Using the RTI/STI Programme Guidance Tool to Control RTIs in the State of Ceará, Brazil

Background—Rapid Assessment—Recommendations—Evaluation
The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through the organization, which was created in 1948, the health professions of member countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world of a level of health that will permit them to lead a socially and economically productive life. The Reproductive Health and Research Programme (RHR) focuses specifically on identifying sound interventions for and providing technical assistance to the implementation of reproductive health programmes.

Horizons is a global operations research programme designed to identify components of effective HIV/AIDS programmes and policies; test potential solutions to problems in prevention, care, support, and service delivery; and disseminate and utilize findings. Horizons is implemented by the Population Council under cooperative agreement HRN-A-00-97-00012-00 with the United States Agency for International Development (USAID). Horizons partners are: International Center for Research on Women, International HIV/AIDS Alliance, PATH, Tulane University, Family Health International, and Johns Hopkins University.

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TABLE OF CONTENTS

Introduction 3
Background of Health Conditions 5
Rapid Assessment 11
Recommendations 21
Evaluation 25
Annex 1: People Interviewed for Evaluation 39
Annex 2: Coordinating Team 41
INTRODUCTION

Putting RTIs on the policy agenda

Reproductive tract infections (RTIs)—which include endogenous, iatrogenic, and sexually transmitted infections (STIs)—contribute substantially to the global burden of disease. The HIV pandemic is integrally related to this problem: HIV/AIDS, an STI in its own right, is also synergistically influenced by the presence of other RTIs (for example, transmission is increased in the presence of other infections).

These infections cause varying degrees of morbidity. Untreated or inappropriately managed RTIs can result in severe consequences for women, men, and neonates. Complications and sequelae of RTIs include pelvic inflammatory disease, ectopic pregnancy, infertility, and adverse outcomes of pregnancy, neonatal morbidity, and death (in the case of HIV/AIDS and genital cancers).

The global effort to control these pathologies has been the object of studies and operational research in many settings. Initially, such research prioritized primary interventions for prevention of reproductive tract infections; however, it soon became clear that prevention by itself was not sufficient: a group of actions also was necessary to control the established causes of these infections. Each country or state must define a set of interventions appropriate to their particular and distinct situation.

The RTI/STI Programme Guidance Tool

The RTI/STI Programme Guidance Tool (PGT) identifies and addresses the management, technical, sociocultural, and economic issues that affect the ability of a health system to deliver effective interventions.

The PGT is based on the experiences of countries implementing the Strategic Approach to Improving the Quality of Care of Reproductive Health Services—a methodology that has been implemented by WHO and its partners in 18 countries to date. This approach promotes the concept that appropriate decisions concerning policy and programme development should be based on an understanding of the relationships between those infected with RTIs or at risk of RTI infection, the service delivery system, and the mix of services and interventions being provided.

The goal of the RTI/STI Programme Guidance Tool is to obtain a comprehensive mix of interventions for RTI control, which may differ with locations or national programmes. The PGT addresses RTIs (including STIs), examines service capacity, and highlights clients’ perspectives and needs while focusing on quality of care. This locally-led process of programme design encourages collaboration and partnership among a broad range of stakeholders concerned about RTI control and reproductive health.
The World Health Organization and the Population Council’s Horizons Program are working in partnership with the Government of Brazil to implement and evaluate a decision-making process to assist programme managers in prioritizing interventions for addressing reproductive tract infections.

This paper presents an overview of the health conditions in the state of Ceará in Brazil, including the incidence and prevalence of RTIs (including AIDS) followed by a discussion of behaviors of at-risk populations. Finally, this paper presents key problems that must be addressed to better serve people with reproductive tract infections and lists actions that must be taken by the government.

This paper includes:

- A background review of demographic, socioeconomic, and reproductive health conditions in Ceará, Brazil, focusing on STIs, HIV/AIDS, and other infections;
- Results of a rapid assessment of RTIs conducted in Ceará, Brazil;
- Recommendations for priority interventions; and
- Evaluation of the PGT process.
BACKGROUND OF HEALTH CONDITIONS

In 1999, the Brazilian national STI/AIDS programme selected the state of Ceará to carry out a situational diagnosis of reproductive tract infections. The goal: to determine the extent and nature of the problem, suggest priority policy strategies for the control of RTIs, and assure that the final recommendations are translated into political action.

This background paper summarizes the main information on the extent and nature of the RTI problem in Ceará and the local response to the problem.

Health and economic indicators

Ceará State in the northeastern region of Brazil has a population of about seven million people living in an area covering 140,000km. Economic advances in the last twelve years have not had a significant impact upon people's standard of living. As a result, Ceará has fallen behind other states in terms of education, health, and quality of life indicators in general.

Research carried out locally shows that until recently, control of RTIs in the state were hampered by these problems:

- Lack of epidemiological data;
- Inadequate distribution of health services and professionals;
- Disorganized existing services;
- Lack of training of health professionals for adequate case management;
- Reduced laboratory capacity to provide etiologic diagnosis;
- Drug shortages; and
- Discrimination against patients and lack of confidentiality and privacy.

Because of these inadequacies, services are under-utilized and patients seek care outside of the formal health care settings, mainly in pharmacies. The situation in Ceará is typical of the rest of the country.

National policies for STI control

Brazil's national AIDS/STI programme, created in 1988, focused mainly on:

- Prevention, through community education about risk perception, changes in behavior, and promoting the use of condoms;
- Case detection, by providing efficient services and screening for syphilis during prenatal care; and
• Immediate treatment, using the syndromic approach during the first appointment, with an emphasis on patient counseling. The flow diagrams for the syndromic approach were drawn up in 1993.

The main goals of the National Coordination for STIs and AIDS of the Ministry of Health are:

• Integration of the care of RTIs into the primary care service;
• Elimination of congenital syphilis; and
• Involvement of pharmacies in treatment activities.

A loan agreement signed with the World Bank in 1994 permitted a faster implementation of actions related to prevention and patient care. Resources are channeled through the annual Operative Plans to state and municipal organizers of STI/AIDS control.

**Incidence and prevalence**

**Data on incidence and prevalence of RTIs**

Data on prevalence of RTIs were gathered from a range of studies at various health centers and clinics. Findings from the largest of the studies, the HIV/STI Project, showed that 78 percent of the patients practiced heterosexual sex although 16 percent said they had had more than one male or female partner. The number of people whose partners had multiple partners (37 percent of the total), was greater than the percentage of people who had partners who used drugs, had a history of drug transfusion, or tested HIV positive. The prevalence of HIV positive patients among the population studied was 1.8 percent, but the prevalence among male homosexual and bisexual patients was 9 percent.

Studies of RTI prevalence at various clinics and hospitals showed high prevalence of vaginal discharge and genital warts in women and genital warts and urethral discharge in men, among other conditions.

Table 1 provides a general overview of RTI findings from a variety of studies.

**AIDS epidemiology in Ceará**

From 1983 to 1999, Ceará reported 2704 AIDS cases, with the epidemic reaching almost 73 percent of the state’s 184 municipalities. The largest concentration of cases was in Fortaleza, the state capital, with 69 percent of the total. The cumulative rate of incidence is 42.5 per 100,000 people. The HIV epidemic in the state has shown a slow but steady progression. Eighty percent of those infected were men.

According to data from the National Coordination for STI/AIDS in the Ministry of Health, Ceará is among the top three northeastern states in terms of numbers of reported cases,
below only Bahia and Pernambuco. However, when relative incidence is taken into account, Ceará comes second on the regional scale.

<table>
<thead>
<tr>
<th>Table 1 Surveys/studies conducted of RTI prevalence</th>
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<tbody>
<tr>
<td>1. Cervical cancer screening, 1998-1999</td>
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<td>2. STIs at Meireles Health Center, 1997-1998</td>
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<td>3. STI clinic, University Hospital</td>
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<td>4. HIV/STI pilot project</td>
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<td>5. HIVSTI extension project</td>
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<td>6. STIs in pregnant women, 2000</td>
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<td>7. Prevalence of chlamydia, 2000</td>
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<td>8. STI syndromes in STI referral centers, 1999</td>
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</table>

A survey conducted in 1993 and 1994 of 2 754 people sought to determine the prevalence of HIV and HTLV in six groups: pregnant women, tuberculosis patients, male and female sex workers, STI patients, and prisoners. Of the groups, male sex workers had the highest prevalence of HIV: 3 percent.

Ceará participated in the HIV Sentinel Project, developed by the National Coordination for STI/AIDS in 1997. The study, conducted at six health centers, showed that accident and emergency room patients had the highest prevalence of STIs: 2 percent.
Structures for the care of people with HIV and RTIs

The demand for HIV care led to the emergence of specialized care services (SAE), a basic model for services created by the Ministry of Health. The specialized services were conceived as out-patient support that ensures care during the patient’s periods of clinical treatment, and advises and guides them to other types of services. This model has provided guidelines for the implementation of HIV services, defined criteria for quality, and suggested the quantity of material and human resources necessary for a well-organized service.

The state also has a network of anonymous testing centers, along with referral centers that offer HIV testing. Screening of blood is systematic at blood banks.

Investment in personnel training, physical space, and equipment since 1986 have resulted in infrastructure for RTI and HIV/AIDS care at major hospitals, maternity hospitals, and laboratories.

Current trends of the epidemic

Over the years, AIDS has spread throughout the state. Until 1990, AIDS cases were restricted to the capital and 27 municipalities; now the epidemic has spread to 134 municipalities. Over time, heterosexual transmission has increased progressively and is now the cause of almost 54 percent of all infections. When cases due to multiple exposures are analyzed, such as combined heterosexual exposure and intravenous drug use, the data show an increase of 54 percent between the years 1990 to 1994 and 1995 to 1997. Another important change is the increased number of women with AIDS: the ratio of male to female cases fell from 12:1 in 1990 to 3:1 in 1998, probably a result of sexual relations with infected bisexual males and/or injecting drug users.

Learning how people behave

Although studies on sexual behaviors that increase the risk of HIV infection in population groups in Ceará are infrequent, a few specific groups were studied in the 1990s.

A 1994 study focused on 100 female school teachers aged 22 to 53 who taught at all 26 public schools in the city of Fortaleza. Half of the teachers had degrees; 70 percent taught subjects in the humanities. One-third of the teachers said they had sexual relations for the first time between the ages of 17 and 22. Ten percent thought that HIV could infect only women with many partners. Less than one-quarter of the teachers said they used condoms and only 3 percent said they always used them. The reason most frequently given by sexually active women for not using condoms was belief in a partner’s faithfulness.

A study carried out in Fortaleza in 1995 focused on knowledge, beliefs, attitudes, and sexual behavior of men who have sex with other men. Four hundred men between the ages of 14 and 65 were recruited into the study at locations frequented by this population: public
squares, bars, nightclubs, and cinemas. Forty-four percent of these men said they participated in high-risk sexual activity—penetrative or receptive anal sex or vaginal sex, without condoms. These men who were most frequently involved in high-risk relations and had the highest number of partners were the ones who were least informed about AIDS. The men also regarded anal sex as the best sex and took great pleasure in unprotected sex. Nearly a quarter of the participants reported at least one sexual encounter with a female partner in the previous year. Two-thirds of the men who had unprotected sex with their female partners also had unprotected anal sex with their male partners.

A 1998 study involving the same male population in Fortaleza showed a decrease of 36 percent in high-risk sex compared with the earlier study. One possible reason for this behavior change was that the men in this group had become more educated and might have been exposed to more information.

The subjects of a 1996 study were 650 adolescents from state and private secondary schools who were interviewed about their sexual behavior using a semi-structured, confidential questionnaire. Schools at both the highest and lower socioeconomic levels were included. The study showed that a significantly higher proportion of the male students—70 percent—reported having started sexual activities, compared with 26 percent of the girls. The most precociously sexually active boys were those who did not practice a religion and who came from higher income families. However, both females and students from lower socioeconomic level schools were more likely to engage in unprotected sex.

Although knowledge is important in risk reduction, it was not sufficient to stop high-risk behavior. The adolescents had significant information about the way AIDS is transmitted and prevented, but their behavior did not reflect this.

More studies are required to get to know these populations better, monitor their behavior, and increase their capacity to adopt preventative strategies against AIDS and other STIs.

**Responses to the problem**

**Projects under way**

A number of projects have been initiated in recent years:

- **“Amor à Vida” (Love for Life) Project**: promotes sexual health education for state schoolteachers, adolescents, health agents, and community leaders in Ceará’s municipalities. (Project of the Health, Social Services, and Education Secretariats.)
- **Peer education among adolescents**: enlists teens to train other teens to carry out peer education on RTIs/AIDS in state schools in Fortaleza. (Project of the Secretariat for Municipal Social Development.)
- **“Aliança-Luz” (Alliance-Light), JICA**: promotes the social marketing of condoms. (Project financed by the Japan International Cooperation Agency.)
- **Radio broadcasters against AIDS**: enlists radio broadcasters in Ceará to provide information on reproductive health and STIs/AIDS. (Project coordinated by a
In addition, these new projects aimed at improving health care are underway:

**HIV/STI Project Ceará:** aims to improve the care offered to people with STIs through the creation of a hierarchical referral and counter-referral system. Started in 1995, this project created referral services in public sector health units (12 in Fortaleza and 5 in the interior) to achieve integration of services at the primary level.

**Pathfinder Project:** implements integrated reproductive health and STI care in clinics in Fortaleza and the Interior. (Project of Pathfinder, started in 1998.)

In spite of the numerous initiatives currently taking place in the state, it is evident that improvements are necessary in both the quantity and quality of the information available on the extent and nature of the RTI problem in Ceará.
The rapid assessment, using qualitative research methodology, took place in May 2000, with the results presented at a dissemination seminar three months later. The work, led by professionals and local authorities, was participative in nature. The assessment sought to determine the extent and nature of the problem: the local prevalence of RTIs, frequency of symptoms and their etiology, principal determinants of the RTI problem, people affected, where people seek treatment, and the community’s main perception of the problem.

The group responsible for the qualitative evaluation prioritized sexually transmitted infections (STIs). The results of the field research provide a picture that calls for energetic measures to:

- Expand access to health care by vulnerable populations, as this is still precarious and very difficult;
- Search for additional outlets for care in the informal sector, especially in pharmacies;
- Change the population’s low perception of risk in relation to the acquisition of a STI;
- Overcome resistance to the use of condoms;
- Dispel misconceptions about transmission, prevention, and treatment;
- Improve relationships between professionals and clients from both the human and technical point of view;
- Prioritize STIs at an institutional level; and
- Increase the population’s access to information.

We hope that the State will take advantage of this unique opportunity to outline and implement effective lines of action for the control of these pathologies, whose consequences can have an irreversible impact on the health of the Brazilian people.

**The process**

The situational analysis includes rapid collection of additional data, identification of priorities, and consensus on priorities identified as essential for development of programmes.

This process is based on the following strategic questions:

- Which interventions should be included in the RTI control programmes?
- Which existing interventions need reinforcement or expansion?
- Which existing interventions need to be reconsidered?
- Which interventions need to be introduced or reintroduced?
To this end, the first stage of the process required a series of activities that included:

- Formation of a coordination team and a technical advisory committee;
- Development of a background paper on RTI/STI to describe the situation and to identify gaps in RTI/STI programmes (based on surveillance data), knowledge about health/illness beliefs, sexual behaviours, and a review of available health services;
- Review of RTI/STI issues with policymakers and the identification of additional data needs;
- Implementation of a rapid qualitative field assessment to fill those gaps; and
- Organization of a dissemination workshop with stakeholders to reach consensus on priorities for interventions.

The goal of this project was to develop, implement, and evaluate a strategic process for decision-making to prioritize interventions for established sexually transmitted and other reproductive tract infections.

**Assessment-planning seminar**

Participants at the assessment-planning seminar analyzed the background paper and suggested nine themes for preparatory discussions to outline the fieldwork:

- Sexual behavior in the general population;
- Sexual behavior in specific populations;
- HIV and AIDS infection;
- Sexually transmitted diseases;
- Prevention;
- Perception of risk, perceived STI symptoms, and seeking treatment;
- Gender, sexuality, and sexual violence;
- Care services for reproductive health/hierarchical levels of care; and
- Strategies for RTI control.

Based on an analysis of the results of these discussions, the following categories for research were defined:

- Health policies;
- Private and public sector health services;
- Pharmacies;
- Family units;
- The male population;
- Sex workers;
- Homosexuals; and
- Adolescents.
Field research

The field research consisted of semi-structured interview questionnaires and informal group discussions, based on the lists of topics or guides to themes, and observations at health units. The focus was the management of established reproductive tract infections. Sites were selected to provide a sampling of experiences. Sources of information include: authorities, providers, pharmacy counter staff, community leaders, users, potential clients, and adolescents. A tool was developed for health units.

The preparatory meetings were an opportunity to share knowledge and experience in the areas of reproductive tract infections and qualitative research. These discussions covered a variety of themes, including: national principles and policies for STI control; strategic approaches; information contained in the background paper; the importance of STI control and the obstacles to this control; and qualitative methodology.

Since the focus of the situational diagnosis is the management of established reproductive tract infections, this model was adopted as the basis for discussions. It allows an analysis of the obstacles faced by STI patients, distributed in the proportion of people:

- At risk of acquiring an STI;
- At risk who become infected;
- Who notice the symptoms;
- Who look for care;
- Assisted;
- Assisted who are correctly diagnosed and treated;
- Treated who are cured; and
- Whose partner also is treated.

Sample researched

According to qualitative methodology, the researcher conducts interviews until the information collected begins to show a considerable amount of repetition. Table 2 shows the variety and scope of interviews. Table 3 lists the subjects discussed.

<table>
<thead>
<tr>
<th>Table 2  Categories and numbers of interviews</th>
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<tbody>
<tr>
<td>Authorities</td>
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<tr>
<td>Health units</td>
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<tr>
<td>Providers</td>
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<tr>
<td>Source of Information</td>
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<tr>
<td>Users</td>
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<tr>
<td>Potential clients</td>
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<td>Community leaders</td>
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<tr>
<td>Adolescents</td>
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<tr>
<td>Pharmacy counter staff</td>
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</table>

Table 3  Subjects discussed with different sources of information

<table>
<thead>
<tr>
<th>Authorities</th>
<th>Community leaders</th>
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</thead>
<tbody>
<tr>
<td>Main health problems in city or region</td>
<td>Knowledge of RTIs</td>
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<tr>
<td>Level of SUS management</td>
<td>Estimated prevalence of RTIs in the population</td>
</tr>
<tr>
<td>Priority locations for health</td>
<td>Availability, quality, and use of STI services</td>
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<tr>
<td>STI control policies</td>
<td>Views on the knowledge, attitudes, and practices in the community regarding STI prevention and treatment</td>
</tr>
<tr>
<td>Sources and allocation of resources</td>
<td>Barriers to use of the services</td>
</tr>
<tr>
<td>Views on STI control</td>
<td>Views on the quality of STI care</td>
</tr>
<tr>
<td>Logistics for the purchase of condoms and STI drugs</td>
<td>Views on STI control</td>
</tr>
<tr>
<td>Suggestions</td>
<td>Basic training and supervision (specific to health agents)</td>
</tr>
<tr>
<td></td>
<td>Suggestions</td>
</tr>
<tr>
<td>Health units</td>
<td>Users</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<tr>
<td>Services offered</td>
<td>Knowledge and use of available services</td>
</tr>
<tr>
<td>Barriers to the use of services</td>
<td>Barriers to access to services</td>
</tr>
<tr>
<td>Promotion of STI services</td>
<td>Knowledge, attitudes, and practices relating to RTIs</td>
</tr>
<tr>
<td>Patient flow</td>
<td>Perception of the quality of services</td>
</tr>
<tr>
<td>Referral systems available</td>
<td>Participation in educational activities at the unit</td>
</tr>
<tr>
<td>Human resources</td>
<td>Information obtained about the problem presented, possible consequences, and precautions to take during treatment</td>
</tr>
<tr>
<td>Equipment and materials</td>
<td>Knowledge about preventing STIs, with emphasis on the use of condoms</td>
</tr>
<tr>
<td>Staff training</td>
<td>Misconceptions about RTIs</td>
</tr>
<tr>
<td>Unit’s infrastructure</td>
<td>Suggestions</td>
</tr>
<tr>
<td>Availability of drugs and condoms for distribution to patients</td>
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<td>Control of infection</td>
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<td>Information given to patients</td>
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<td>Actions to motivate staff</td>
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<tr>
<td>Mechanisms to evaluate client satisfaction</td>
<td></td>
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Table 3: Subjects discussed with different sources of information (con’t)
### Providers

- Views on the barriers to use of services
- Knowledge of RTIs
- STI case management
- Patient demand, availability of service care facilities
- Information given to patients, including IEC material available and used
- Basic training, updating, and supervision received
- Views on the quality of care
- Knowledge and use of the Syndromic Approach for STI case management
- Routine practices and precautions to minimize occupational hazards
- Recovery control and summons of STI patient’s partners

### Pharmacy counter staff

- Estimates of demand of clients with STIs
- Most frequently observed STIs
- Services offered/not offered
- Views on STI patients
- Clients views on the barriers to using the health services
- Misconceptions of RTIs
- Knowledge of the availability of public services for RTI care
- Directing patients to and relationships with the formal care sector
- Quality control of drugs and condoms
- Views on the quality of care for STI cases
- Suggestions

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### Table 3  Subjects discussed with different sources of information (con’t)

#### Adolescents

- Knowledge of genital anatomy and contraceptive methods
- Knowledge of STIs, forms of transmission and prevention
- Practices related to the treatment of STIs
- Knowledge of the care available for STIs
- Barriers to use of services in the formal sector
- Sources of information (What have you learnt? Who helped you? Whom do you ask to get information?)
- Access to condoms
- Misconceptions about RTIs
- Suggestions

#### Potential clients

- Knowledge of STIs, forms of transmission and prevention
- Recognition of STI symptoms
- Patterns in seeking health services
- View of people with STIs
- Knowledge of STI care services in the public sector
- Barriers to use of services
- Misconceptions about RTIs
- Suggestions
Preliminary Results

People’s comments were analysed in light of three major perspectives: access to health services, perception of the services, and perception of risk. The assessment also examined knowledge, attitudes, and practice relating to RTIs.

The following were found to be barriers to care in the formal sector:

- Difficulty in obtaining an appointment card and long waits in queues; the patient has to arrive very early at the health center; there is a “market” in appointment cards;
- Shame and embarrassment; discrimination against patients;
- Fear of recrimination; fear of lack of confidentiality and privacy in appointments;
- Lack of promotion of existing services;
- Lack of drugs and condoms;
- Difficult access for men to public sector facilities; in general, men seek care in pharmacies, with urethritis the most frequent complaint;
- Common use of self-medication;
- Difficult access to laboratory tests;
- Long distance between the health unit and the place of residence;
- Negative perception of the quality of care;
- Difficulties in the patient—health professional relationship; and
- High cost of services in the private sector.

On the plus side, drugs and condoms were stored well in pharmacies; use-by dates and hallmarks conformed to legislation.

Many people referred to an “ideal” model of care for STIs carried out by a specialized team. Users and potential clients associated the idea of “efficient services” with the distribution of drugs and quick appointments.

What people know about STIs

Some people had misperceptions or false information about how STIs are acquired: through carelessness and unhygienic habits, multiple and “incorrect” choice of partners, and having alcoholic drinks during sex. A person’s risk of acquiring STIs is seen as being increased by unprotected sex, frequent changes of partner, and blood transfusions. People believed that STIs were transmitted in bathrooms, toilets, and changing rooms.

Some people interviewed believed in a strong link between infidelity and the acquisition of a STI, but others denied the existence of AIDS and other STIs. People did not consider themselves to be at risk of acquiring a STI so long as they were in a monogamous relationship. They also confused the transmission of STIs in general with the transmission of AIDS.
The general population perceived that it is easy to catch an STI through unprotected sex and understood that condom use provided effective protection. Yet, even people with a positive attitude toward condoms admit, “most people don’t use them.” People appeared to have general information about some STIs; the most mentioned were AIDS, herpes, gonorrhea, and syphilis. The most popular sources of information on STIs were: TV, family members, teachers, and health care providers, as well as from speeches, posters, and courses.

**Adolescents**

Adolescents also had mistaken assumptions about STI transmission, blaming toilets, warm seats, kisses, shared objects, and insect bites. They also thought STIs could be prevented through use of hormonal contraceptives. Efficacious methods of prevention were knowing your partner and staying at home. People commented that avoiding alcohol, pork, and chicken were precautions to take during treatment. They also advised use of pharmacies. As for condoms, “they don’t really protect against STIs,” “they can cause inflammation,” and “they might come off and get lost inside the vagina after sex.”

**Health care providers**

The majority of health care providers in the formal sector had not received training in the syndromic approach for STIs; neither have they been nor are they supervised. The assessment team noted that patient care was better when given by the professionals who had received training in STIs. This was evident in the health units that were taking part in the HIV/STI Project and the Pathfinder Project, both aimed to improve STI care management and integration of STI care with reproductive health.

Patient-health provider relationships in the formal sector need to be greatly improved; there is poor communication and a lack of dialogue.

The technical standard of care in pharmacies is precarious, with incorrect drugs recommended and physical examinations carried out by counter staff. However, patients feel welcome there and confidentiality appears to be carefully maintained.

**Health units**

In each location, three different levels of units were observed: a basic family health unit, an intermediary referral unit, and a tertiary unit. Few units have an organized STI service available and most units need training and implementation of infection control measures. Supplies of drugs and/or condoms for STI appointments were inadequate and double protection was not being recommended by family planning services. Patient-health provider relationships needed improvement.

All units lacked educational activities on STIs, with little material given to patients; the few materials observed were mostly about AIDS.
Tertiary units had higher standards of cleanliness. In the basic family health units, conditions of care were generally precarious, with improvised infrastructure and a lack of privacy for appointments. Care activities usually were limited to prenatal checks, family planning, and cervical cancer screening. Some units did not even have a gynaecological table.

**Authorities**

STIs are rarely mentioned as being among the biggest problems or priorities for the region’s health. When they are mentioned, no actions are taken and no specific funds for control are provided in the budget.

Training of management teams in the fields of epidemiology, planning, and evaluation needs improvement through knowledge. In most of the municipalities where STI control initiatives were observed, resources from external projects were financing activities. Despite claims that sustainability is important, in most cases there are no investments of this type. Most municipalities rely on state funding for STI control activities.

**Aspects related to gender differences**

Both men and women consider STIs to result from male infidelity, but female carriers of STIs meet more prejudice and discrimination.

Women have easier access to public services than men through prenatal, family planning, and cervical cancer screening appointments, but men have easier access to pharmacies, especially if male counter staff offer services. No female condoms were found in any of the pharmacies visited. Where they had been available, they were withdrawn because of lack of sales due to their high price.

Female adolescents said they were ashamed to ask a partner to use a condom. Male adolescents discussed themes related to sex more easily. They said they felt “under pressure” to have sex, especially from their partners. “If I don’t do it,” they say, people “will think I’m gay.” Both boys and girls said they do not like to use condoms, but they tended to blame their partners to justify non-use. The boys likened using a condom to “sucking a sweet without taking the wrapper off.” Boys find it easier to get information about sex from their parents, especially their mothers.

Adolescents have difficulty gaining access to both the formal and informal sectors. They do not usually receive treatment but instead use domestic herbs and baths with medicinal plants. Girls in particular show a great “thirst” for information on STIs. There was an outstanding difference in adolescents’ access to information and health services in areas that took part in the Amor à Vida (Love for Life) project.

**Discussion**
These results allow various important observations to be made regarding reproductive tract infections in the state. They can act as the basis for the elaboration of strategies for the control of STIs in diverse locations in Ceará.

The consensus among the members of the coordination team was that the principal focus was on STIs, mainly due to the fact that the other RTIs, such as endogenous and iatrogenic infections, would require another set of research instruments. The extent and transcendence of STIs was also taken into consideration in this choice.

The following set of identified problems is noteworthy:

- Difficult access to the formal health services for STI patients, especially for members of vulnerable groups, such as sex workers and truck drivers;
- Self-medication of STI carriers with the explicit participation of pharmacies;
- Lack of drugs and condoms for distribution to patients with STIs;
- Lack of condoms for the clients of family planning services to encourage dual protection;
- Uneven or poor quality of care in both the formal and the informal sectors;
- Difficult access for adolescents to information about sexuality and STIs and to health services, leading to a serious neglect of this population (The correct treatment of STIs would have a big effect in prevention of future complications and sequelae, such as sterility);
- Lack of training and supervision of health professionals in the correct handling of STI cases;
- Need for control of STIs to be given priority at an institutional level;
- Lack of adequate measures to ensure that standards to control hospital infections are followed in the health units;
- Lack of perception of the risk of acquiring an STI, especially by people in monogamous relationships;
- Mistaken concepts of how STIs are transmitted, indicating the need for public information;
- Shortage of educational material to encourage early detection of STI symptoms by health services;
- Need to improve relationships between users of the services and health professionals; and
- Gender differences related to STIs, which contribute to misinformation, prejudice, and difficult access to services.

The results confirm a series of hypotheses that were formulated at the start of the field research. Discussions of these important considerations will result in recommended strategies to improve care for people with STIs. The great interest in this topic by health professionals, government leaders, and authorities from the health, social services, and education ministries raise expectations about future positive action.

When the occurrence of STI cases is correlated with their serious consequences and sequelae— including infertility, perinatal and maternal mortality, anogenital cancer, and the
increased risk of HIV infection—the importance of implementing effective control measures is easily understood.
RECOMMENDATIONS: PRIORITY INTERVENTIONS

A consultative workshop was held on 19 and 20 August 2002 in Fortaleza, Ceará, Brazil to review the results of a rapid assessment of RTIs in the country that was conducted in September 2000. The purpose was to review and reorganize the strategic recommendations identified during the fieldwork, to discuss the interruption of the PGT process, and to plan future actions. The workshop was organized by the Instituto de Saúde e Desenvolvimento Social do Ceará (ISDS) and the World Health Organization, with financial and technical support from the Horizons Program/Population Council and the Brazilian Ministry of Health (MOH) National Coordination for STD/AIDS (CN-STD/AIDS). The meeting brought together 66 professionals from Brazil and other countries with broad experience in RTIs, representatives of the State of Ceará and municipalities, national and international organizations, universities, and nongovernmental organizations (NGOs).

Three main recommendations emerged from this meeting: 1) allocate resources for STI control from the state and municipal budgets; 2) carry out educational and training programmes on STIs for adolescents, teachers, and health workers; 3) implement STI care at the basic level (family health programme) and assure integration of programmes, organization of services, surveillance, and health promotion.

Analysis and strategies

The results of the field research illuminate the need for action to improve these problem areas:

- Difficult access to good quality care, particularly by high-risk groups;
- Self-medication and dependence on the informal sector, especially pharmacies;
- Low perception of risk by people about how RTIs are acquired and transmitted;
- Resistance to the use of condoms in sexual relations;
- Misconceptions regarding transmission, prevention, and treatment;
- Deficiency of professionals in their interpersonal relations with people with RTIs;
- Lack of adequate drug supplies and other materials for care of people with RTIs;
- Poor quality and quantity of information available to the public; and
- Lack of priority given to RTI control in public policies.

Sufficient resources should be allocated in both state and municipal budgets for control and treatment of RTIs. The following would enable these actions:

- Carry out educational programmes about RTIs at various levels, including mass campaigns to encourage people at risk to seek testing and treatment, and inclusion of the subject in school and university curricula;
• Train teachers and adolescents to act as trainers of peer counselors;
• Implement RTI care at the basic level of health care, integrating it with reproductive health services, including prenatal care, family planning, and cancer prevention;
• Organize health care services to provide high quality care for people with RTIs;
• Train health professionals in the syndromic approach to RTIs and counseling, ensuring the inclusion of all physicians and nurses in the Programa de Saúde da Família;
• Provide adequate supplies of equipment and material needed to care for patients for RTIs;
• Increase access to health care for high-risk populations and people who have RTIs;
• Advocate for RTI prevention and treatment; and
• Carry out surveillance of RTI epidemiology in the state of Ceará.

This rapid assessment of the prevalence and epidemiology of reproductive tract infections provides a unique opportunity for the state of Ceará to educate people about prevention and transmission of RTIs and to improve and expand services to people at risk. Actions taken now by the state can have an irreversible positive impact on people’s health.

**Prioritized recommendations for control of RTIs**

**Resource allocation within the planning budget of the State of Ceará and municipalities**

• Establish partnerships (national, international organizations and others);
• Conduct consensus and advocacy activities in the Bipartite Committee and in the State Health Committee. The Bipartite Committee, which is composed of five representatives of the State Health Secretariat and five representatives of the municipalities (usually municipal health secretaries), meets twice a month to make all relevant decisions concerning the State health system, particularly the relationship between the State and municipalities; and
• Supply needed materials, medicines, and equipment for RTIs.

**Training and educational activities:**

• Train teachers and adolescents (peer educators);
• Integrate different sectors (e.g. SOCEGO, the Obstetrics and Gynecology Society of Ceará, and schools);
• Continue education seminars (e.g. SOCEGO, UFC, the Federal University of Ceará, and SESA, the State Health Secretariat); and
• Conduct education sessions with clients waiting for medical appointments (trained personnel, reception before appointment, educational activities in laboratories, etc). These kinds of activities could be in partnership with SOCEGO, UFC, and SESA.
Implementation of care and management of RTIs at the primary health care level

- Prevent and manage RTIs with specific populations
  - Create mobile units
  - Introduce night shifts;
- Use the Family Health Programme/Programa de Saúde da Família (PSF) as one of the entry points for RTI prevention and care;
- Secure provision of medicines and equipment for RTI; and
- Increase the number of referral centers.

Awareness campaign about RTIs for health professionals (including the private sector)

- Diagnosis
- Treatment
- Notification
- Newsletters
- Consensus with private health plans
The utility and impact of the PGT process was assessed over a ten-day period (26 May to 6 June 2003) by interviewing key people involved in the process in seven municipalities in Ceará and two health districts in Fortaleza.

The findings show that the PGT process was perceived as being extremely helpful in orchestrating the work and the efforts of many institutions already involved in STI control. It was an important tool to get decision-makers involved, to improve public awareness, and to integrate actions, promoting policy changes at different levels. However, since there were many other well-organized projects regarding RTI control going on in Ceará, such as HIV/AIDS Project Ceará (implemented in 1995, funded by European Union and the Ministry of Health in Brazil, and technically supported by the University of Bordeaux), it became difficult to determine to which extent each one had contributed to changes in STI policies, control, treatment, and prevention.

A lot has been done in the service delivery area. The primary level health centers were trained and have resources to diagnose and treat STIs, and only the more difficult cases are referred to the specialized clinics. Adolescents and teachers from more than 80 municipalities were trained in STI prevention through IEC methodologies.

Only one research project was written and submitted to the Population Council Institutional Review Board in March 2001, but the process was not completed until recently. Some results from the rapid assessment were presented in national meetings and incorporated into ongoing projects funded by the State Health Department (SESA). Lack of time and lack of a central PGT coordination to establish priorities were identified as limitations for writing proposals.

**Evaluation objectives**

The overall evaluation objectives in Ceará were to assess the programmatic outcome and utility of a decisionmaking tool to assist programme managers in prioritizing interventions for addressing established RTIs.

**Primary objectives of the PGT evaluation were:**

- To assess the extent to which strategic recommendations arising from the PGT process have been implemented (programmatic outcome); and
- To assess the perceived utility of the PGT tool by programme managers and other state and country level stakeholders (utility).
Secondary objectives were:

- To identify key contextual factors that may influence RTI programmes and the PGT process in particular, such as ongoing health sector reform issues (contextual analysis); and
- To assess the extent to which the guiding principles of the PGT process were met with respect to inter and intra-sectoral collaboration achieved for RTI control, the country-led process, and multidisciplinary involvement.

Methodology

The programmatic outcome was assessed by interviewing key stakeholders and service delivery staff and by reviewing documentation verifying the completion of activities. The results were recorded in a matrix (see Table 4 at the end of this section). The matrix contains the recommendations and activities defined during the PGT process and the indicators defined for each recommendation. Individual and group interviews were conducted with key stakeholders and health care providers at the state and municipal level. The matrix was completed based on results of the interviews and documents review.

The perceived utility of the PGT process was assessed through group and individual interviews with key stakeholders and health care providers at state and municipal levels.

The contextual analysis was examined through documents that contained information on the health care system and other areas that could affect the RTI programme. The individuals and groups interviewed were asked specific questions about contextual factors that could have influenced or are influencing the RTI programme and the PGT process in particular.

The extent to which the principles of collaboration, country-led process, and multidisciplinary involvement were carried out in the PGT process was estimated through group and individual interviews with key stakeholders and health care providers at both state and municipal levels.

Overall, the team completed these nine steps:

- Gathered background information on the RTI situation and the PGT process to date, including a list of strategic recommendations and contextual factors;
- Completed progress matrix and defined indicators for programmatic outcome evaluation (see Table 4 below);
- Held initial meeting with national staff involved in the PGT process to clarify the roles and expectations for each person;
- Held meeting with the national STI working group for initial assessment of people's views and experiences with the PGT;
- Conducted individual interviews with key stakeholders at the state level;
- Conducted individual interviews with key stakeholders at the municipal level at three sites: 1) where the rapid assessment was conducted and there was a specific
intervention from the STI/ HIV-Ceará Project; 2) where the rapid assessment was conducted but no direct intervention was carried out; and 3) where neither the rapid assessment nor the intervention were conducted. In all the three sites, some recommendations were implemented;

- Analysed data from interviews and group discussions;
- Held debriefing meeting with national level staff to discuss findings and future options; and
- Circulated draft report to all interested parties for further comments.

**RTI Management in Brazil and in Ceará State**

According to the preliminary report, national policies for STI control were not developed until the end of the 1980s. The national AIDS/STI programme was created in 1988; strategies for STI control were developed, focusing mainly on:

- **Prevention**, through community education about risk perception, changes in behaviour, and promoting the use of condoms;
- **Case detection**, by providing efficient services and screening for syphilis during prenatal care; and
- **Immediate treatment**, using the syndromic approach during the first appointment, with an emphasis on patient counseling. The flow diagrams for the syndromic approach were drawn up in 1993.

The main goals of the Ministry of Health’s national programme for STI control were to integrate the care of STIs into the primary care service, eliminate congenital syphilis, and involve pharmacies in control actions.

In 1994, a loan agreement was signed with the World Bank permitting faster implementation of actions concerning prevention and patient care. Resources were channeled to state and municipal organizers of STI/AIDS control, through the Annual Operative Plans.

Ceará, located in the northeastern region, is one of the 26 states in Brazil, occupying an area of 140 000km² and with a population of approximately 7 million people. In the last fifteen years, various economic advances have increased the range of activities in the state’s secondary and tertiary sectors. However, these initiatives have not had a significant impact upon social indicators; Ceará has not developed as favorably as other states in terms of the population’s standard of education, health indicators, and quality of life indicators in general.

Research carried out locally demonstrated that Ceará State faced obstacles in controlling RTIs, including:

- Lack of epidemiological data;
- Inadequate distribution of health services and professionals;
- Disorganized existing services;
- Lack of training of health professionals for adequate case management;
Reduced laboratory capacity to provide etiologic diagnosis;
Drug shortages; and
Patient discrimination and lack of confidentiality and privacy.

According to experts, these deficiencies resulted in inadequate access to and underutilization of the services available and patients who seek care outside of formal health care settings, mainly in pharmacies.

The rest of the country also fits this description, according to official government documents.

With the allocation of resources from the Ministry of Health and international donors, research development and service delivery on STI/ HIV became high priority in Ceará State. By 1999, there were two accredited hospitals and one Maternity Teaching Hospital in Fortaleza, one laboratory (LACEN) with infrastructure for STI/ HIV and AIDS, and 12 Referral Centers for STI in Fortaleza. Five municipalities (Sobral, Aracati, Crato, Crateús, and Quixadá) each established a referral center for STIs, and one hospital was established in Sobral. The main laboratory (LACEN) provided test results for three additional states in Northeast Brazil.

Many governmental and nongovernmental projects have been implemented in Ceará since 1995 in response to the STI/ HIV problem.

**Prevention**

"Amor à Vida“ (Love for Life) Project

Project involving the Health, Social Services, and Education Secretariats, aims to promote sexual health education for state school teachers, adolescents, health agents, and community leaders in Ceará’s municipalities. This project is being expanded all over Ceará State.

**Peer education amongst adolescents**

Project of the Secretariat for Municipal Social Development creates information multipliers on STIs/ AIDS among adolescents in state schools in Fortaleza, to expand peer education.

"Aliança-Luz“ (Alliance-Light)

Project financed by the Japan International Cooperation Agency aims to promote the social marketing of condoms. This project was completed in 2002.

**Radio broadcasters against AIDS**
Project coordinated by the Institute for Health and Social Development and financed by USAID through Pathfinder, aims to create information multipliers on reproductive health and STIs/AIDS among radio broadcasters in Ceará.

**Care providers**

**HIV/STI Project Ceará**

Started in 1995 to improve the care offered to carriers of STIs through the creation of a hierarchical referral and counter-referral system. Referral services designated in health units of the public sector (12 in Fortaleza and 5 in the interior) were charged with forming and supervising the basic units in their area, aiming for integration at the primary level. The project was completed in February 2003.

**Pathfinder Project**

Started in 1998 to implement integrated actions on reproductive health and STI care in six basic units in Fortaleza and four in the Interior.

**Study population**

The HIV/STI Project Ceará became the main partner for the PGT process and has facilitated the coordination with other partners. Their team took the lead in organizing the three workshops and the fieldwork, involving many state and municipal authorities in the process. Their commitment to the RTI cause was evident from their energy and the written materials provided during the evaluation.

Five interviews were held in Fortaleza with key state-level stakeholders in order to evaluate the programmatic outcomes and the utility of the PGT process. Fifteen additional individual interviews were held in three other municipalities. In one of the sites, a meeting was held with adolescents who participated in activities related to RTI prevention; additional meetings were held with the state RTI working group and with key stakeholders representing various organizations that participated in the PGT process (or part of it). A phone interview was held with a representative from the Ministry of Health (who was in Brasilia) who participated in the third workshop. Annex 1 lists the categories of people interviewed.

**Findings**

**Programmatic outcomes**

The programmatic outcomes of the PGT process can be assessed based on the progress made in implementing the recommendations selected as priorities. Table 4 at the end of this paper contains the summary of progress made in implementing the three recommendations
prioritized in the third workshop in August 2002. It should be noted that some of these recommendations were implemented before the PGT was initiated, because the RTI control team has been operating since 1995. During the third workshop, there was an effort to raise awareness of key decision-makers to prioritize RTI actions so the recommendations could be institutionalized.

**Utility of the RTI Programme Guidance Tool**

In general, those involved in the PGT process agreed that the tool contributed significantly to improving the management of RTIs and implementing actions such as decentralization. The fieldwork clearly brought up the need to invest in primary care units; since then, 184 PSF centers (Family Health Centers of the Programa de Saúde da Família) were opened in Ceará, with constant training and supervision assured by the Secretariat.

The PGT methodology also was important in bringing together many actors in RTI control who had conducted scattered activities in different areas. According to team members, the PGT process orchestrated the actions and actors, integrating and motivating institutions that were already working together. Stakeholders became aware of the importance of allocating resources to RTI, and this resulted in municipal and state funding for training, treatment, and prevention. The RTI referral center units were expanded to 30 other municipalities in the state, showing the commitment from decision-makers to the RTI cause. Some successful projects such as “Amor à Vida” became more visible to stakeholders and the suggestion was made to implement it in the entire state.

Many participants mentioned that they were so enthusiastic about the process they had incorporated the PGT principles in their work habits. They remembered the workshops clearly and said that participation in the fieldwork was the most interesting part of the methodology.

A well-integrated group in Aracati is working in RTI treatment and prevention. The health secretary collaborates with the educational and social services secretaries and local NGOs in many projects. Although these groups were working together before PGT, they perceived the fieldwork, the dissemination of the results, and the workshop participation as extremely useful in involving more people in the cause. The health secretary became strongly committed to sustaining RTI policies in the municipality after participating in the workshops; he was completely convinced of the importance of RTI control and prioritized the actions necessary to achieve this goal. Some interventions were institutionalized in Aracati; for example, medication for STI was incorporated into the priority medications list, with municipal health council approval.

According to one stakeholder who participated in the whole PGT process, the methodology had an impact in Baturité during the rapid assessment. Some stakeholders and health care providers who were involved in the process became aware of the priorities for controlling STIs in the city. However, most of them left their positions or the city after the rapid assessment and the process was not continued. During evaluation, the stakeholders from the Baturité department of health were not aware of the rapid assessment or the PGT process. Despite that, the health department does have an STI control programme and local data
showed a decrease in the number of syphilis, gonorrhea, and HPV cases from 2000 to 2002. Some activities, such as a guaranteed supply of medication at PSF and referral centers and training courses for PSF health workers in RTI and family planning, were under way at that time, making it difficult to determine which improvements were due to the PGT and which were being implemented at the same time in the whole of Ceará state.

In Cascavel, another municipality where evaluation took place, there is no official policy to allocate resources to RTI control, but the state Health Secretary personally allocates funds from the health department to buy medication for STI programmes. There is no guarantee, however, that the funding will continue if this particular person leaves his post. Although Cascavel was not directly involved in the PGT process or in Project Ceará and did not participate in the rapid assessment, activities related to RTI care in the family health are related to the priority interventions determined in the PGT workshops. During the past two years the municipality has invested in decentralization of activities, in education, and in integration of services according to the national orientation. Cascavel implemented a STI referral center and the project “Amor à Vida,” with the technical and financial support of the state department of health (SESA). In summary, in Cascavel, despite the absence of any direct specific PGT action, much has been accomplished in RTI control.

**Criticisms of the PGT methodology**

Here are the most important criticisms about the PGT methodology made by the interviewees:

- It is not easy to find people with all the desired characteristics for the PGT process (RTI experts, with knowledge of qualitative methodology and the status of stakeholders);
- While it is easy to become involved with the PGT process, it can be difficult to sustain this involvement. The PGT process motivates, but it is an intense and demanding process, difficult to maintain. It requires too many time-consuming meetings and the commitment of busy people. It is hard to maintain the integration and the involvement;
- In Ceará State, the PGT process lacked its own identity and was confused with other successful interventions; and
- The workshop results did not reach all the units involved in the PGT process.

**Contextual factors**

Some contextual factors were identified as influencing RTI programmes and the PGT in particular:

- Political changes, such as the recent presidential and state elections in Brazil, can affect RTI programmes. The political party ruling now is not the same as the one in power last year and the teams have changed. Some local teams were dissolved due to political issues.
Health resources and personnel at the state and municipal levels have had to be allocated to respond to the dengue epidemic, which became a priority.

Most of the people involved in the PGT are overwhelmed with work, with little time to schedule meetings or to keep the same energy as in the first year of the process. No one was assigned to reinforce the suggestions, to schedule meetings, and to write the suggested research protocols. Since most of the priority interventions were already being implemented, each person went on with his or her own task.

The National Council on STI/HIV of the Ministry of Health was not involved in the PGT process from the beginning. PGT, therefore, became a localized project related to some specific people and not to institutions, making the continuity of the process more difficult.

The PGT manager change at WHO headquarters in Geneva contributed to the lack of PGT team integration between 2000 and 2002. Some actions went on, but they were not as integrated as during the first year of the PGT.

WHO did not write an official letter to the State Health Department inviting them to participate in the PGT process. The PGT's main partner was ISDS-CECAD, an NGO committed to the STI cause. In consequence, governmental commitment was not strong enough to guarantee the monitoring, motivation, and coordination of the PGT actions and team.

The variety of ongoing RTI projects in Ceará, especially the STD/HIV Project Ceará implemented in 1995 and completed in 2002, organized experts and stakeholders around RTI control. This can be considered a favorable factor influencing the PGT process. PGT utilized the Project Ceará infrastructure and each one complemented the other. A group related to Project Ceará still meets and discusses implementation problems, and technical aspects, even after funding ended.

**RTI/STI PGT guiding principles**

The guiding principles of the PGT process were certainly met in Ceará. It was a state-led process with governmental and nongovernmental institutions equally involved, bringing together a significant number of experts, stakeholders, and health care providers. It was a multidisciplinary group, where all were equally empowered. Collaboration among institutions was reinforced along the PGT process. The guiding principles of the PGT were incorporated in the way that state institutions deal with health problems; other actions, such as gender violence control, are being incorporated into the RTI project.

**Conclusions**

When the PGT process started in Ceará in 1999, the state programme had already implemented some of the assessment recommendations regarding the control of STIs. The combination of projects and interest in the cause integrated the work of many experts from the Ministry of Health, State Health Department, universities, and STD/HIV Project Ceará. These projects put into practice referral centers for STIs in many municipalities in the state, training the health staff on syndromic approach and offering constant expert supervision.
Most of these groups’ guidelines were similar to the PGT principles: integrating health programmes under STI prevention and treatment, involving state and municipal stakeholders to guarantee the allocation of resources to STI, team work, and decentralization of care.

The PGT methodology landed on fertile soil. Most of the prioritized interventions defined by the PGT process were, to some extent, already being implemented through Project Ceará activities. Thus, it became difficult to evaluate the programmatic outcomes that directly resulted from the PGT process. Some actions proposed at the second and third workshops were already being implemented in many municipalities. One action that was implemented extensively after PGT was the integration of STI management in the basic units; this came about from changes in health policy and political commitment.

As to the utility of the process, the interviewees were unanimous in agreeing that it was a useful tool, especially in integrating the team and the actions. It also helped to convince decisionmakers of the importance of taking responsibility for RTI control.

In spite of the well-recognized lack of resources and need for funding, mentioned by every person interviewed, none of the research proposals suggested at the end of the third workshop were submitted for funding. Experts and stakeholders argued that there was no central PGT coordination to push them to write the proposals. The participants were too busy with their own work and thus had no time to write grant proposals (difficulties with the English language also were a factor). Besides, funding was in some ways supplied by Project Ceará until February 2002, with a grant extension for an extra year.

The main obstacle to continuation of the PGT process was lack of coordination. The institution responsible for implementing the interventions and maintaining the team (SESA) was not able to conduct the process as a whole.

The evaluation process was considered very important to the team in Ceará because they were able to review many of the suggestions from the third seminar, and thus had a better perception of what was accomplished and what was lacking. The stakeholders at the central level became aware that they should have submitted proposals requesting funds; now they are organizing to do so.

In general, most of the people interviewed showed great commitment to their work and to the RTI control cause.

**Suggestions for improvement of PGT**

- Involve community leadership in the workshops, fieldwork, and analysis; and
- Hold regional workshops to make it easier for stakeholders from micro-regions to participate and contribute.
<table>
<thead>
<tr>
<th>Strategic recommendation</th>
<th>Recommended activities</th>
<th>Indicator¹</th>
<th>Progress / Comments²</th>
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<tbody>
<tr>
<td><strong>Rec #1</strong> Allocate resources to RTI control and prevention and organizational development</td>
<td><strong>Activity #1</strong> Mobilize Municipal Health secretariats to the importance of STI control</td>
<td>It is true for the places visited</td>
<td>The interviewees mentioned they were mobilized to the RTI problems after participating in the workshops. The one that was not directly involved in the PGT process said he had always been involved with STI control, ever since medical school. The PGT team tried to involve as many managers as possible in the cause.</td>
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<tr>
<td><strong>Activity #2</strong> Allocate resources for RTI treatment and prevention at municipal level</td>
<td>Included in the Municipal budget</td>
<td>Medication and condoms are available for RTI prevention and treatment at PSF and referral clinics at the municipalities visited. After the end of STD/HIV Project Ceará (2002), medication distribution system became more complicated due to bureaucratic paperwork required by the state level. Some municipalities included RTI medication in the list of essential drugs, although they are not listed in the priority seven areas for action determined by the Ministry of Health.</td>
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<tr>
<td>Strategic recommendation</td>
<td>Recommended activities</td>
<td>Indicator³</td>
<td>Progress / Comments²</td>
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<tr>
<td><strong>Rec #1</strong> Allocate resources to RTI control and prevention and organizational development (con’t)</td>
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<tr>
<td><strong>Activity #3</strong> Allocate resources for training health care workers at primary level and in the referral centers in RTI diagnosis and treatment</td>
<td>Training is being provided by SESA, the state health secretariat</td>
<td>SESA is committed to training all PSF health workers and these activities are being held constantly with SESA resources and the technical assistance of a pool of RTI experts. Because the PSF programme staff rotates a lot, training is ongoing, increasing costs.</td>
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<tr>
<td><strong>Activity #4</strong> Guarantee equipments and materials</td>
<td>SESA has more resources than last year</td>
<td>Materials are not equally distributed to all municipalities in spite of more funds available. Some places lacked basic materials like gloves. There is a lack of personnel everywhere.</td>
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<td><strong>Activity #5</strong> Introduce RTI control in the agenda of local Council meetings</td>
<td>In Fortaleza for sure</td>
<td>Results from the PGT process were shown to the Municipal Council in Fortaleza; it helped to officially create the City STI Coordinator position to integrate all actions.</td>
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<td><strong>Activity #7</strong> Guarantee dissemination of successful projects to other municipalities (“Amor à vida”)</td>
<td>Successfully implemented</td>
<td>The project expanded from 20 to 80 municipalities reached by the programme through the Adolescent Cell, from SESA, including evaluation of the programme.</td>
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<tr>
<td><strong>Rec. #2</strong> Train teachers and adolescents in RTI prevention</td>
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<tr>
<td><strong>Activity #1</strong> Map school, number of students and teachers to be reached.</td>
<td>Was done in one site (and it works), but not in the others</td>
<td>Schools, health staff, and NGOs joined forces in one of the municipalities and built a programme for adolescents that is well organized and integrated and reaches most of the students in the area. Activities took place at the other sites, without integration.</td>
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<tr>
<td><strong>Activity #2</strong> Hold workshops with middle school and high school teachers</td>
<td>Not so well implemented</td>
<td>In some sites, teachers resisted training on RTIs because of cultural questions related to sexuality (embarrassment, difficulty talking about the subject).</td>
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<td><strong>Activity #4</strong> Guarantee equipments and materials</td>
<td>SESA has more resources than last year</td>
<td>Materials are not equally distributed to all municipalities in spite of more funds available. Some places lacked basic materials like gloves. There is a lack of personnel everywhere.</td>
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<tr>
<td><strong>Activity #5</strong> Introduce RTI control in the agenda of local Council meetings</td>
<td>In Fortaleza for sure</td>
<td>Results from the PGT process were shown to the Municipal Council in Fortaleza; it helped to officially create the City STI Coordinator position to integrate all actions.</td>
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<tr>
<td><strong>Activity #7</strong> Guarantee dissemination of successful projects to other municipalities (“Amor à vida”)</td>
<td>Successfully implemented</td>
<td>The project expanded from 20 to 80 municipalities reached by the programme through the Adolescent Cell, from SESA, including evaluation of the programme.</td>
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<tr>
<td>Strategic recommendation</td>
<td>Recommended activities</td>
<td>Indicator</td>
<td>Progress / Comments</td>
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| **Rec. #2**  
Train teachers and adolescents in RTI prevention (con’t) | **Activity #3**  
Hold workshops with adolescents for peer group education | Well organized and working in some areas (journals, murals, art, plays) | Some municipalities are much better organized than others, with NGO cooperation and high quality educational materials. Those are the sites where the team is well integrated.  
In other places, IEC activities are not constant and are limited to interventions during Carnival. |
| **Activity #4**  
Disseminate “Amor à vida” project to all municipalities, with emphasis on STIs and adolescence | High quality materials; map of municipalities reached; constant training and supervision | “Amor à vida” started in 1997 with funds from the United Nations and other partners, works in STI prevention, sexuality, and awareness in adolescents. It is being expanded and reached more than 80 municipalities in 2003 with funding from SESA.  
The programme became well known among the stakeholders after the PGT. This project is best articulated at the state level; variations at the municipal level depend on the local coordinator. |
| **Activity #5**  
Include specific disciplines about STIs in the school curriculum | Included in some curricula | Transversal theme is included in the curriculum in the yearly school planning. However, teachers complain of lack of support and time to develop the activities. In some localities the activities happen year round and in others just on specific dates, such as Carnival. |
| **Activity #6**  
Form partnerships with other public and non governmental institutions to integrate actions | Integration with NGOs works | Reproductive health and pre-natal care are integrated with STI control focused on teenage pregnancy prevention. The project is expanding to include other themes, such as violence and family.  
SESA- Adolescent Cell Unit trained health workers from PSF about adolescent needs. |
| **Rec. #3**  
Implementing RTI care at primary level, (PSF) assuring the integration of activities, especially in the reproductive health services | **Activity #1**  
Train all PSF health workers in syndromic approach (theoretical and practical) | Many training programmes were carried out | Training in RTI occurs for all new health care providers working at PSF. They are also trained in other areas prioritized by the Ministry of Health, such as children’s and women’s health care, adolescent care, etc. Training is long and not integrated.  
PSF staff rotates a lot! Training has to occur constantly, consuming many resources. |
<table>
<thead>
<tr>
<th>Strategic recommendation</th>
<th>Recommended activities</th>
<th>Indicator</th>
<th>Progress / Comments</th>
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<tbody>
<tr>
<td><strong>Rec. #3</strong> Implement RTI care at primary level, (PSF) assuring the integration of activities, especially in the reproductive health services (con’t)</td>
<td><strong>Activity #2</strong> Guarantee supplies (material, equipment and medication) at PSF clinics</td>
<td>Some</td>
<td>All sites visited mentioned that there is medicine available for STIs at PSF clinics. Some sites included RTI medication on basic medication list.</td>
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<td></td>
<td><strong>Activity #3</strong> Make educational material available at PSF</td>
<td>Some</td>
<td>IEC materials are available at PSF units, varying in quantity depending on the site.</td>
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<td></td>
<td><strong>Activity #4</strong> STI care for vulnerable patients</td>
<td>Adolescents and women are considered but not other specific populations</td>
<td>Few projects were developed with specific populations, such as truck drivers or sex workers. The ideas are there but no action was taken. There is concern about treating men because there are few male doctors or nurses to examine them; in many cases, men do not feel comfortable being treated by a woman.</td>
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<td><strong>Activity #5</strong> Include the theme adolescent in the training courses to PSF</td>
<td>This is happening</td>
<td>Adolescent health care, with a focus on knowledge, attitudes, and practices of this population, is the main theme in training seminars for PSF staff, provided by SESA. They utilize IEC materials produced by NESA/UERJ and the Ministry of Health in 2002.</td>
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<td><strong>Activity #6</strong> Strengthen the organization of services between referral centers and PSF</td>
<td>Could be improved</td>
<td>PSF staff trained on STI treatment apparently is referring complicated cases only to the referral centers. Supervision in the referral centers is improving the capacity to treat the referred patients well. What is missing is the referral back to PSF, integrating actions.</td>
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<td></td>
<td><strong>Activity #7</strong> Integrate cancer prevention, prenatal, STI management, family planning, and dental care services at PSF</td>
<td>STI care in prenatal services</td>
<td>Integration of actions was OK in Fortaleza, but not in other smaller municipalities.</td>
</tr>
</tbody>
</table>
ANNEX 1

PEOPLE INTERVIEWED FOR EVALUATION

Fortaleza

Individual interviews

Programme director, HIV/STD Project-Ceará
State Health Secretariat, Unit of Adolescent Health
Director, Family Health Programme
Micro-regional director, Ceará State Health Secretariat
Staff, HIV/STD Project-Ceará

Group interviews

Project Manager, BENFAM/ISDS
Director, LACEN
State coordinator, STD/AIDS
State Health Secretariat, Unit of Reproductive Health Department
Director Maternity Teaching Hospital, UFC
STI programme coordinator, Teaching hospital UFC
Surveillance Sector Director, SESA
Staff, Reference center
Staff, Reference center coordinator
Municipal coordinator, STD/AIDS programme
Staff, Municipal Coordination STD/AIDS
Coordinator, Women’s Right Movement in Ceará
Psychologist

Aracati

Municipal Health Secretariat
Micro-regional manager
Coordinator of the referral team for STD
Staff nurse, Family Health Programme
Staff doctor, Family Health Programme
NGO Coordinators “Lua Cheia”
Group of adolescents in a public school

Cascavel

Municipal Health Secretariat
Staff nurse, Secretary of Health
Staff, STD/HIV reference center
Staff, Family Health Clinic Doctor
Staff, Educational programmes

Baturité

Municipal Health Secretariat
Micro-regional Secretariat
Micro-regional Manager
Family Health Coordinator
Staff doctor, STD/HIV reference center
The central coordination team and the technical advisory committee were made up of the following professionals, each representing their organization:

<table>
<thead>
<tr>
<th>Central Coordination</th>
<th>HIV/STI Project - Ceará</th>
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</thead>
<tbody>
<tr>
<td>Telma Sales de Queiroz</td>
<td>HIV/STI Project - Ceará</td>
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<tr>
<td>Maria Alix Leite Araújo</td>
<td>HIV/STI Project - Ceará</td>
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<tr>
<td>Silvia Bastos</td>
<td>State Coordination STI/AIDS</td>
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<tr>
<td>Gilvani Granjeiro</td>
<td>BEMFAM / ISDS</td>
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<tr>
<td>Iracema Sampaio Feitosa</td>
<td>LACEN</td>
</tr>
<tr>
<td>Telma Alves Martins</td>
<td>State Coordination STI/AIDS</td>
</tr>
<tr>
<td>Pierre-Yves Bello</td>
<td>HIV/STI Project - Ceará</td>
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<tr>
<td>Terezinha do Menino Jesus Silva</td>
<td>Community Health Department - Federal University of Ceará (UFC)</td>
</tr>
<tr>
<td>Rosarina de Fátima Sampaio</td>
<td>Ceará Prostitutes Association</td>
</tr>
<tr>
<td>Dirlene Mafalda</td>
<td>Unit of Reproductive Health - State Health Secretariat (SESA)</td>
</tr>
<tr>
<td>Silvia Bomfim Hyppólito</td>
<td>Assis Chateaubriand Maternity Teaching Hospital - UFC</td>
</tr>
<tr>
<td>Francisca Albanisa Leite</td>
<td>HIV/STI Project - Ceará</td>
</tr>
<tr>
<td>Evandro Teixeira</td>
<td>Coordination of the municipalities - SESA</td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
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<tr>
<td>Verônica Lima</td>
<td>Secretariat of Health of Fortaleza</td>
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<tr>
<td>Sheyla Borges</td>
<td>Secretariat of Health of Fortaleza</td>
</tr>
<tr>
<td><strong>Technical Advisory Committee</strong></td>
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</tr>
<tr>
<td>Ilka Rondinelli</td>
<td>Pathfinder Project–Brazil</td>
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<tr>
<td>Fábio Moherdau</td>
<td>CN STI/ AIDS–MS</td>
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<tr>
<td>Francisca Maria Andrade (Tati)</td>
<td>Ceará State Health Secretariat–SESA</td>
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<tr>
<td>Lígia Kerr</td>
<td>Community Health Department–UFC</td>
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<tr>
<td>Daisuke Onuki</td>
<td>Aliança–Luz Project / JICA</td>
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<tr>
<td>Maria Hermenegilda da Silva</td>
<td>Cearense Council for women’s Rights (CCDM)</td>
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<tr>
<td>Ivo Castelo Branco Coêlho</td>
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<td>Helvécio Bueno</td>
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<td>Ana Lúcia Vasconcelos</td>
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<td>Silvia Mamede</td>
<td>State School of Public Health</td>
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<tr>
<td>Rogério Gondim</td>
<td>AIDS Prevention Support Group–GAPA</td>
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<tr>
<td>Francisco Orlaneudo de Lima</td>
<td>Asa Branca Resistance Group–GRAB</td>
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<td>José Wellington</td>
<td>National Health Foundation–FNS</td>
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<tr>
<td>Neide Augusta Marques</td>
<td>Elementary Education Secretariat of Ceará</td>
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<tr>
<td>Name</td>
<td>Institution</td>
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<tr>
<td>Tereza Cristina E. Bezerra</td>
<td>Ceará State University</td>
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<tr>
<td>Luiza Marilac</td>
<td>Epidemiology Sector-SESA</td>
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<tr>
<td>Málbio Rolim</td>
<td>Community Health Department-UFC</td>
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<tr>
<td>Luciano Corrêia</td>
<td>Community Health Department-UFC</td>
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<tr>
<td>Luiza Freitas</td>
<td>Psychology Course-UNIFOR</td>
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<tr>
<td>Kevin O’Reilly</td>
<td>WHO</td>
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<td>Antonio Gerbase</td>
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<tr>
<td>Christina Marcham</td>
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<tr>
<td>Margarita Diaz</td>
<td>Reprolatina-Campinas</td>
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<tr>
<td>Victoria Montrone</td>
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<tr>
<td>Lúcia Duarte</td>
<td>Ceará State University</td>
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<tr>
<td>Júlia Bucher</td>
<td>University of Fortaleza</td>
</tr>
<tr>
<td>Rosa Saíd</td>
<td>JHU/PCS local office</td>
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