Journée de lutte contre les infections sexuellement transmissibles (IST) et promotion de la santé sexuelle

6 mars 2015

Direction générale de la santé

Liberté • Égalité • Fraternité
RÉPUBLIQUE FRANÇAISE

MINISTÈRE
DES AFFAIRES SOCIALES,
DE LA SANTÉ
ET DES DROITS DES FEMMES

Leçons de passé et nouvelles stratégies pour lutter contre la syphilis et les IST au niveau international

Prof. Dr. Antonio Carlos Gerbase

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MINISTÈRE
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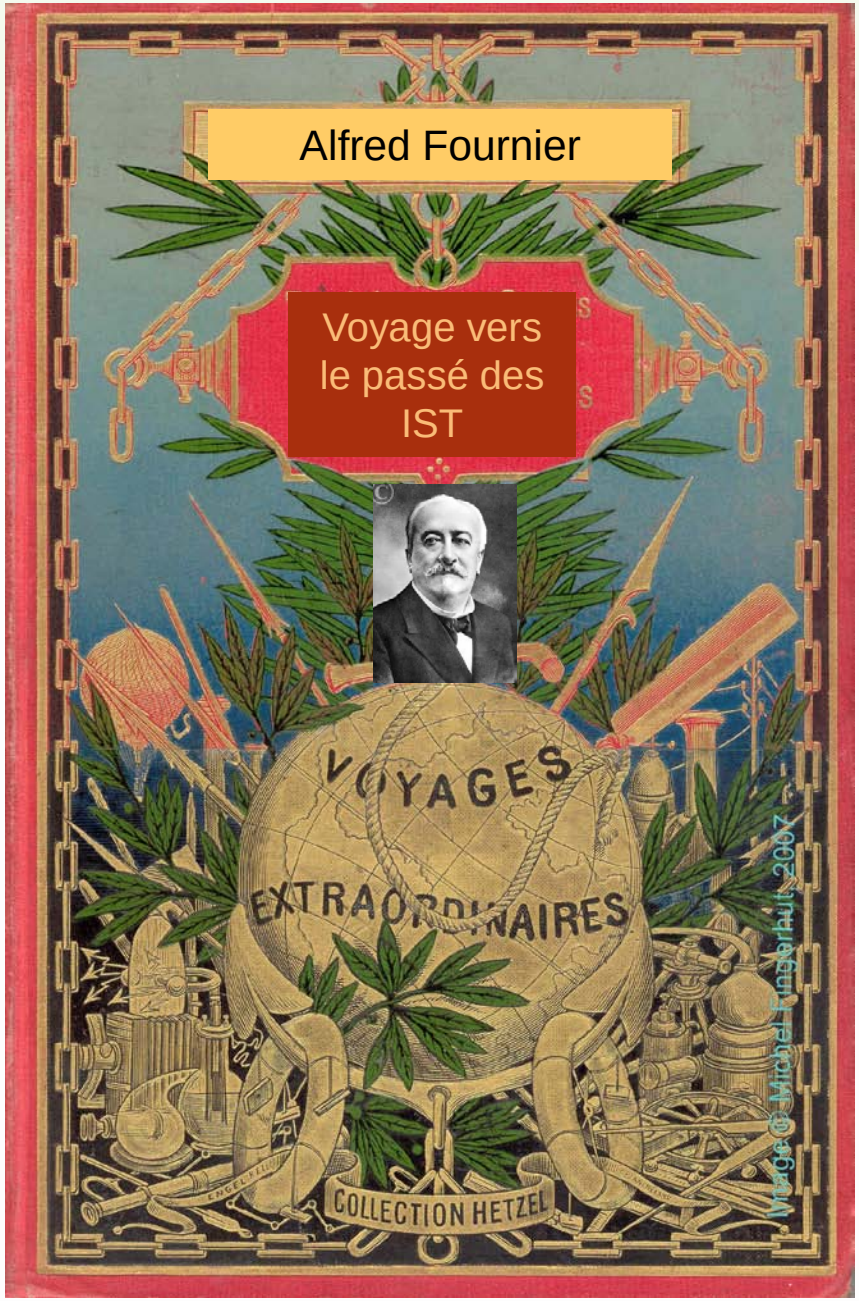
ET DES DROITS DES FEMMES

À savoir…



Alfred Fournier
1832-1914

Jules Verne
1828-1905

- Passion
- Science
- Détails
- Action
- Prestige
- Influence

"Le Curieux", l'abbatiale Sainte-Foy de Conques, XIIe siècle

- L’histoire est la démarche préliminaire à une autre, non moins indispensable: celle qui consiste à s’élever assez haut pour embrasser les faits en une vue d’ensemble, de manière à saisir le pourquoi de leur déroulement et à en tirer des conclusions propres à éclairer nos choix pour l’avenir

  Henry Babel, “La vérité sur Genève”, 1995

- Sans mémoire on peut pas vivre, elle élève l'homme au-dessus du monde animal, constitue la forme de son âme et au même temps, est aussi trompeuse, si insaisissable, si perfide…

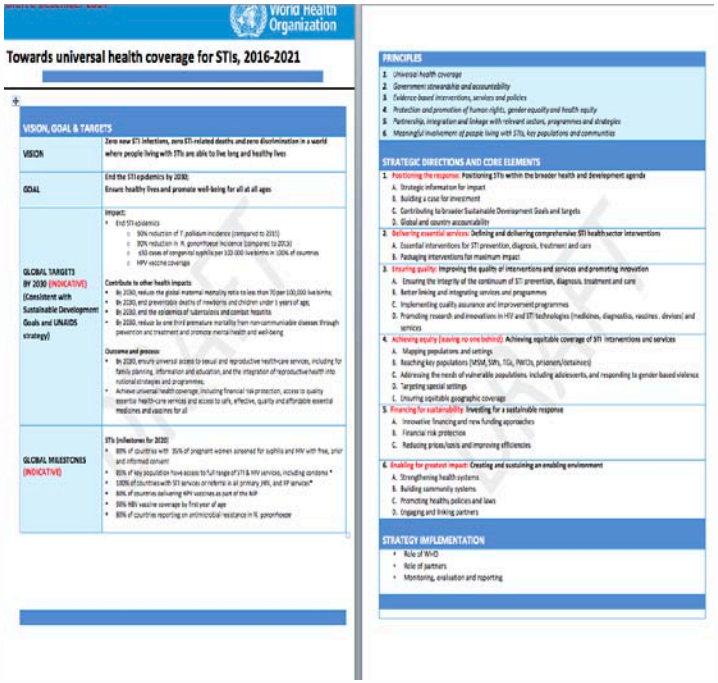
  Ryszard Kapuscinski, “Voyages avec Hérodote“ 2006

- … un musée pas d’images mortes, mais d’images soumises aux découvertes et aux renouvellements de mes regards

  Jacques Le Goff, Un Moyen Age en Images, 2007

Vestiges présents, plusieurs couches….

Vestiges XV^{ème}, VI^{ème} siècles, Romains e Allobroges découverts sous le cinéma « Alhambra », Genève 2015



World Health Organization

Towards universal health coverage for STIs, 2016-2021

VISION, GOAL & TARGETS

VISION

Zero new STI infections, zero STI-related deaths and zero discrimination in a world where people living with STIs are able to live long and healthy lives

GOAL

End the STI epidemics by 2030;
Ensure healthy lives and promote well-being for all at all ages

GLOBAL TARGETS BY 2030 (INDICATIVE) (Consistent with Sustainable Development Goals and UNAIDS strategy)

Impact:

- End STI epidemics
  - 90% reduction of T. pallidum incidence (compared to 2015)
  - 90% reduction in N. gonorrhoeae incidence (compared to 2013)
  - ≤50 cases of congenital syphilis per 100 000 livebirths in 100% of countries
  - HPV vaccine coverage

Contribute to other health impacts:

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 livebirths;
- By 2030, end preventable deaths of newborns and children under 5 years of age;
- By 2030, end the epidemics of tuberculosis and combat hepatitis
- By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

Outcome and process:

- By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes;
- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

GLOBAL MILESTONES (INDICATIVE)

STIs (milestones for 2020)

- 80% of countries with ≥95% of pregnant women screened for syphilis and HIV with free, prior and informed consent
- 95% of key population have access to full range of STI & HIV services, including condoms *
- 100% of countries with STI services on referral in all primary, HIV, and VF service*
- 80% of countries delivering HPV vaccines as part of the NIP
- 90% HBV vaccine coverage by first year of age
- 80% of countries reporting on antimicrobial resistance in N. gonorrhoeae

PRINCIPLES

1. Universal health coverage
2. Government stewardship and accountability
3. Evidence-based interventions, services and policies
4. Protection and promotion of human rights, gender equality and health equity
5. Partnership, integration and linkage with relevant sectors, programmes and strategies
6. Meaningful involvement of people living with STIs, key populations and communities

STRATEGIC DIRECTIONS AND CORE ELEMENTS

1. Positioning the response: Positioning STIs within the broader health and development agenda
   - A. Strategic information for impact
   - B. Building a case for investment
   - C. Contributing to broader Sustainable Development Goals and targets
   - D. Global and country accountability
2. Delivering essential services: Defining and delivering comprehensive STI health sector interventions
   - A. Essential interventions for STI prevention, diagnosis, treatment and care
   - B. Packaging interventions for maximum impact
3. Ensuring quality: Improving the quality of interventions and services and promoting innovation
   - A. Ensuring the integrity of the continuum of STI prevention, diagnosis, treatment and care
   - B. Better linking and integrating services and programmes
   - C. Implementing quality assurance and improvement programmes
   - D. Promoting research and innovations in HIV and STI technologies (medicines, diagnostics, vaccines , devices) and services
4. Achieving equity (leaving no one behind): Achieving equitable coverage of STI interventions and services
   - A. Mapping populations and settings
   - B. Reaching key populations (MSM, SWs, TGs, PWIDs, prisoners/detainees)
   - C. Addressing the needs of vulnerable populations, including adolescents, and responding to gender-based violence
   - D. Targeting special settings
   - E. Ensuring equitable geographic coverage
5. Financing for sustainability: Investing for a sustainable response
   - A. Innovative financing and new funding approaches
   - B. Financial risk protection
   - C. Reducing prices/costs and improving efficiencies
6. Enabling for greatest impact: Creating and sustaining an enabling environment
   - A. Strengthening health systems
   - B. Building community systems
   - C. Promoting healthy policies and laws
   - D. Engaging and linking partners

STRATEGY IMPLEMENTATION

- Role of WHO
- Role of partners
- Monitoring, evaluation and reporting

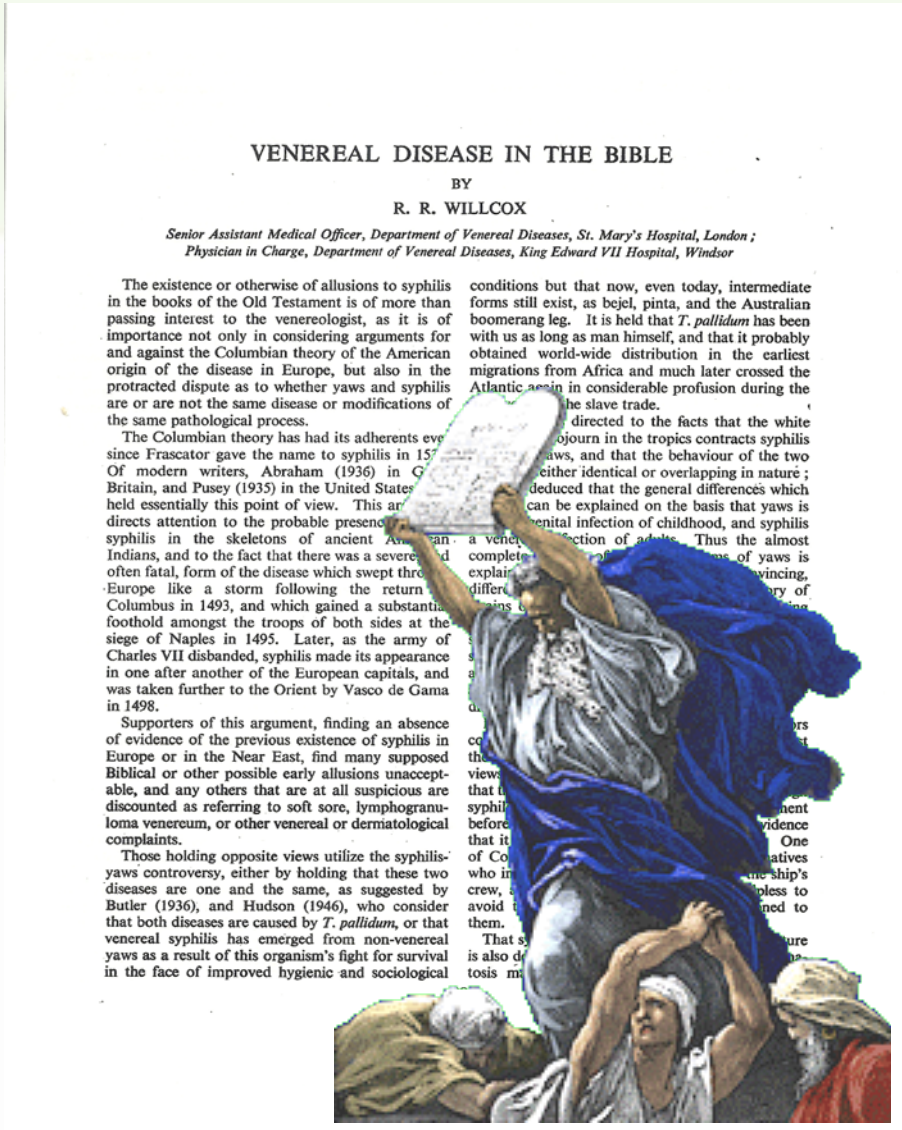
Vestiges du XX^{ème} jusque a antiquité sous la nouvelle stratégie IST de l'OMS, Genève

Quelques moments-clés pour réflexion

7ème-8ème AC. - Sinaï

- Première description urétrites
- Culte de Baal-Peaor lié à une activité sexuelle intense
- Guerres avec le Midianites suivies d'une épidémie de EU
- Massacre des femmes qui ont eu un contact avec les soldats
- Mesures de santé publique immédiates: quarantaine, contrôle de l'activité sexuelle, hygiène, sacrifices

Diagnostique de la situation et une stratégie claire: composants corrects, incorrects et inacceptables: élimination des femmes midianites affectées.



VENEREAL DISEASE IN THE BIBLE

BY

R. R. WILLCOX

Senior Assistant Medical Officer, Department of Venereal Diseases, St. Mary's Hospital, London; Physician in Charge, Department of Venereal Diseases, King Edward VII Hospital, Windsor

The existence or otherwise of allusions to syphilis in the books of the Old Testament is of more than passing interest to the venereologist, as it is of importance not only in considering arguments for and against the Columbian theory of the American origin of the disease in Europe, but also in the protracted dispute as to whether yaws and syphilis are or are not the same disease or modifications of the same pathological process.

The Columbian theory has had its adherents eve since Frascator gave the name to syphilis in 15 Of modern writers, Abraham (1936) in G Britain, and Pusey (1935) in the United State held essentially this point of view. This ar directs attention to the probable presenc syphilis in the skeletons of ancient A an Indians, and to the fact that there was a severe d often fatal, form of the disease which swept thr Europe like a storm following the return Columbus in 1493, and which gained a substanti foothold amongst the troops of both sides at the siege of Naples in 1495. Later, as the army of Charles VII disbanded, syphilis made its appearance in one after another of the European capitals, and was taken further to the Orient by Vasco de Gama in 1498.

Supporters of this argument, finding an absence of evidence of the previous existence of syphilis in Europe or in the Near East, find many supposed Biblical or other possible early allusions unacceptable, and any others that are at all suspicious are discounted as referring to soft sore, lymphogranuloma venereum, or other venereal or dermatological complaints.

Those holding opposite views utilize the syphilis-yaws controversy, either by holding that these two diseases are one and the same, as suggested by Butler (1936), and Hudson (1946), who consider that both diseases are caused by *T. pallidum*, or that venereal syphilis has emerged from non-venereal yaws as a result of this organism's fight for survival in the face of improved hygienic and sociological conditions but that now, even today, intermediate forms still exist, as bejel, pinta, and the Australian boomerang leg. It is held that *T. pallidum* has been with us as long as man himself, and that it probably obtained world-wide distribution in the earliest migrations from Africa and much later crossed the Atlantic again in considerable profusion during the the slave trade.

directed to the facts that the white ojourn in the tropics contracts syphilis aws, and that the behaviour of the two either identical or overlapping in nature; deduced that the general differences which can be explained on the basis that yaws is enital infection of childhood, and syphilis fection of adults. Thus the almost of yaws is vincing, ry of

1492-1497

YEARBOOK OF PHYSICAL ANTHROPOLOGY 54:99–133 (2011)

The Origin and Antiquity of Syphilis Revisited: An Appraisal of Old World Pre-Columbian Evidence for Treponemal Infection

Kristin N. Harper,[1]* Molly K. Zuckerman,[2] Megan L. Harper,[3] John D. Kingston,[4] and George J. Armelagos[4]

[1]*Robert Wood Johnson Health and Society Scholars Program*
[2]*Department of Anthropology and Middle Eastern Cultures, MS 39762*
[3]*Department of Anthropology, University of Missouri St. Lou*
[4]*Department of Anthropology, Emory University, Atlanta, GA*

ematoses; paleopathol

rs, scholars have y of syphilis. Did New World to the Old World before ed reports of pre- ase using a stand- tainty of diagnosis and novel informa- e cases, including g the reports, we ld treponemal dis-

f Charles VIII in he French king's that the disease was the first by, 1972; Quétel, ly of mercenaries, he troops returned disease (Williams 1500, it was wide- Because the epi- Columbus's return

bus's crew had contracted the disease in the New World and brought it back to the Old World arose in popular and medical literature by the early 16th century. Some chroniclers also stated that the crew had shown symptoms of a novel disease and that an affliction resembling syphilis had been present on the island of Hispaniola from Valde theor ular Ser howe prese 1935) World origin 1991) chron of vig anthr 2002)

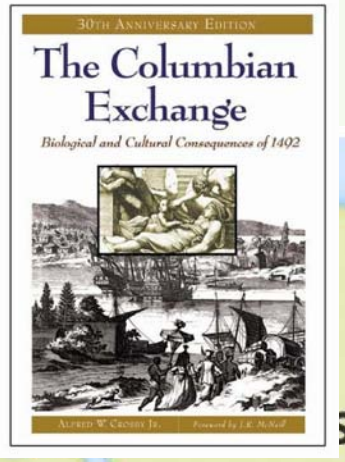
Unlike many other infectious diseases, sy closely related but nonvenereal diseases, (endemic syphilis), generate distinctive human skeleton (Hackett, 1976; Ortner, 2 of evidence for treponemal disease in the record has, not surprisingly, increased ove and more skeletons have been recovered a the New World, several pre-Columbian c documented by the early 20th century Hrdlička, 1922; Williams, 1932; Haltom 1938; Bullen, 1972), though these were

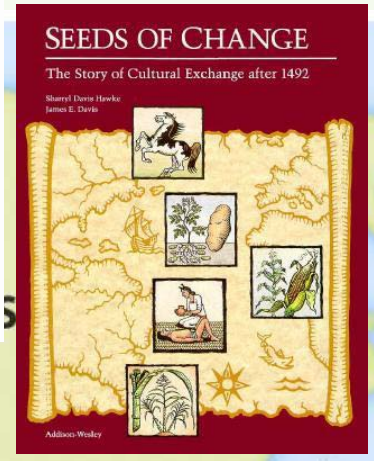
©2011

- Nouvelle épidémie due à la transmission sexuelle
- Origine américaine est la plus acceptée aujourd'hui
- Période de changements et beaucoup de liberté sexuelle
- Guerres e mondialisation comme moteur de dissémination
- Mal Français, Mal Espagnol, Mal de Naples, Mal Polonais, Mal Alémanique, Mal Portugais …au Japon

- *On accuse les autres…*
- *Facteurs socio-économiques et comportementaux comme moteurs de l'épidémie*
- *Absence de traitement*
- *Culpabilisation, stigma,*
- *Isolement*

L'échange colombien

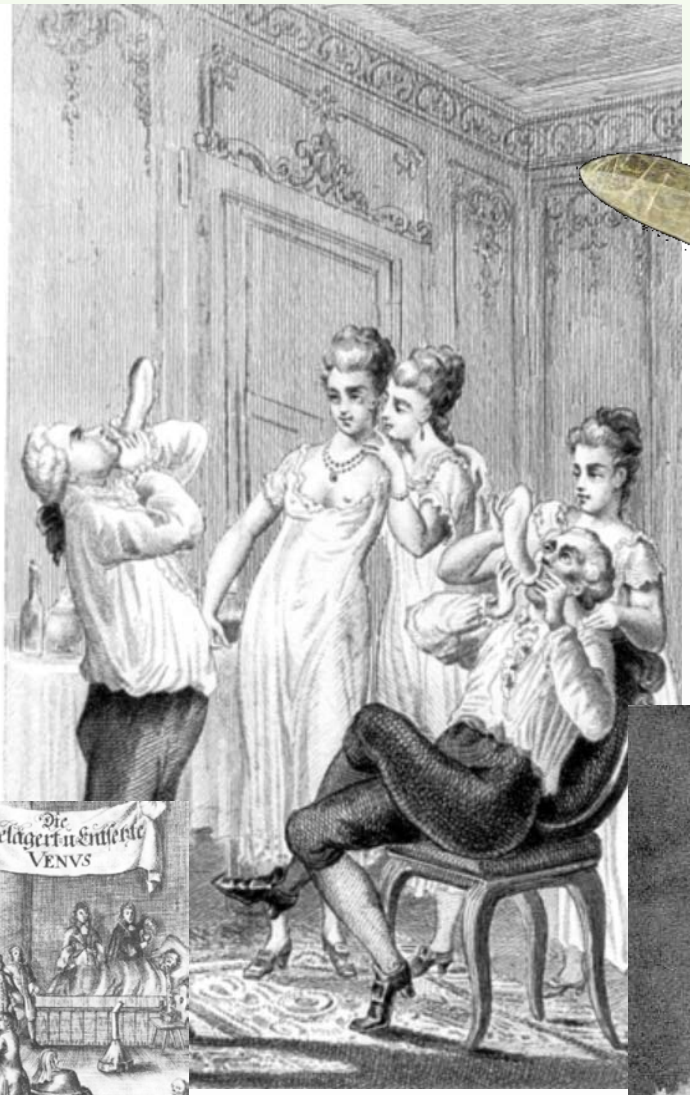


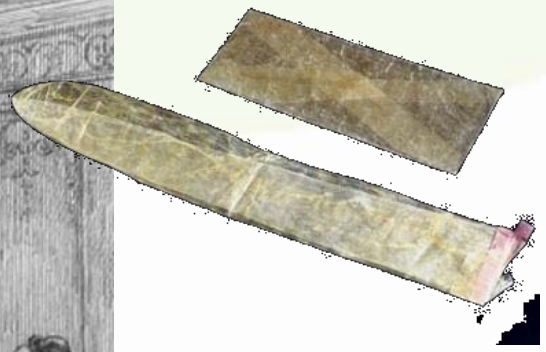


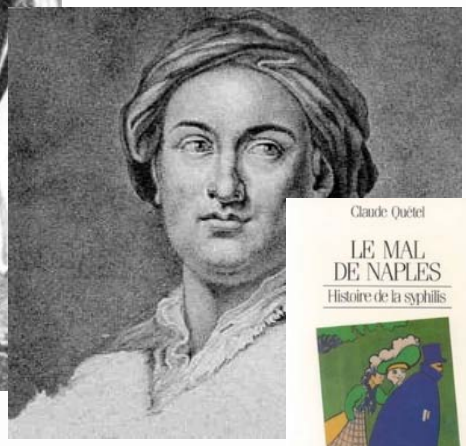
18ème

- De la répression et prison au 17ème vers plus d'hôpitaux au 18ème
- Plus de liberté sexuelle
- Une seule maladie?
- Haute incidence, moins grave, moins peur
- Préservatifs !
- Mercure come Roi pour la syphilis
- « La cristalline » synonyme de homosexualité parmi les libertins
- Plus de IST, descriptions cliniques, pas de traitement efficace

- *faible science, faible réponse*
- *moins grave, plus acceptable*
- *sexe comme expression des « lumières », de la liberté*
- *Préservatif: toujours là*





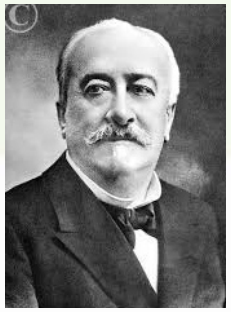


20 x la vérole?

19ème – début 20ème

- Le développement de la microbiologie e de la clinique
- Interventions de santé publique. Programmes ciblés.
- Internement hospitalier x dispensaires
- Examen périodique
- La prévention morale
- La manque de traitement efficace

- *L ïmportance de la recherche*
- *Le leadership est clé*
- *Le débat sur la prostitution*
- *Le débat clinique spécialisé x intégration*
- *La relation des autorités avec les prostituées et le publique*

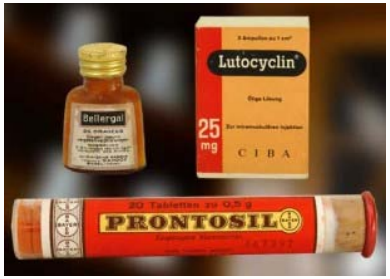


..consultations « nombreuses, gratuites, d'accès facile, ouvertes à des heures où l'ouvrier puisse s'y rendre sans préjudice pour son travail et pour sa bourse»

« traitement des maladies vénériennes est vraiment efficace quand il « cesse d'être coercition pour devenir un plaisir » Val-de-Grâce, 239-1, Rapport du médecin Clément Simon»

1900 - 1943

- Cabinets de prophylaxie individuels
- Les traitements arrivent
- Le diagnostique se développe
- Le débat traitement x prévention
- L'approche morale x l'approche pratique
- Messages basés sur la dissuasion et tactiques alarmistes
- La rationalisation de l'arsénique
- Dépistage massif - Syphilophobie



La guerre 14-18: France

Jea-Yves le Naour http://www.cairn.info/revue-annales-de-demographie-historique-2002-1-page-107.htm

Mesures pour éradiquer le péril vénérien

• Augmenter l'angoisse (ex. les Avariés)

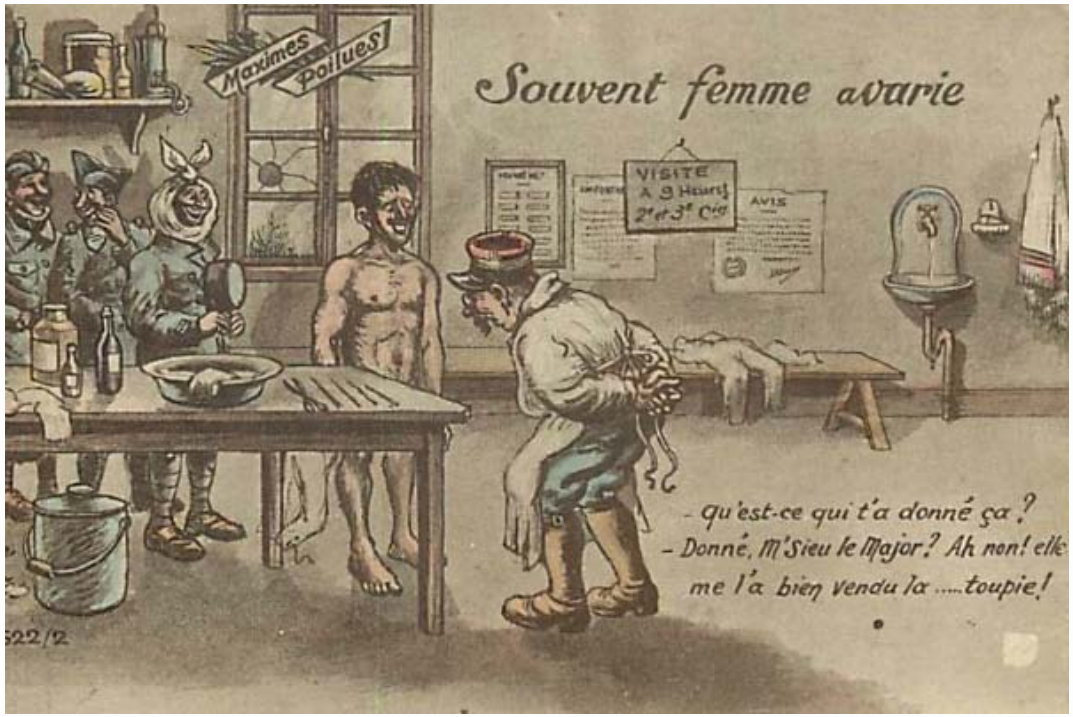
• Contrainte (la visite périodique des mobilisés, le traitement obligatoire, l'internement médical, l'obligation de dénoncer le contaminant).

et de plus en plus

• responsabilité individuelle que consacre le dispensaire antivénérien (40 - 1916, 120 - 1919, 1000 - 1927)

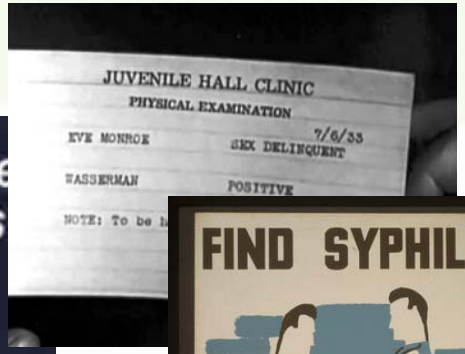
•Traitement disponible

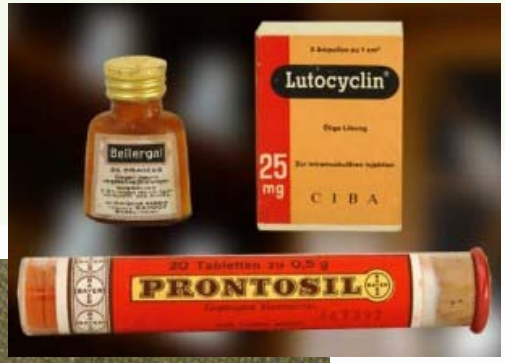
•Expérience avec le cabinet prophylactique

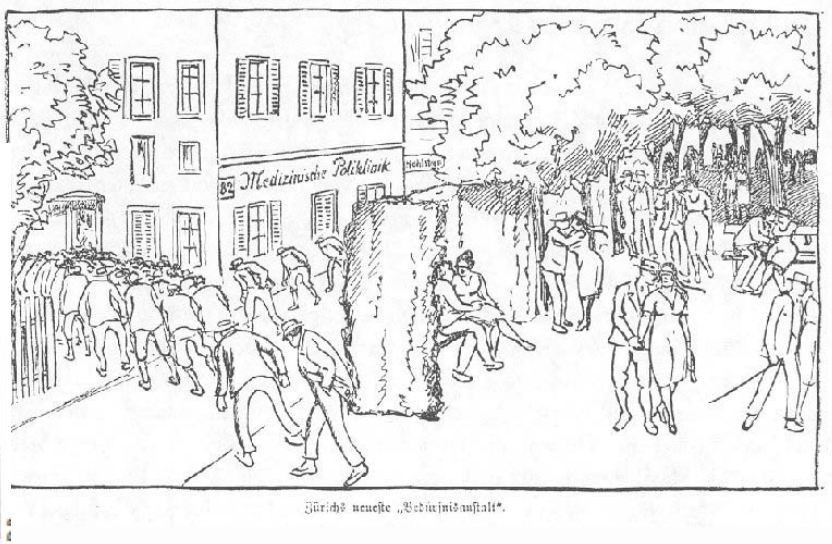


« revue des queues »

Entre les deux guerres







Zürichs neueste „Bedürfnis-anstalt".

The Oslo Study: 1890-1910 to 1929
The Tuskegee Study: 1932 - 1972

Genitourin Med 1994;70:215–217

The History of Sexually Transmitted Diseases. No 9 in a series edited by Milton Lewis and Michael Waugh.

The history of venereology in Norway

Ole Fyrand, Astri Granholt

Abstract

Syphilis became a problem at the beginning of the eighteenth century when a virulent microbe was brought to Norway. This new disease was called "radesyken", a Nordic name for "the wicked disease". "Rade" hospitals were built and this was the beginning of the Norwegian hospital system. Professor Caesar Boeck refused to use mercury in the treatment of syphilis; 2000 of his patients were included in the Oslo study of untreated syphilis. With the use of penicillin and other antibiotics, syphilis

was in union with Denmark, with the government located in Copenhagen, and when the country was geographically and administratively isolated. The few educated medical doctors in the large towns were not able to stop the plague. In 1763 a number of doctors were sent from Denmark in order to combat the disease in the patients' homes—an impossible enterprise owing to the poor social conditions. Consequently, a number of "rade" hospitals were built in different parts of Norway in the second half of the century; and this was the beginning of the Norwegian hospital system.

Departme
Dermatol
Hospital
Rikshospit
Pilestredet
OSLO, No
O Fyrand

Oslo City
of Health
Environm
for STD S
plass 5 N-
Norway
A Granholt

Accepted for publication
12 February 1993

called "radesyken", an old Nordic name for "the wicked disease".

This happened at a time when Norway

doctor, Ludvig Harboe, in the period between 1852 and 1870, Boeck treated 1075 patients with syphilisation at his clinic. This

Review

THE OSLO STUDY OF THE NATURAL HISTORY OF UNTREATED SYPHILIS

AN EPIDEMIOLOGIC INVESTIGATION BASED ON A RESTUDY OF THE BOECK-BRUUSGAARD MATERIAL

A REVIEW AND APPRAISAL

E. GURNEY CLARK, M.D., DR. P.H.,* NEW YORK, N. Y., AND NIELS DANBOLT, M.D.,** OSLO, NORWAY

(Received for publication April 23, 1955.)

INTRODUCTION

GJESTLAND has recently completed in monographic form[1] a retrospective follow-up study of Boeck's famous collection of untreated syphilitics. This recent investigation is an outstanding example of the application of modern

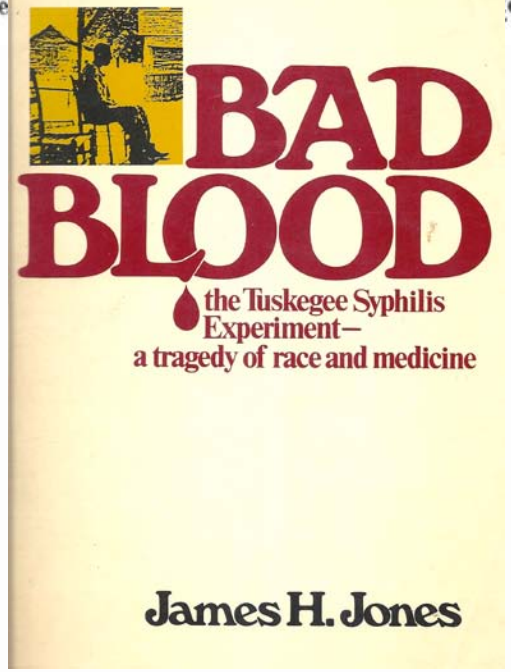
UNTREATED SYPHILIS IN THE MALE NEGRO

A COMPARATIVE STUDY OF TREATED AND UNTREATED CASES.[1]

Read before the annual meeting of the American Medical Association, Section on Dermatology and Syphilology, Kansas City, Mo., May 11–15, 1936.

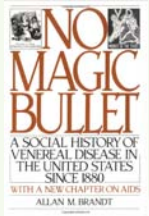
R. A. VONDERLEHR, Assistant Surgeon General,
TALIAFERRO CLARK, Medical Director (Retired),
O. C. WE… Surgeon, and J. R. H… Jr., Assistant Surgeon, United States

A dete… n preventing the
transmis… in the control of
this dise… ect which treat-



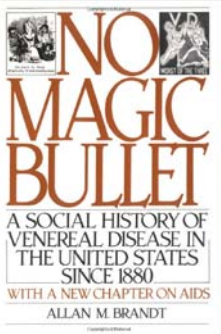
La guerre de 39-45: le changement

- http://www.editions-sepia.com/catalog/pdf/exposition_preservatif.pdf
- *No Magic Bullet, Brandt, A.M.1985*



- Education sexuelle
- Répression de la prostitution
- **Prophylaxie**
- **Traitement**
- Screening
- Recherche des contaminants

Citations 39-45, US Army



- « On ne peut pas rendre l'activité sexuelle impopulaire »
- « Les Anges, on les trouve seulement au ciel »
- « Nous ne pouvons pas étouffer les instincts de l'homme. Nous ne pouvons pas légiférer son appétit »

X

- « La valeur spirituelle de la Syphilis »
- « La stratégie avec les condoms est indécente, répulsive et non américaine »
- « On doit contrôler l'activité sexuelle »
- « Condom c'est une incohérence »

Les guerres 14-18 et 39-45: armée Canadienne

http://www.cpha.ca/fr/programs/history/achievements/02-id/02-vd_to_hiv.aspx

14-18: Hygiène Sociale:

- mariage précoce
- l'hétérosexualité
- monogamie,
- la décence et le conformisme
- prostitution et l'immoralité étaient considérées comme des menaces nationales - Répression de la prostitution
- les rapports sexuels normaux et convenables avaient lieu seulement entre des personnes mariées dans le but de se reproduire.

43-45

- Education sanitaire
- Traitement
- Préservatifs
- Trousses prophylactiques aux soldats avant les permissions.

Le soldat Louis Dufour du « Essex Scottish Regiment » près d'une enseigne avertissant les dangers des maladies vénériennes. Pays-Bas (1945)

Ces initiatives et le recours à la pénicilline dès 1943 pour le personnel posté outre-mer ont diminué de 50% parmi le personnel militaire canadien par rapport au taux d'incidence de la Première Guerre mondiale.

1946

- Traitement pour prévention
- Elimination?

1950's

la fin...
???

WHO CHRONICLE

VOLUME 15, 1961

WORLD HEALTH ORGANIZATION
GENEVA

Venereal diseases and treponematoses

The delegate of Iran stated that the WHO-assisted venereal disease control programme which started in his country in 1953 has proved so successful that it is now difficult to find primary and secondary cases of syphilis for study by medical students. The delegate of Peru also stressed the importance of the Organization's work for the control of the venereal diseases. Syphilis has diminished in importance in his country, though the other venereal diseases and in particular non-specific urethritis continue to be a problem.

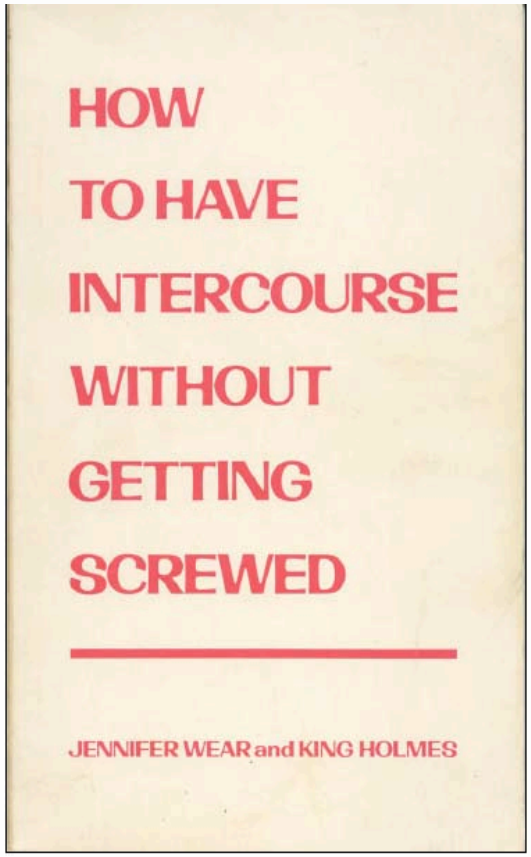
The delegate of Italy expressed concern over the increased incidence of certain venereal diseases. He thought that WHO should study the reasons for failures in venereal disease control, and should intensify its research programme in this field. He welcomed the encouragement given by the Organization to the experimental culture of

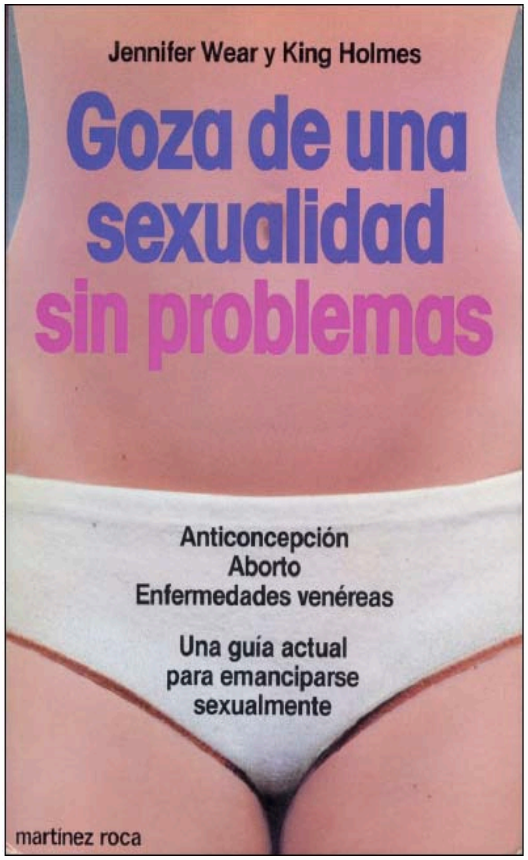
168

1968

Avec la réponse de sante publique démantelé…

1971

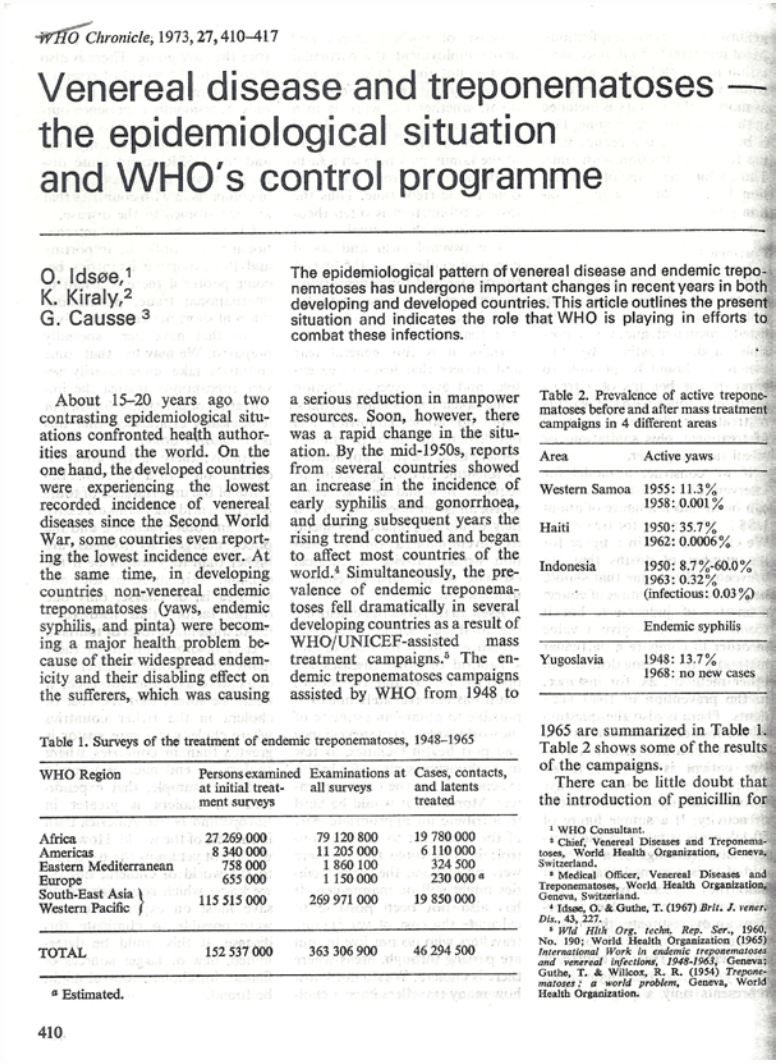




- Plus IST, plus Herpes, plus UNG
- « Traitement est prévention »
- Vers zéro stigma?
- Approche sous le drapeau de la libération sexuelle

1973

Archives de la OMS - 2015



WHO Chronicle, 1973, 27, 410–417

Venereal disease and treponematoses — the epidemiological situation and WHO's control programme

O. Idsøe,[1]
K. Kiraly,[2]
G. Causse [3]

The epidemiological pattern of venereal disease and endemic treponematoses has undergone important changes in recent years in both developing and developed countries. This article outlines the present situation and indicates the role that WHO is playing in efforts to combat these infections.

About 15–20 years ago two contrasting epidemiological situations confronted health authorities around the world. On the one hand, the developed countries were experiencing the lowest recorded incidence of venereal diseases since the Second World War, some countries even reporting the lowest incidence ever. At the same time, in developing countries non-venereal endemic treponematoses (yaws, endemic syphilis, and pinta) were becoming a major health problem because of their widespread endemicity and their disabling effect on the sufferers, which was causing a serious reduction in manpower resources. Soon, however, there was a rapid change in the situation. By the mid-1950s, reports from several countries showed an increase in the incidence of early syphilis and gonorrhoea, and during subsequent years the rising trend continued and began to affect most countries of the world.[4] Simultaneously, the prevalence of endemic treponematoses fell dramatically in several developing countries as a result of WHO/UNICEF-assisted mass treatment campaigns.[5] The endemic treponematoses campaigns assisted by WHO from 1948 to 1965 are summarized in Table 1. Table 2 shows some of the results of the campaigns.

There can be little doubt that the introduction of penicillin for

Table 1. Surveys of the treatment of endemic treponematoses, 1948–1965

WHO Region	Persons examined at initial treatment surveys	Examinations at all surveys	Cases, contacts, and latents treated
Africa	27 269 000	79 120 800	19 780 000
Americas	8 340 000	11 205 000	6 110 000
Eastern Mediterranean	758 000	1 860 100	324 500
Europe	655 000	1 150 000	230 000 [a]
South-East Asia / Western Pacific	115 515 000	269 971 000	19 850 000
TOTAL	152 537 000	363 306 900	46 294 500

[a] Estimated.

Table 2. Prevalence of active treponematoses before and after mass treatment campaigns in 4 different areas

Area	Active yaws
Western Samoa	1955: 11.3% 1958: 0.001%
Haiti	1950: 35.7% 1962: 0.0006%
Indonesia	1950: 8.7%-60.0% 1963: 0.32% (infectious: 0.03%)
	Endemic syphilis
Yugoslavia	1948: 13.7% 1968: no new cases

[1] WHO Consultant.
[2] Chief, Venereal Diseases and Treponematoses, World Health Organization, Geneva, Switzerland.
[3] Medical Officer, Venereal Diseases and Treponematoses, World Health Organization, Geneva, Switzerland.
[4] Idsøe, O. & Guthe, T. (1967) *Brit. J. vener. Dis.*, 43, 227.
[5] *Wld Hlth Org. techn. Rep. Ser.*, 1960, No. 190; World Health Organization (1965) *International Work in endemic treponematoses and venereal infections, 1948-1963*, Geneva; Guthe, T. & Willcox, R. R. (1954) *Treponematoses: a world problem*, Geneva, World Health Organization.

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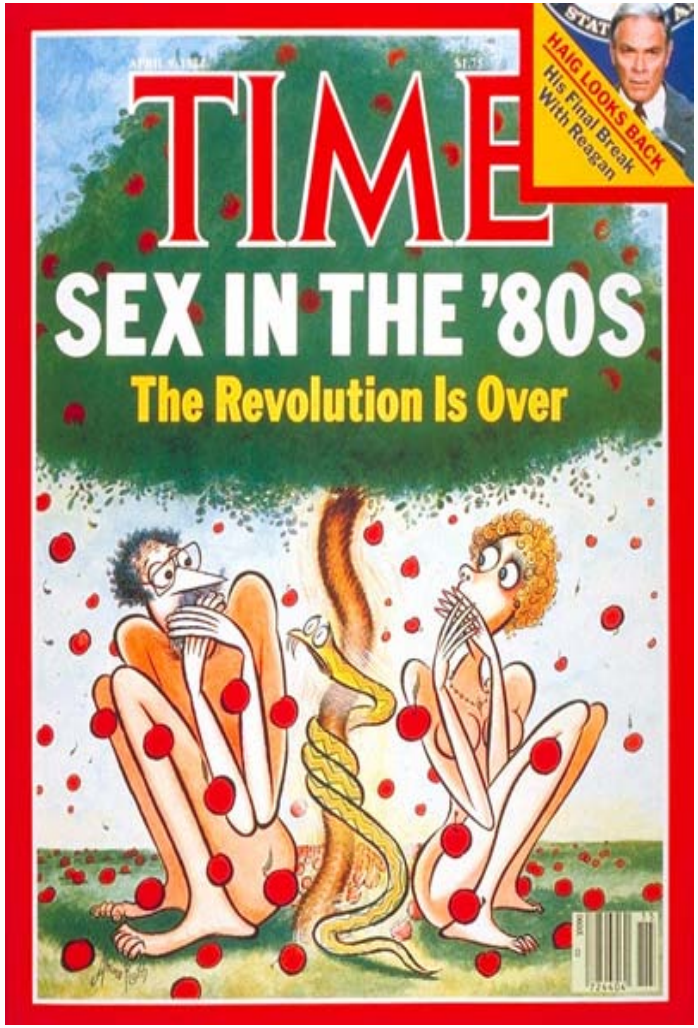
- **Dr Thorstein GUTHE** (Norway): 1948, by transfer from the Interim Commission, as Medical Officer, Chief Venereal Diseases (VD), renamed 01/01/1953, Venereal Diseases and Treponematoses (VDT). Left 31/07/1971

  Il a participé à l'équipe de fleuret et épée individuelle aux Jeux olympiques d'été 1936 …

- **Dr Kalman KIRALY** (Hungary): Joined 20/01/1972 as Medical Officer, Chief Venereal Diseases and Treponematoses (VDT). Left 31/01/1074
- **Dr Georges Yvoy CAUSSE** (France): Came as consultant on various assignments 1971/1972. Joined 01/04/1972 as Medical Officer, Venereal Diseases and Treponematoses (VDT). Reassigned 01/09/1974, Chief Venereal Diseases and Treponematoses (VDT). Reassigned 01/04/1977, Chief Bacterial and Venereal Infections (BVI). Left 01/03/1985.
- **Dr André MEHEUS** (Belgium): Came as consultant to act as Chief Medical Officer in VDT Unit (15/09 to 12/12/1986). Joined 01/01/1987 as Medical Officer, Manager Sexually Transmitted Diseases (STD). Left 01/01/1993.

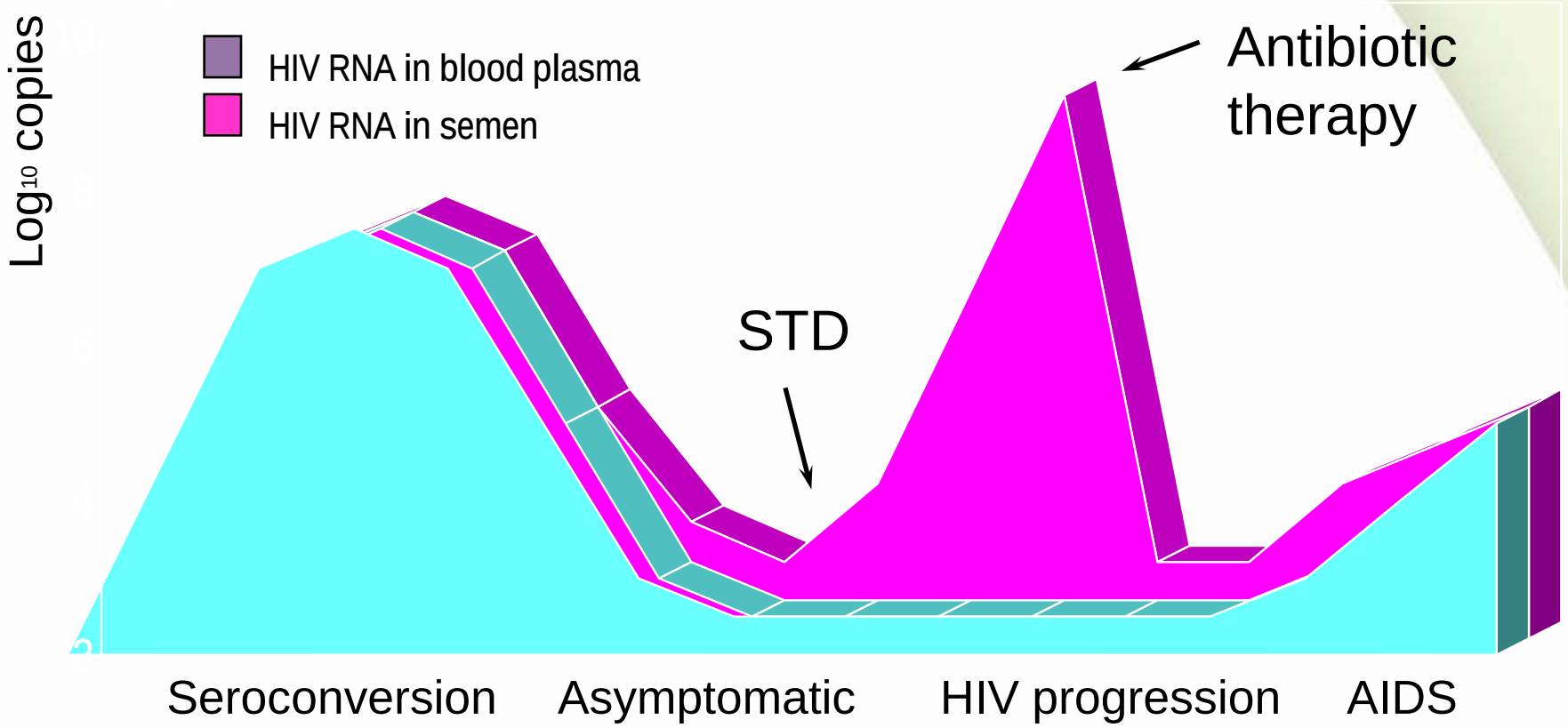
1981 - 1986



- SIDA arrive
- Tout est prévention
- L'Incidence IST tombe
- L'Incidence Syphilis tombe
- Droit de l'Homme domine débat de prévention et traitement

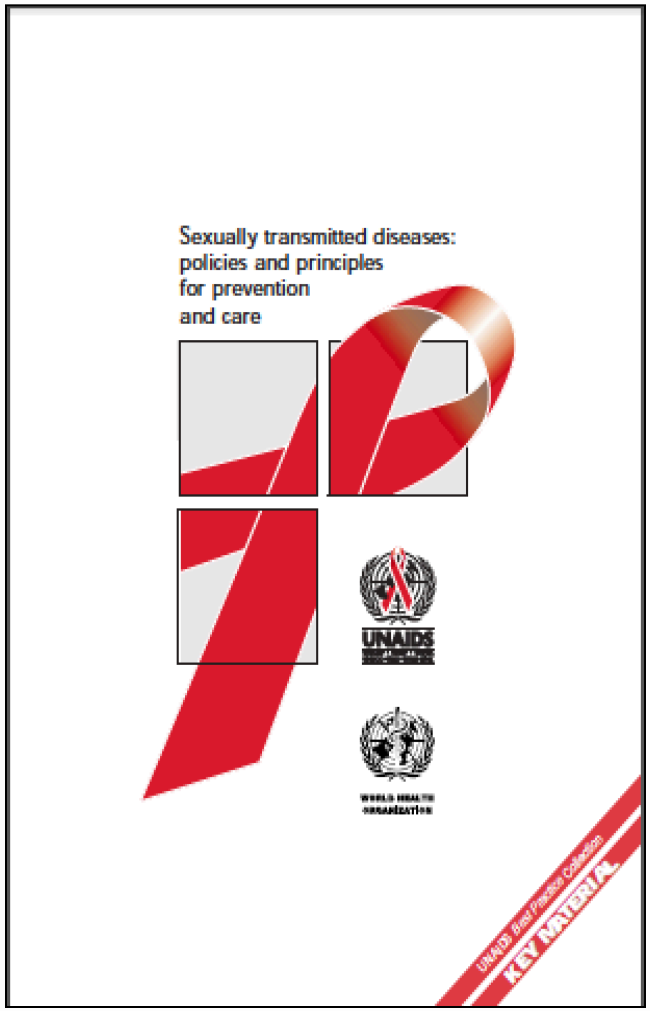
1989 Les MST sont incluses dans la stratégie VIH/SIDA

L'impact des IST dans la quantité de VIH dans le sperme



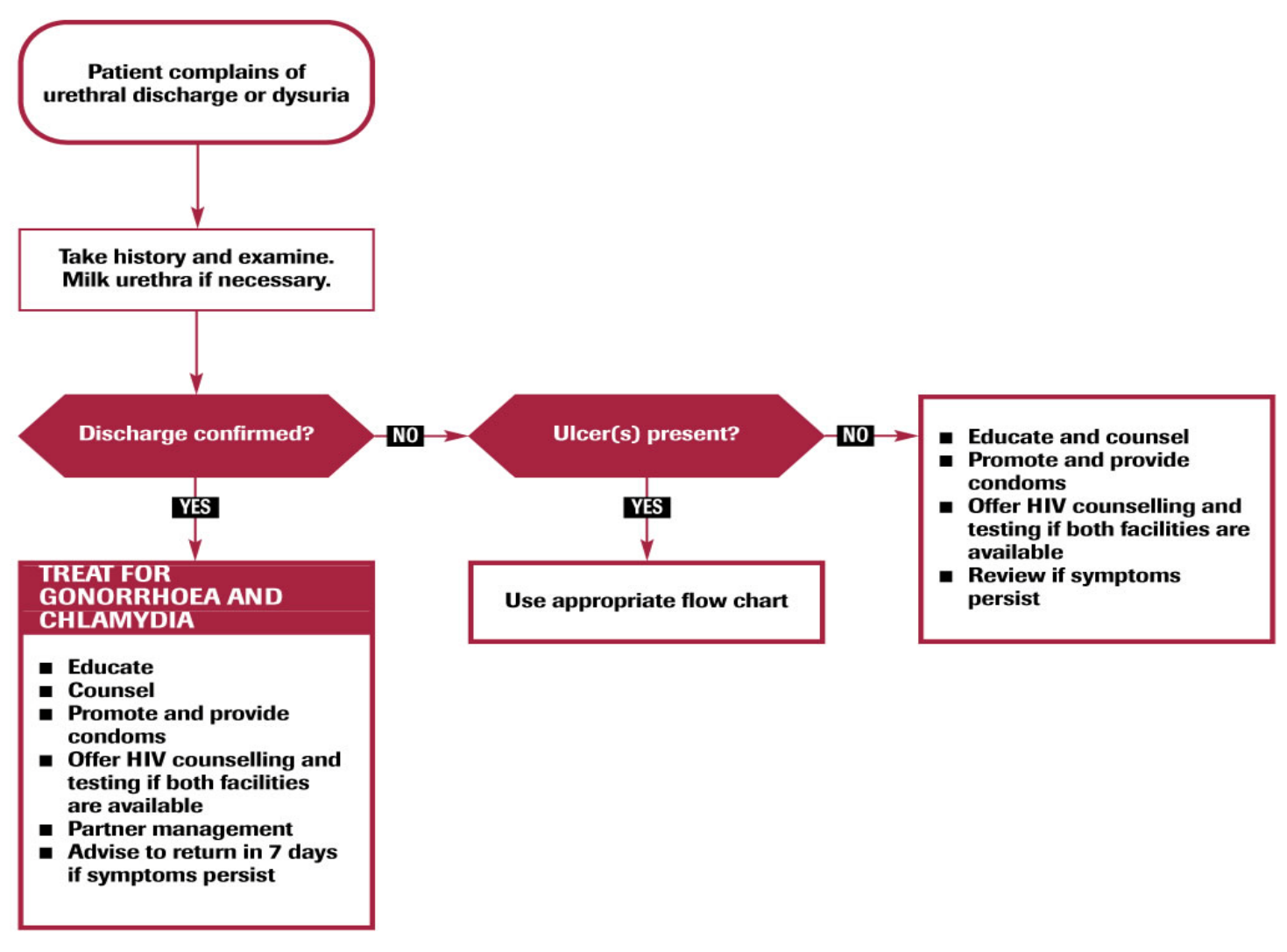
From ISSTDR, Seville 1997; M. Cohen, plenary presentation

1994



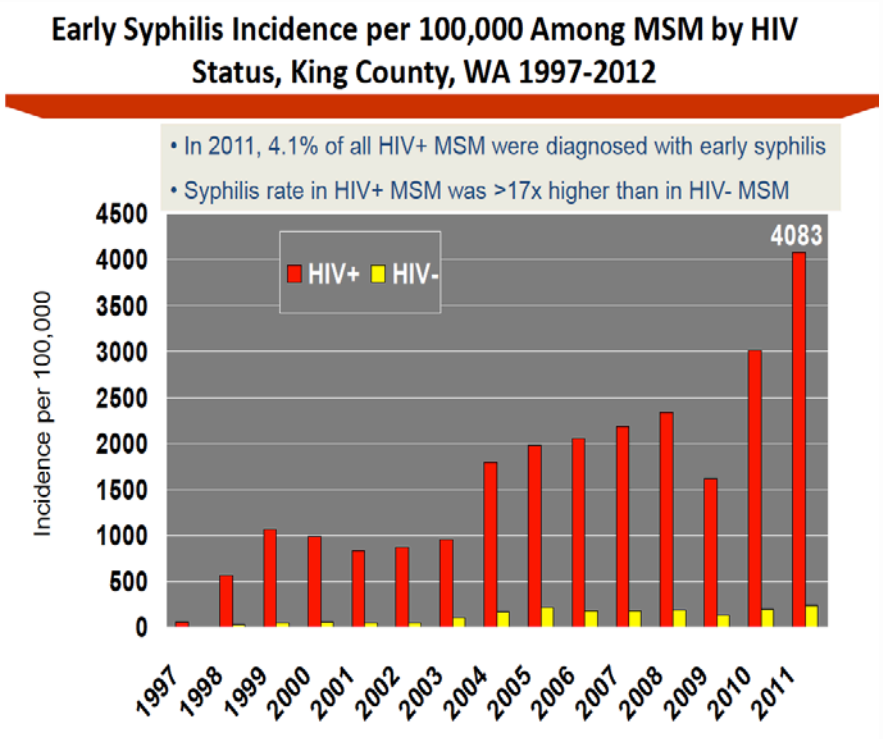
- Le traitement des IST comme prévention du VIH
- Prévention IST VIH intégrée
- Services pour populations clé
- Approche syndromique
- Prévention mère enfant
- Gestion des partenaires sexuelles

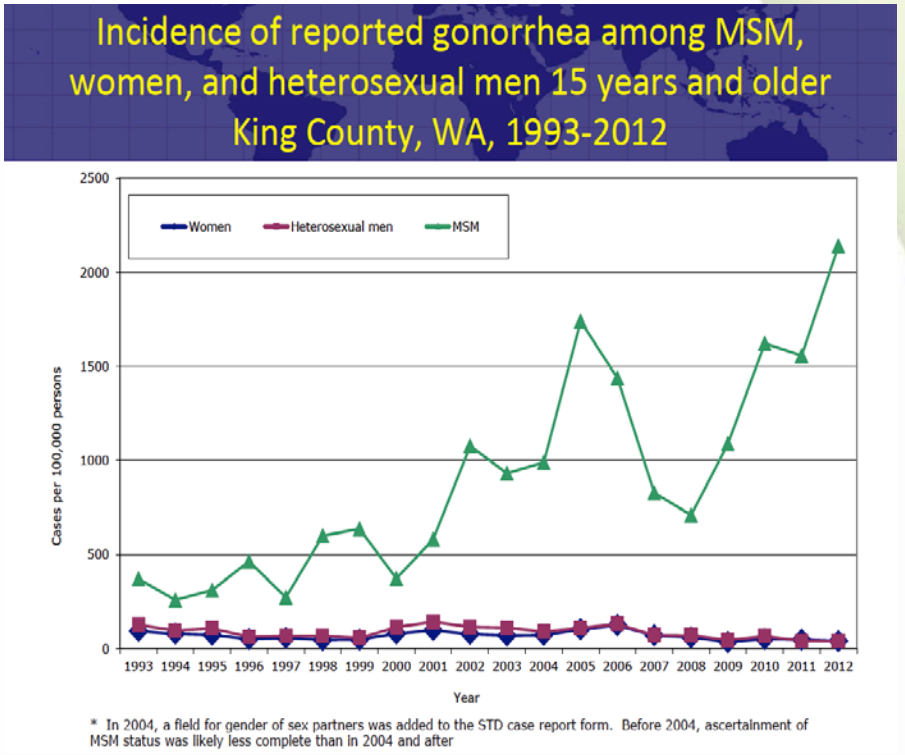
L'approche syndromique: écoulement urétral



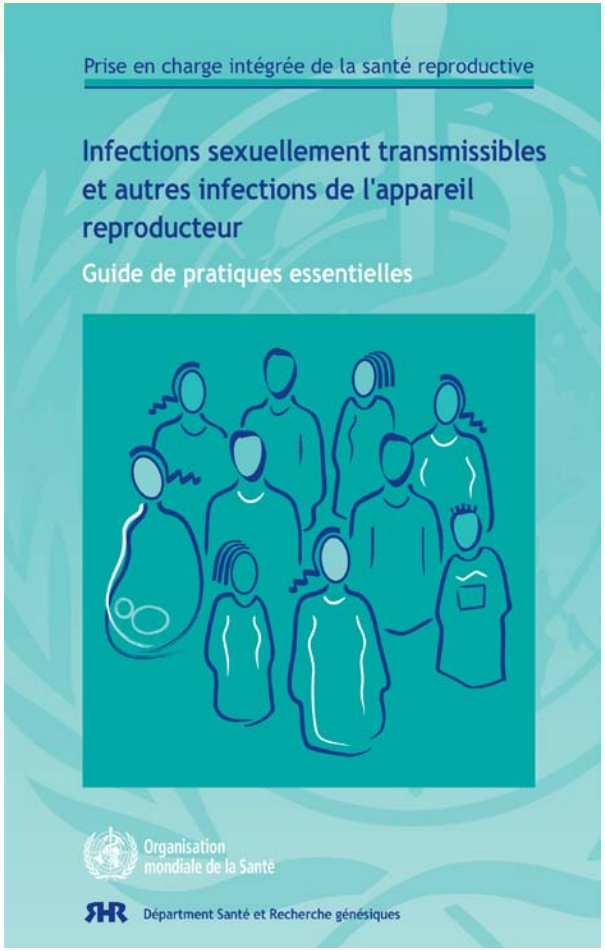
1996

Dramatique augmentation de l'incidence des IST et de la Syphilis après l introduction des ARV pour le traitement du SIDA



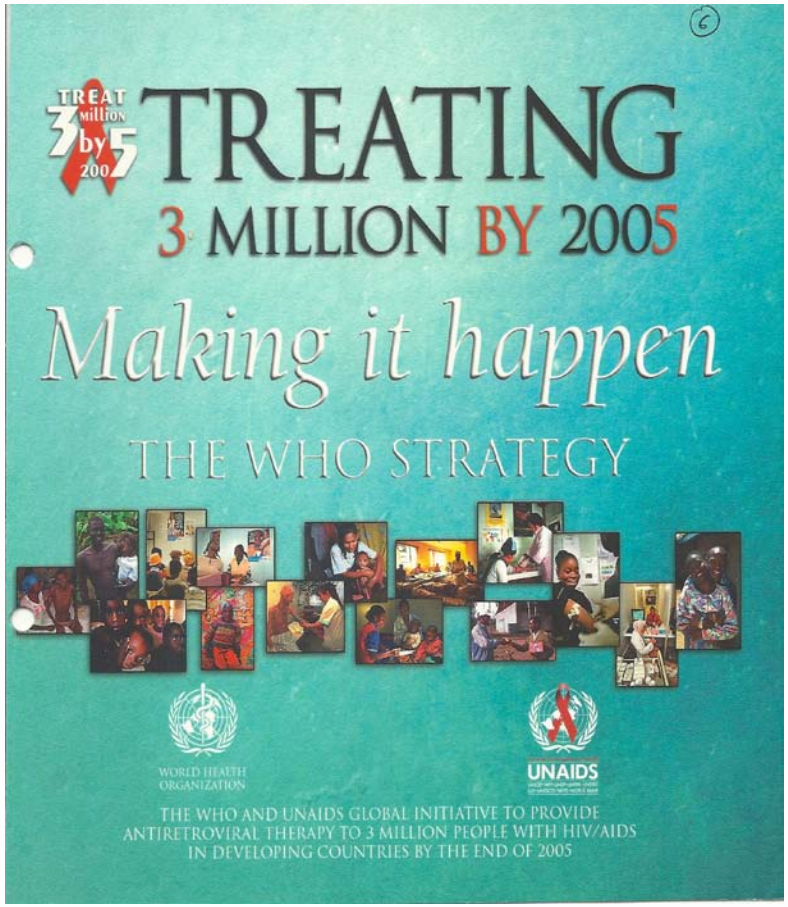


2001 IST et Santé Génésique



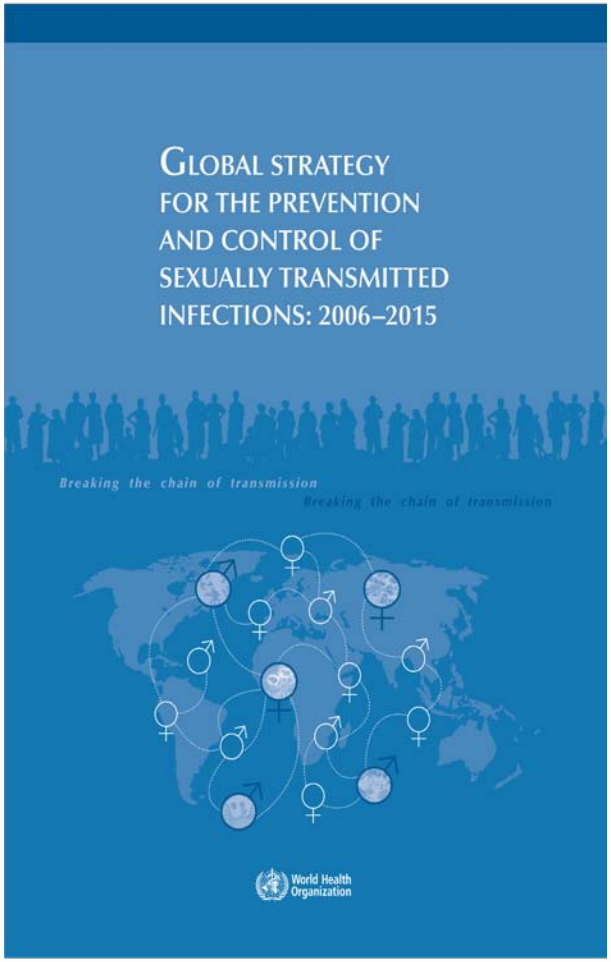
- Synergies avec la reproductions e santé sexuelle
- Promotion de l'intégration avec planification familiale, services de santé génésique et attention primaire

2003-2005



- Tout pour le traitement du SIDA
- IST et prévention oubliées

2006



- Plaidoyer pour plus de ressources, de partenariats, de politiques e tde lois pour:
  - Renforcer prévention et de traitement
  - Focus sur les populations vulnérables: PS, MSM, Jeune
  - IST mise en contexte de la santé reproductive
  - Dépistage de la syphilis
  - Prévention de la transmission verticale
  - Surveillance

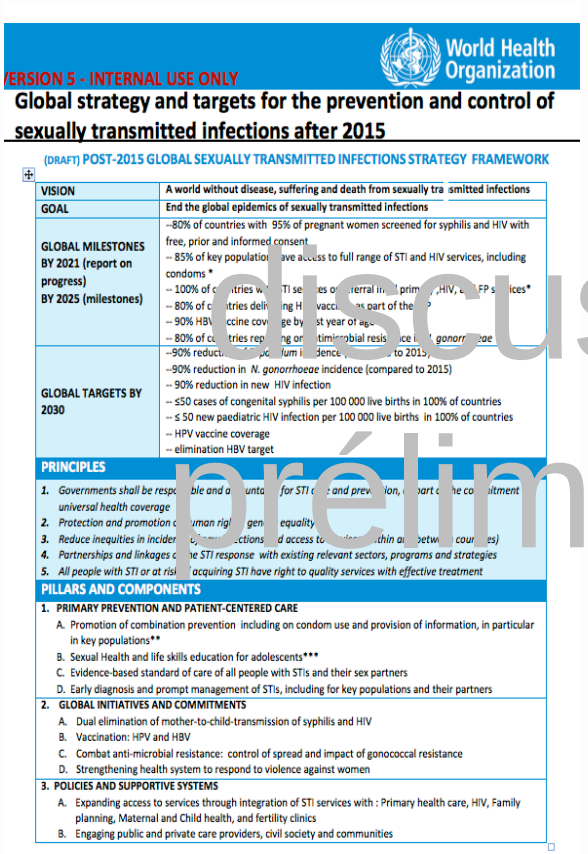
2014 et le future: étapes et des cibles

discussions préliminaires

GLOBAL MILESTONES (INDICATIVE)	**STIs (milestones for 2020)** • 80% of countries with 95% of pregnant women screened for syphilis and HIV with free, prior and informed consent • 85% of key population have access to full range of STI & HIV services, including condoms * • 100% of countries with STI services or referral in all primary ,HIV, and FP services* • 80% of countries delivering HPV vaccines as part of the NIP • 90% HBV vaccine coverage by first year of age • 80% of countries reporting on antimicrobial resistance in *N. gonorrhoeae*

GLOBAL TARGETS BY 2030 (INDICATIVE) (Consistent with Sustainable Development Goals and UNAIDS strategy)	**Impact:**
	• End STI epidemics
	  ○ 90% reduction of *T. pallidum* incidence (compared to 2015)
	  ○ 90% reduction in *N. gonorrhoeae* incidence (compared to 2015)
	  ○ ≤50 cases of congenital syphilis per 100 000 live births in 100% of countries
	  ○ HPV vaccine coverage
	
	Contribute to other health impacts:
	• By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births;
	• By 2030, end preventable deaths of newborns and children under 5 years of age;
	• By 2030, end the epidemics of tuberculosis and combat hepatitis
	• By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
	
	Outcome and process:
	• By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes;
	• Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

2014 et le future: travail en marche – ligne 1



World Health Organization

VERSION 5 - INTERNAL USE ONLY

Global strategy and targets for the prevention and control of sexually transmitted infections after 2015

(DRAFT) POST-2015 GLOBAL SEXUALLY TRANSMITTED INFECTIONS STRATEGY FRAMEWORK

VISION	A world without disease, suffering and death from sexually transmitted infections
GOAL	End the global epidemics of sexually transmitted infections
GLOBAL MILESTONES BY 2021 (report on progress) BY 2025 (milestones)	--80% of countries with 95% of pregnant women screened for syphilis and HIV with free, prior and informed consent -- 85% of key population have access to full range of STI and HIV services, including condoms * -- 100% of countries with STI services or referral in primary, HIV, and FP services* -- 80% of countries delivering HPV vaccine as part of the -- 90% HBV vaccine coverage by last year of age -- 80% of countries reporting on antimicrobial resistance in *N. gonorrhoae*
GLOBAL TARGETS BY 2030	--90% reduction in syphilis incidence compared to 2015) --90% reduction in *N. gonorrhoeae* incidence (compared to 2015) -- 90% reduction in new HIV infection -- ≤50 cases of congenital syphilis per 100 000 live births in 100% of countries -- ≤ 50 new paediatric HIV infection per 100 000 live births in 100% of countries -- HPV vaccine coverage -- elimination HBV target

PRINCIPLES

1. *Governments shall be responsible and accountable for STI care and prevention, as part of the commitment universal health coverage*
2. *Protection and promotion of human rights, gender equality*
3. *Reduce inequities in incidence, infections and access to services within and between countries)*
4. *Partnerships and linkages of the STI response with existing relevant sectors, programs and strategies*
5. *All people with STI or at risk of acquiring STI have right to quality services with effective treatment*

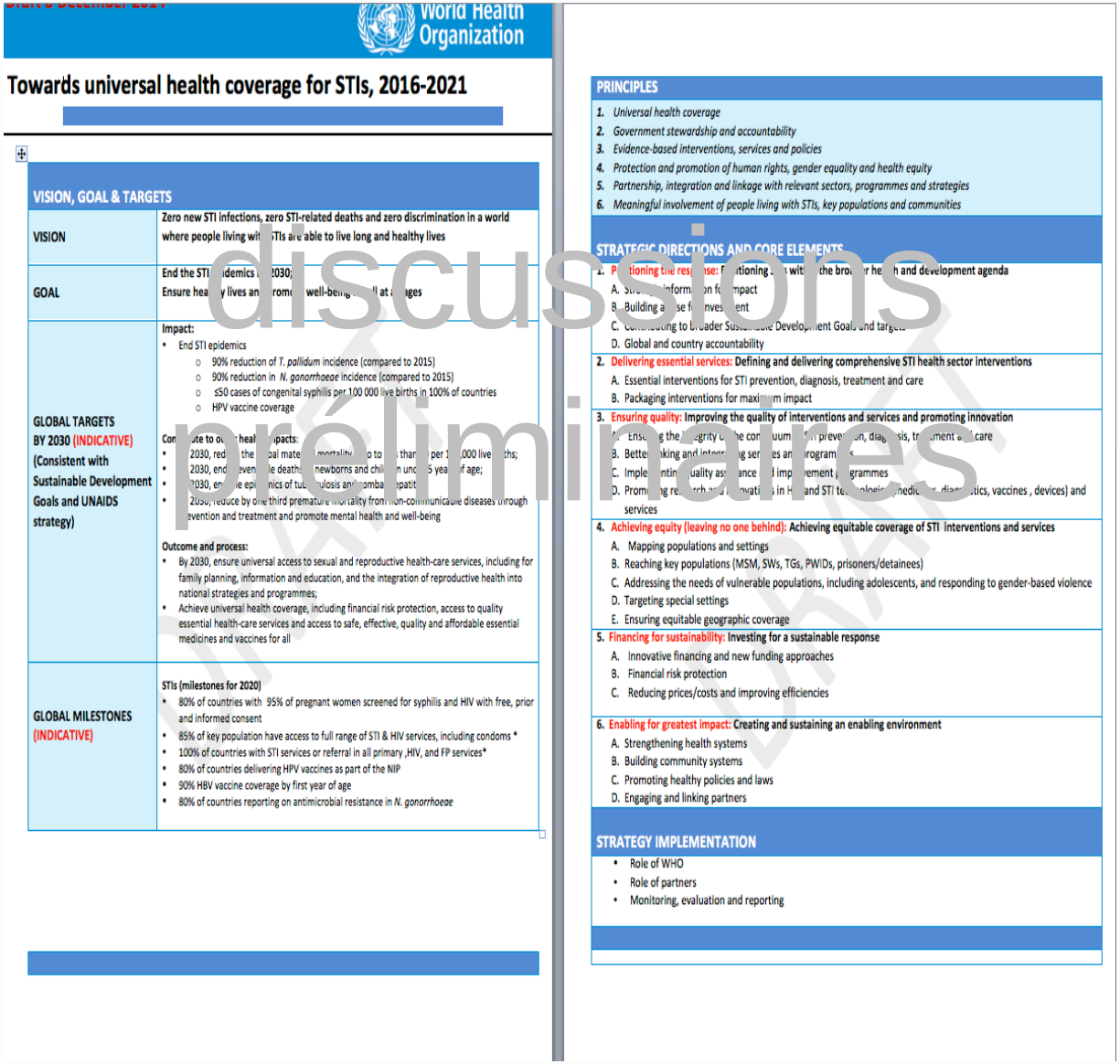
PILLARS AND COMPONENTS

1. **PRIMARY PREVENTION AND PATIENT-CENTERED CARE**
   - A. Promotion of combination prevention including on condom use and provision of information, in particular in key populations**
   - B. Sexual Health and life skills education for adolescents***
   - C. Evidence-based standard of care of all people with STIs and their sex partners
   - D. Early diagnosis and prompt management of STIs, including for key populations and their partners
2. **GLOBAL INITIATIVES AND COMMITMENTS**
   - A. Dual elimination of mother-to-child-transmission of syphilis and HIV
   - B. Vaccination: HPV and HBV
   - C. Combat anti-microbial resistance: control of spread and impact of gonococcal resistance
   - D. Strengthening health system to respond to violence against women
3. **POLICIES AND SUPPORTIVE SYSTEMS**
   - A. Expanding access to services through integration of STI services with : Primary health care, HIV, Family planning, Maternal and Child health, and fertility clinics
   - B. Engaging public and private care providers, civil society and communities
   - C. Ensuring sustainable financing for allocation of adequate resources to STI response
   - D. Strengthening monitoring and evaluation in the private and public sector in partnership with global agencies
   - E. Creating a legal and policy environment which ensure prevention and treatment of STIs without discrimination, coercion, harassment and violence
4. **INTENSIFIED RESEARCH AND INNOVATION**
   - A. Discovery, development and rapid uptake of new rapid tests, multipurpose prevention technologies, vaccines and effective treatment; as well as other effective prevention
   - B. Research to optimize implementation and impact of new interventions, and promote innovations

- *Definition of what is full range of services – by reference to the consolidated guidelines on HIV prevention, diagnosis treatment and care for key populations
- **Def. key population as defined by UNAIDS: sex workers, MSM,
- equity and targets in countries: to capture the dimension of target for countries and equity between countries as well as equity within countries
- ?? UNAIDS similar indicator – discuss to extend to general population?
- WB indicator – also NCPI indicator
- Adolescent services will be detailed

- Prévention primaire et soins centrés au patient
- Initiatives mondiales et compromis
- Politiques et systèmes de soutien

2014 et le future: travail en marche – ligne 2



World Health Organization

Towards universal health coverage for STIs, 2016-2021

VISION, GOAL & TARGETS	
VISION	Zero new STI infections, zero STI-related deaths and zero discrimination in a world where people living with STIs are able to live long and healthy lives
GOAL	End the STI epidemics by 2030; Ensure healthy lives and promote well-being for all at all ages
GLOBAL TARGETS BY 2030 (INDICATIVE) (Consistent with Sustainable Development Goals and UNAIDS strategy)	**Impact:** • End STI epidemics o 90% reduction of *T. pallidum* incidence (compared to 2015) o 90% reduction in *N. gonorrhoeae* incidence (compared to 2015) o ≤50 cases of congenital syphilis per 100 000 live births in 100% of countries o HPV vaccine coverage Contribute to other health impacts: • 2030, reduce the global maternal mortality ratio to less than per 100 000 live births; • 2030, end preventable deaths of newborns and children under 5 years of age; • 2030, end the epidemics of tuberculosis and malaria and combat hepatitis; • 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being **Outcome and process:** • By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; • Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
GLOBAL MILESTONES (INDICATIVE)	**STIs (milestones for 2020)** • 80% of countries with 95% of pregnant women screened for syphilis and HIV with free, prior and informed consent • 85% of key population have access to full range of STI & HIV services, including condoms * • 100% of countries with STI services or referral in all primary ,HIV, and FP services* • 80% of countries delivering HPV vaccines as part of the NIP • 90% HBV vaccine coverage by first year of age • 80% of countries reporting on antimicrobial resistance in *N. gonorrhoeae*

PRINCIPLES

1. *Universal health coverage*
2. *Government stewardship and accountability*
3. *Evidence-based interventions, services and policies*
4. *Protection and promotion of human rights, gender equality and health equity*
5. *Partnership, integration and linkage with relevant sectors, programmes and strategies*
6. *Meaningful involvement of people living with STIs, key populations and communities*

STRATEGIC DIRECTIONS AND CORE ELEMENTS

1. Positioning the response: Positioning STIs within the broader health and development agenda
   - A. Strategic information for impact
   - B. Building a case for investment
   - C. Contributing to broader Sustainable Development Goals and targets
   - D. Global and country accountability
2. Delivering essential services: Defining and delivering comprehensive STI health sector interventions
   - A. Essential interventions for STI prevention, diagnosis, treatment and care
   - B. Packaging interventions for maximum impact
3. Ensuring quality: Improving the quality of interventions and services and promoting innovation
   - A. Ensuring the integrity of the continuum for prevention, diagnosis, treatment and care
   - B. Better linking and integrating services and programmes
   - C. Implementing quality assurance and improvement programmes
   - D. Promoting research and innovations in HIV and STI technologies (medicines, diagnostics, vaccines , devices) and services
4. Achieving equity (leaving no one behind): Achieving equitable coverage of STI interventions and services
   - A. Mapping populations and settings
   - B. Reaching key populations (MSM, SWs, TGs, PWIDs, prisoners/detainees)
   - C. Addressing the needs of vulnerable populations, including adolescents, and responding to gender-based violence
   - D. Targeting special settings
   - E. Ensuring equitable geographic coverage
5. Financing for sustainability: Investing for a sustainable response
   - A. Innovative financing and new funding approaches
   - B. Financial risk protection
   - C. Reducing prices/costs and improving efficiencies
6. Enabling for greatest impact: Creating and sustaining an enabling environment
   - A. Strengthening health systems
   - B. Building community systems
   - C. Promoting healthy policies and laws
   - D. Engaging and linking partners

STRATEGY IMPLEMENTATION

- Role of WHO
- Role of partners
- Monitoring, evaluation and reporting

- Plaidoyer
- Liaison avec d'autres initiatives
- Prévention et soin
- Qualité
- Équité
- Concentrer sur les populations clés
- Financement
- Renforcement des systèmes de santé

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et

José Gerbase