

Meeting Proceedings

***Understanding STDs and the Public
Health Approaches to Their Control:
The Appropriate Role of Family
Planning Programs***

Rosslyn, Virginia
December 7, 1994

Family Health International



This meeting was funded by the United States Agency for International Development,
Office of Population, Cooperative Agreement Number DPE-3041-A-00-0043-00

Understanding STDs and the Public Health Approaches to Their Control The Appropriate Role of Family Planning Programs

Purpose and Objectives

The purpose of the meeting was to create a common understanding of the prevention, diagnosis and treatment issues for STD control and to provide an opportunity to participate in group discussions on these issues. The objectives included:

- to learn the basic principles of STD transmission and control,
- to present lessons learned from programs and research related to STD/HIV prevention and control,
- to discuss the importance of evaluation for determining what works and what doesn't,
- to discuss major approaches to integration of STD prevention and control in family planning programs that address identified issues and constraints and are consistent with USAID's guiding principles

Approach

To bring together representatives of various organizations in the fields of population and health to discuss the issues faced in the prevention and control of STDs, especially as these issues affect family planning programs.

Topics

- Basic Principles of STD Transmission and Control
- General Issues and Constraints / The Public Health Approach
- Behavior Change Lessons Learned from STD/HIV Prevention Programs
- Messages for Women at Risk because of Partner Behavior
- Importance of Evaluation

The meeting agenda and list of persons who registered for the meeting is attached to this report.

Meeting Summary

December 7, 1994 Family Health International (FHI) convened a meeting on "Understanding STDs and the Public Health Approaches to Their Control: The Appropriate Role of Family Planning Programs" at the request of USAID. More than 100 participants from USAID and various organizations working in family planning and health attended the one-day meeting which provided a basic understanding of important issues and an exchange of ideas and experiences between experts and program implementors. Speakers presented on basic principles of STD transmission and control, general issues and constraints, lessons learned

from STD/HIV prevention programs, messages for women at risk because of partner behaviors and the importance of evaluation

The following summarizes the issues raised by speakers and participants

- To have a public health impact, family planning programs need to work with STD core transmitters such as commercial sex workers or persons with many partners, working with typical family planning program clientele, most of whom are not core transmitters, may improve the health of individuals, but will have a limited effect on stopping the epidemic
- There are two reasons for family planning programs to be interested in STDs 1) having an STD increases one's risk for HIV transmission, and 2) having an STD results in increased risk for reproductive tract problems in women and in her child if she is pregnant, such as congenital syphilis and eye or lung infections
- The variations in the prevalence of gonorrhea, chlamydia and syphilis in women attending antenatal clinics in the developing world emphasizes the need for a methodology that can assist family planning programs to know the extent of the STD problem among their clientele
- Family planning programs mainly serve women, many STDs are undetected and untreated in this group because of mildly symptomatic or asymptomatic infections
- Syndromic management may be the most practical for family planning programs, but the approach ignores asymptomatic cases which may constitute a majority of cases in women
- Preventing reinfection by reaching partners is essential
- Although barrier methods may be less effective in typical use in preventing pregnancy than other methods of contraception, their protection against STDs may make their use preferable for at-risk women
- Although women attending family planning programs may be at risk of STD/HIV infection, often it is not because of their behaviors, but because of the high-risk behaviors of their partners, family planning programs are not very skilled in reaching and communicating with male partners
- In a population in which risk is a result of partner behavior, it is difficult to develop a risk assessment tool that will identify asymptomatic women who are at risk and should be screened for STDs
- There are women at risk because of their own behaviors commercial sex workers, women with multiple partners, and women who engage in serial monogamy (a series of

relationships, each one monogamous) The message for these women is clear -- partner reduction, condom use and treatment of STDs

- For those family planning clients at risk because of partner behavior, effective messages are less clear, many women are unable to change their partners' behavior Family planning programs that want to integrate STD prevention services need to increase efforts to directly target men
- It may be unrealistic to advocate that every man remains faithful to his wife, but if a husband is not faithful, he should be convinced that he has a serious responsibility to protect her and their children from infection
- STD/HIV prevention is a game of inches Changing some behavior is better than changing no behavior Prevention programs must expect difficulty in clients making change, relapse in behavior and less than complete success
- Providing information is a logical starting point for change, but it is usually not enough It is important to convey only what is necessary, to talk about misconceptions and to check comprehension
- Sex education (family life education) does not lead to earlier or increased sexual activity in youth Lessons learned from these programs include
 - School programs promoting both postponement and protected sex were more effective than those promoting abstinence alone
 - Programs were more effective when given before young people became sexually active
 - Programs were more effective when they emphasized skills and social norms rather than only knowledge
- Effective programs emphasize skill and confidence building, focus on specific behaviors, provide instruction in how to resist negative influences, reinforce positive peer norms and establish policies to support safer sexual behavior
- The contributions of family planning to STD prevention is especially important when family planning services are the main source of health care for women of reproductive ages in developing countries
- Whatever programs choose to do in the integration of STD services into family planning services, it will be necessary to find out what works and what doesn't
- Family planning resources are limited, both in terms of personnel and commodities, the benefit of adding services must be worth the cost of such services

Session I Introduction

The meeting began with introductory remarks from JoAnn Lewis, Senior Vice President, Reproductive Health Programs, FHI, who welcomed participants to the meeting. The meeting should answer two questions: why should family planning programs be involved in STD prevention and control and what should the programs be doing. There are two levels of strategies and activities, those that will control the epidemic and those that will provide better services for individuals. Family planning programs will most often contribute to the latter.

Jim Shelton, Acting Deputy Director, Office of Population, USAID, gave an overview of the meeting objectives and USAID's guiding principles for supporting STD prevention and control in a family planning context. USAID's philosophy is that reproductive health interventions, especially prevention, can and should be added to existing family planning programs. Efforts should focus on those interventions that have the highest benefit for the women most in need and those that are most cost-effective.

The guiding principles for USAID include

- keep family planning as the predominant priority,
- achieve the greatest public health impact on STDs with scarce resources,
- consider positive/negative interactions with family planning,
- consider overall STD control effort of which family planning efforts would be part,
- get beyond the clinic paradigm,
- evaluate and learn from results

Family planning programs may want to focus on primary prevention efforts and informing the community. Treatment should be focused in specialized situations where programs are working with core transmitters and should be closely monitored. In planning to work in the area of STD prevention, diagnosis and treatment, the following constraints must be recognized:

- programs will have negligible public health effects outside core transmitter arena,
- most women are asymptomatic,
- clinical infrastructure is often poor,
- diagnostic tests, where they are available, are expensive or not very accurate,
- treating by use of symptoms (syndromic approach) is not very accurate,
- large variety of STDs exist and some have no practical treatment,
- antibiotic problems include
 - cost
 - availability
 - resistance
 - allergies
 - compliance
 - diversion of drugs for other uses
 - U S origin

- preventing reinfection by reaching contacts is essential,
- opportunity and other costs must be considered

Session II Issues in Diagnosis and Treatment of STDs

Basic Principles of STD Transmission and Control Diagnosis and Treatment Issues for Family Planning Programs

Speaker Gina Dallabetta, Associate Director, STD Unit, AIDSCAP, FHI

Dr Dallabetta discussed various STDs, their diagnoses and treatment There are two reasons for family planning programs to be interested in STDs 1) having an STD increases one's risk for HIV transmission, and 2) having an STD results in increased risk for reproductive tract problems in the woman and in her child if she is pregnant, such as congenital syphilis and eye or lung infections

The Problem

The following three charts (pp 6-8) show the prevalence of gonorrhea, chlamydia and syphilis in women attending antenatal clinics in selected developing world countries The variation emphasizes the need for a methodology that can assist family planning programs to know the extent of the STD problem among their clientele Activities must be based on the risk profile of the population being served

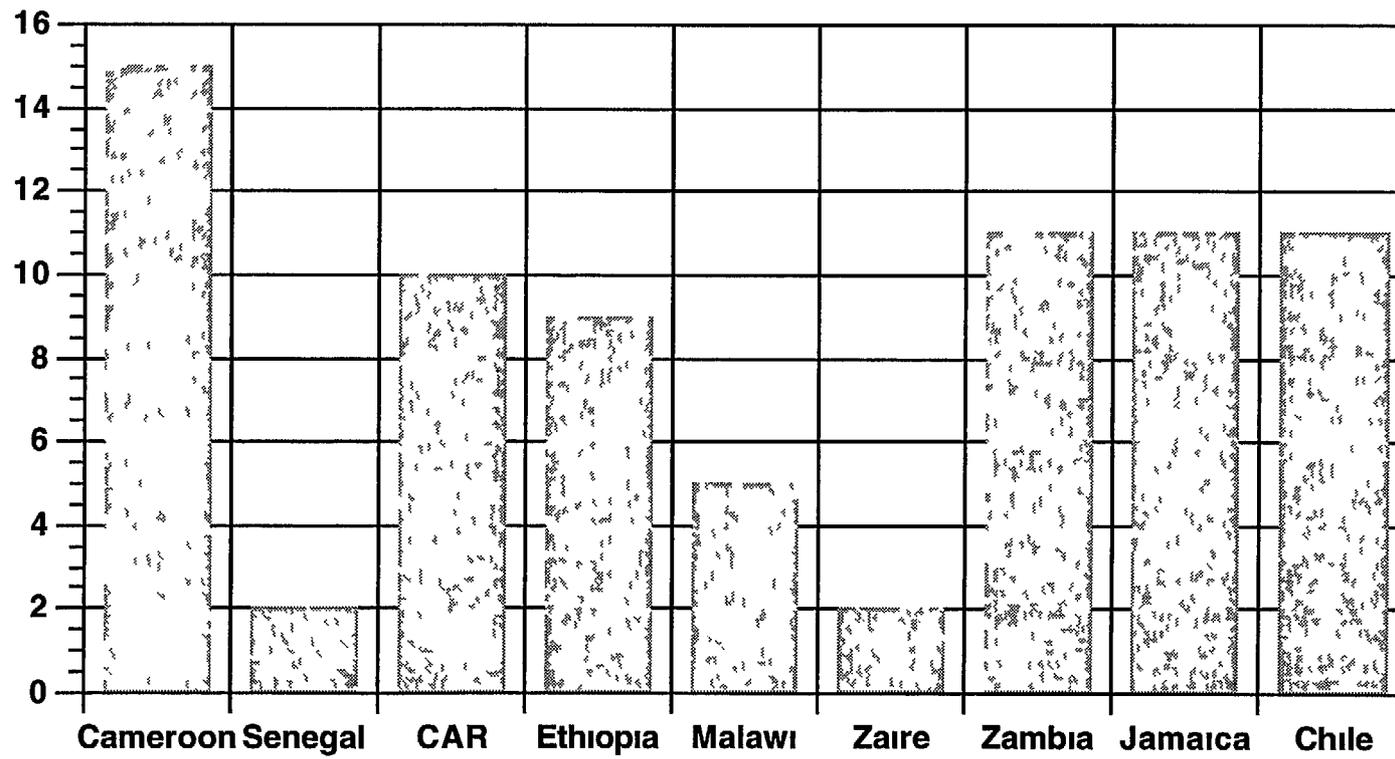
The extent of the problem for family planning programs is illustrated in the fourth chart (p 9) Of every 100 women in the program catchment area, a much greater proportion will have a reproductive tract infection than will present for treatment

The Options

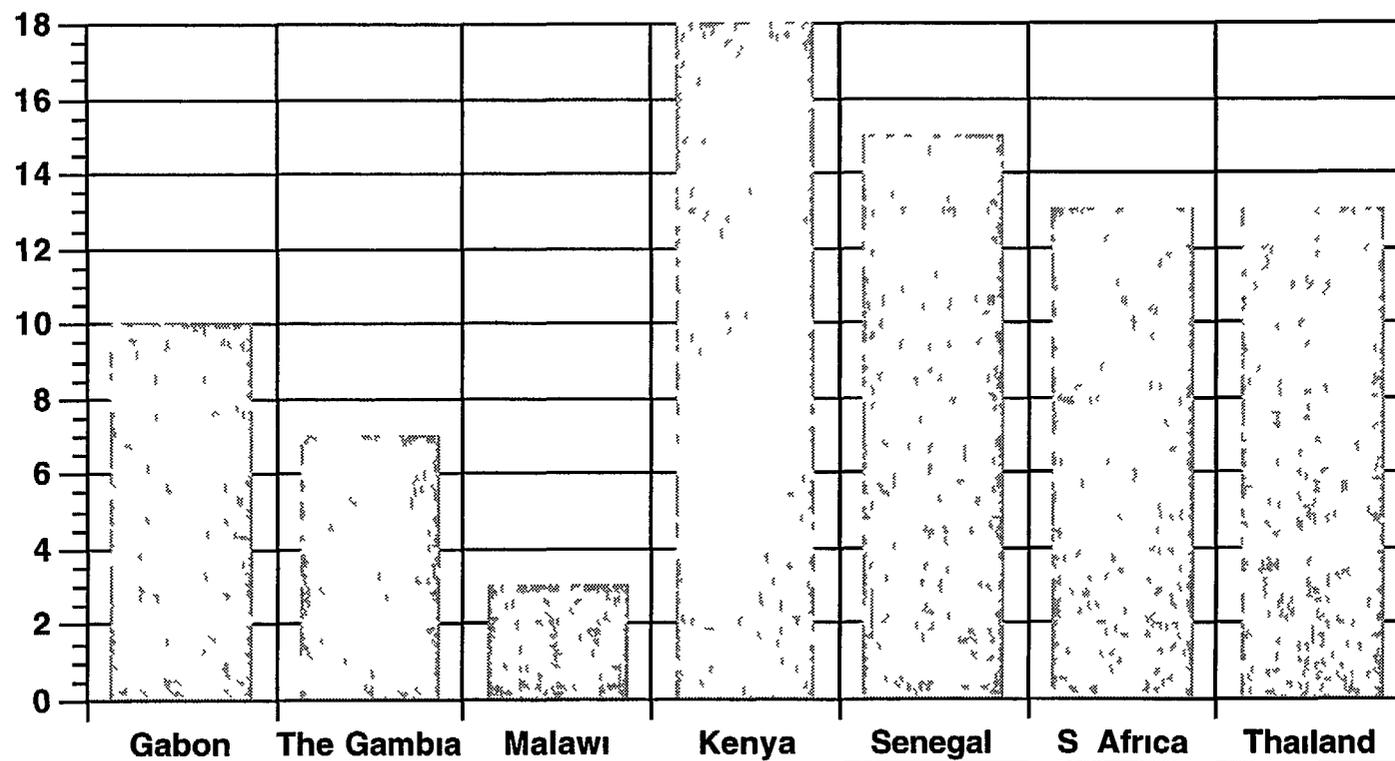
Four major STD syndromes were presented and such classic STDs as gonorrhea, chlamydia, trichomoniasis, herpes, syphilis and chancroid were discussed The following points were made about diagnosis and treatment of STDs

- Although some STDs are not curable, all are preventable
- There are four goals of treatment of STDs to cure the actual disease, to prevent complications and sequelae, to prevent transmission of the actual disease and to reduce the efficacy of HIV transmission
- STD diagnosis is complicated STDs are managed in three ways
 - by syndrome management which relies on the recognition of characteristic signs and symptoms, the patient is treated for major organisms responsible for the syndrome,
 - by clinical diagnosis, which relies on clinical recognition This approach fails because of nonclassic presentations and concurrent infections,

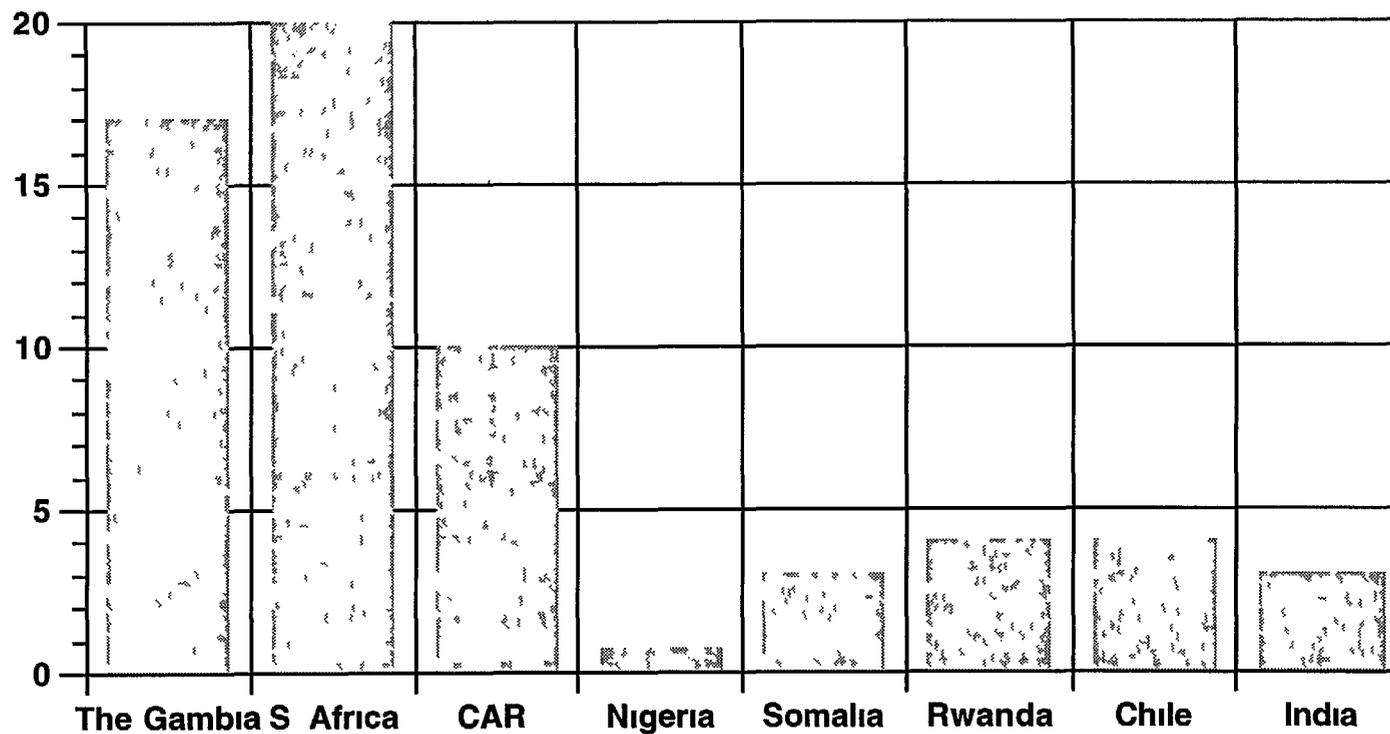
Prevalence of gonococcal infection in women in antenatal clinics



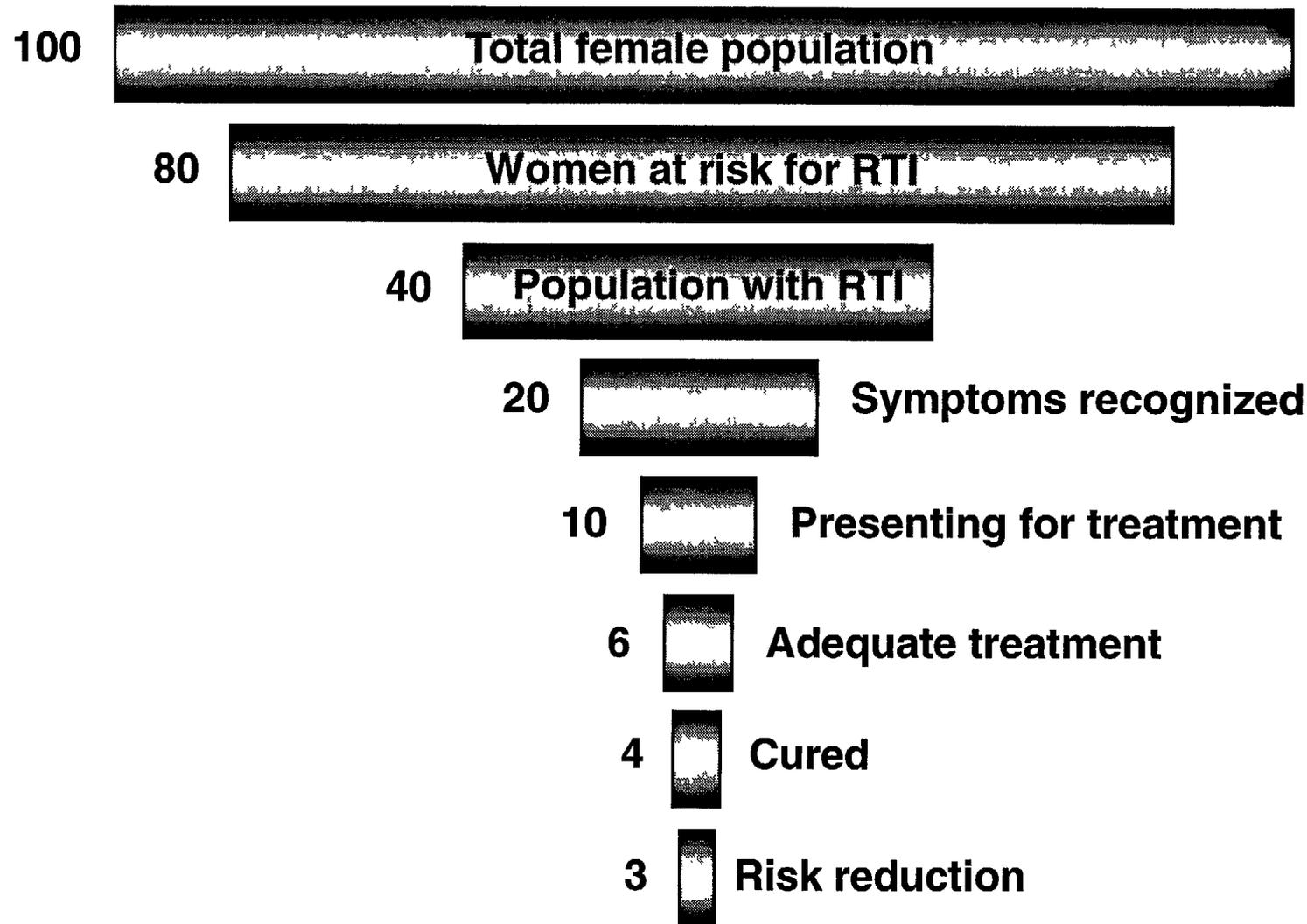
Prevalence of chlamydia infection in women in antenatal clinics



Prevalence of positive syphilis serology in women in antenatal clinics



Women with Reproductive Tract Infections



- by etiologic diagnosis where laboratory tests are used to identify the actual causative organism, these tests are expensive, often impractical and results are usually not available during initial visit
- Conducting diagnostic tests for lower genital tract infections in women at family planning clinics have the following constraints
 - the tests are not always sensitive for infection,
 - all require some additional equipment and supplies and specialized training for personnel,
 - some diagnostic tests are inexpensive and fast (for example, syphilis serology), others require extensive resources and days for results to be obtained
- Syndrome management may be the most practical for family planning programs The advantages are
 - simple, can be implemented on a large scale,
 - minimal training and can be used by a broad range of health workers,
 - allows for diagnosis and treatment in one visit,
 - theoretically, more cost effective than clinical or etiologic diagnosis

Concerns have been raised that some patients may be over-treated The approach ignores asymptomatic cases, and there may be overuse of some drugs that may be expensive

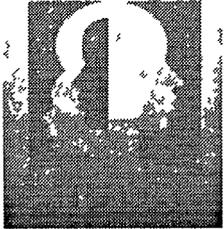
- Complete management of STDs has the following steps
 - effective treatment
 - education on the need to complete course of therapy
 - education on how to prevent future infections
 - partner referral
 - condom education
- STD drugs can be expensive, in general there is a lack of effective STD drugs in the public sector in the developing world

There currently exist activities that make sense for family planning programs in the area of STD diagnosis and treatment Initially the focus should be on symptomatic women or on utilizing rapid, inexpensive screening tests such as syphilis serology The following chart (p 11) shows level of involvement and the advantages and disadvantages that may pertain to each level

General Issues and Constraints / The Public Health Approach

Speaker Willard Cates, Corporate Director, Medical Affairs, FHI

Dr Cates discussed the magnitude of the STD problem for women, family planning and STD programs' similarities and differences, the contraceptive impact on STDs, public health implications of the addition of STD prevention and management in family planning programs, and program needs if integration is to occur



STD Management in FP Clinics

	Advantages	Disadvantages
FP provider manages STD	One stop for client	Additional STD training for all FP providers Additional management burden
Refer to STD provider in FP clinic	STD training necessary for only a few Outcome of referral known Quality of services known	STD care dependent on few personnel Additional management burden
Refer to designated STD provider in other site	Clinic services coordinated	Outcome of referral not known Quality of services not ensured
Refer to STD care elsewhere	Easy	Outcome of referral not known Quality of services not known

The Problem

The HIV epidemic has focused new attention on the problems related to STDs WHO estimates that new HIV infections are averaging between 3 and 11 million per year, new STDs other than HIV average 250 million per year Studies have shown that more than 50% of women have problems with HIV, STDs and maternal health For rural women in three countries reported symptoms were not as reliable as clinical evidence in identifying women with problems

Women diagnosed with reproductive tract problems

	<u>Symptoms (%)</u>	<u>Clinical evidence (%)</u>
India	50	92
Bangladesh	25	66
Egypt	13	51

The Options

The coordination of STD and family planning services would improve client convenience The case for integrating STD services into family planning programs relies on the similarities of STDs and family planning

- Sexual contact is necessary for "transmission "
- Women suffer the main consequences, either unplanned pregnancy or pelvic inflammatory disease, which can lead to infertility
- Young, low-income populations are at highest risk

However, certain characteristics of the separate problems of reproductive tract infections and unplanned pregnancy make integration more difficult to achieve than might be expected

Characteristic	RTIs	Unplanned Pregnancy
1 Percentage capable of transmitting	20%	90%
2 Transmission risk per coital event	Bacterial -- 30%-60% Viral -- 0 1%-10%	0-20%
3 Prevention focus	Partner selection	Coital frequency
4 Basic science focus	Microbiologic	Physiologic
5 Treatment	Antibiotic	Hormones, surgery
6 Approach to patient	Directive	Nondirective
7 Gender focus in clinics	Male	Female
8 Health care emphasis	Crisis (symptomatic)	Preventive (asymptomatic)
9 Type of contact for transmission	Genital contact, discharge	Spermatozoa

The choice of particular contraceptives affects the risk of both STDs as well as unplanned pregnancy. Most studies find substantial reductions in the risk of STDs when condoms are used correctly and consistently. Women whose partners used condoms generally faced a lower risk of such diseases as gonorrhea, chlamydial infection, trichomoniasis, genital herpes and pelvic inflammatory disease.

As with condoms, studies using different methods among different populations consistently support the hypothesis that spermicide use reduces the risk of contracting bacterial STDs. Diaphragms or sponges used with spermicides, or spermicides used alone all protect against STDs. Unlike bacterial STDs, considerable disagreement exists over whether to recommend N-9 spermicide use against viral infections, especially HIV. More data are necessary to answer this question with confidence.

Although barrier methods may be less effective in typical use in preventing pregnancy than other methods of contraception, their protection against STDs may make their use preferable for at-risk women.

Some family planning providers are offering clients at risk of STDs two contraceptive methods -- one to prevent pregnancy and one to prevent diseases. The approach seems to work best for clients who are highly motivated because they consider themselves or their partners at high risk of HIV or other STDs. Studies of dual method use focusing on compliance show that dual method users rely on condoms less consistently than those who use condoms alone.

The following constraints to integrating STD services into family planning programs were identified:

- Family planning resources are limited, both in terms of personnel and commodities, the benefit of adding services must be worth the cost of such services.
- Family planning programs mainly serve women, many STDs are undetected and untreated in this group because of mildly symptomatic or asymptomatic infections.
- Although women attending family planning programs may be at risk of STD/HIV infection, often it is not because of their behaviors, but because of the high-risk behaviors of their partners, family planning personnel are not always skilled in reaching and communicating with male partners.
- In a population in which risk is a result of partner behavior, it is difficult to develop a risk assessment tool that will identify asymptomatic women who are at risk and should be screened for STDs.
- To have a public health impact, family planning programs need to work with STD core transmitters such as commercial sex workers or persons with many partners, working with typical family planning program clientele, most of whom are not core transmitters, will improve the health of individuals, but will have a limited effect on stopping the epidemic.

The Needs

Three areas of development and research are necessary to enhance the integration of STD service into family planning programs

- development of better female controlled methods that protect against STDs,
- development of rapid, inexpensive STD detection methods to identify asymptomatic cases, and
- careful evaluation of the cost-benefits of adding STD services

Session III Issues in Behavior Change for Prevention of STDs

Behavior Change Lessons Learned from STD/HIV Prevention Programs

Speaker Ron Stall, Associate Adjunct Professor, Center for AIDS Prevention Studies (talk prepared by Thomas Coates, Director, Center for AIDS Prevention Studies)

Dr Stall discussed the principles and strategies for STD/HIV prevention, focusing on the problems of women who are likely family planning program clients In developing prevention programs, four principles must be kept in mind

- No prevention program will ever be perfect -- reaching all at risk and changing all risk behaviors
- Continued unsafe sex should not be a surprise
- One size does not fit all -- no one message or risk behavior strategy will work for a person throughout life
- Conditions causing unsafe sex change over time

Programs must expect difficulty in clients making change, relapse in behavior and less than complete success

The Problem

There is a "double standard" social norm Monogamy is expected for women and promiscuity for men In general in developing countries, women do not have control over sex A study of 946 Latina women in the US showed that

- 20 reported rape or sexual abuse,
- 73% said partners insisted on sex even if she was not interested,
- 23% said partners yelled at them,
- 3% said partners hit them,
- 14% said they were harmed during sex

Women in areas with high prevalence of HIV are "faithful but fearful "

In Rwanda the prevalence of HIV among urban childbearing women is 32%. Among those urban women who reported only one lifetime partner (similar to many family planning clients), the prevalence rate was 25%. The rates for the rural areas of Rwanda, although lower, showed a similar trend.

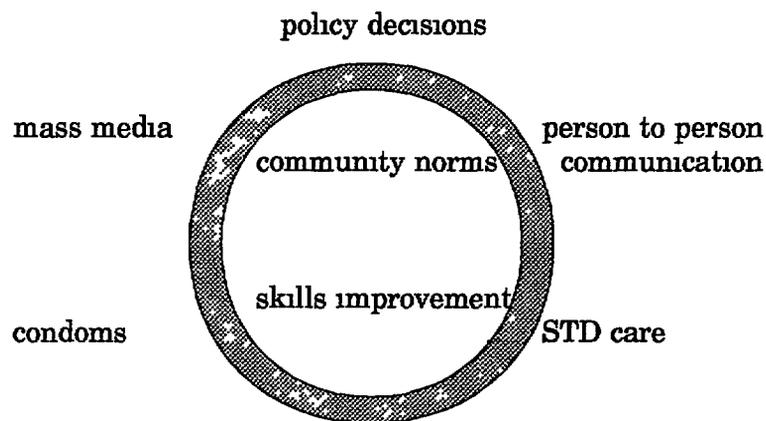
Three conditions lead to high rates of STD or HIV transmission: 1) a high prevalence of infection in the population, 2) high-risk behaviors in partners, and 3) a high frequency of unprotected intercourse with both regular and irregular partners.

The Options

Strategies for reducing STD/HIV infections include

- abstinence,
- monogamy (if it is mutual and both partners are uninfected),
- condom use with primary partner,
- condom use with secondary partners

The most successful HIV prevention programs work at several levels, psychological, interpersonal and social and include a number of components:



Programs have addressed psychological levels through increasing knowledge, motivations and skills. Providing information is a logical starting point for change, but it is usually not enough. It is important to convey only what is necessary, to talk about misconceptions and to check comprehension.

Sex education (family life education) does not lead to earlier or increased sexual activity in youth. Nineteen studies were reviewed, none showed an increase in sexual activity. Six studies showed delayed onset of sexual activity, six showed a decrease in overall sexual activity and ten showed increased adoption of safe practices by sexually active youth.

Lessons learned from these programs included

- School programs promoting both postponement and protected sex were more effective than those promoting abstinence alone
- Programs were more effective when given before young people became sexually active
- Programs were more effective when they emphasized skills and social norms rather than only knowledge

Many programs have thought to increase motivation through "fear" messages. The level of fear induced must be moderate or people will deny them. Messages must not just say what *not* to do but must say *what to do*. The most important skills to be taught are how to use condoms and how to negotiate condom use.

Programs have addressed interpersonal levels through individual or couple counseling. Counseling provides an opportunity to assess risk of STDs, discuss concerns or issues, identify barriers to safe sex and learn and rehearse skills such as condom use and negotiation.

Programs have addressed social levels by attempting to modify social norms to support low-risk behaviors. The tools they have used to do this include policy changes, structural changes, social marketing, mass media and community mobilization. Some of the structural changes that have worked include

- Changes in truck routes to allow drivers more time with families
- Employment policies that keep families intact
- Staggering payday to discourage brothel attendance
- Check cashing facilities to dissuade payday alcohol use
- Access to STD care at worksites

Effective programs share certain characteristics

- They emphasize skill and confidence building
- They focus on specific behaviors
- They provide instruction in how to resist negative influences
- They reinforce positive peer norms
- They establish policies to support safer sexual behavior

STD/HIV prevention is a game of inches. Changing some behavior is better than changing no behavior.

Messages for Women at Risk because of Partner Behaviors

Speaker LaHoma Romocki, Associate Director, AIDS USA, FHI

Ms Romocki discussed the difficulty of designing messages for women at risk because of partner behavior. Public health professionals have to figure out a way to prevent STD/HIV transmission in a population whose only risk factor is engaging in sex with their husbands.

The Problem

About one-third of all those infected with HIV are now women, and by the year 2000 it is expected that there will be more women infected than men. Many of the new infections will be in married, monogamous women.

There are women at risk because of their own behaviors: commercial sex workers, women with multiple partners, and women who engage in serial monogamy (a series of relationships, each one monogamous). The message for these women is clear -- partner reduction, condom use and treatment of STDs. Success can be shown. In Thailand, in 1987 self-reported condom use among prostitutes was 14%, by 1992, it was 94%. Within this time frame, the number of men seeking treatment for STD infections fell from 200,000 to 40,000. But many studies show that prostitutes will consistently use condoms with their clients, but rarely with their boyfriends or husbands.

What about the more typical family planning client -- the woman who is not a prostitute, does not have multiple partners and has not engaged in serial monogamy. None of the messages -- reduce partners, use condoms, treat STDs (women are often asymptomatic) -- are very relevant / appropriate or effective.

The Options

Because of lack of trained staff and scarce resources, it may not be possible to provide STD education and counseling to every woman who seeks service from a family planning program. The extent of program activities may have to depend on two things, the prevalence of STDs in the catchment area and the ability to develop a tool that successfully assesses risk for each client.

In order to assess risk, staff must be well trained in taking sexual histories, providing information, education and counseling on sexuality. Staff will need enhanced communication skills such as listening carefully to what the women themselves want and strategies to raise sexuality with clients and respond to clients' questions. To identify a woman at risk because of partner behaviors, it may be necessary to ask if her husband has extramarital sexual relations or if her husband is away from home often. Each family planning program must decide who will be counseled.

- only those who ask for advice,
- every client, whatever the reason for the visit,
- only those at high risk,
- only regular users of the program,
- only those at some risk

For those family planning clients at risk because of their own behavior, the messages should include

- personal susceptibility,
- threat STDs pose to her future fertility,
- most FP methods do not protect against STDs,
- abstinence,
- other contraceptive choices,
- how to use a condom / provide condoms,
- negotiation skills,
- seek treatment for STDs

For those family planning clients at risk because of partner behavior, messages might include all of the above, plus

- ask partner to use condoms in extramarital relationships or to terminate them,
- ask partner to use condoms in marital relationship or use a female barrier method,
- use dual methods,
- tell partner barrier method "only method client can use,"

Some women will be able to act on these behavior change messages. For another large segment of women, trying to execute changes to protect themselves may lead to being abandoned, neglected or abused.

Most of the options discussed so far focus on the women. However, it is not usually their behaviors that need changing -- but their partners'. Family planning programs that want to integrate STD prevention services need to increase the efforts to target men. Men might be reached through

- employment-based programs
- peer counseling
- social marketing
- opinion leaders
- grassroots organizations
- sports organizations
- religious and political authorities
- couple counseling
- a male clinic
- male outreach staff and workers

- making the facility more hospitable to men
- preparing educational/other materials for men
- pairing up with STD programs to collaborate on partner notification
- group counseling

According to the UNFPA, it is the lack of useful information and services, rather than lack of interest, that has kept men from taking a more active role in family planning. It may be unrealistic to advocate that every man remains faithful to his wife, but if a husband is not faithful, he should be convinced that he has a serious moral responsibility to protect her from infection.

Other strategies that may assist women at risk because of partner behaviors include

- couple counseling,
- outreach to couples in their homes,
- group counseling -- at the clinic or via community organizations or local women's groups to encourage women to talk to each other and work together to change community sexual norms
- mass media used to improve the image of condoms and sexual responsibility of men

Since risk assessment and symptomatic diagnosis are not very accurate for the typical family planning client, it is unlikely that family planning programs will be able to have a major impact on the STD epidemic. The contributions of family planning to STD prevention is especially important when family planning services are the main source of health care for women of reproductive ages. Family planning programs must acknowledge the limitations of both clients and staff and reach out to the male partners and the community at large.

Session IV· Evaluation

Importance of Evaluation

Speaker Susan Hassig, Associate Director, Evaluation Unit, AIDSCAP, FHI

Whatever programs choose to do in the integration of STD services into family planning services, it will be necessary to find out what works and what doesn't. Scarce resources demand this.

There are three types of evaluation. Process evaluation documents inputs and outputs such as number of clients educated, number of staff trained or number of condoms distributed. Outcome evaluation measures intermediate effects such as percent of women who report using a condom at last intercourse. Impact evaluation measures long-term effects such as reduction in STD prevalence rates for family planning clients.

In addition to process evaluation, it is important that either outcome and/or impact evaluation be conducted to answer the question "what works?"

In developing evaluation plans, indicators (things to be measured) must be defined and rational targets set, data collection methods (qualitative and/or quantitative) must be determined and a plan for using and disseminating results should be formulated

Evaluation is a systematic process that looks at what was done, to whom and how and what outcome was observed. In analyzing results, evaluators should look at both intended and unintended effects, attempt to determine if change can be attributed to the program, draw inferences from the data and determine the meaning of outcomes

Session V Working Group Discussions and Presentations

Small groups were formed and asked to focus on specific activities and strategies that relate to clinic settings, nonclinic settings, reaching adolescents, reaching men, using mass media and influencing relevant policies. Group presentations are summarized

Integration Activities for Clinic Settings

The group identified three activities

- Improve prevention activities through helping women to understand their risk, counseling, making clinics more accessible and the selective use of dual method protection
- Improve management of symptomatic clients by learning syndrome management, determining the availability of treatment, providing for partner notification and enhancing communication with STD clinics
- Provide clinical or etiological screening of at-risk women where feasible, especially for IUD acceptors

Integration Activities for Nonclinic Settings

The group identified the following activities that could be undertaken by workers in nonclinic based family planning programs

- Use IEC to clarify risk factors and demystify behavior change
- Train staff to understand the relationships between family planning methods and protection against STD/HIV, to understand how transmission occurs and what the consequences are, to recognize symptoms, to conduct risk assessments, to promote and distribute condoms and to understand cultural constraints
- Train staff to communicate effectively with clients
- Train staff to identify clients at high risk or who are symptomatic and institute referral and follow-up system that includes partner notification

Strategies for Reaching Adolescents

The group recognized that youth have special needs. They are vulnerable and constrained by lack of access to services, lack of resources and different social norms and communication patterns. Their sexual experiences and behaviors are not yet set and they rely heavily on peers. The following strategies were recommended:

- assess their needs,
- change social norms (through role models, peer education),
- use relevant education medium (mass media, comic books),
- provide separate services through special clinic hours or programs taken to places where youth hang out,
- involve parents

Strategies for Reaching Men

The group made the following recommendations:

- focus IEC on men with high-risk behaviors,
- initiate interventions to change behavior at work and play sites,
- use social networks and individuals who influence men,
- work through men's groups,
- develop referral systems for men,
- use mass media to encourage normative change,
- upgrade care in STD clinics

Strategies for Mass Media

The group emphasized that the use of mass media is the quickest way to transmit information to a large number of people. Recommendations included:

- Mass media can provide a supportive context for other program aspects including training, access to services and interpersonal communication
- Positive messages targeted to men can emphasize responsibility and family health
- Use of media can increase coverage, family planning programs can motivate media to get involved

Strategies for Influencing Relevant Policies

The group organized the policy recommendations by international, country and program, reflecting the different levels of policy influence. The following recommendations were made:

International

- Build on ICPD momentum to promote donor support for condoms and STD drugs
- Promote donor coordination and information sharing

Country

- Conduct current STD and FP program situational analysis and use findings to educate policy makers
- Encourage donor, government and NGO coordination in reducing restrictions on importation of condoms and STD drugs
- Involve women's and men's advocacy groups in working to change dysfunctional policies

Program

- Reevaluate quality of care standards and guidelines
- Reevaluate program indicators of success
- Provide support to health care workers through training, supervision, infection control and dissemination of lessons learned

Session VI: Wrap-Up

Speaker Jeffrey Spieler, Chief, Research Division, USAID

Mr Spieler in summarizing the meeting pointed out that although we have learned some things about prevention programs, more is needed. It is time to think and act. The following unanswered questions need to be researched:

- What is the role of men?
- What nonclinic approaches can be used to do the most good for the most people for the least cost? (the public health approach)
- Does quality of care make a difference?
- What are the indicators of success for STD services and reproductive health?

A lot of money can be spent on diagnosis, treatment and prevention of STDs. This must be put in the context of other reproductive health problems and other health problems. We cannot escape from the resource issue.

Appendix A

Agenda

Agenda

Understanding STDs and the Public Health Approaches to Their Control The Appropriate Role of Family Planning Programs Rosslyn Westpark Hotel Shenandoah A & B

8 00-8 30 *Registration*

8 30-8 35 *Welcome*

Ms JoAnn Lewis, Senior Vice President, Reproductive Health Programs, FHI
Dr James Shelton, Acting Deputy Director, Office of Population, USAID

8 35-8 45 *Purpose of Meeting/USAID Philosophy*

Dr James Shelton, Acting Deputy Director, Office of Population, USAID

8 45-9 30 *Basic Principles of STD Transmission and Control Diagnosis and Treatment Issues for Family Planning Programs*

Dr Gina Dallabetta, Associate Director, STD Unit, AIDSCAP, FHI

9 30-9 45 *Discussion*

9 45-10 05 *General Issues and Constraints/The Public Health Approach*
Dr Willard Cates, Corporate Director, Medical Affairs, FHI

10 05-10 15 *Discussion*

Break 10 15 - 10 30

10 30-11 30 *Behavior Change Lessons Learned from STD/HIV Prevention Programs*

Dr Thomas Coates, Director, Center for AIDS Prevention Studies

11 30-11 45 *Discussion*

11 45-12 15 *Messages for Women at Risk because of Partner Behaviors*

Ms LaHoma Romocki, Associate Director, AIDS USA, FHI

12 15-12 30 *Discussion*

Lunch 12 30 - 1 45

1 45-2 05 *Importance of Evaluation*

Dr Susan Hassig, Associate Director, Evaluation Unit, AIDSCAP, FHI

2 05-2 15 *Discussion*

2 15-3 30 *Consensus Building (breakout sessions)*

Integration Activities for Non-clinic Settings, Laurie Fox, Facilitator
Integration Activities for Clinic Settings, Willard Cates, Facilitator
Strategies for Reaching Adolescents, Lynda Cole, Facilitator
Strategies for Reaching Men, Michael Welsh, Facilitator
Strategies for Mass Media, LaHoma Romocki, Facilitator
Strategies for Influencing Relevant Policies, JoAnn Lewis, Facilitator

Break 3 30 - 3 45

3 45-5 00 *Reports from break-out groups*

5 00-5 15 *Wrap-up*

Mr Jeffrey Spieler, Chief, Research Division, USAID

Appendix B

List of Registered Participants

Registered Participants

Academy for Educational Development
May Post

American College of Nurse Midwives
Charlotte Quimby (SEATS/MotherCare)

AVSC International
Evelyn Landry
Amy Pollack

Basic Health Management (POPTECH)
Reed Wulsin

Bureau of the Census (International Programs Center)
Karen Stanecki
Peter Way

Carolina Population Center
Linda Lacey

CARE
Paurvi Bhatt
Carlos Cardenas

CEDPA (ACCESS)
Sumali Ray-Ross
Susan Richieder

Center for AIDS Prevention Studies
Ron Stall

Centers for Disease Control
Celia Woodfill

CONRAD
Susan Allen
Christine Mauck

Development Associates (Family Health Training Project)
Ann Davenport
Mary Lamb

East-West Center

Tim Brown (Demographic Data Initiatives)

Family Health International

Maxine Ankrah (AIDSCAP)

Ward Cates

Lynda Cole

Gina Dallabetta (AIDSCAP)

Mary Lyn Field (AIDSCA)

Laune Fox

Susan Hassig (AIDSCAP)

Paula Hollerbach (AIDSCAP)

JoAnn Lewis

LaHoma Romocki

Michael Welsh

Tracy Smarrella (AIDSCAP)

Robin White (AIDSCAP)

The Futures Group

Kokila Agarwal (RAPID)

Gretchen Bachman (SOMARC)

Nadine Burton (OPTION)

Cecile Johnston (SOMARC)

Georgetown University Medical Center (Institute for Reproductive Health)

Miriam Labbok

Virginia Lamprecht

Jennifer El-Waran

Veronica Fletcher

Health and Development Policy Project

Joan Underwood

International Center for Research on Women

Geeta Rao Gupta

Ellen Weiss

INTRAH (PACIIb)

Marcia Angle

IPPF/WHR

Julie Becker

Judith Helzner

JHU/PCS

Karen Heckert

Laune Liskin

JHPIEGO

Harry Francis
Noel McIntosh

Jorge Scientific

Sarah Davis
Joanne Spicehandler

John Snow Inc

Laurel Cappa (SEATS)
Carolyn Hart
Suzanne Thomas

Macro International (DHS)

Kate Stewart
Martin Vaessen
Ann Way

Management Sciences for Health

Alison Ellis
Edgar Necochea

PANOS Institute

Diane McGlynn
Cecilia Snyder

PATH

Elaine Murphy
Jacqueline Sherns

Population Council

Christa Coggins
Andrea Eschen
Andy Fisher
James Foreit
Robert Miller

Population Reference Bureau

Rhonda Smith

PROFIT

Remi Sogunro (Development Associates)
Fernanda Kaplan (Boston University)

PSI

Brad Lucas
Judith Timyan

Tulane University (The Evaluation Project)

Lisanne Brown

UNDP

Schuyler Frautschi

USAID

Sigrid Anderson

Felice Apter

Allen Brimmer

Trisha Bright

Craig Carlson

Patricia Coffey

Barbara deZalduendo

Barbara Feringa

Mónica Gogna

Marjorie Horn

Roy Jacobstein

Mihira Karra

Judy Manning

Don McGee

Erin McNeill

Lisa Messersmith

Michele Moloney

Thomas Morris

Karen Nurick

Bonnie Pedersen

Willa Pressman

Estelle Quain

Scott Radloff

Elizabeth Ralston

Silvina Ramos

Mark Rilling

Carol Rice

Joe Rosenstein

Jim Shelton

Jeff Speiler

Joanne Spicehandler

Nancy Stark

World Bank

Hnin Hnin Pyne

Debrework Zewdie