Promoting excellence in HIV and sexual healthcare

Dr Mike Youle is Director of HIV Clinical Research at the Royal Free Centre for HIV Medicine in London, UK. He is also founder and Director of JUSTRI, a UK-based, internationally focused, not-for-profit organisation, which works with allies in healthcare and patient communities, international agencies and the pharmaceutical industry to build successful responses to HIV and related conditions, such as hepatitis B and C and tuberculosis. JUSTRI initiates and supports projects and trainings, supplies locally relevant resources, and facilitates international innovation in the provision of care for people living with these infections.

In this interview, Mike, with input from colleagues in London and Zagreb(1), offers insights into the challenges affecting sexual health services in South-East Europe and provides examples of some of the pioneering work JUSTRI is supporting in this part of the Region, including helping set up the first sexual health clinic for men who have sex with men.

Can you give us an overview of sexual health trends in South-East Europe today?

JUSTRI has been working in South-East Europe since 2006. With the exception of Romania, most countries have low levels of HIV prevalence. However, the number of young gay men presenting with multiple STIs and HIV is rising. In countries such as Croatia and Romania, where young people have easy access to other countries in the European Union and populations can

http://www.medflash.org.uk/euro-efeature/eurobulletin-efeature-1
mix freely, we have elements coming together to create the perfect storm: relatively low knowledge and poor understanding about sexual health; no habitual sexual health screening; dermatovenerology (DV) clinics managing syphilis but not chlamydia or gonorrhoea, and infectious disease doctors treating specific conditions, but not working within the context of sexual health prevention, treatment and care. More young people are on the move, mixing with populations where there are higher rates of STIs, including HIV, and we are seeing behaviour that mimics trends in some Western European countries, where people are now less concerned about HIV, so there is a decline in safer sex. Increasing numbers of naive young men from countries where HIV prevalence is low are travelling, contracting STIs, and returning to their countries.

What do you see as the main challenges affecting sexual health services in South-East Europe?

Essentially, there is no real sexual health strategy in most of these countries. If you’re a woman, and you have an STI, you will go to a gynaecologist, who will help you. You will be dealt with as an individual, but there is no surveillance to track trends. A man with a discharge is likely to go to his GP and might get antibiotics; there is no doubt that the antibiotic-resistant gonorrhoea we are seeing here in the UK will spread rapidly across Europe.

Actually, there are several challenges resulting from the lack of sexual health strategic overview in most of these countries. There isn’t really a concept of reproductive health, and HIV is heavily stigmatized. Services exist in their hermetically sealed silos; individual women may be able to find friendly gynaecologists, but in capital cities it would be a mistake to assume that, for example, the chief HIV specialist had ever met the chief gynaecologist. It’s also important to remember that this is the first generation to emerge from autonomically managed services within which the senior doctor was all-powerful, and the hospital chiefs were political appointees. In some settings there is a religious dimension that will have an impact on whether or not a hospital chief will agree to set up a sexual health clinic. This region has also been the victim of a massive brain drain – the average doctor might be earning between 350 and 400 Euros a month, and the average nurse’s monthly salary would be something like 250 Euros: approximately 50% of Bulgarian medical students move abroad when they graduate.

JUSTRI helped to set up a “one stop” STI service in Zagreb for men who have sex with men (MSM) in October 2014, which offers testing, counselling and treatment free of charge and without referral(2). Within the first seven months the number of gonorrhoea patients seen was half the reported number of cases for the previous year in the whole of Croatia.

What are the main achievements of the pioneering service you have set up in Zagreb? What led to your setting up that particular service?

Our colleagues in Zagreb, led by Dr Sime Zelenak, are the best people to speak about this pioneering project; they set it up with an initial grant from JUSTRI. It was the first clinic dedicated to men (including MSM) in South-East Europe – a sexual health afternoon clinic session, once a week. From October 2014 until July 2015, 140 men were seen at the service (91out of the 140 were MSM). Sixty one of the 140 men reported symptoms at presentation and 44/140 had had a previous STI of whom 13, all MSM, had had proven syphilis. Forty five had never taken an HIV test (17 MSM) before testing in the clinic(3).

Click here to read the Zagreb Clinic Fact File

JUSTRI plans to support the setting up of similar clinics in the region; training sessions have taken place with doctors from Bosnia-Herzegovina, Serbia, Montenegro and Bulgaria. JUSTRI sees itself knitting people together; the threads then go off in different directions, but the good thing is that people are now talking to each other. It’s important to remember that most countries in the region have specialist infectious disease hospitals; people suspected of having an infectious disease, which would include STIs, present or are referred to these hospitals where there are skilled doctors. Each country has a handful of people who specialize in HIV, but Macedonia, for example, has no more than about 200 HIV patients, while only Serbia, Romania, Albania and Croatia have more than 1000 patients each. There are HIV champions in these countries who are now talking to each other regularly. Historically nurses have been discounted in a very hierarchical healthcare system; that is now changing: JUSTRI has pioneered training that empowers them to take a more active role. The Ministry of Health in Croatia is now interested in sexual health, due to the success of the work in Zagreb.

We’re looking to establish sexual health clinics in Serbia, Macedonia, Sofia (Bulgaria), Iasi (Romania) and Istanbul; the clinic in Zagreb has clearly demonstrated the value of dedicated sexual health clinics.

Is stigma and discrimination still widespread? What transferrable lessons have you learned about setting up services for men who have sex with men?

There are no places in South East Europe where being gay is seen as normal, although there are small gay communities everywhere. People tend not to know their HIV status, which is why it is important to do outreach work. In Timisoara, in Romania, gay men living with HIV set up a group with 20 people. In Turkey, HIV-positive groups, and gay groups exist, but they didn’t want to mix. The stigma is huge; groups communicate almost exclusively via social media.

In general, men with symptoms will go to a doctor or a pharmacy, and be treated with antibiotics. Both they and the pharmacy will be short of condoms – condom availability is poor, and those which are available are very expensive. JUSTRI brought a box of condoms into a cruising area in Zagreb, where a social worker gave them out. It immediately became clear that older men got ten condoms each, while younger men got two or three; this is still a hierarchical society, where seniority counts.

The JUSTRI slide website(4) and how-to guides are impressive resources which you make available to professionals interested in setting up similar services; do you know who downloads them, and how they are used?

Our slide website has approximately 10,000 slides, all available free of charge; the website just asks that you register. We know that they have been accessed from 122 countries. The how-to guides – latest editions include How to establish an...
**HIV sexual health clinic, How to establish an HIV women’s clinic** and **How to establish a viral hepatitis clinic** - are more of a slow-burn; we see them as an a la carte set of options from which people can select the approach most relevant for their context.

**What are the major lessons learned from your work in South-East Europe?**

It’s a very hierarchical system; talking to patients about medicine is seen as a doctor’s job. Nurses are skilled, but their potential is overlooked. Where JUSTRI has trained nurses, they are now working effectively. It’s slow work; of course professionals are protective of their areas of work, but the results speak for themselves. There's also an element of competitiveness; if Novi Sad asks for a clinic, then Belgrade immediately wants one, at least in part because it doesn’t want to be without one if there’s a specialist clinic in Novi Sad.

Co-infection is an important part of HIV, affecting between 10% and 30% of HIV cases; the rate of hepatitis B infection in Romania is high, and hepatitis C is increasing as a result of drug use. There is very little treatment, although treatment for hepatitis C is coming through.

There is a large epidemic of multi-drug-resistant TB in Romania. Treatment is very siloed; some health care professionals are reluctant to treat people living with HIV and there is very little liaison between TB and HIV medical services.

Another lesson learned is that Eastern Europeans welcome the opportunity to meet experts; JUSTRI has successfully brought professionals together who have continued to collaborate partly through flying out experts that people are keen to learn from.

This region contains a mass of contradictions; I’ve seen better HIV services in Africa than in some parts of the region, where antibody tests and HIV drugs remain unavailable. Or take a country like Montenegro – it isn’t in the EU. Yet it uses the euro, and NATO has invited Montenegro to start accession talks...

**Building on your success, where would you like to go next?**

Iran would be an important country; they have a huge HIV epidemic, a thawing environment and a well-ordered medical system. With external support and distance learning, a lot could be achieved. I’d also be interested in working in the Central Asian Republics. Russia would be too difficult, for several reasons, but it would be great to have the chance to do more work in Ukraine, the Baltic republics and Poland.

**If you had one message for people trying to set up STI services in South East Europe, what would it be?**

If you’re setting up new services, make sure you’re working with people who have done it before. Resources and templates do exist, and people out there are willing to help. Don’t be afraid to adopt the JUSTRI approach, which will encourage you to:

1. Do what they say isn’t useful – but you know is;
2. Do what crosses boundaries that are there – but needn’t be;
3. Do what they say won’t work – but you know almost certainly will...

**Footnotes:**

(1) The interview included input from Louie Pong, Clinical Nurse Specialist in Sexual Health, Royal Free London NHS Foundation Trust. Data from the Zagreb clinic have been provided by Dr Sime Zekan, MD, Medical School University of Zagreb, Croatia.

(2) The Zagreb clinic is managed by Dr Sime Zekan, an infectious disease specialist. The clinic continues to provide a much-needed service; to date it has served more than 250 men.

(3) The figures have been taken from a presentation given by Dr Sime Zekan at the 15th European AIDS conference in Barcelona in October 2015, which can be accessed here: [http://www.justrislide.com/pdfs/A8714.pdf](http://www.justrislide.com/pdfs/A8714.pdf)

(4) [http://www.justrislide.com/](http://www.justrislide.com/) (login required)

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