
- ❑ Current and former drug users;
- ❑ Disadvantaged population groups: the Rroma population, poor people, institutionalized teenagers, etc.

SPECIFIC OBJECTIVES. PRIORITY ACTION AREAS

GO 1. To reduce the incidence of sexually transmitted infections in the sexually active population, especially among young people, through the sustained promotion of low-risk sexual behavior and an increase in use and accessibility of specific services

Specific objectives:

1.1. To reduce by at least 10% the incidence of syphilis cases in the fertile population by 2006 as compared to 2002

Priority action areas:

- To systematically develop communication activities in order to determine behavior change in the entire population through various channels (media, family physician, work place, and school). The campaigns will cover areas such as: STI amplitude and tendencies in population, advantages of condom use, existence of asymptomatic diseases and their consequences on fertility or birth, importance of notifying one's partner about an infection, easiness in treatment, importance of medical services use and acceptability.
- To increase condoms' accessibility and use by promoting facilities for poor population and the population in the rural areas; fundraising and / or donations from internal public and private funding sources and especially from international sources for this type of facilities.
- To strengthen the health care promotion network in order to carry out such activities in each district; promotion of team work within the District Public Health Authorities and cooperation with other public institutions, local authorities and non-governmental organizations.

- To increase acceptability and use of voluntary testing and regulating the confidentiality of such testing; development of counseling services with the testing services and at the level of primary health care.
- To improve early detection by integrating STI medical services into primary health care services and improvement of the patient flow; screening activities performed by family physicians.
- Providers who have the necessary training in this field should provide quality services.
- To build capacity at the governmental and non-governmental level in order to conduct qualitative and quantitative surveys on high-risk behaviors of various population groups and to identify the most appropriate communication channels.
- To conduct a new survey on reproductive health by the end of the strategy implementation to bring information regarding the population's behavior towards sexually transmitted infections.

1.2. To reduce by at least 20% the incidence of syphilis cases in teenagers and young people (aged between 14 and 29) by 2006 as compared to 2002

Priority action areas:

- To systematically develop communication activities in order to determine behavior change in teenagers and young people; these communication activities should promote sound sexual behavior and they should use communication channels adapted for the target age groups.
- To involve young people in the development and implementation of programs meant for them by promoting partnerships with the Ministry of Education, Research and Training and non-governmental organizations that have experience in developing programs for young people.
- To promote sexual education in education institutions at every level; to involved well-prepared trainers.
- To increase the acceptability and resort to voluntary testing and to regulate the confidentiality of this testing.
- To strengthen and use the physicians network in schools for the BCC, early detection and counseling activities; top promote on-going STI education for the medical staff in schools.
- To build capacity at the governmental and non-governmental level in order to conduct qualitative and quantitative surveys and to determine the most appropriate information channels.

1.3. To increase the use of condoms in teenagers and young people by at least 50% during the first sexual intercourse and by 65% for sexual intercourse with occasional partners by 2006 as compared to 1999

Priority action areas:

- To increase the population's access (from an economic and geographic point of view) to condoms, especially that of the population in rural areas and to ensure continuity in provisioning and distribution.
- To provide condoms at accessible prices in certain places (such as discos) or to distribute condoms for free to certain vulnerable population groups (prisoners, prostitutes, institutionalized persons).
- To systematically conduct communication activities in order to change teenagers' and young people's behavior and to promote the use of condoms. Educational activities can be carried out in school, outside the school, at the work place and in closed communities.
- To train and involve community nurses especially in rural areas in promoting sound sexual behavior.
- To develop specialized programs for institutionalized young people in cooperation with the appropriate authorities.
- To follow the evolution of the condom use in teenagers and young people by conducting another survey in reproductive health by the end of the strategy implementation and by holding regular investigations.

1.4. To include all high schools and vocational schools in STI prevention educational activities by 2006.

Priority action areas:

- To work with the Ministry of Education, Research and Youth for the introduction of sex education in all school curricula adjusted for every education cycle.
- To introduce the knowledge and tools for sex education in the training courses for teachers.
- To increase the capacity of the medicine school network to provide counseling in sex education.
- To strengthen the cooperation with non-governmental organizations that implement programs in schools.
- To identify best practices or to develop programs for their expansion and support from a financial standpoint.
- To expand the regional program of the World Health Organization "Health Promoting Schools" in every district of Romania.

GO 2. To reduce the incidence of sexually transmitted infections in vulnerable population groups through the sustained promotion of low-risk sexual behavior and an increase in the use and accessibility of specific services

Specific objectives:

2.1. To develop and implement annual / multi-annual multi-sector national programs for STI prevention and consequences related to the commercial sex practice by 2006

Priority action areas:

- To increase accessibility and to promote the use of condoms and distribution of condoms free of charge among CSW and their clients.
- To initiate communication activities for behavior change that should be tailored to the local situation and target both CSW and their clients; to promote partnerships with the local authorities, police forces and non-governmental organizations that have experience in carrying out such activities.
- To identify best experiences and best practices models in this field by increasing the cooperation with non-governmental organizations that carry out activities in this field and international organizations that have implemented similar programs in other countries.
- To increase the use of STI screening, counseling and medical services by CSW, as well as the accessibility of these services.
- To develop a national policy on reducing the negative consequences of prostitution (for instance human trafficking) in order to increase the CSW access to health care and social services.
- To develop methodologies for conducting relevant surveys among commercial sex workers.
- To attract international technical assistance and financial support for qualitative and quantitative surveys.

2.2. To develop at least a program a year on STI risk reduction in current and former drug users

Priority action areas:

- To develop communication activities for behavior change that should target young people from areas that are potentially at risk for drug trafficking and consumption.
- To include programs of reduction of the risk associated to drug consumption into the public health programs developed by various public institutions.
- To develop partnerships between non-governmental and governmental organizations in order to implement campaigns for STI risk reduction in drug users.
- To introduce information and education for STI prevention in detoxification services.
- To develop a surveillance component within all services related to reduction of the risks associated to drug consumption.
- To increase accessibility and to promote condom use; to distribute free condoms.
- To develop methodologies to conduct relevant surveys among current and former drug users

- To attract international technical assistance and financial support for qualitative and quantitative surveys.

2.3. To develop and implement annual / multi-annual multi-sector national programs of STI prevention for prisoners by 2006

Priority action areas:

- To initiate and maintain an on-going cooperation with the Ministry of Justice and other involved organizations in order to coordinate programs on health and sex education promotion.
- To build institutional capacity in order to implement programs of promotion of sound sexual behavior within the penitentiary systems and early detection of STIs.
- To develop and implement training modules for various categories of staff and prisoner educators.
- To support the development of comprehensive and continuous BCC programs by using appropriate channels (including audio and video equipment available in penitentiaries for message transmission or identification, training and involvement of some members of these communities in BCC activities).
- To increase accessibility and to promote condom use; to distribute free condoms.
- To develop counseling services.
- To lobby the appropriate Ministry for conducting surveys on reproductive health among prisoners.
- To attract international technical assistance and financial support for qualitative and quantitative surveys.

2.4. To develop and implement annual / multi-annual multi-sector national programs of STI prevention in military and gendarmes units by 2006

Priority action areas:

- To initiate and maintain an on-going cooperation with the appropriate Ministries in order to coordinate programs on health and sex education promotion.
- To lobby the appropriate Ministries for the development and funding of activities for promotion of low-risk sexual behavior and early detection of STIs.
- To build institutional capacity in order to implement programs of promotion of sound sexual behavior in military and gendarme units.
- To support the development of comprehensive and continuous BCC programs by using appropriate information channels and activities to determine sexual behavior changes.
- To increase condom accessibility and use.
- To develop counseling services.
- To lobby the appropriate Ministry for conducting surveys on reproductive health among the population in military and gendarmes units.

- To attract international technical assistance and financial support for qualitative and quantitative surveys.

2.5. To develop and implement annual / multi-annual multi-sector national programs of STI prevention in MSM by 2006

Priority action areas:

- To increase accessibility and use of condoms and suitable lubricants.
- To develop communication activities for behavior change that should be tailored to the local situation; to promote partnerships with non-governmental organizations that have experience in this field, as well as with MSM organizations in order to carry out these activities.
- To identify best experiences and best practices models in this field by increasing the cooperation with non-governmental organizations that carry out activities in this field and international organizations that implemented similar programs in other countries.
- To promote the use of medical services and to promote accessibility for MSM persons to STI screening, counseling and health care.
- To build capacity at the governmental and non-governmental level in order to conduct qualitative and quantitative surveys on high-risk behaviors among MSM.
- To develop methodologies in order to conduct surveys among MSM.
- To attract international technical assistance and financial support for qualitative and quantitative surveys.

2.6. To develop and implement annual / multi-annual multi-sector national programs of STI prevention in the Roma communities by 2006

Priority action areas:

- To integrate the various strategies for the development of Roma communities by involving community leaders in the process of development and implementation of activities; to integrate STI prevention activities into current and subsequent programs that focus on the economical and social status of disfavored communities.
- To develop the necessary means to promote sound life styles given the peculiarities of the Roma language, education and social and cultural environment.
- To train and involve medical staff in development and implementation of BCC programs.
- To improve the access to STI screening, counseling and health care services.
- To increase the acceptability, accessibility and use of condoms.
- To build capacity at the governmental and non-governmental level in order to conduct qualitative and quantitative surveys on high-risk behavior of Roma population.
- To attract international technical assistance and financial support for qualitative and quantitative surveys.

GO 3. To develop the national system of epidemiological surveillance of sexually transmitted infections in compliance with the European Commission decisions.

Specific objectives:

3.1. To integrate the STI surveillance system into the national system of surveillance of infectious diseases by 2005

Priority action areas:

- To promote the District Public Health Authorities as the focal point for coordination of all activities of STI surveillance; therefore the DPHA will have an overview of the STI epidemiological situation at a local level by gathering all the necessary information.
- To increase the role of public health institutes in STI surveillance; they will provide specific professional support in this area in order to improve the analysis and investigation capacity at a regional level.
- To include elements of surveillance high-risk behavior in the national surveillance program.
- To coordinate at a national level STI epidemiological surveillance that will be provided by a special division with the General Directorate of Public Health and State Sanitary Inspection - MOH; this division will represent the focal point for international activities that focus on STI surveillance.
- To start using the STI case definitions currently used in the European Union (see appendix no. 6).
- All ministries with health care systems will participate in the activities of the STI surveillance system.

3.2. To develop and implement a coherent information system in the field of STIs by the end of 2005 in order to obtain the data necessary to develop STI medical policy decisions on time

Priority action areas:

- To integrate all the health care centers that perform STI screening into the information flow and to report the results obtained in the micro-biology / serology laboratories.
- To regulate the reporting for each STI case, including the reporting of cases of congenital and peri-natal STI.
- To regulate and monitor the compulsory reporting for STI cases by private health care centers.
- To introduce sentinel surveillance systems for certain STIs.
- To build capacity in order to conduct regular surveys on STI incidence in identified vulnerable population groups.
- To develop the necessary infrastructure in order to introduce an information system in all the key points of the STI surveillance system; this implies the development of a management information system at the national level, the development of a special

software, and the acquisition of computers by all health care centers involved in managing this type of information.

- To improve and standardize the formats used in data collection and transmission in this field.
- Starting from 2005, the Ministry of Health and the Computing, Health Care Statistics and Medical Documentation Center should issue regular newsletters focusing on the analysis of the evolution of the main factors in the STI surveillance system at regional and national levels.
- To ensure that all information is transmitted electronically (from the periphery to the center and vice-versa) in order to facilitate rapid communication; a web page might be developed for this purpose starting from 2005.

3.3. To diagnose STI cases only in certified laboratories by the end of 2006

Priority action areas:

- To develop a methodology guide for STI laboratory surveillance and to put it into use by laboratories at all levels of the system; the guide should include standards for equipment, services, responsibilities, case definitions, confirmation techniques, forms used in the system, and feedback.
- To initiate necessary procedures for the introduction of quality standards and quality external control for laboratories involved in STI surveillance.
- To provide on-going training to medical staff who will work in laboratories that provide services in the STI field.
- To designate reference laboratories for STIs.

GO 4. To develop and improve the performances of the national health care system in order to be able to plan and provide comprehensive and complex health care services to infected and affected persons

Specific objectives:

4.1. 50% of primary health care services will provide STI early detection and appropriate management of STI cases by the end of 2006

Priority action areas:

- To provide family physicians and physicians working with the family planning network with training programs that includes the provisions of the STI Diagnostic and Treatment Guide.
- To provide special training in STIs for nurses.
- To revise the treatment guides regularly.
- To organize free training programs for trainers (family physicians) who will disseminate knowledge in STIs in their turn.

- To draft and disseminate materials on STIs to target family physicians and physicians from the family planning network.
- To conduct surveys coordinated by dermato-venereologists at the primary health care level on the validity and implementation of new tests for rapid diagnosis of STIs.
- To conduct on-going evaluations at the primary health care level of syndromic treatment algorithms and their adjustment depending on certain parameters (such as peculiarities of the available types of investigations, modifications of STI epidemiology, and modifications of the susceptibility of some germs to antibiotics).
- To increase the number of investigations for STI diagnosis that can be recommended by physicians who provide primary health care and who have a contract with the Health Insurance House in compliance with the recommendations included in the Diagnosis and Treatment Guide.
- To provide financial and human resources in order to continue the treatment and surveillance of STI cases.

4.2. To increase by 100% the direct accessibility to ambulatory public health care services for STI cases through a quantitative and qualitative improvement of medical services / facilities as well as an improvement of the regulatory framework by 2005 as compared to 1999

Priority action areas:

- To amend the legislation in effect in order to allow STI patients to have direct access to examinations by dermato-venereologists.
- To provide dermato-venereologists with on-going medical training that should include also training in STIs and family planning counseling services.
- To provide special training in STIs for nurses.
- To develop ambulatory services to allow the provision of rapid diagnosis and direct treatment under surveillance for STI patients irrespective of whether they hold medical insurance or not.
- To provide financial and human resources in order to continue the treatment and surveillance of STI cases.

4.3. To increase by 25% the number of people who see a doctor of their own accord for STI diagnosis and treatment by 2005 as compared to 1999

Priority action areas:

- To increase the number and capacity of outpatient centers and ambulatory services.
- To develop user-friendly, patient-oriented ambulatory services to meet young people's needs in particular.
- To provide access to STI tests in a system of quality, client-oriented services that observe confidentiality.
- To multiply programs that facilitate access to STI tests and treatment for various high-risk groups at a national level.

- To develop educational campaigns targeting youth (aged between 12 and 20) to present the main signs / symptoms of STIs and to encourage them to seek examination / treatment of their own accord.

4.4. To train medical staff for providing health care for STI patients in compliance with the international quality standards in effect. By the end of 2004, 50% of the medical staff involved in health care for STI patients will undergo at least a training program as part of the on-going medical training system

Priority action areas:

- To formulate recommendations for the revision of the curricula of the Colleges of Medicine in order to introduce the STI Diagnosis and Treatment Guide and those elements that are relevant for the on-going medical training of nurses and social workers.
- To introduce the STI Diagnosis and Treatment Guide in the on-going medical training programs of dermato-venereologists, family physicians and physicians from the family planning network.
- To create and develop by 2006 an open distance education system to provide, by internet, access in real time to the latest information on sexually transmitted infections.
- To assess the quality of medical services for STI patients and the degree of implementation of the recommendations included in the STI Diagnosis and Treatment Guide.

GO 5. To develop new services and to tailor them to the needs of vulnerable population groups or groups with special health care needs (pregnant women)

Specific objectives:

5.1. To provide integrated, comprehensive free services for pregnant women at all levels of health care by the end of 2004 and to eliminate congenital syphilis and neonatal conjunctivitis caused by sexually transmitted infections by 2006

Priority action areas:

- To increase to 80% the proportion of women who see a physician in the first quarter of pregnancy by 2006.
- To develop an information campaign for women and pregnant women to highlight the effectiveness of current methods of diagnosis and treatment of syphilis that would allow prevention of congenital syphilis provided that treatment is initiated on time.
- To conduct a survey to identify the main causes of congenital syphilis in order to develop a targeted approach (for instance: a) patient-related causes: lack of information, late examination / lack of examination by the physician, b) causes related to the health care system: incorrect treatment, late treatment).

- To conduct a pilot survey on the introduction of Chlamydia screening for women under 25 who have not been pregnant and who are at risk for developing sexually transmitted infections, and to use the results in developing a cost-effective screening strategy.
- To build local capacity to provide integrated services by establishing multi-discipline and multi-sector task forces to develop vertical prevention programs in compliance with available national guides.
- To increase the number of family physicians who have expertise in HIV and STI counseling.
- To increase the counseling and voluntary testing capacity by 2006 as compared to 1999 by at least 100%.
- To introduce free and universal access to HIV counseling and screening for pregnant women.
- To increase access of pregnant women in rural areas or disfavored communities to HIV and STI counseling by using the services of community organizations or social workers.
- To initiate campaigns in order to register all fertile women in the records of family physicians.
- To develop campaigns targeting the entire population in order to create awareness of the advantages of prenatal examination.
- To ensure universal access to screening and counseling for pregnant women.

5.2. To formulate quality standards for medical services provided to STI patients and to have them implemented by at least 50% of medical services providers in this field by 2005 at all levels of health care (family physician, specialized outpatient, hospital) or with other service providers

Priority action areas:

- To define quality standards in the field of health care for STI patients.
- To train specialized staff to provide counseling services in the field of sexually transmitted infections.
- To promote regulations in order to encourage/motivate the provision of counseling services.
- To include all patients and their partners in counseling programs.
- To provide support in order to build NGO capacity to provide alternative health care and support services for affected or infected persons.

5.3. To integrate health care services for sexually transmitted infections into reproductive health services provided mainly by family planning offices

Priority action areas:

- To train the medical staff that provides primary health care services in STIs in compliance with the recommendations included in the STI Diagnosis and Treatment Guide.
- To conduct a pilot survey in order to identify the main STI factors that have a negative impact on the reproductive morbidity for patients who go to family planning offices for screening strategies.
- To provide indiscriminate access to any necessary medical service, including mental health care services.

GO 6. To ensure health policies and a regulatory framework to meet the requirements of sexually transmitted infections

Specific objectives:

6.1. To complete the legislative and regulatory framework in the field of epidemiological surveillance and management of cases of sexually transmitted infections in compliance with the European Union requirements

Priority action areas:

- To analyze all existing legislative documents on STIs in order to comply with EU legislation.
 - To develop legislative documents in compliance with the guidelines of the European Commission (decision 2119/98/EC that stipulates the creation of a network of epidemiological surveillance and control of infectious infections, decision 2000/57/EC on rapid signaling and response for the prevention and control of infectious diseases and decision 2000/96/EC on covering infectious diseases by the EC Countries network). These actions are necessary for the EU integration process and will allow for unitary reporting of morbidity data and for comparisons between the situation in Romania and that of EU countries.
 - To disseminate and monitor the implementation of EU legislation provisions at a national level.
- 6.2.** To complete the legislative and regulatory framework in order to integrate STI health care into primary and secondary health care and to develop new services necessary for a complex approach to STIs by the end of 2004

Priority action areas:

- To approve the Minister of Health Order on the Program for Prevention and Control of Sexually Transmitted Infections. The order stipulates the responsibilities and tasks of health care centers and medical staff in STI detection, reporting, surveillance and control, case definitions, information system – records and information flow between health care centers and STI prevention actions.
- To revise, modify and complete the Law on Public Health (law no. 100/1998) in order to include reference terms, objectives, and the structure of the entire surveillance system for infectious diseases.

- To draft general legislative documents with impact on STI prevention and control for at-risk groups such as CSW.
- To revise, modify, and complete the framework contract on the conditions of provision of STI health care within the health insurance system, in compliance with the legislation in effect.
- To develop a flexible system to allow for the follow up, revision and improvement of legislative aspects based on existing needs.

6.3. To pass regulations on the confidentiality of information related to sexually transmitted infections by 2005

Priority action areas:

- To observe the provisions of the law on patients' rights and the deontological code regarding confidentiality.
- To develop and distribute a procedures guide for observation of the confidentiality of information in the case of patients with STIs, such as:
 - Information on the registration and reporting of patient information (referral of the patient to another physician, information flow, medical records, results of laboratory tests)
 - To create conditions for confidentiality when a STI patient sees a physician in a health care center (by scheduling patient examinations in a way that minimizes waiting time, counseling patients in private rooms, creation of acoustic barriers; the patient's name should not be disclosed to sexual contacts or others without the patient's consent)
- To develop a proactive attitude toward one's own health condition and to encourage seeking a doctor's advice for any problem that might suggest the presence of an STI.

6.4. To develop coherent health care policies in the field of STIs to include the organization of services, inter-sector cooperation, and information distribution by 2006

Priority action areas:

- To identify partners in the community, the public sector, and the private sector who should participate in the implementation of the strategy and in STI prevention activities. They will create viable partnerships for the STI prevention program with groups that carry out their activity in reproductive health, schools, religious organizations, detention centers, etc.
- To integrate STI services into other medical subjects in order to reduce the stigma associated with STIs.
- To improve access to clinical services and drugs by increasing the range of counseling and treatment centers.
- To use the media to transmit key messages to the population in general and vulnerable groups in particular. To identify key persons who will participate and coordinate

communication activities. Media campaigns that target the entire population should focus on providing information on STI prevention methods.

- To introduce and maintain a quality insurance system at all the levels of health care for STIs.
- To develop social services guides for infected and affected people.
- To monitor the enforcement of legislation including by building the capacity of organizations of infected and affected people.
- To monitor discrimination in order to prevent and eliminate it.
- To improve the population's access to services of prevention, control and surveillance of STIs (location of the health care center, appointment system, health care center working hours, evaluation system regarding patient satisfaction with provided services).

IMPLEMENTATION FRAMEWORK

1. General Framework

The activities for HIV/AIDS control and those for STI control are complementary. International organizations recommend that the two programs should be integrated or, if they are separate, that they should follow coordinated planning or share specific, selected activities.

In order to be implemented successfully, the STI control strategy must be integrated into the HIV/AIDS Strategy and the Sexual and Reproductive Health Strategy for maximal effectiveness and for proper and judicious financing. It is also necessary to decentralize activities through a process involving good management and a flexible and effective surveillance and evaluation system. Consistent regulations in order to maintain centralized reporting in real time and to ensure appropriate community involvement are also needed.

The coordination of the strategy implementation at a central level includes:

- Consensus in order to generate health policy decisions and regulations at a national level and to highlight the role of STI control for the public health, particularly as STIs relate to the larger fields of HIV/AIDS and reproductive health.
- An inter-sector approach, with the involvement of other Ministries, academic institutions, professional and non-governmental organizations, and EU groups; international agencies or organizations should be involved in programs for STI prevention and control.
- Specific activities for health promotion and STI prevention, targeting vulnerable population groups and including an operational research to provide information about such groups, their geographic distribution, the prevalence of STIs and etiologic agents, available prevention and control, etc.

- A functional national surveillance system, the information from which will be used in the decision-making process, including evaluation of the strategy.
- Fund allocation for STI prevention and treatment. When there are insufficient financial resources, priorities will be identified for their allocation and distribution. The provision of health care services and patient flow within the health care system should be planned; facilities for special-need or low-income patients, including free access to health care and treatment, should be provided; and there should be continuity in providing these services. The delivery and quality of services will be monitored.
- Coordination and monitoring of on-going medical training and education for different categories of professionals involved with STIs, in order to maintain an acceptable level of quality health care services.
- A national medium- and long-term action plan for the implementation of the present strategy, including specific actions to be undertaken in order to achieve the proposed objectives, as well as responsibilities, resources, deadlines, and indicators to measure progress.
- A system for monitoring and evaluation of strategy implementation.

2. Healthcare Reform, Legislative Framework and EU Accession Process

Romania is in a continuing process of health care system reform and harmonization of its legislation and policies with the requirements for European Union accession. The legislative framework is changing; some laws are being amended while other laws are being passed. The reorganization and decentralization of the health care system through the introduction of the health insurance system have reduced the role of central authorities in controlling infectious diseases, including STIs. However, the Ministry of Health and the National Health Insurance House have not followed up with unitary regulations in order to improve the system of control of sexually transmitted infections. The general social and economic situation and social evolution should also be considered for an effective implementation of an STI prevention and control strategy.

In order to implement the present strategy successfully, the following elements will be emphasized:

- To integrate health care policies into general social and economic development policies.
- To ensure a coherent legislation that regulates the health care system; to promote and support other legislative initiatives (such as the law on prostitution) or inter-sector regulations (in collaboration with other Ministries that have an interest in this field).
- To support the integration of priority domains of public health into the official documentation related to the EU accession process, such as the Romania National Accession Program or other international documents.
- To include the priorities and provisions of the Ministry of Health on STI control in the framework contract that regulates the health insurance system and health services provision and contracting.

European Union countries have an epidemiological surveillance and control network for infectious disease (Amsterdam Treaty, art. 152). Within the EU accession process, Romania will have to deal with matters related to infectious diseases, including STIs. Therefore, it will be necessary to revise the current legislation and to improve the system of surveillance of infectious diseases at a national level. The present strategy fully takes into consideration areas that are regulated by EU documentation regarding infectious diseases, including STIs: (1) the reporting system and the existence of a national action plan for surveillance and control of infectious diseases; (2) the existence of an electronic data collection system that is compatible with that used in EU countries; (3) the role of national authorities in the activity, organization, and funding of the epidemiological surveillance system; (4) the activity of diagnosis laboratories in compliance with EU standards and equipped with quality systems, and provision of quality systems for those that need them; (5) on-going training of specialists, including laboratory technicians, staff involved in the reporting system, and staff involved in health promotion activities; (6) regional collaboration and collaboration with EU member countries.

Legislative documents and actions will be developed to create the coherent framework necessary for implementation of this strategy. The WHO report “Assessment of the National Surveillance System for Infectious Diseases, Romania 2001” contains similar recommendations. The report highlights the fact that it is important for Romania to create a coherent regulatory framework, in compliance with EU requirements.

- To harmonize the national regulations concerning infectious disease epidemiological surveillance with EU regulations.
- To draft legislation in compliance with the European Parliament and the European Commission decisions (decision 2000/96/EC).
- To introduce an integrated epidemiological surveillance system for infectious diseases, including sexually transmitted infections, and to integrate it into the EU epidemiological surveillance and rapid detection system for infectious diseases.
- To identify health indicators that are comparable and compatible with EU indicators, and to develop management information systems for data collection in compliance with international standards.
- To increase the number of health care projects developed as part of European Union programs, and to revise regularly the assistance and multi-lateral cooperation projects that focus on the health care system in Romania, in order to cover all priority areas and avoid the duplication of projects or programs.
- The Ministry of Health will issue an Order on the Program of Surveillance and Control of Sexually Transmitted Infections. The order will encompass responsibilities at each level of the system for health care centers and medical staff, case definitions, an information system for epidemiological surveillance, and forms for case reporting.
- To revise, modify, and complete the Law on Public Health (Law no. 100/1998); to include reference terms, objectives, and the structure of the entire surveillance system for infectious diseases.

3. Roles and responsibilities

The Ministry of Health, as the Government body, has primary responsibility for the successful implementation of the National Strategy for Prevention and Control of Sexually Transmitted Infections. The General Directorate for Public Health and State Sanitary Inspection (GDPHSSI) - MOH will coordinate all the necessary activities for the achievement of the objectives included in this strategy. At the same time, GDPHSSI will coordinate its activities with other departments of the ministry, with subordinate public institutions, and with the National Health Insurance House.

GDPHSSI will also be responsible, on behalf of MOH, for the coordination of MOH activities with the activities of other Ministries, non-governmental organizations, and representatives of international agencies or organizations involved in STI prevention and control.

GDPHSSI will develop the medium- and long-term national action plan in order to implement the present strategy. This plan will include activities necessary to achieve the proposed objectives, responsibilities, resources, deadlines, and indicators for evaluation of the progress made towards the proposed objectives. Each year, GDPHSSI will develop, coordinate, and monitor the implementation of the subprogram for STI prevention, surveillance, and control within the national public health care programs financed by MOH in compliance with the action plan, within the limit of available funds. The STI control subprogram will be coordinated with the MOH reproductive health subprogram, and with on-going programs implemented by other Ministries or by Romanian and international organizations.

The public institutions responsible for the strategy implementation are the District Public Health Authorities, the Cantacuzino National Research and Development Institute for Microbiology and Immunology, Public Health Institutes, the Center for Computing, Health Care Statistics, and Medical Documentation, the National Health Insurance House and its regional offices, etc. The action plan will present the responsibilities of each of these institutions in detail.

The other ministries playing a key role in the achievement of the proposed objectives are the Ministry of Education, Research, and Youth, the National Authority for Protection of Children's Rights and Adoption, the Ministry of Labor, Social Solidarity and Family, the Ministry of Justice, the Ministry of National Defense, the Ministry of Transportation, Construction, and IT, and the Ministry of Administration and the Interior. The Ministry of Health will promote the cooperation with these ministries and will initiate the process of signing protocols for the implementation of the main activities targeting vulnerable population groups, which are under the scope of responsibility of these ministries.

The local authorities will play an increasingly important role in identifying needs at the community level and in implementing programs that meet these needs. The decentralization process has been amplified through Ordinance 70/2002, which stipulates that local authorities will

own and manage the health care centers. Consequently, local authorities will become more concerned with the population's health status, including STI prevention and control. MOH will promote the cooperation with local authorities and will support them in building their institutional capacities in order to approach health-related matters.

Civil society, which is represented by non-governmental organizations, is an important resource that should be taken into consideration when creating partnerships. Non-governmental organizations are still young, as they were established after the political changes in 1989. However, over the last decade, they have managed to cover areas or services that are not covered by public institutions, such as the prevention and promotion of sound behaviors or the provision of new services. For instance, they offer counseling services for groups at risk: young people, people living with HIV, CSW, MSM, etc. MOH will promote the direct cooperation with non-governmental organizations that develop consistent activities in the field of STIs or that have the capacity to do so, including by funding specific activities that cannot be carried out by the subordinated public institutions.

The private sector should be fully involved in the process of reporting detected cases or potential contacts. At present, reporting of sexually transmitted infections is compulsory for all centers that provide health care services, both public and private. However, private service providers often do not comply with this regulation. Therefore, the MOH action plan will include regulations on the monitoring of private services providers through the DPHAs, as well as measures through which the DPHAs will not renew free practice authorizations for physicians who do not observe the regulations on compulsory reporting.

Cooperation within the health care sector

Within the health care system, all health services providers will cooperate closely at all levels: primary, secondary or tertiary. They will intensify prevention and early detection activities. The MOH action plan will regulate patient flow between the various health care levels and institutions in order to simplify it and to shorten the length of time necessary to detect a disease and begin treatment.

STI detection forms part of normal medical duties for all physicians, regardless of their specialty. Family physicians should also play an increasing role. In the future, they will be responsible for certain screening programs and they will provide diversified services, including counseling for affected / infected persons.

In order to prevent congenital syphilis, it is necessary to coordinate with providers of health care services for pregnant women and fertile women. The laboratories network is also important, and all laboratories should conform to the same quality standards.

Cooperation increases the effectiveness and efficiency of STI prevention actions, reduces the number of parallel activities, and can generate an improvement of the health condition of certain target groups. STI prevention and control programs should be integrated into family planning programs, prenatal health programs, HIV/AIDS prevention programs, and child and woman health programs.

The public health care actions focusing on the education of high-risk persons should be coordinated by all parties involved. An effective strategy for the reduction of transmission of these diseases is to involve social workers or create partnerships with representatives of vulnerable groups. This would increase their confidence and would allow services and intervention to be provided more easily (see, for instance, health care mediators within Roma communities or NGOs involved in gay rights activities). It is important to gain community confidence. Community trust makes it easier to implement targeted screenings and to work effectively on behavior change. Also, a close collaboration will be developed with key persons within community-level institutions. Thus, it is essential for all STI prevention programs to develop a permanent relationship among all organizations that have the capacity to affect the results and the objectives of STI control programs.

Collaboration with international organizations is essential. At present, the international agencies and organizations active in the Romanian health sector are very much interested in infectious disease prevention and control, including prevention and control of sexually transmitted infections. The partnerships, programs, and projects that are technically and financially supported are important due both to the international expertise that these organizations provide, and to the consistent funds that are granted.

The World Health Organization, through its Regional Office for Europe, provides Romania with technical assistance through a biannual collaboration agreement. It also facilitates access to the latest scientific public health news and promotes Romania's collaboration with other international organizations. As far as STIs are concerned, WHO experts evaluated sexually transmitted infection and the HIV/AIDS situation in Romania in 2000. In 2001, the Ministry of Health asked for WHO support to evaluate the national surveillance system for infectious disease, including STIs. The project objectives focused on evaluating the structure, process, and results of the surveillance system for infectious disease, including STIs, for compliance with European Union requirements. Romania will continue to request WHO support in implementing the present strategy.

United Nations organizations in Romania (UNFPA, UNICEF, UNAIDS) provide technical and financial support in different areas of public health through official agreements with the Romanian Government. UN organizations also target sexually transmitted infections including HIV/AIDS. In this respect, they substantially finance programs for STI prevention and for the promotion of healthy behavior. Both public institutions and non-governmental organizations coordinate these programs. One UNFPA guideline refers to the promotion of healthy sexual behaviors among young people, and UNFPA is one of the main financing resources for STI-related programs. It supports the implementation of the present strategy and is a strategic partner for MOH.

The European Union. A new PHARE project was launched in 2002 to improve the national system for epidemiological surveillance and infectious disease control. The project will last from 2002 to 2005. Its objectives are: to revise current legislation and to improve the national surveillance structure for infectious disease control and prevention; to revise the performance, organizational structure, and financial resources of the epidemiological surveillance and reporting system and to establish a new National Action Plan; to improve the national reporting system for

infectious disease; to implement a data collection system compatible with that of the European Union; to assess and improve infectious disease diagnosis laboratories; to train epidemiology, microbiology, laboratory, reporting, and health promotion personnel; to cooperate with other national focal points and with the most important EU laboratories.

The United States Agency for International Development (USAID) provides consistent financial and technical support for reproductive health in Romania. Through the *JSI Research and Training Institute (JSI)*, USAID is implementing a five-year program for family health in Romania, including sexually transmitted infection prevention and control, entitled “The Romanian Family Health Initiative” (RFHI). JSI coordinates and implements this program, having as partners both governmental institutions and NGOs. RFHI tackles legislation, resource allocation, service delivery and BCC. JSI also supports the MOH as a strategic partner to implement the present strategy.

The World Bank. The second World Bank loan for health care finances a complex program targeting all sectors of the health care system. The public health care component contains a wide range of activities, from drafting the National Strategy for Public Health to providing training for staff working in health care promotion and building the institutional capacity of the public health care system. Among other objectives, these projects also focus on HIV/AIDS and STI prevention. A national program for sexually transmitted infection control is being implemented. Its objectives are: to reduce the incidence of syphilis to 30 cases/100,000 inhabitants; to eliminate congenital syphilis by 2005; to conduct a survey on the incidence of *Chlamydia trachomatis* by the end of 2003; to increase the use of condoms by vulnerable population groups; to increase the rate of population at risk that requests medical counseling and treatment. The program will last for four years (2002-2005).

Other organizations. Other governmental and non-governmental international organizations support various programs or initiatives at the local level or through civil society representatives. There is close cooperation between professional associations in the country and similar international organizations, which facilitates experts’ access to the latest information and experiences in their fields of activity.

4. Resources mobilization

The Government is responsible for providing the financial resources necessary for implementation of this strategy. Because the state budget provides limited funding, the Ministry of Health plans to achieve the proposed objectives through a comprehensive financing strategy that includes:

- Financial resources from the state budget through national public health care programs. The subprogram for sexually transmitted infections control will be developed for 2004 in compliance with strategy guidelines.
- Financial resources from the state budget through activities that should be financed by other Ministries that have their own health care network or that organize activities for STI prevention and control (the Ministry of Education, Research and Youth, the National Authority for Protection of Children’s Rights and Adoption, the Ministry of Labor, Social

Solidarity and Family, the Ministry of Justice, the Ministry of National Defense, the Ministry of Transportation, Construction, and IT, and the Ministry of Administration and the Interior).

- Financial resources from the health insurance system in order to support diagnosis activities, treatment, and other health care services for infected and affected persons, in compliance with MOH policy.
- Reimbursable funds (World Bank).
- Grants (to attract new PHARE programs; the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, which is financing an extensive five-year project in Romania; the Stability Pact; bilateral agreements and others which will be identified)
- Partnership with civil society. Non-governmental organizations bring much expertise and experience, and their approach should be complementary to activities carried out by public institutions. Also, international governmental and non-governmental organizations and EU programs support various programs and initiatives at the local level or through civil society representatives. The Ministry of Health will focus on the integration of these bilateral programs, the creation of a database for the dissemination and replication of the most effective interventions, and real collaboration between the Ministry and public institutions and the non-governmental organizations.
- Technical and financial support provided by international agencies or organizations (WHO; UNFPA; UNAIDS; UNICEF; USAID/JSI) for the implementation of various components of this strategy.

5. Monitoring and evaluation

The General Department for Public Health and State Sanitary Inspection within the MOH will ensure the management and supervision of the strategy's implementation. The supervision is a two-way process; events are monitored and supervised, which allows for the provision of feedback and encourages and supports implementation by identifying potential problems and their possible solutions.

The process of monitoring and evaluation is essential, as it provides information about the achievement of the proposed objectives and the effectiveness of the activities carried out in order to achieve them. Monitoring and evaluation measure the success of activities from the point of view of their impact, as well as from that of processes and results.

Monitoring represents a permanent process used for estimating the degree to which strategy actions and activities occur as planned and for identifying shortcomings in order to make changes and corrections if necessary. Monitoring provides information about the performance of activities in compliance with defined performance standards and allows for comparisons between actual and expected progress. Monitoring is process-oriented. It focuses on activities (such as appropriate training or the performance of services providers) rather than on results (knowledge or behavior change) and impact (morbidity and mortality reduction or health improvement). The supervision and monitoring take place simultaneously.

Evaluation is the process of systematic examination of the effects and impact of activities and programs included in the strategy in order to estimate to what extent the proposed objectives were achieved.

The monitoring and evaluation of STI control activities will provide essential information on how to improve future STI control activities or programs. The monitoring and evaluation process will analyze the volume, rapidity, and quality of the performed activities and will answer questions such as: Are implementation programs adequate? Are program activities adjusted to the environment in which they are implemented? Are program activities implemented correctly and in a timely fashion? Do they cover the proper areas and do they fit within the budget? Do program activities achieve the proposed objectives?

Performance monitoring will be compulsory at every stage, both for final and intermediary results, in order to identify the strengths and weaknesses affecting program implementation. This implies the existence of a monitoring plan for each component or program (for instance, separate plans for surveillance, screening, case management and promotion of activities for sound behavior). These plans will be integrated into the monitoring and evaluation system of this strategy.

The monitoring and evaluation system should include indicators that are necessary for the measurement of each objective or component. The monitoring and evaluation system should also define the sources of information from the beginning. For the resources, process, and results measurement, the sources of information will be defined in the programs or components of the programs. The impact of the program implementation can only be evaluated through surveys that are conducted for this purpose. For instance, the National Survey on Reproductive Health 1999 can be considered a reference term for the existing state of affairs prior to the strategy implementation for many objectives. Therefore, the Ministry of Health will lobby various donors for the repetition of this survey by the end of the implementation of this strategy.

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- Program Operations Guidelines for STI Prevention – Leadership and Program Management, p L1-L9, Guidelines for STI Prevention, Surveillance and Data Management, p S1-S39, Center for Diseases Control, Atlanta 1998. <http://www.cdc.gov/std/program/>
- Draft order of the Minister of Health and Family on the Program of Surveillance and Control of Sexually Transmitted Infections, 2003
- Relationships of HIV and STI Declines in Thailand to Behavioral Change: A synthesis of existing studies. UNAIDS Best Practice Collection, Geneva, 1998 available at the following address:
<http://www.unaids.org/publications/documents/epidemiology/determinants/una98e2.pdf>
- Sexually Transmitted Infections: policies and principles for prevention and care – Best Practice – Key material, WHO/UNAIDS, Geneva 1997; available at the following address:
<http://www.unaids.org/publications/documents/impact/std/una97e6.pdf>
- Strategy of the Ministry of Health for Reproductive Health and Sexuality, Bucharest, 2003
- World Health Organization – Guidelines for the management of sexually transmitted infections, 2001
- Legislation - appendix no. 5

APPENDIXES

APPENDIX NO. 1: Losing Track of Patients from Infection to Cure

number of infected persons

number of persons who are aware of their infection

number of persons who seek medical treatment

number of persons diagnosed with STIs

number of persons who are under treatment

number of cured persons

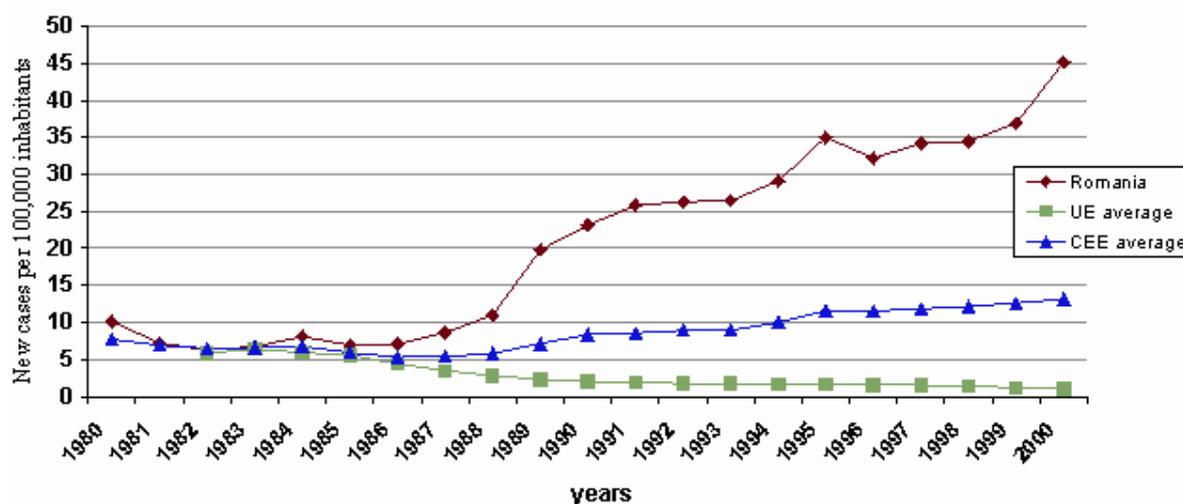
number of infected uncured persons

Ratio of cured / uncured persons varies with the region depending on the actions undertaken in every phase by individuals or health care centers.

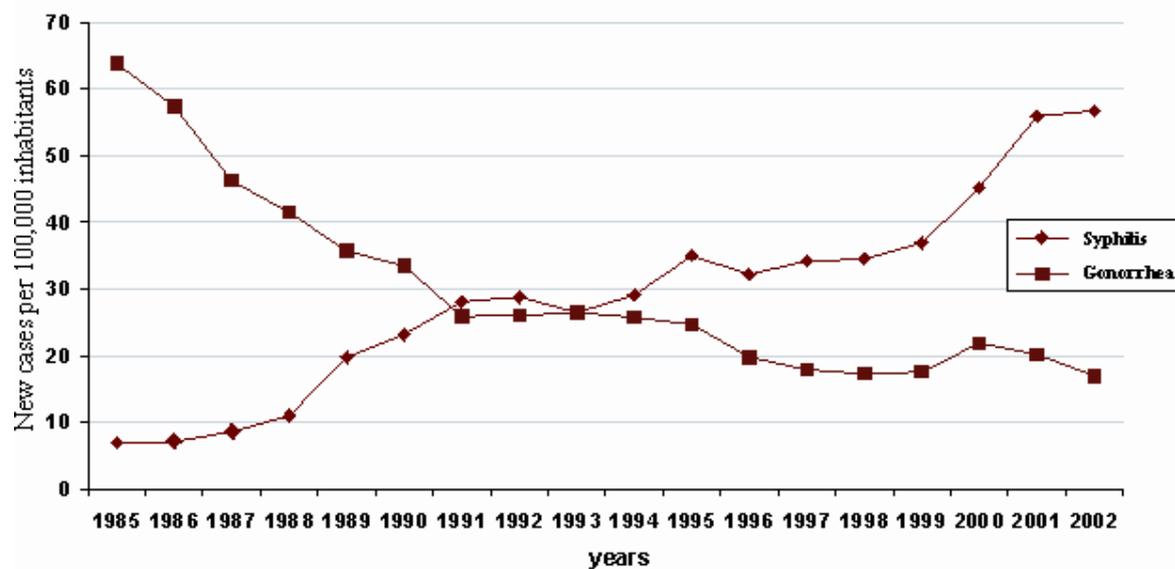
Source: Sexually transmitted infections; policies and principles for prevention and care, UNAIDS best practice collection

Appendix 2: Syphilis and Gonorrhoea morbidity trends, Romania 1989-2002

SYPHILIS INCIDENCE RATE TREND, PER 100,000 INHABITANTS ROMANIA, EU AVERAGE, CEE AVERAGE, 1980-2000

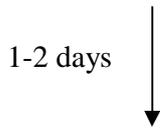


REPORTED INCIDENCE TRENDS FOR SYPHILIS AND GONORRHEA, ROMANIA, 1985-2002

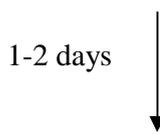


APPENDIX NO. 3: STI Patient / Suspect Flow

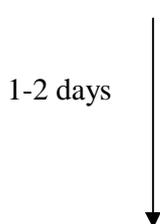
STI Suspect / Patient



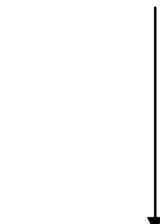
Family physician



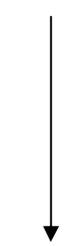
Specialist in dermato-venereology
in specialised outpatient center



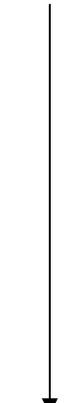
Hospital – Hospitalization
(with/without an appointment)



Diagnosis and Treatment



Treatment



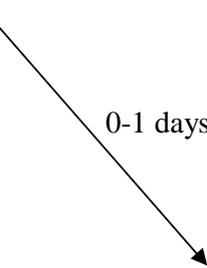
0-1days

Obtaining free medication



0-1 days

Administration of injectable drugs



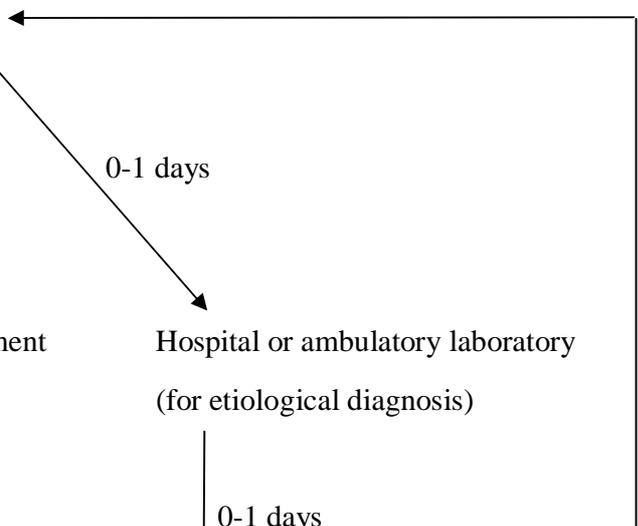
0-1 days

Hospital or ambulatory laboratory
(for etiological diagnosis)



0-1 days

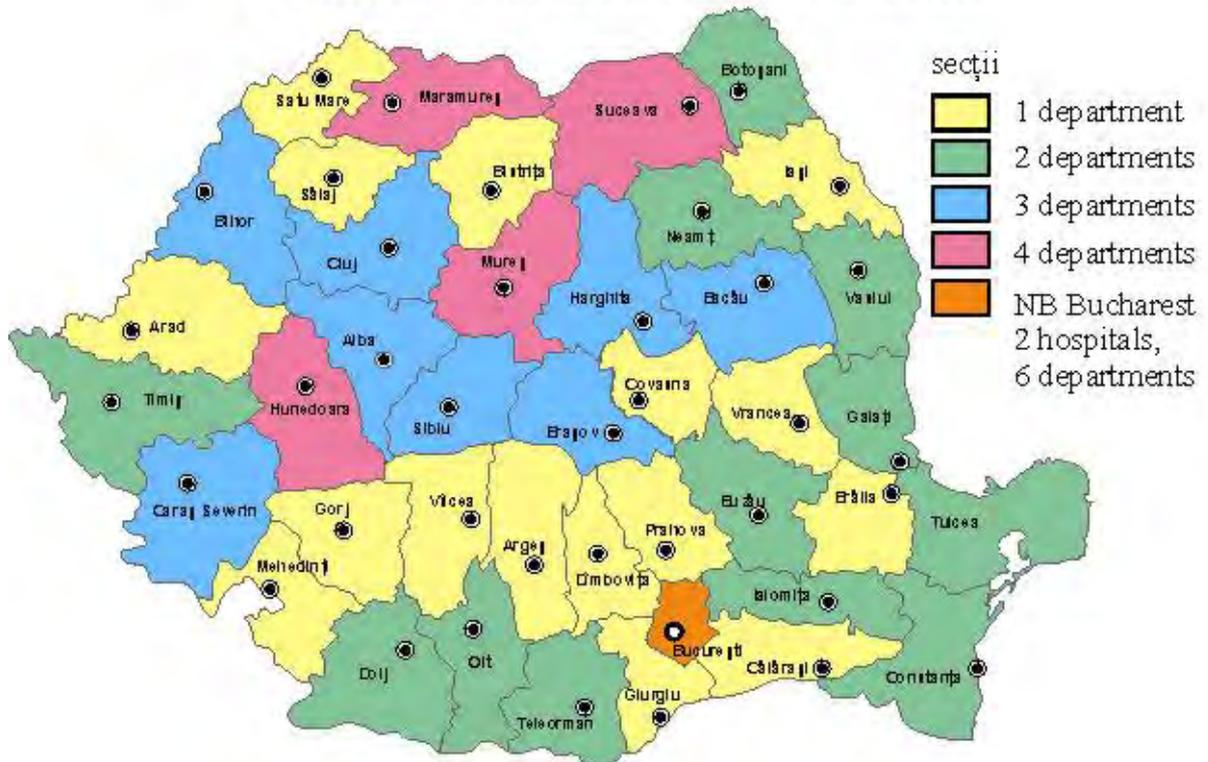
Results of investigations



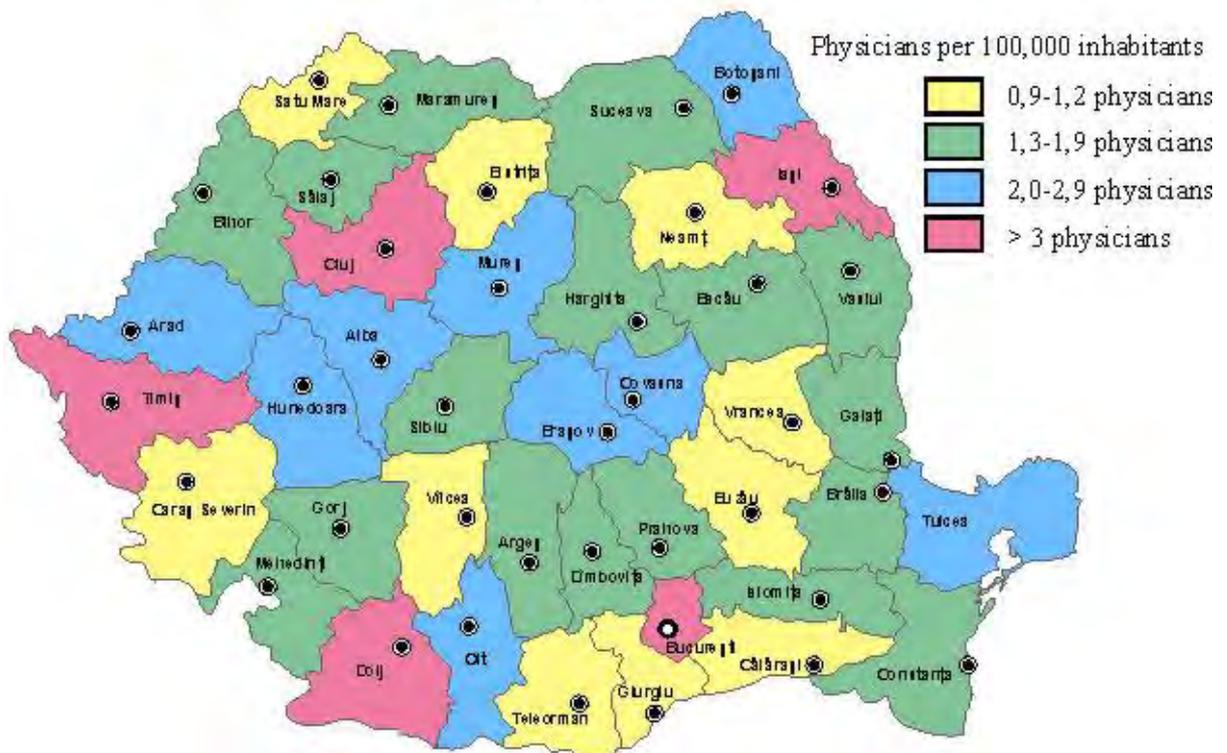
0-1
days

Appendix 4: DV specialists and DV departments' distribution

DV DEPARTMENTS DISTRIBUTION, ROMANIA, 2001



DV SPECIALISTS DISTRIBUTION PER 100,000 INHABITANTS, ROMANIA, 1998



APPENDIX NO. 5: Legislative Framework that Regulates STI Prevention, Surveillance, Control and Health Care services in Romania

Decree no. 141/1953 – STI patients undergo treatment and inform their partners about their condition

Order of the Ministry of Health no. 132/1979 – measures of prevention and confrontation of sexually transmitted infections

Order of the Ministry of Health no. 544/1995 – approval of the Program of prevention and Control of Venereal Diseases; responsibilities of health care centers and medical staff in prevention and confrontation of sexually transmitted infections

Public Health Law (Law no. 100/1998, Ministry of Health) - art. 33: the General Department of Public Health within the MOH has the responsibility to develop the national strategy of health care promotion.

Art. 15 mentions distinct policies and programs for HIV/AIDS and other STIs.

Order of the Ministry of Health no. 638/1978 – compulsory reporting of infectious diseases

Order of the Ministry of Health **no. 8/2000** – rapid information on epidemiology and hygiene issues. Weekly reporting to the Inspector's Office for Public Health and Monthly reporting to the MOH regarding the hotbeds of syphilis and gonorrhea with more than three cases and to report to the DPH on the day of detection the suspect or confirmed cases of syphilis and gonorrhea

Order of the Ministry of Health **no. 588/2000** – compulsory monthly reporting to the General Department of Public Health and State Inspection of complex data coming from all the district laboratories regarding HIV, syphilis and gonorrhea cases

Order of the Ministry of Health and Family **no. 141/2002** regarding the reorganization of the national network of infectious diseases surveillance and control

Joint order of the MOH and NHIH no. 248/March 21, 2003 and 149/March 21, 2003 for approval of the health care subprograms in 2003 includes the Subprogram of control of sexually transmitted infections

Government Decision no. 169/February 13, 2003 regarding the organization and funding of health care programs in 2003 specifies funding sources for health care programs and the total budget allotted for the EU program of public health care

Order of the MOH no. 20/December 2003 on the approval of methodological norms for implementation of the Framework Contract regarding the conditions of provision of primary health care services within the health insurance system

Law on the patient's rights no 46/January 21, 2003 chapter 4 – the patient's right to confidentiality of information and privacy - art. 25 (1) any interference with the patient's private, family life is forbidden, except for the cases when this interference has a positive influence on the diagnosis, treatment or care and only with the patient's consent. (2) cases when a patient is a danger to himself / herself or the public health are considered to be exceptions

**APPENDIX NO. 6: Case Definitions of Communicable Sexually Transmitted Infections
(in compliance with the Decision of the European Union Commission of March 19,
2002⁸)**

A. SYPHILIS

PRIMARY SYPHILIS

Clinical description

Phase of infection with *Treponema pallidum* characterized by one or several chancres. Chancres can differ significantly from the point of view of their clinical aspect.

Criteria of laboratory diagnosis

Detection of specific IgM by EIA

T-pallidum demonstration in samples taken from the patient through: ultra-microscopy, direct immuno-fluorescence with anti-T pallidum anti-bodies or other equivalent methods

For probable cases:

A reactive serology test (a non-treponemic test: VDRL or RPR or a treponemic test: FTA-ABS or MHA-TP or TPHA)

Case classification:

Possible: NA (non-applicable)

Probable: Clinically compatible case having one or several chancres that indicate primary syphilis and any of the reactive serology tests

Confirmed: Clinically compatible case that was confirmed by para-clinical methods

SECONDARY SYPHILIS

Clinical description

Stage of infection with *T. pallidum* characterized by localized or diffuse mucous skin lesions, often associated with generalised lymph-adenopathy. Chancres can still be present there.

Criteria of laboratory diagnosis

T-pallidum demonstration in samples taken from the patient through: ultra-microscopy, direct immuno-fluorescence with anti-T pallidum anti-bodies or other equivalent methods

For probable cases:

A reactive serology test (a non-treponemic test: VDRL or RPR or a treponemic test: FTA-ABS or MHA-TP or TPHA)

⁸ Commission decision of March 19, 2002 laying down case definitions for reporting communicable diseases to the Community network under Decision no. 2119/1998/EC of the European Parliament and of the Council. Official Journal of the European Communities L86/44, April 3, 2002.

Case classification:

Possible: NA (non-applicable)

Probable: Clinically compatible case with any of the reactive serology tests

Confirmed: Clinically compatible case that was confirmed by para-clinical methods

LATENT SYPHILIS

Clinical description

Stage of infection with *T. pallidum* in which the bacteria persists in the infected person's body without producing signs or symptoms

Criteria of laboratory diagnosis

Demonstration of a positive reaction with an EIA specific test, but without para-clinical evidences of infectious syphilis (se primary and secondary syphilis)

Case classification:

Possible: NA (non-applicable)

Probable: Absence of clinical syphilis signs and symptoms and a positive para-clinical test

Confirmed: NA (non-applicable)

B. GONORRHEA

Clinical description

Clinical aspect compatible with gonorrhoea such as: urethritis, cervicitis or salpingitis

Criteria of laboratory diagnosis

Isolation of *N. gonorrhoea* from the pathological material that was taken from the patient

Detection of antigens or nucleic acid of *N. gonorrhoea*

Presence of Gram-negative diplococci, intracellular, inside the cells in the test obtained from the urethral discharge in man

Case classification:

Possible: NA (non-applicable)

Probable: NA (non-applicable)

Confirmed: Case that was confirmed by para-clinical methods

C. GENITAL INFECTION WITH CHLAMYDIA TRACHOMATIS

Clinical description

Clinical aspect compatible with Chlamydia such as: urethritis, epididimitis, cervicitis, acute salpingitis or other sexually transmitted syndromes

Criteria of laboratory diagnosis

C. trachomatis Isolation through culture from material taken from the uro-genital tract

Presence of antigens or nucleic acid of C. trachomatis in the material taken from the uro-genital tract

Case classification:

Possible: NA (non-applicable)

Probable: NA (non-applicable)

Confirmed: Case that was confirmed by para-clinical methods

The national strategy of prevention and control of sexually transmitted infections has been developed under the aegis of the General Directorate for Public Health and State Sanitary Inspection of the Ministry of Health, General Director Dr. Alexandru Rafila.

The working group that developed this document is made up of the following persons: Dr. Dana Farcasanu, Dr. Dan Nicolaiciuc, Dr. Catalin Popescu and Dr. Carmen Moga.

Technical input was also provided from the followings: Commission of Dermato-Venereology of the MOH, Commission of Epidemiology of the MOH, General Directorate for Health Care – MOH, Direction of Family Health Care and Social Services – MOH, National Health Insurance House, College of Physicians in Romania, National Institute for Research and Development in Health, Computing, Health Care Statistics and Medical Documentation Center – MOH, District Public Health Authorities in Bucharest, Calarasi, Constanta, non-governmental organizations (SECS, Youth for Youth) and the representatives of UNFPA, JSI Research & Training Institute, WHO Romania, and UNAIDS office in Romania.

The following organizations provided financial support for the development of this document: the United States Agency for International Development (USAID) through JSI Research & Training Institute, the United Nations Population Fund (UNFPA) and the United Nations AIDS Program (UNAIDS).