JOINT UNFPA-UNICEF-WHO MEETING ON PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS IN THE PACIFIC

8-11 November 2005
Nadi, Fiji

Manila, Philippines
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REPORT

JOINT UNFPA-UNICEF-WHO MEETING ON PREVENTION AND CONTROL
OF SEXUALLY TRANSMITTED INFECTIONS IN THE PACIFIC

8-11 November 2005
Nadi, Fiji

Convened by

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NOTE

The views expressed in this report are those of the participants in the Joint UNFPA-UNICEF-WHO Meeting on Prevention and Control of Sexually Transmitted Infections in the Pacific and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Joint UNFPA-UNICEF-WHO Meeting on Prevention and Control of Sexually Transmitted Infections in the Pacific from 8 to 11 November 2005 in Nadi, Fiji.
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Keywords: Sexually transmitted diseases – prevention and control / Acquired immunodeficiency syndrome – prevention and control / HIV infections – prevention and control / Tuberculosis – prevention and control / Population surveillance / Pacific Islands
Abbreviations

ADB   Asian Development Bank
AIDS  Acquired Immunodeficiency Syndrome
ANC   Antenatal Clinic
ARH   Adolescent Reproductive Health
ASHR  Adolescent Sexual and Reproductive Health
ATTF  AIDS Task Force of Fiji
AusAID Australian Agency for International Development
CCM   Country Coordinating Mechanism (of GFATM)
CDC   Centre for Disease Control and Prevention (of USA)
FSW   Female Sex Worker(s)
GFATM Global Fund to Fight AIDS, TM and Malaria
HIV   Human Immunodeficiency Virus
IPPF  International Planned Parenthood Foundation
LCR   Ligase Chain Reaction
MSM   Men who have sex with Men
NGO   Non-Governmental Organization
NZAID New Zealand Agency for International Development
PCR   Polymerase Chain Reaction
PID   Pelvic Inflammatory Disease
POLHN Pacific Open Learning Health Network
PRHP  Pacific Regional HIV/AIDS Project
RH    Reproductive Health
RTI   Reproductive Tract Infection(s)
SPC   Secretariat of the Pacific Community
STI   Sexually Transmitted Infection(s)
UNAIDS The Joint United Nations Programme on HIV/AIDS
UNFPA United Nations Population Fund
VCCT  Voluntary Counselling and Confidential Testing
WHO   World Health Organization
SUMMARY

The Joint UNFPA-UNICEF-WHO Meeting on Prevention and Control of Sexually Transmitted Infections in the Pacific was held at the Mocambo Hotel in Nadi, Fiji, from 8 to 11 November 2005 with the following objectives:

(1) To review the current sexually transmitted infection (STI) situation in the Pacific island countries and areas;

(2) to share experiences, lessons learnt and the latest developments in STI prevention and control; and

(3) to identify issues, gaps and key actions needed for effective prevention and control of STI in the Pacific island countries and areas.

The programme included technical presentations, situation reports from countries and partners and open forum discussion across a broad range of issues related to the epidemiology, prevention and control of STIs: the status of STIs in countries in the Pacific region; new STI case management strategies; the role of laboratories in STI case management, screening and surveillance systems; special needs for dealing with STIs in high-risk groups like antenatal women, sex workers and their clients, and youth; the integration of STIs into reproductive health services; and Pacific STI networking, both current and planned. Meeting participants reached a number of conclusions and made recommendations. These included: recognition of the important individual and public health hazards that STIs present in the Pacific region; the special clinical and epidemiological challenges that are presented by chlamydiosis; the utility of syndromic case management in controlling STIs, the importance of STI intervention programmes targeting “core” and “bridging” groups; and the role of partnerships and STI networks in the Pacific region. Each participating country identified its immediate priority needs as well as priorities for regional support.
1. INTRODUCTION

The Joint UNFPA-UNICEF-WHO Meeting on Prevention and Control of Sexually Transmitted Infections in the Pacific was held at the Mocambo Hotel in Nadi, Fiji, from 8 to 11 November 2005.

1.1 Objectives

(1) To review the current sexually transmitted infection (STI) situation in the Pacific island countries and areas;

(2) to share experiences, lessons learnt and the latest developments in STI prevention and control; and

(3) to identify issues, gaps and key actions needed for effective prevention and control of STI in the Pacific island countries and areas.

The detailed programme of the meeting is attached as Annex 1.

1.2 Participants and resource persons

There were a total of 20 participants at the meeting, including representatives from American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, Niue, the Commonwealth of the Northern Mariana Islands, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu. Also attending the meeting were observers/representatives from the Australian Agency for International Development (AusAID); the International Planned Parenthood Federation (IPPF); Fiji School of Medicine; Fiji School of Nursing; the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the New Zealand Agency for International Development (NZAID); the Pacific Regional HIV/AIDS Project, Secretariat of the Pacific Community; Sexual Health and Family Planning Australia; and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The list of participants, consultants, temporary adviser, observers and secretariat staff is attached under Annex 2.

1.3 Organization of the meeting

The meeting was held in the Conference Room of the Mocambo Hotel in Nadi, Fiji, from 8 to 11 November 2005. Methods used in the meeting included presentations, working group sessions and plenary discussions.
1.4 Welcome statements

Following an opening benediction by Dr Seini Kupu (Tonga), representatives from the host country and sponsoring agencies made opening remarks.

The Honourable Tomasi Sauqaqa, Assistant Minister of Health, Fiji, welcomed the meeting participants on behalf of the host country. He observed that STIs are a global health problem of special significance to the Pacific area especially since many STIs are understood to facilitate HIV transmission. Vulnerable groups in the Pacific include the 15-29 year-old age group, sex workers, men who have sex with men (MSM) and mobile populations. Despite its recognized importance, he was of the opinion that the problem is being underreported by many countries in the area because of the stigma associated with the disease. Improved surveillance systems and prevention programmes, such as condom promotion, remain priority interventions for the Pacific. Assistant Minister Sauqaqa encouraged participants to work hard towards the objectives of the meeting and said he would be looking forward to its conclusions and recommendations.

Ms Giulia Vallese of the UNFPA Office for the Pacific extended welcoming remarks to the group on behalf of the UNFPA Representative, Mr Najib Assifi. Ms Vallese observed that STI control is at the heart of UNFPA’s mandate but that it is only by working together that victory can be achieved. There is a role for everyone: teachers, the media, church leaders and health service providers. She observed further that one strategy alone would not work in all countries and that there should be a focus on the role of both men and women in disease transmission. In addition, prevention should be at the centre of national efforts. UNFPA was looking forward to the meeting’s outcomes and to the opportunity to continue to work in partnership with all in pursuit of STI control in the region.

Dr Rosalina Sa’aga Banuve, UNICEF Assistant Project Officer, Health and Nutrition, provided welcoming remarks on behalf of the UNICEF Pacific Representative, Ms Gillian Mellsop. Drawing on a theme discussed at a recent Pan Pacific Conference in Auckland, New Zealand, Dr Banuve said that STIs are a “gathering storm” that is drawing energy from the presence of multiple conditions such as poverty, gender inequalities, denial, multi-partner sex and a pretence that issues such as homosexuality do not exist in the region. “United for Children, Unite against AIDS” is a new UNICEF programme that is directing attention towards the impact of HIV on children, as well as adolescents and women of child-bearing age. Dr Banuve also flagged the need for health care providers to be alert to the potential that STIs among children can be the result of sexual abuse. She expressed UNICEF’s commitment to continue to work together with all in the fight against STIs.

Dr Chen Ken, WHO Representative in the South Pacific, read opening remarks to the participants from Dr Shigeru Omi, Regional Director, WHO Western Pacific Region. In his welcoming address, Dr Omi observed that, with only a couple of exceptions, virtually all Pacific island countries and areas were represented at the meeting. He thanked all participants, observers and sponsors for their continuing technical and financial support for a comprehensive approach for such an important public health problem that, among other impacts, accounted for 17% of economic losses in countries around the world. The meeting was to be an occasion to review past programmatic successes as well as problems within the Pacific region, and to look to the
potentials that are offered by new technologies and advances in the diagnosis and treatment of STIs. Dr Omi appealed to development partners to continue to work closely with countries in support of national efforts to control STIs.

1.5 Opening of the meeting

Dr Chen Ken officially opened the meeting and invited all attendees to introduce themselves. He proposed and the participants agreed by acclamation that chairpersons for the four days of the meeting would be, respectively, Dr Kabwea Tiban (Kiribati), Dr Bernadette Schumann (Guam), Dr Godfrey Waidabu (Nauru) and Dr Viopapa Atherton Annandale (Samoa). Dr Bernard Fabre-Teste, Regional Adviser in Sexually Transmitted Infections including HIV/AIDS (HSI), WHO Western Pacific Region, gave an overview of the objectives and agenda of the meeting. They were similarly approved by acclamation.

2. PROCEEDINGS

2.1 Current global and regional STI situation and control strategies

2.1.1 Overview of STI epidemiological situation in the world and in the Western Pacific Region

Mr Richard Steen (WHO Headquarters) and Dr Nguyen Thi Thanh Thuy (Epidemiologist, HSI, WHO Western Pacific Regional Office) made a joint presentation on the epidemiological situation of STIs globally and in the Western Pacific Region. While the situation is far from static, most recent estimates have concluded that there are about 340 million new cases of curable STIs seen annually around the world. However, great differences are found among countries, both in terms of the impact of the STIs and the degree to which they are or are not being addressed. Surveys in some countries, such as Cambodia, have demonstrated that decreases in STI prevalence appear to be intimately related to increases in condom use.

Within the Western Pacific Region, current information reveals the same kind of diversity as seen globally in STI incidence and prevalence among different countries. With a few exceptions, STIs appear to be on the increase in the area generally. There is no belief that STI antimicrobial resistance is a problem as yet in the Western Pacific Region, although continued vigilance against that threat is clearly necessary.

2.1.2 STI interventions for preventing HIV

Mr Richard Steen reviewed some of the evidence linking STI interventions to HIV prevention. He observed that there is strong evidence for the association from epidemiology, biology and the results of intervention trials. On the most basic biological level, the shedding of HIV particles in urethral and vaginal secretions from HIV-infected individuals has been demonstrated to be elevated in the presence of genital ulcerative diseases (GUD). It has been estimated that the risk of acquiring HIV from a person dually infected with HIV and GUD may be increased between 10 and 300 times, depending on the sex of the infected partner and thus the direction of transmission. Controlled trial data have also demonstrated an association between
STI treatment programmes and HIV incidence. In conclusion, Mr Steen stressed that the relationship between HIV and STI transmission is no longer a hypothesis, but is overwhelmingly supported by sound scientific evidence.

2.1.3 Overview of current STI control strategies

Dr Graham Nielsen, (WHO Temporary Adviser) provided participants with an epidemiological framework to enable them to see the role played by different STI control strategies, such as prevention activities, targeted services for those at high risk, effective services for persons with symptoms, screening programmes for specific STIs in specific populations, partner management programmes and effective monitoring and surveillance systems. Dr Nielsen also ran through the dynamics of the formula for the reproductive rate of infectious diseases \( R_0 = \beta c D \) and how different interventions impact different elements of that theoretical framework. The presentation demonstrated especially the effectiveness of the syndromic management of STIs as opposed to etiologically based care where laboratory support is weak. Notwithstanding progress, Dr Nielsen catalogued some of the current challenges to STI control, including public and political disillusionment with STI programmes, antimicrobial resistance, difficulty in diagnosing and handling asymptomatic infections, difficulty in diagnostics for some STIs in women, ongoing issues of marginalized populations and difficulties in openly discussing sex-related issues.

Open forum:

One participant observed that much attention is being paid to sex workers in STI control programmes and that similar attention should be also directed towards their clients. Another asked whether there had been religious opposition to condom promotion in places like Cambodia and what lessons that might provide to areas like the Western Pacific. Yet another participant wondered aloud if there might not be opportunities for overlap between antiretroviral and STI treatment programmes.

It was observed in discussion that in the predominately Catholic country of the Philippines, condom promotion programmes are organized at the local level and without a lot of public and political fanfare so as not to engender opposition from the religious community. Stressing the disease prophylactic aspects of condom use, as opposed to contraceptive use, is perhaps another way to sidetrack religious opposition.

One participant questioned the presenters on the basis for the relationship between circumcision and STI/HIV transmission and on what might be the effect of female circumcision (also known as female genital mutilation) on disease transmission. In response, it was observed that the circumcision link between STI and HIV transmission is based on empirical findings and that there is still debate on the biological mechanisms underlying the association. As for female circumcision, it is widely recognized that this is a dangerous cultural practice that should be discouraged in any circumstance.

There was a general discussion on the potential role of traditional healers in STI programmes and the collaborative role that they can play with health care professionals if approached and incorporated properly.
The semantics of ‘contact tracing’ versus ‘partner notification’ or ‘partner treatment’ was discussed, concluding that ‘partner management’ is currently the recommended term, since it suggests both prevention and treatment. However it is labelled, working with sexual partners of STI infected individuals is an especially difficult and potentially unrewarding task. Often men will identify low-risk partners (such as regular sexual partners or spouses) but will not identify persons of more epidemiological significance, such as sex workers. It was also recognized in discussion that sometimes the ‘venue’ where the STI was acquired, such as a brothel, massage parlour or bar, might be a more fruitful place in which to target partner interventions.

2.2 STI surveillance systems in the Pacific island countries and areas

Dr Nguyen Thi Thanh Thuy gave a brief introductory presentation on this agenda item. She noted that surveillance systems are important for: measuring the incidence and prevalence of STIs; improving STI case management; strengthening education activities; evaluating programme successes; and developing funding proposals. The monitoring of antimicrobial resistance is also gaining in importance. She stressed that it is critical to understand the shortcomings in any particular surveillance system if the information it generates is to be interpreted and used properly. Dr Thuy also presented selected surveillance and survey data from Asian and Western Pacific countries. These data demonstrate that herpes simplex virus 2 (HSV2), trichomoniasis and chlamydiosis are the most common STIs and that STI prevalence, with a few exceptions where effective condom promotion and other service programmes have been implemented, is increasing in most countries, particularly among young age groups.

Dr Seng Sopheap (WHO Fiji) invited selected country participants to present information on surveillance systems in their countries.

Dr Nguyen Ngoc Lam (French Polynesia) said that STIs are a legally reportable disease in French Polynesia and that reports are generally based on etiological diagnoses. He conceded, however, that data collection is not well centralized and that there is often difficulty in interpreting information. Chlamydiosis and hepatitis B are the most commonly recognized STIs in French Polynesia. There are plans to undertake some behavioural and STI prevalence studies in the coming year. Thought is also being given to how to better coordinate with laboratories and how to strengthen collaboration with and reporting from private physicians.

Dr Mobomo Kiromat (Papua New Guinea) reported that the prevalence rates of chlamydiosis and gonorrhoea in Papua New Guinea are the highest in the region. HIV prevalence is also now greater that 1%, indicating that the country is experiencing a generalized epidemic. Most data from STI surveillance systems is from syndromic case reporting, is irregular in submission, and needs to be hand-tabulated. The country has, however, taken advantage of partner interest to combat HIV, and is planning to use increased resources to improve STI surveillance, treatment, prevention and care.

Dr Bernadette P. Schumann (Guam) explained that STI case reporting is also legally mandated in Guam and that the Ministry of Health’s Bureau of Communicable Disease Control receives regular reports from a broad spectrum of clinical centres, blood banking units, military facilities and laboratories. Although reporting forms are not always completed thoroughly, it has been possible to generate useful results from automated data analysis. These include an ability to
analyse the geographic distribution and ethnic profiles of STI cases. Analysis of data from a recent HSS survey is currently under way.

Dr Viopapa Atherton Annandale (Samoa) said that STIs are also a reportable disease in Samoa and that most reported cases are diagnosed etiologically. Reports are received predominately from women attending antenatal clinics, blood donors and STI clinic patients, although reporting formats and schedules have yet to be standardized. An antenatal clinic study in 1999-2000 revealed that 31% of pregnant women had at least one STI/reproductive tract infection (RTI). Chlamydiosis is the most prevalent STI in the 15-24 year-old age group.

Dr Thomas Sala Vurobaravo (Vanuatu) said that syndromic STI case reports are received monthly at central and provincial offices of the Ministry of Health in Vanuatu. The reports are tabulated by hand. He also reported on plans to undertake an STI prevalence survey in the future.

Open forum:

In general discussions, several participants noted that they also encounter difficulties in not having well standardized STI reporting procedures and in the duplication of forms and sources of reporting. A number of countries also observed that there is significant underreporting of STIs from private sector practitioners who actually see many cases but hold the information about diagnoses in confidence. Participants generally recognized that chlamydiosis is one of the most common and most problematic STIs they see in their countries.

There was considerable discussion about antimicrobial resistance testing and monitoring. One participant doubted that laboratories in his country would know the procedures for setting up such a surveillance system. It was observed by other participants that the SPC is developing training materials for antimicrobial resistance monitoring, with GFATM resources. Dr Thuy stated that the Suva Fiji STI clinic has been regularly monitoring antimicrobial resistance in that facility and they have found only a small amount of penicillin resistance to date. Another participant noted, however, that the technically illegal but common practice of pharmacies dispensing antibiotics directly to clients is contributing to antibiotic overuse and exacerbating the potential for development of antibiotic resistance.

2.3 Update on new developments and innovative approaches in STI control

Mr Richard Steen gave a lengthy presentation on both new technological and new programme approaches in STI control. He gave background on the development of the new Global STI Strategy, which appears to be in the final stages of approval within WHO. The strategy incorporates new technologies for rapid diagnosis, therapeutics and vaccines. In addition, it addresses new approaches for STI control such as PDAS (plan, do, assess and scale-up), periodic presumptive treatment, user-friendly and gender-sensitive clinics, and integrated service delivery. Mr Steen also discussed new approaches for STI services for sex workers. With regard to the latter, he stressed that control of STIs in a community cannot be effective unless a comprehensive service delivery programme includes at least one component to address the epidemiologically important ‘core’ groups, such as sex workers. While he concluded that there is no ‘one size fits all’ solution to STI control programmes, and that all strategies have to be adapted to local epidemiological and cultural situations, screening and periodic presumptive treatment of sex workers is one programme approach that has been demonstrated as especially effective and
holds promise from wider application in many countries. Finally, Mr Steen discussed recent experience with scale-up in the Avahan project in four states in India. Here, the strategy is focusing heavily on the truck driver ‘bridge group’. The project is also organizing drop-in centres for sex workers, where they receive general support services in addition to STI counselling and services.

Open forum:

There was much general discussion regarding the difficulty of identifying and working with sex workers in many Pacific island countries. Observations from the participants from some of the smaller island states included “we just do not know who or where they are” and “our brothels are behind the house and under the trees.” For others, sex workers are difficult to access because they are free-lancers or part-time workers, like students, who seem intent on picking up some easy extra money. In other larger countries with developed tourist industries, sex work is more organized and is often managed by ‘a queen’, who is a critical link in accessing workers. A number of participants also noted that NGOs working in their countries are very useful and skilled in accessing and working with sex workers.

It was observed during discussions that people like taxi drivers are often very knowledgeable about who are the sex workers in the community. In addition, it was noted that it is usually best to address concerns of sex workers about STI in the first instance. HIV concerns perhaps should not be the subject of initial contact as this is a subject of great fear for sex workers and may generate resistance until an atmosphere of trust can be established.

A question was raised as to whether periodic presumptive treatment is a useful strategy where sex work in a community is on a small scale. The response was that it is indeed useful on a small scale and that programme managers should not be discouraged if they are unable to access all sex workers. Some types of sex workers are extremely hard to reach in any type of programme. It is important to start with those that are at higher risk, such as persons with a greater number of partner contacts and exchanges.

One country participant reported on initial success with a men’s clinic, held one day a week at the primary care facility. This was set up, not only as an STI clinic, but to deal with a variety of men’s problems, such as diarrhoea and heart disease. However, as time has gone on and men have gained confidence in the concept, it has, in fact, begun to deal with a lot of STIs among men. Male sex workers are also being recognized as a growing and serious problem in some of the northern and US-affiliated island areas. Male sex work appears most linked with tourism and travel of US military personnel to and from bases in neighbouring countries. In those areas, it is also recognized that the internet has become a common method of soliciting and contacting sexual partners.

One participant wondered out loud if health care workers should not be doing more to look into the root causes of sex work in a community rather than just treating STIs. Although there was no disagreement, it was similarly recognized that all human societies seem to have to deal with sex work and that its elimination does not appear likely under the best of circumstances.
2.4 STI status and challenges of STI control in the Pacific island countries and areas

2.4.1 Reports from selected countries

Dr Corinne Capuano (WHO Country Liaison Officer, Vanuatu) made a presentation on very preliminary results from a programme to give presumptive treatment for chlamydiosis and trichomoniasis to women attending antenatal clinics and to their partners. An earlier survey of antenatal clinic attendees in 1999 revealed a high prevalence of these STIs (e.g. over 20% of women had chlamydial infections). Starting in 2001 in both Port Vila and Luganville, the programme was later continued in Port Vila only, because of logistical constraints in Luganville. Assessing the results of this programme in a survey of STIs among antenatal clinic attendees in 2005 in Port Vila, a significant drop in the prevalence of chlamydiosis, gonorrhoea and syphilis was observed when compared with baseline 1999 studies (e.g. chlamydiosis prevalence had declined from 21.4% to 13.2%). Although the results have yet to be fully analysed, it appears that presumptive treatment among this high-risk population played at least some role in reducing STI prevalence.

Dr Kabwea Tiban (Kiribati) reported that STI syndrome case management is employed in his country and that VCCT (voluntary confidential counselling and testing) is also being expanded, with support from the GFATM. The greatest problem being confronted is the availability of drugs. He noted that the role of seafarers in STI transmission is also of great concern and there is at least initial thought being given to presumptive treatment for that group.

Dr Seini Kupu (Tonga) observed that STI surveillance, especially monitoring of antibiotic resistance, is the principle concern in the country. She observed further that health officials in Tonga are challenged by the need to access and manage the partners of women diagnosed with STIs. Plans are being explored to improve the STI surveillance system, including a revision of the forms used for reporting.

Dr Eric Rafai (Fiji) reported that Fiji is currently focusing on STIs among young people and is using young people in the development of educational materials and in programme design. They are also using syndromic case management and are developing new guidelines appropriate to Fiji, a process that has taken longer than originally anticipated. A major challenge for the future is improving the STI surveillance system.

2.4.2 Reports from selected nongovernmental organizations and regional organizations

Dr Wame Baravilala (UNFPA) opened his presentation with the wry observation that, for UNFPA, there are three simple primary strategies for STI prevention: “condoms, condoms and condoms.” Noting that no United Nations agency really has the mandate to work with sex workers, UNFPA is, in fact, concentrating more on the needs of this STI core group, especially through NGO support. In addition, UNFPA is developing STI guidelines and regional training programmes. UNFPA agrees with UNICEF that additional attention needs to be directed to the reproductive health of young people. Among the greatest challenges that UNFPA sees for the future is a need for better coordination between the many agencies working with countries.

Ms Jane Keith-Reid (AIDS Task Force of Fiji) observed that ATFF is basically a local NGO that started out 10 years ago, although they are increasingly becoming involved in regional
activities. Originally beginning as an outreach and drop-in-centre for sexually active youth, it was soon drawn into the needs of men who have sex with men and sex workers. With WHO's support and under the supervision of the Fiji Minister of Health, they have moved into VCCT, but are still unable to offer STI treatment services because of the unavailability of medical support. One of their current challenges is to better evaluate the effectiveness of their services, a challenge they are now addressing with help from the University of the South Pacific.

Dr Dennie Iniakwala (Secretariat of the Pacific Community) gave an extensive report on the many activities of the SPC in relation to STIs and HIV. Working with other regional partners and in different SPC member countries, those activities include support for improvements in surveillance systems, promoting behaviour change technologies in reducing risk behaviours, mobilizing funds, and strengthening case management and health systems. The greatest current challenges for SPC were reported to be difficulties in collecting routine surveillance data on STIs and in closely coordinating with other regional partners.

Ms Vani Dulaki (International Planned Parenthood Federation) reported that IPPF is working with local organizations in nine Pacific island countries. Most of their activities concentrate on HIV/AIDS, although they are indirectly concerned with STIs. They are particularly involved in condom social marketing and referral of STI cases to government medical facilities. Partnership and coordination with other international partners, including the timely sharing of information about activities, is among IPPF’s greatest concerns at the current time.

Open forum:

All participants were invited to say something about the STI activities in their countries. Issues raised by different participants included: (1) a weak understanding of the STI problem in their country, especially regarding who are and how to access core groups; (2) surveillance systems that are weak in collecting and analysing data; (3) partner management that is complicated by logistics and cultural sensitivities; (4) religious and cultural constraints in condom promotion; (5) the lack of reliable sources of affordable STI drugs; (6) coordination difficulties with other national government units; (7) coordination problems with other international partners; (8) government policies that hamper access to high-risk groups; (9) shortages of health personnel; (10) high turnover of health staff, which particularly confounds continuity in ongoing STI programmes; (11) weaknesses in laboratory support; and, (12) difficulties in arranging comprehensive STI services for small and disbursed populations.

In general discussion, participants also noted that: (1) countries with small populations might in fact be capable of doing near total population STI surveys; (2) the use of ancillary health personnel, like health educators, is useful in lightening the load of medical personnel; (3) current international interest in HIV/AIDS is in fact opening opportunities for the funding of expanded STI prevention and control activities; (4) partnership with NGOs is a useful way to get around staffing and funding shortfalls in government facilities; and (5) integrating STI screening in VCT centres is judged to be a cost-saving measure in one country.
2.5 STI case management: Challenges and recommendations

Dr Graham Neilsen (WHO Temporary Adviser) initiated the session by reminding participants that there are three principle objectives in STI control activities: prevent the development, complications and sequellae of disease; interrupt the transmission of STIs; and reduce the risk of HIV infection. He went on to stress that comprehensive syndromic case management is an extremely valuable and effective tool in STI programming when coupled with activities that promote safer sexual behaviour, condom use and health care seeking behaviours, the integration of STI care into health services, targeting of services to vulnerable populations and controlling congenital syphilis. He explained the basic outlines of syndromic case management and the WHO training modules that have been prepared to support that approach. The strengths of the STI syndromic case management approach was also reviewed (e.g., most likely cause of disease will be treated effectively in the absence of laboratory support, allows treatment at first visit, etc.) as well as weakness in the approach (e.g. unsuitable for asymptomatic patients, overtreatment and undue exposure to potential side-effects of drugs). Finally, Dr Neilsen elaborated on supplementary approaches that include: (1) presumptive treatment, (2) enhanced syndromic management and (3) periodic presumptive treatment, the latter two of which are especially adapted to the special needs of working with female sex workers, men who have sex with men and transgender sexual workers.

Dr Seini Kupu (Tonga) presented an update on STI case management in the Pacific. She began with a review of the background on GFATM support to SPC to implement a multi-country project in 11 Pacific island countries. As part of that GFATM grant, funds were provided to the Fiji School of Medicine to help develop STI case management guidelines that were specific to the Pacific and associated STI training manuals, to be piloted in five countries in the Pacific. Dr Kupu discussed many of the challenges that the effort was encountering, although she was optimistic that it would improve overall the provision of quality and culturally appropriate services to manage STI within the limits of available resources in Pacific island countries and areas.

Open forum:

In open discussions, one participant questioned how syndromic management guidelines had been adapted for the Pacific. In response, it was observed that the process was largely ‘empirical’ and that, as people gained more experience in using the guidelines, they would likely be modified. There were also questions and discussion regarding the difficulty of diagnosing and managing syphilis in the Pacific, where yaws is complicating its diagnosis. Confidence was expressed that the Pacific-specific protocols have done a good job in the management of syphilis. It was also noted that WHO is improving its guidelines for syphilis, especially as they relate to congenital syphilis, and that the Pacific island guidelines, currently being developed with Global Fund support, might want to take note of those developments.

One participant expressed fear that all the improvements in syndromic case management guidelines for the Pacific would come to naught without the support of political and financial commitments to make sure that health staff are trained and supervised in their use. There was general agreement with that observation.
There was an extensive discussion on the difference between presumptive treatment and periodic presumptive treatment and how those approaches related to treatment for vulnerable groups like antenatal clinic attendees or core groups like female sex workers. In general, it was elaborated that presumptive treatment is basically an approach for any group with a high prevalence of STIs, whereas periodic presumptive treatment is especially designed for core groups (especially female sex workers) who are of epidemiological importance in that they are repeatedly exposed to STIs and also have a high probability of spreading STIs to others in the community through bridging groups.

2.6 Role of the laboratory in STI case management

Mr John Elliot (WHO Temporary Adviser) led a discussion on laboratory roles and methods in support of national STI programmes. He observed first that laboratories can assist with a number of different STI programme functions, including: (a) diagnosis; (b) screening; (c) case-finding; and importantly, (d) support for syndromic patient management. The selection of a specific laboratory test for an STI programme depends in considerable measure on the function it is to serve, as well as such criteria as the test’s sensitivity/specificity, reliability, feasibility and acceptability/affordability.

Mr Elliot presented many of the technical details on the alternative laboratory tests that are currently available for the diagnosis of the common STIs/RTIs, such as gonorrhoea, trichomoniasis, candidiasis, bacterial vaginosis, syphilis, chlamydiosis and HIV/AIDS. Because of its importance in the context of the Western Pacific Region, special note was made of the cost-reliability of tests, methods of specimen transport and the likelihood of laboratory staff maintaining technical competence with such tests where they might be infrequently used. Mr Elliot especially encouraged national STI control programmes to use the laboratory capabilities that exist in countries and localities (e.g., Gram stains and moist films) to maintain the technical competence of laboratory staff and to monitor syndromic diagnoses protocols. On the critical issue of testing for Chlamydia, Mr Elliot confirmed that there is as yet no easy, inexpensive and reliable laboratory test available. More expensive polymerase chain reaction (PCR)/ligase chain reaction (LCR) appears the only feasible laboratory option available.

Open forum/panel:

To respond to questions and comments in open discussion, Mr Elliot was joined in a panel with Dr Josefa Koroivuetu (WHO Temporary Adviser), Ms Vasiti Uluiiviti (WHO Temporary Adviser) and Dr George Slama (WHO, South Pacific). Participants posed a number of initial questions about specimen transport media and methods. It was noted by panel members that both the Stuarts and Amies media, used for Neisseria gonorrhoeae transport, are useful for transport times that do not exceed 24-36 hours. Several charcoal-based media transports have similar time limits, but have the disadvantage of complicating the laboratory’s diagnostic procedures. The high cost of specimen transport is also an important issue for those countries and areas seeking to use the services of the regional Guam Public Health Laboratory. It was observed that the Guam laboratory is currently required to send samples to Hawaii for confirmatory HIV testing, and that airline biohazard regulations are such that transport costs are in excess of US$ 300 per sample.

There was also considerable discussion about the relative merits of Abbot’s Determine and Serodia for HIV testing. Although the reliability (sensitivity and specificity) of both tests are
similarly excellent, the cost of tests can be a factor, depending on whether they are being used for occasional, individual evaluations or as part of multiple evaluations in a screening programme. Both tests, used sequentially in the examination of any particular patient, can provide near 100% assurance that doubly HIV-positive results are diagnostic. WHO, however, still recommends that confirmatory laboratory testing be conducted before a definitive diagnosis is made. Notwithstanding that general requirement, additional WHO recommendations do stipulate that where patient compliance is an issue in VCCT programmes, and where there is a recognized high prevalence of HIV in a population, doubly positive ‘screening’ tests (using two different methods of analysis) can be used as a basis to inform patients of the results. Confirmatory tests should nonetheless be arranged if at all possible at a later time.

Several participants addressed the issue of laboratory testing for syphilis in the Western Pacific Region, where the past presence and now resurgence of yaws is a complicating factor. It was confirmed by the panel that there is as yet no laboratory test that can distinguish between yaws and syphilis. On the question of persistent positive serology after a treated *Treponema pallidum* (TP) infection, it was noted that a new or current infection can be diagnosed using a quantitative rapid plasma regain (RPR) test. In that regard, it was noted that RPR titre is usually quite high with an early infection, but will fall rapidly following successful treatment. In comparison, the TPPA/TPHA titre may fall, but much more slowly. In any event, a qualitative TP test, such as the Abbot Determine-TP, will stay positive for life.

There was much discussion about what might be done in the future to address the important problem of Chlamydiosis in the Western Pacific Region. Relatively expensive PCR technology appears the only option. Several countries and organizations are aware of two different proposals that are circulating offering assistance in securing and using PCR instrumentation in the Region. One relatively sketchy and weakly elaborated proposal by an individual health professional from Australia appears to have very optimistic capital and maintenance cost estimates associated with the introduction of PCR equipment at one or several laboratory centres in the Region. Another proposal has recently been fielded by the Pasteur Institute for the installation and trial of ‘real-time PCR’ technology in the Western Pacific. The latter proposal is especially attractive because real-time PCR has the advantages of securing rapid results and is also useful in diagnosis of all the Pacific Public Health Surveillance Network’s targeted diseases, but the process should start by conducting an assessment. There appeared to be consensus in the discussions that it is important to undertake a careful assessment of the proposals in the first instance, and also to consider rationally the issues of when, where and how to introduce such expensive and complex laboratory technology in the Western Pacific.

2.7 STI screening in the Pacific

Dr Graham Neilsen (WHO Temporary Adviser) ran through a series of slides outlining the basic considerations that must be resolved before making a decision to launch a programme to screen for STIs: (1) what is the public health goal? (e.g. disease eradication, reduction of prevalence, early diagnosis, etc.); (2) which population group should be screened?; (3) screen for which STIs?; (4) which tests should be used?; and (5) how often should it be repeated? Although there were a number of additional issues he felt are important in any screening programme, such as the need for confidentiality of data, counselling services for persons screened and the potential for stigmatization of populations screened, he directed the participants’ attention to the cost, cost-effectiveness and cost-benefit of screening versus a presumptive treatment programme for a high-
risk population. Given the dilemma of what to do about chlamydiosis in the Pacific, he challenged participants to sort through issues of screening for the disease, rather than presumptively treating a target population such as ANC attendees.

Open forum:

Participants ignored, initially, the high capital cost of purchasing PCR technology. Instead they started with the US$ 10 to US$ 20 cost per test for *Chlamydia* screening. Assuming a programme that screens 1000 persons for chlamydial infection in a population that has a 10% infection rate, it was generally concluded that an intervention based on a screening programme (e.g. costs of screening plus treatment costs for the 10% found to be positive) would cost roughly the same as treating the whole 1000 persons presumptively for chlamydiosis. Others debated the cost figures, observing that the costs of Azithromycin for treatment could be much lower if generic brands were used, or that the costs of PCR would be much higher if it were necessary to ship samples to a distant laboratory, as is probable in the Pacific. Under those circumstances, the cost of the presumptive treatment strategy would be considerably lower than for a strategy of PCR screening before treatment.

Another participant questioned why cheaper serological tests could not be used in a *Chlamydia* screening programme. With regard to that question, it was observed that, currently, available serological tests are of no use for sexually transmitted chlamydial infections.

Participants also explored the utility of PCR screening of ANC attendees for syphilis. Although this is a possibility using real-time PCR technology, it was observed that there are other cheaper screening tests that can probably do an equally good job.

Finally, there was a general discussion among participants on the mandatory STI screening required in their countries. There are only a few countries legally mandating screening, such as for HIV infection for persons immigrating or applying for long-term stay visas or syphilis screening for ANC attendees (available only in larger towns.) The discussion led to a debate on whether mandatory HIV screening is a desirable programme for ANC attendees in the Pacific context. It was argued that mandatory HIV screening is probably not necessary in the Pacific in view of the high compliance that countries already report for voluntary HIV testing (virtually 100% by all reports) and the fact that HIV prevalence among ANC attendees is thus far very low.

2.8 STI control among young people in the Pacific

2.8.1 Introductory presentations

Dr Annette Robertson (UNFPA Office of the Pacific) began her presentation with the observation that there are very few studies and limited basic knowledge about the special needs of STI control programmes for young people and adolescents. This is especially problematic since a number of prevalence studies in Pacific islands have demonstrated quite clearly that STIs are most prevalent in those under 25 years of age and, in some cases, in the 15–19 year-old cohort. Dr Robertson reported further on the UNFPA Regional Adolescent Sexual and Reproductive Health (ASRH) Project in 10 Pacific island countries. The project is committed to creating a supporting environment and increasing youth access to reproductive health information and services. She also reviewed some of the criteria for
Dr Rufina Latu* (Regional AHD Project Advisor, SPC) explained that the link between PID (Pelvic inflammatory disease) and infertility is an especially dangerous consequence of STIs in adolescents and young people. She elaborated further that the SPC ASRH project is concentrating on the ‘ABCS’ approach: access to accurate information; basic life skills; comprehensive health services; and, safe and supportive environment. The SPC is also incorporating aspects of UNICEF’s Basic Life Skills programme into the ASRH project.

Ms Iemaima Harea* (Adolescent Reproductive Health Coordinator, Tonga Family Health Association) reported briefly on a clinic that has been developed in Tonga to provide a wide variety of reproductive health services, including STI diagnosis and care, to young people down to 15 years-olds.

Mr Manu Samuela* (ARH Coordinator, Samoa Ministry of Health) reported on recent efforts in Samoa to organize adolescent health services. It was noted that many young people in Samoa have incorrect information about HIV/AIDS and STIs. The ARH project has been visiting schools in Samoa regularly to discuss issues related to adolescent health and STIs. Especially unusual in ARH activities in Samoa has been the extent to which there has been coordination with and incorporation of church teachings in reproductive health education for young people.

2.8.2 Selected reports from countries, NGOs and regional organizations

Dr Stephen Homasi (Tuvalu) reported that the prevalence rates of syphilis and hepatitis B have been found to be high in the under 25 year-old age group in his country. There is a central STI clinic in Funafuti and integrated STI syndromic treatment is available on the outer islands, where staff have been trained, including training in adolescent care, through the ARH project. They are also working on the introduction of ARH into the school curriculum in Tuvalu, coordinated with the UNICEF Basic Life Skills programme. However, this has turned out to be more difficult than originally planned because of rigid rules about the academic curriculum in the country.

Dr Nguyen Ngoc Lam (French Polynesia) reported that there are no special programmes for youth and adolescent STI care in French Polynesia and, as far as he knew, no special programmes within schools apart from school hygiene centres. There is the ‘Adolescent House’, which deals with a great breadth of psychological and social issues among young people, but the facility has no special programmes on STIs.

Dr John Selwin Paulsen (Solomon Islands) made a presentation on youth activities in his country, noting at the outset that the prevalence of STIs among young people has generally been on the increase. The early age of sexual debut, multi-partner sexual activity and low condom use are seen as factors contributing to the increase. He reported that there are a number of programmes in Solomon Islands addressing the issue, including a youth-friendly clinic and both in-school dispensaries and an out-of-school clinic run by the Solomon Islands Planned Parenthood Association.

* Informally invited to share experience in the implementation of STI control among young people in their respective countries.
Dr Dennie Iniakwala (Secretariat of the Pacific Community) reported that the SPC has a Pacific Youth Bureau responsible for a broad range of youth issues. The unit has recently developed a new programme strategy that is currently being reviewed. Specific to HIV/AIDS and STIs, the SPC also manages an ARH project and the Pacific Regional HIV/AIDS Project (PRHP), which receives support from AusAID and the Government of France. Their GFATM grant will support activities for youth peer education. It appears also that new youth-related projects will soon start with support from the Asian Development Bank (ADB) and NZAID.

Ms Maggie Kenyon (Sexual Health and Family Planning, Australia) reported that her organization was working in six Pacific island countries, and is dedicated especially to getting sexual and reproductive health into school curricula. Funding is the organization’s greatest challenge because many funding agencies are so heavily devoted to HIV/AIDS activities. She encouraged countries to work closely with NGOs, who are especially capable of delivering services at the community level.

Ms Vani Dulaki (International Planned Parenthood Federation) reported briefly that the IPPF has a network of local organizations in Pacific island countries and areas that are involved intimately with the full breadth of adolescent and youth reproductive health activities.

Open forum:

A participant began the discussions by asking what UNFPA and other organizations are doing about abortion services, an important ARH need in some countries. UNFPA explained that their governing and funding bodies have limited their programming in that area to activities to prevent abortions and to helping with the health complications associated with abortions. Another participant felt that the experience of Samoa in coordinating closely with church and religious leaders is a model that other Pacific island countries should try to emulate. Yet another participant appealed to all countries to pay attention to difficult-to-reach but highly vulnerable out-of-school youth.

2.9 STI control among high-risk groups

Ms Gaik Gui Ong (Technical Officer, WHO Western Pacific Regional Office) reviewed some of the epidemiological dynamics of the spread of HIV from high-risk core groups, especially female sex workers. She explained the basic strategy of the 100% Condom Use Programme, which is being supported by WHO in eight Asian countries and has, in both Thailand and Cambodia, been demonstrated to have a significant impact in reducing STIs and HIV infections among entertainment-establishment-based sex workers. Data from newer programmes in China and the Lao People’s Democratic Republic show significant increases in the use of condoms, followed by a reduction in STI among sex workers. Ms Ong stressed that the 100% Condom Use Programme is more than just an effort to promote condom use and make condoms more accessible. It incorporates a strategy to ensure that condoms are used. The programme has methods to sanction sex entertainment establishments if they do not ensure that clients use a condom in all risky sexual contacts with workers.

Dr Graham Neilsen (WHO Temporary Adviser) reviewed many of the health issues related to MSM and transgenders. Importantly, he reported that among transgenders, some of whom are also involved in sex work, the issue of STIs is not among their highest health concerns. Because
of transgender men’s desire to feminize themselves and because there are so few health personnel experienced in that process, the ‘anarchic’ use of hormones presents the greatest health problems for the transgender population. Dr Neilsen encouraged participants to be more alert to the health problems of transgenders and, despite their secondary concerns about STIs, to be aware that STIs are a growing problem among that high-risk group.

Ms Jane Keith-Reid (WHO Temporary Adviser) reported on the experience of the AIDS Task Fore of Fiji in dealing with STI control among vulnerable groups in Suva. She observed that there are many different types of sex workers in the community who are highly mobile and whose numbers fluctuate greatly depending upon the influx of tourists in other areas of Fiji. She stressed that outreach strategies are critical to accessing those vulnerable men and women and included the development of ‘key contacts’, ‘safe houses’ and NGO partnerships. She also stressed that sex workers have very flexible hours of work and that health service agencies too have to adapt to flexible hours of service delivery and the recruitment of non-judgmental staff with good and empathetic communication skills. It is important too that there be a level of community policy and legislative support in order to access such highly vulnerable, but marginalized populations.

Open forum:

Several participants recognized the need for their communities to identify and begin to work with vulnerable male and female sex workers more effectively. Mapping of sex entertainment establishments and workers was proposed as a necessary first step. One participant observed that condom promotion is a particularly sensitive issue politically in his country and that it has to be pursued with appreciation of Pacific island cultural perspectives. There was considerable discussion on STIs among seafarers in the Pacific region and how safer sex programmes and condom promotion could be organized for them. Although there are no simple answers, it was suggested that sex workers might be trained in better negotiating condom use with seafarers or that health personnel might try to work with shipping firms and boat captains.

There were also questions from participants about the difference in psychological ‘motivation’ between MSM and transgenders. It was elaborated that men having sex with men derives basically from a sexual orientation, while transgender motivation was basically an issue of gender orientation.

2.10 Integration of STI into reproductive health services

Dr Wame Baravilala (UNFPA) gave a presentation beginning with an explanation of the prerequisites for effective STI care. The problem he wished participants to explore was how HIV/AIDS programmes, STI programmes and sexual and reproductive health programmes have inadequately accommodated the intersecting needs of patients/clients in the delivery of services. Vertical programmes are situated in national health systems, bilateral and multilateral partners fund programmes separately, and linkages within and between United Nations agencies have been limited. Although there has been some nominal support for better integration, leaders in the field have not yet found a way to move forward. In that regard, Dr Baravilala noted that the integration of HIV/AIDS, STI and reproductive health (RH) programmes is not the addition of a new vertical service under the same roof but a process by which there is a bringing together of all programme activities on the level of policy, planning and implementation.
Dr Baravilala divided country participants into four groups and asked them to reflect on the situation in their countries regarding which specific STI services are stand-alone and which are integrated with RH activities. Finally he asked what plans might be under consideration for integrated RH and STI services.

Open forum:

After working together, participants gave a brief summary of the extent to which STI and RH services are separate or integrated in their areas. In the brief reports and subsequent discussions, it was clear that a wide spectrum of approaches is being used across the Pacific region and even within different areas of any one country. Specialized STI clinics are often the norm for larger urban centres, while services are integrated in rural or outlying areas. HIV and STI services are integrated in a number of countries. STI services are also linked with TB and leprosy clinics in one area. There are also significant differences between countries in the extent to which private sector clinics are dealing with STIs and in the roles that NGOs play in STI, HIV/AIDS and RH services.

One participant posed a question about the extent to which GFATM funds could be used for integrating STI services in private hospitals. It was explained that sub-recipients of GFATM funds could, in principle, re-programme funds, although this must be done with GFATM approval if it involves substantial funds. Another country participant said that their Family Health Association is working very well and that there would be little support for complicating issues by trying to integrate STI services. Several other participants expressed a contrary view, that integration is necessary because of health manpower shortages and that, in any event, it is awkward to redirect clients to an STI clinic when they are already in a health facility. Overall, a number of countries expressed support for integration of services, although there remains the big question of how to integrate.

2.11 Concept of a network of excellence

2.11.1 Establishment of an STI network in the Pacific

Dr Warme Baravila (UNFPA) presented a series of slides, drawn from the work of Dr Sibongile Dludlu, laying out the concept of networking systems among individuals and institutions sharing similar goals. While recognizing that there are already internet-based networks that health professionals use to share information in the Pacific region (e.g. PacNET and Aidstok), Dr Warme asked for the participants’ views on whether it would be useful to develop a new network devoted to STI issues. He noted that such an STI network, STI-NET LAC, had been instituted in the WHO Region of the Americas, which might prove a useful model for the Pacific.

Open forum:

The idea of an STI network in the Pacific received a great deal of support from participants, many noting that it was a “good idea” and “long overdue.” There was some discussion as to whether STI issues could be incorporated into other existing networks, although it was generally thought that those other networks are already fully occupied with HIV/AIDS
issues. While supportive of the idea, there were also many questions about how such a network
would be organized, who would be invited to join and how it could be financed.

2.11.2 Continuous STI training (POLHN)

Mr Steven Baxendale (WHO, South Pacific) gave a presentation with background on the
Pacific Open Learning Health Network (POLHN). An open learning website and learning
management system, POLHN has established computerized learning centres at 17 sites across the
Pacific region and has piloted 15 different online workshops. POLHN has been a WHO-funded
‘proof-of-concept’ project that has generally been seen as a success. There are now decisions to
be made about the future of POHLN and Mr Baxendale asked participants to provide input on
new courses or collaboration with other organizations that might be desirable.

Open forum:

One country participant asked why POHLN had not been established in his country? Mr Baxendale, new to this responsibility in WHO, said he did not know the background on such
decisions in the past, but he agreed in principle that the country should be considered for the
establishment of a new long-distance learning site. Another participant said that the cost of
internet dialup is extremely high in the Pacific, which has been an obstacle to many people
subscribing to past courses. Mr Baxendale agreed that bandwidth was extremely costly in the
Pacific and that, thus far, POHLN has not found a way around this. A number of participants
expressed the strong opinion that ‘academic credit’ should be awarded to those who complete
POHLN training courses. Mr Baxendale agreed this was an important point and that POHLN had
indeed negotiated with and obtained consent for universities in the region to accredit a couple of
courses in the past. However, it is a very difficult task because universities are generally cautious
about such joint ventures. In response to other questions, he explained that the cost of organizing
a course is between $US 50 000 and $US 500 000, depending on its complexity, and that the
current running costs of POHLN are between $US 500 000 and $US 600 000 per year. There has
been some discussion with the GFATM Principal Recipients about funding POHLN for some
training needs associated with their projects but it is as yet unclear if or how that might be
resolved.

2.12 Identification of issues, gaps and key actions for the future

Mr Richard Steen (WHO Headquarters) and Dr Robert Fischer (WHO Consultant) asked
participants to reflect on the presentations and identify those issues they felt to be of greatest
current need in their countries. Two open-ended lists of issues were suggested to participants,
one for both country and regional action. Participants were asked to work in groups but to try to
identify the top three country priorities and the single regional priority they judged most urgent
for their individual country. For the top country priority, participants were asked also to discuss
their views of the immediate next actions they thought necessary and feasible.

Following group work, each participant reported on his/her identified priorities and actions.
The reports were tabulated as the presentations were made. (See Table I next page)
<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PRIORITIES</th>
<th>ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Samoa</td>
<td>5 2 4</td>
<td>Assessment to confirm potential core groups; education on HIV/AIDS, STI, family planning, condom promotion to newly identified core groups; referral for treatment and support</td>
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<tr>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 3</td>
</tr>
<tr>
<td>Cook Islands</td>
<td>1 3 4</td>
<td>Training, partner management, development of STI guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 1 &amp; 3; 5&amp;7; 2</td>
</tr>
<tr>
<td>Fiji</td>
<td>1 3 2</td>
<td>Review of STI case management guidelines, integrate STI into communicable disease guidelines; strengthen the clinical component of partners NGOs; strengthen capacity of service providers</td>
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<tr>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 3 &amp; 8; 5&amp; 6&amp; 7&amp; 8</td>
</tr>
<tr>
<td>French Polynesia</td>
<td>1 3 5</td>
<td>Workshop, continuous medical education; manual for management of STI</td>
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<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 9. commitment (PIAF)</td>
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<tr>
<td>Guam</td>
<td>6 7 5</td>
<td>Prevalence of STI c/o core groups; set up screening programme in connection with health certificate; treatment and support</td>
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<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 2 (WB and PCR)</td>
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<tr>
<td>Kiribati</td>
<td>4 1 6&amp;7</td>
<td>Development of a resource centre; baseline survey c/o young people; integration of ARH in service delivery points</td>
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<tr>
<td></td>
<td></td>
<td><strong>Regional:</strong> 1 (availability of pre-qualified STI drugs)</td>
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<tr>
<td>Marshall Islands</td>
<td></td>
<td></td>
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<tr>
<td>Federated States of Micronesia</td>
<td>3 8 4</td>
<td>Set up STI database; public-private data collection; TA needed</td>
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<tr>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 2</td>
</tr>
<tr>
<td>New Caledonia</td>
<td>3 1 4</td>
<td>Collect data from public and private sectors; SGS</td>
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<tr>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 5</td>
</tr>
<tr>
<td>Nauru</td>
<td>1 3 10</td>
<td>Lobby for political commitment</td>
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<tr>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 5</td>
</tr>
<tr>
<td>Niue</td>
<td>2 1 4</td>
<td>Survey ANC and high school students; screening based on results; presumptive treatment</td>
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<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 3</td>
</tr>
<tr>
<td>Northern Mariana Islands</td>
<td></td>
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<tr>
<td>Palau</td>
<td>3 4 8</td>
<td>Database for STI data collection; reporting system for public and private sectors</td>
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<tr>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 2</td>
</tr>
</tbody>
</table>
### PRIORITIES FOR STI CONTROL NEEDS IN COUNTRIES
(SEE NUMBER CODE KEYS BELOW)

<table>
<thead>
<tr>
<th>Country</th>
<th>Priority 1</th>
<th>Priority 2</th>
<th>Priority 3</th>
<th>Description</th>
<th>Regional Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua New Guinea</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>Strengthen ARH programme</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 7</td>
<td></td>
</tr>
<tr>
<td>Samoa</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>Development of a universal system and utilization of data</td>
<td>5; TA for lab capacity, training of health care workers, NGOs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Regional:</strong> 5; <strong>TA for lab capacity, training of health care workers, NGOs</strong></td>
<td></td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>Capacity building (knowledge and skills); infrastructure development: clinic for STI case management; strengthening of laboratory capacity for AB resistance monitoring</td>
<td>2 &amp; 4</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Regional Priority:</strong> 2 &amp; 4</td>
<td></td>
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<tr>
<td>Tokelau</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>Training in STI</td>
<td>2 (rapid testing for STI), 3 &amp; 5 &amp;7</td>
</tr>
<tr>
<td>Tonga</td>
<td>1</td>
<td>6,7</td>
<td>8,10</td>
<td>Guidelines finalization &amp; printing &amp; dissemination; in-country training in STI case management</td>
<td>4 Lab capacity of Mataika, AB resistance (transport of media); 6; 8</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td><strong>Regional Priority:</strong> 4</td>
<td></td>
</tr>
<tr>
<td>Tuvalu</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>Revise STI case management guidelines; train NGO partners;</td>
<td>1 (more affordable pre-qualified STI drugs)</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>1</td>
<td>9</td>
<td>8</td>
<td>Nationwide information gathering and discussion with the authorities on STI case management and referral</td>
<td>4</td>
</tr>
</tbody>
</table>

* Key to Number Codes

**Country Priorities:**
1. Strengthening of STI case management (all aspects)
2. Control of chlamydiosis and other curable STI (all aspects)
3. Surveillance (all aspects such as data collection and utilization)
4. Young people (e.g., awareness, outreach, friendly services, etc.)
5. Identifying and reaching core groups (e.g., sex workers, MSM, etc.)
6. Developing interventions for core groups
7. Developing interventions for male bridging groups (e.g., seafarers, military, etc)
8. NGO partnerships to reach key populations
9. Integration of STI activities
10. Policy issues; (e.g., regulations, human resources, etc)
11. Others to be specified

**Regional Support Priorities**
1. More affordable drugs
2. Improved laboratory capacity
3. Training support
4. Antimicrobial resistance monitoring
5. Surveillance support
6. Network of excellence
7. Technical assistance mechanisms
8. Distance continuous education (POLHN)
9. Others to be specified
2.13 Partnership in STI control in the Pacific

A panel of selected countries and partners were invited to make presentations on (1) what they thought were crucial elements to ensure effective partnerships in STI control activities and, (2) for international partners, what actions they thought they could undertake in the future to address priorities identified by countries in the preceding agenda item. (See 2.12 above)

Dr Eric Rafai (Fiji) said that shared ‘ownership’ of activities, between countries and other agencies, is the most crucial element in successful partnerships. Partners should use and strengthen existing channels rather than circumventing them. Assistance with training programmes at the Fiji School of Medicine is a high priority.

Dr Kabwea Tiban (Kiribati) said that it was critical for partnerships in countries to concentrate on the issue of sustainability. He felt it was particularly important that activities have goals to build national capabilities so that health programmes can ultimately be carried out with national human and financial resources.

Dr Dennie Iniakwala (SPC) made a presentation on the basic vision and strategy of the SPC. For effective partnership, he felt that all activities have to be well integrated into national priorities and should incorporate the ‘3 Ones’ principle. He said that, for the future, country activities supported by the PRHP, GFATM and ADB would constitute the great bulk of SPC’s STI-related work.

Dr Wame Baravilala (UNFPA) said that his organization is currently going through an exercise to develop a strategy to meet the service needs of Pacific island countries and areas. Current priorities include the provision and promotion of condoms and VCCT. Relevant to the needs identified in the meeting, he reminded participants that UNFPA has good facilities to buy and store STI drugs that are on WHO-approved lists.

Dr Bernard Fabre-Teste (WHO Regional Adviser in Sexually Transmitted Diseases including HIV/AIDS) reported that prevention of STIs remains a priority for WHO. A critical aspect of partnerships is the sharing of information, objectives and human and financial resources and the joint development of activities. In a slide presentation, he went through each of the country and regional priorities that had been identified by participants in group work sessions and outlined the current and planned WHO activities designed to address those needs.

Ms Vani Dulaki (IPPF) underlined the importance of collaborating with existing structures in STI country activities, which she felt to be especially important with regard to the crucial role that NGOs are playing in STI control. She also stressed that countries have to speak up and express their wants and needs very clearly in dialogue with partners.

Ms Susan Ivatts (AusAID) stated that her organization shared the view of other participants that STIs are an important public health problem in the Pacific. Coordination around the ‘3 Ones’ is also a subject in need of constant attention. She reiterated that there needs to be ‘mutual advocacy’ and that countries have to be vocal about their perceived needs when negotiating with partners. Human resource constraints and high staff turnover are particularly important issues in the Pacific, even where financial resources are available.
Dr Sachida Nand (NZAID) said that his organization too is highly supportive of programming for prevention and control of STIs. NZAID is providing financial support to other organizations like UNICEF and UNFPA.

Open forum:

A number of participants brought up the issue of potentially expanding partnerships in the Pacific to include more collaboration with organizations like the United States Centres for Disease Control (CDC). In that regard, it was noted that that CDC is involved in several of their projects and is also a member of the GFATM Pacific Island Regional Multi-Country Mechanism (PIRMCCM). Another participant suggested that invitees for meetings in the future might include organizations such as the Overseas Asian Pacific Organization. It was explained that WHO tries to balance carefully the number of country participants in relation to the number of partners and observers.

Picking up on a recurring theme in the meeting, Dr Tomara Kwarteng (PRHP) said that her agency receives many HIV/AIDS proposals but that countries must speak up and request funding for STI activities if that is what they want. Ms Susan Ivatts (AusAID) endorsed that recommendation, observing that the Australian government holds annual high-level meetings with partner governments and that it is important for national health officials concerned about STI to work within their governments to make sure that the item is on the agenda if that is indeed a national priority.

Several participants raised the issue of difficulty in coordinating with so many partner agencies. It appears there is much willingness and potential assistance that partners could provide but that it is sometimes impossible to know who to ask for help. Several of the partner agencies said that countries could make their needs known to almost any of the major partners. If those agencies could not help directly, they would almost certainly offer advice on where requests should be redirected.

It was also observed that there would be a need for a special effort in the planning stage to support the implementation of a Pacific Regional HIV/AIDS Strategy and Implementation Plan through better coordination of partner support. Although still under discussion, the plan is for a joint team of United Nations and other partner representative, a ‘coalition of the willing’ or ‘COW’, to provide technical support, both at sub-regional and country levels, in identifying priorities and dividing work according to a division of labour that has already been established by UNAIDS.

3. CONCLUSIONS AND RECOMMENDATIONS

Participants agreed upon the following conclusions and recommendations:

1. STIs are an important public health problem in the countries of the Pacific region. Chlamydiosis, a curable STI, is very often the most common STI seen in countries, especially among adolescents and young people. It is of special concern because it is frequently an
asymptomatic infection among women and can have devastating reproductive-tract consequences, including pelvic inflammatory disease, infertility and life-threatening ectopic pregnancy. **It is recommended that countries and partners be especially cognizant of the need to address adequately prevention and control programmes for STIs.**

2. On both biological and empirical bases, the relationship between STIs and HIV is indisputable. STIs, especially those that have ulcerative manifestations, can increase the potential for acquisition of HIV infection and can increase the likelihood that a dually STI-HIV-infected person will transmit HIV to a third party during sexual contact. Studies in other parts of the world, now being replicated in some countries in the Pacific, have demonstrated convincingly that a reduction of STI prevalence in high-risk groups can have an impact on reducing HIV prevalence in the same groups and their sexual partners. **It is recommended that the important relationship between STIs and HIV be given appropriate attention in programmes that address both HIV and STIs.**

3. Despite the fact that many countries in the Pacific region require mandatory reporting of STIs to government authorities, important weaknesses still exist in national STI surveillance systems. Reporting is incomplete, especially reports from the private sector, and reported information is under-analysed and under-used. Among the chief reasons for these weaknesses is the lack of strong political commitment to enforce regulations and the lack of resources to administer surveillance systems adequately. **It is recommended that all countries and international partners work to strengthen national and regional STI surveillance systems, including reporting and antimicrobial resistance monitoring.**

4. STI syndromic case management is a valuable tool for guiding the treatment of symptomatic STIs in a community. Use of that approach, especially in settings that do not have adequate laboratory support, increases the probability that a correct diagnosis will be made, that the correct treatment will be provided on the first contact with patients, and that disease transmission and disease complications will be reduced. **It is recommended that all efforts be fully supported to adapt international STI syndromic case management protocols and training packages appropriate to the Pacific region and to provide the training necessary for their wide dissemination and use.**

5. It is recognized that ‘core’ (e.g. male and female sex workers) and ‘bridging’ groups (e.g. clients of sex workers, seafarers, etc.) play an important role in the epidemiology of STIs. It is further recognized that that the control of STIs in a community will not be fully effective unless a comprehensive service delivery programme includes at least some components to address the care needs of those epidemiologically critical groups. Enhanced syndromic management and periodic presumptive treatment are new STI case management approaches that have been judged to be especially appropriate strategies for dealing with STIs in core groups like sex workers when they are also linked with traditional outreach and prevention interventions. **It is recommended that national authorities take all possible actions to identify potential ‘core’ and ‘bridging’ groups in their communities and to consider the adaptation of new approaches, like enhanced syndromic management or periodic presumptive treatment, to the circumstances they confront.**

6. Laboratory support for STI surveillance and care is lacking in many countries and areas of the Pacific. In addition, those laboratory services that do exist are often underutilized by medical
personnel. Access to PCR technology, critical for the etiological diagnosis of chlamydial infection, is especially necessary in the region, although the costs of instrumentation, maintenance and operation represent considerable financial obligations. It is **recommended** that countries and partners do everything possible to secure funding and support for the establishment of regional access to PCR laboratory capabilities to support STI care and surveillance and that all proposals for the introduction of that technology be carefully evaluated for feasibility and sustainability. Notwithstanding current limitations, it is also recommended that health personnel use, to the extent possible, all laboratory support availability in countries to maintain the technical competence of laboratory staff.

7. Testing for HIV is an important service that can and should be offered to all pregnant women in antenatal care. Experience to date in the Pacific has shown that the offer of this service has been well accepted by clients voluntarily. **It is recommended that the HIV testing of ANC clients not be made mandatory in the Pacific region. Efforts should continue to make the service widely available on a voluntary basis in prenatal care.**

8. Adolescents and young people are a highly vulnerable group for both the acquisition and spread of STIs. Studies to date have revealed that the group has among the highest prevalence of STIs in communities across the Pacific region. **It is recommended that national health authorities and partners work to ensure that the special STI prevention and care needs of adolescents and young people are met, including implementation of strategies such as condom promotion, youth-friendly clinics and flexibility in the working hours of clinical facilities.**

9. A Pacific STI network that could serve as a platform for exchange of technical know-how among professionals in the region is seen as a promising idea for the future. **It is recommended that a group of interested parties further develop this idea, including the elaboration of such considerations as technical and organizational requirements and costs.**

10. The Pacific Open Learning Health Network (POLHN) has been a valuable training resource for the Pacific region. **It is recommended that countries and partners seek ways to continue POLHN’s financing and expansion of the network’s training centres for HIV/AIDS and STI human resources to other countries not yet served. It is also recommended that the administrators of POLHN work to reduce the costs of access to training programmes (e.g. costs of Internet dialup and bandwidth), to develop more formal training modules for national staff (e.g., laboratory technicians), and to secure academic credit for the training courses it organizes.**

11. Partnerships of international, bilateral and nongovernmental organizations play an important role in the support of national STI programmes. **It is recommended that all efforts be made to expand the number of partner organizations that can help with STI prevention and control in the Pacific region and to ensure that the partners’ roles are in support of national government priorities.**
ANNEX 1

PROVISIONAL AGENDA

1. Opening ceremony

2. Current global and regional STI situation and control strategies
   2.1 Overview of STI epidemiological situation in the world and in the Western Pacific Region
   2.2 STI interventions for preventing HIV
   2.3 Overview of current STI control strategies
   2.4 Open forum and exchange of experience

3. Update on new developments and innovative approach for STI control
   3.1 Overview of new developments and innovative approaches for STI control
   3.2 Open forum: on application of new tools in the Pacific

4. STI situation in the Pacific island countries
   4.1 Short country presentation based on a suggested format
   4.2 Open forum on the current situation

5. STI status and challenges of STI control in the Pacific island countries
   5.1 Panel discussion based on a suggested format

6. STI case management: challenges and recommendations
   6.1 Short presentations on current approaches to STI case management
   6.2 Open forum: discussion on the current practices and challenges faced by the Pacific island countries with the suggested recommendations

7. Role of laboratory in STI case management in the Pacific
   7.1 Presentation on laboratory support for STI case management
   7.2 Panel discussion on the current status and recommendations on the role of STI laboratory support in STI control in the Pacific

8. STI screening in the Pacific
   8.1 Short presentation on STI screening
   8.2 Plenary discussion on issues and proposed recommendations

9. STI control among adolescents in the context of the Pacific
   9.1 Panel discussion

10. STI control among high-risk groups
   10.1 Presentation on examples of STI control among sex workers in the Western Pacific Region and Fiji
10.2 Plenary discussion: exchange of experience among countries in the Pacific

Annex 1

11. Integration of STI in reproductive health services
   11.1 Short presentation on the topic
   11.2 Small group discussion and proposed recommendations among countries in the Pacific

12. Concept of network of excellence
   12.1 Presentation on the topic
   12.2 Plenary discussion on feasibility, sustainability and establishment of the network in the Pacific
   12.3 Discussion on continuous STI training

13. Identification of issues, gaps and key actions
   13.1 Brief introduction on the process
   13.2 Group work to identify key issues, gaps and actions needed
   13.3 Presentation of group work
   13.4 Plenary discussion

14. Partnership in STI control in the Pacific
   14.1 Panel discussion

15. Conclusions, recommendations and follow-up
   15.1 Summary of meeting outcomes
   15.2 Plenary discussion

16. Closing ceremony
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