Published: September 2018

Advancing control of sexually transmitted infections during the era of the Sustainable Development Goals

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The far-reaching, highly ambitious Sustainable Development Goals (SDGs) build upon the momentum generated by the Millennium Development Goals (MDGs) and are intended as a guide for health, social and economic initiatives until 2030 (1). As with the MDGs, the SDGs are likely to influence the allocation of resources for global health programmes. Issues that are not included in the SDGs may receive less attention and funding, even if the issue is of significant importance. During the time of the MDGs (2000-2015), for example, spending by some donor agencies on non-communicable diseases like diabetes was actually higher in the 1990s than in the late 2000s, possibly as these diseases were not included in the MDGs.

There are seventeen SDGs, with SDG 3 being specific to health. The 3rd SDG aims to ensure healthy lives and promote wellbeing for all, throughout the lifespan. The goals address a wide range of conditions, more so than with the MGDs. SDG-3 also goes beyond a biomedical approach to disease and expressly acknowledges that health cannot be attained without social and economic changes.

Where do STIs fit within the SDGs?

At first glance, however, the place given to health appears somewhat diminished in the SDGs, where health constitutes only one of seventeen goals, while in the MDGs three of the eight goals concerned health. This observation might be true for health in general, but the SDGs give particular emphasis to conditions related to sexual and reproductive health (2). There is indeed much cause for optimism for services such as for family planning and for treating sexually transmitted infections (STIs). Sexual and reproductive health and rights are included as specific targets under both the health (SDG-3) and gender (SDG-5) goals. Notably, achieving gender equity is a standalone goal in the SDGs, something that gender advocates fought hard to achieve. Progress with empowering women would lower their vulnerability to STIs, violence, and the health consequences of fewer economic and social opportunities, all of which are inter-linked. While the focus on sexual and reproductive health is encouraging, there is also cause for pessimism in the STI field. There is no direct mention of the term 'STIs' within the SDGs, while several other communicable diseases are specifically named. Also missing is a direct reference to adolescents' rights to sexual and reproductive health interventions, including comprehensive sexuality education. This is disappointing as there had been much advocacy for the specific inclusion of adolescents in the long lead-up to the SDG declaration.

Two other distinctive features of the SDGs bear mention. Firstly, the goals were designed to be cross-cutting, forming a 'network of targets'(3), wherein each target explicitly refers to multiple goals (4). Though this approach may appear unnecessarily complicated, the aim is to build a coherent approach between health services, and, for example, education and other initiatives to reduce inequalities, trying to avoid silo-like activities. The connections between different areas are especially important for the control of STIs. STIs would be reduced by advances in the quality of healthcare and education in general (SDG-3 and 4); greater gender equality (SDG-5); reductions in inequality and stigma (SDG-10); better economic growth and decent work (SDG-8); safer cities (SDG-11); and stronger partnerships for research and sustainable development (SDG-17).

A second defining feature of the SDGs is that the goals apply to all countries, regardless of income levels. The broad initiatives that are envisioned within the SDGs have global relevance, especially those that counter inequalities. This aims to challenge the *modus operandi* of policy makers and researchers alike, across the world. This is important as, unlike many other diseases, STIs are a significant contributor to the disease burden in all countries. Potentially, then, it is possible to develop one cohesive global STI control strategy that can be applied universally to all countries, regardless of economic status.

Framework for advancing STI control within the SDGs

We propose a framework for refocusing attention on the control of STIs in the forthcoming years, most

especially within low- and middle-income countries (LMICs). The text mainly pertains to STIs other than HIV, as HIV considerations often differ from those for other STIs.

STI services hold many competitive advantages in the SDG era. Fundamental needs should be highlighted. Importantly, the STI field needs to highlight the fact that the burden of STI disease and drug resistance is rising alarmingly in many settings. There are significant gaps in service delivery for STIs. Moreover, services for controlling STIs have been given little attention by the large global funders, such as the Bill and Melinda Gates Foundation, and the Department for International Development is a United Kingdom. Even large commissions on health investments largely discount the value of STI control, aside from the vaccine against Human Papilloma Virus, which prevents cervical cancer and genital warts. Given this context, we propose:

1. strategically promote a few effective and emerging STI interventions;
2. highlight the intersections between HIV and STIs; and
3. select a few population groups and settings to prioritise.

Strategically promote selected STI interventions

These efforts can build on momentum stemming from the success of programmes to eliminate syphilis infections in new-borns, and of the marked advances in the technologies used to diagnose STIs. A clearly defined program of work could galvanise these actions and expand the place of STIs within the global policy agenda.

Some STI interventions appear well suited to the SDG era. In particular, the use of tests done at the time of a patient visit (point-of-care tests). The Human Papilloma Virus vaccine is already considered an intervention of high global importance and could spearhead STI control progress. A vaccine against Herpes Simplex Virus would also spur the field on; The World Health Organisation considers that vaccine among the top 10 priority vaccines to be developed (5).

There is good evidence on most of the steps needed to 'end/eliminate STIs public health impact by 2030', and doubtless, new exciting interventions will emerge. Together these must capture global position, imagination and funding spaces. Lastly, as with all infectious diseases, the STI field needs to demonstrate it can respond effectively to outbreaks of these infections, including outbreaks involving drug-resistant microbes.

The opportunity for a fresh start gives the STI field a chance to move on from any previous failures in research or programming, and to renew its focus on things that will work well. Noting programme and research successes and being clear on how to propagate them will provide areas to be championed, for which, the SDG era is crying out. This era is seeking compelling approaches where success can be demonstrated – the highlighting of solutions, rather than the demonstration of need or gaps in services. Several notable examples of success already exist. For instance, with a comprehensive program, syphilis declined in many population groups in China (6). Also, in Cuba elimination of syphilis in new-borns was achieved (7). Appreciable declines in the incidence of genital ulcers and increasing access to Human Papilloma Virus vaccination are all clearly causes that can be championed.

Further mend the 'fractured paradigm' between HIV and STI

In recent years, the control of syphilis has been enhanced by integrating syphilis and HIV programmes. The joined-up nature of these efforts neatly reflects the core principles of the SDGs. The SDG era provides the perfect foil for mending the 'fractured paradigm' (8), between HIV and other STIs. This paradigm has been as counterproductive for HIV as it has been for non-HIV STIs. In many countries, during the MDG period, basic STI services were left in disarray as STI program resources dwindled. The deterioration in these services raised STIs, which are a significant driver of HIV transmission. Any further weakening of STI control may well undermine progress made in HIV prevention. Fundamentally, more extensive STI control is feasible, and HIV prevention can be strengthened in doing so.

Many examples illustrate the potential synergies between HIV and the STI field, which are essentially inseparable areas. Examples include sex condom provision, reductions in gender-based violence and optimised services for sex workers Well-developed HIV services, such as clinics for antiretroviral therapy, provide useful platforms for collaboration. Further initiatives aiming for convergence between HIV and other STIs could form central pillars of STI approaches to the SDGs.

Focus on vulnerable groups and on equity gains

The predilection of STIs for women and for vulnerable populations makes these infections intrinsically inequitable. Services that ameliorate STIs, by their nature, thus enhance equity. Framing STI services as a key vehicle for reducing health and

other inequities is potentially of much strategic value.

Some population groups are central to both the STI field and the attainment of the SDGs. Young women (15-24 years), in particular, are arguably the highest priority group for STI control and are given centre-place within the SDGs. The growing attention and funding for this group could be channelled into combatting the complex multi-sectoral factors underpinning their heightened vulnerability, including to STIs. STI services in Africa and for migrant women also warrant attention, especially the targeting of young women. Presenting STI interventions as an important means of attaining youth and migrant goals, for example, might well gain some traction.

Way forward

The SDGs present an opportunity to reimagine and then reconfigure global health, and to make health central to sustainable development. The global health community, however, is yet to take on board the implications of 'sustainable development' fully. Failure to do so risks relegating the SGDs to the pile of previous failed health initiatives (9).

In particular, the STI field as a whole needs to develop a response to the question: 'Given the nature of the SDGs, how do we go about justifying investment and accelerating progress in STIs in this new climate?' Business as usual is unlikely to work, it had mixed success in the MDG era, and might even do worse under the SDGs. There is a considerable risk of getting lost in the ocean of competing priorities in this time of the SDGs. STI global leaders, researchers and services themselves will need to be carefully aligned with the case made. A large commission involving potential funding agencies, STI experts and policy leads could be set up to examine the opportunities and priorities for STIs in the next fifteen years, and to present a focused program of work. Commissions, STI conferences and a series of catchphrases could shape the vision and strategies around STI in this era.

Implemented correctly, the STI agenda may well fit better within the SDGs than the MDGs. Each disease area needs to pro-actively make their case in these early years of the SDGs, noting how they contribute to other disease areas and several SDG targets. Paradoxically, it might be best to strongly promote only some STI interventions, ones which are integrative, have multiple impacts and can champion STIs role in attaining the SDGs. The alternative, presenting arguments for comprehensive packages of clinical services, risks getting lost in the relative complexity of the SDGs.

Addressing vulnerability includes lowering the financial barriers to service access. Many intersections between health financing and STIs remain unexploited, especially financial incentives for people to access services. Giving people money, for example, for bringing their sexual partner to the clinic for treatment ticks many of the SDG boxes. Money could also be given to sex workers or men who have sex with men for attending STI services for testing and treatment. Also, links could be made with the private sector who provide much of the treatment for STIs globally. Public-private sector initiatives are possible, again consistent with the SDG framework.

Sustainable development prerogatives have already fomented global shifts (in understanding of climate change, for example). Can the SDGs also usher in a golden era for STIs? Quite possibly, an end to STIs as a public health problem is possible by 2030, with a pro-active, focused agenda crafted around a few compelling interventions relevant to all countries, synergised with HIV and targeted at vulnerable populations.

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