November 2008

STI Global Update

Newsletter of the International Union against Sexually Transmitted Infections

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Contents

President's Column

Dear members of IUSTI and colleagues interested in STIs! We look back to the very successful 24th Conference of the European Region of IUSTI in Milan and a productive Board Meeting of the Executive Committee in Franciacorta. Marco Cusini, the Chair of the Conference, his Local Organizing Committee, and Claudia Heller-Vitouch, the Chair of the Scientific Committee made every effort to plan the meeting as a memorable one. It was very well organized, scientifically interesting, and attracted a high number of participants. Highlights of the scientific programme were the plenary sessions, the symposia covering important topics on STIs, and the many oral presentations which enabled many participants to present new data of their studies. The Scientific Committee selected the 3 best posters for the IUSTI Bronze Medal Award for young scientists, financially supported by GenProbe. Marco Cusini was awarded with the silver medal as the organizer of a regional IUSTI meeting. In the name of IUSTI worldwide I would like to congratulate IUSTI Europe and thank all those who contributed to the meeting's success.

At the Board Meeting of the Executive Committee of IUSTI worldwide, organized in Franciacorta before the IUSTI conference started, some important decisions were made:

IUSTI Europe 2008

IUSTI world meetings

It was agreed upon by all EC members that World Meetings should be held every year in the near future. We have therefore the following schedule for meetings:

2009: 11th IUSTI World Conference, Cape Town, November 9-12: 'Global STIs: Old Problems and New Solutions' (Chair: David Lewis, Co-chair: Kit Fairley, International organisation: Janet Wilson)

2010: 12th IUSTI World Conference: It was agreed upon that IUSTI worldwide will not hold a world meeting in T`bilisi, Georgia, due to the insecure political situation. We hope to appoint another venue in another region.

2011: 13th IUSTI World Conference, New Delhi, November 2-5. (Chair: Somesh Gupta, Co-chair: TBA)

2012: 14th IUSTI World Conference, Melbourne (Chair: Kit Fairley, Co-chair: TBA)

2013: 15th IUSTI World Conference, might be a joint meeting with ISSTDR

IUSTI membership

The number of IUSTI members with full membership is increasing. Please have a look at the IUSTI website and find information on the advantages of being a full IUSTI member. Associate membership is free of charge and offered to all persons interested in STIs. Members of the ASTDA, BASHH, ALAC, and the Australian Sexual Health Association shall be contacted separately.

The website system works now for *online membership application* and renewal! This marks a major development for IUSTI. If your membership is not up-to-date please can we ask you to renew it on-line? In September we had our first genuine new member join by an on-line membership application and payment by PayPal. Their 40 Euros (38.1 after deductions) is in the IUSTI account and the database shows their details - they are based at the Robert Koch Institute and have joined the European region.

IUSTI website

The website is regularly updated. It provides important information about IUSTI, IUSTI events, links, and on regional activities. Please visit the website www.iusti.org.

You will also find and may wish to download all newsletters *"STI Global Update"* and the regional newsletters from the regions Africa and North America.

Personal decisions

The Executive Committee has enthusiastically welcomed Professor Tom Quinn as a Senior Counsellor of the Executive Committee.

Prof. Anton Luger will receive the IUSTI Gold Award for lifetime achievements during an STI symposium in Vienna organized for the celebration of his 90th birthday.

Angelika Stary
IUSTI world president

IUSTI News

The British Association for Sexual Health and HIV has recently produced a DVD to illustrate the use of microscopy to diagnose sexually transmitted infections. It includes how to set up the microscope, perform appropriate stains and interpret the results. Further information is available at *http://www.bsig-resources.org.uk/*.

What's new from the World Health Organisation

Update on implementation of the WHO Global Strategy for the Prevention and Control of STIs: 2006-2015

In May 2006 the 59th World Health Assembly approved the *Global Strategy for the Prevention and Control of Sexually Transmitted Infections*. This was significant because the subject of sexually transmitted infections had not been discussed by this world health body for over ten years. This discussion facilitated putting the control of sexually transmitted infections on the global agenda again.

The strategy provided a global framework proposing three fundamental benefits for investing in STI control, namely, as a cost-effective intervention to prevent HIV infection, to prevent serious morbidity and cancers, especially in women, and to reduce adverse outcomes of pregnancy. It highlighted opportunities for scaling up an effective response to the prevention and control of infections and feasible evidence-based interventions for implementation at country level.

To assist countries and other stakeholders to implement the elements of the strategy an *Action Plan for the implementation of the Global STI Strategy* was developed in collaboration with about one hundred stakeholders who represented national programmes, other agencies of the United Nations system, research institutes, donor agencies and non-governmental organizations. This action plan includes priority activities that can be implemented with existing resources and those that will need additional human and financial resources at country level, and proposes time frames and indicators structured around the essential elements of the strategy which are as follows.

- strengthen support components such as surveillance and laboratory capacity;
- provide good quality care;
- ensure a reliable supply of effective and safe medicines and commodities;
- promote healthy behaviors;
- review policies, laws and regulations that affect STI prevention and care;
- advocate for accelerated response and collaborative actions.

Advocacy for implementation of the strategy has occurred in conferences and meetings at the global, regional and national levels. This prompted the Regional Offices of WHO to adapt the global strategy to the needs of the respective regions. Thus, the *Regional Strategy for the prevention and control of sexually transmitted infections, 2007–2015 for the South-East Asia Region* and the *Regional strategic action plan for the prevention and control of sexually transmitted infections 2008–2012 for the Western Pacific Region* were published. The *Regional strategy for the prevention and control of sexually transmitted infections 2009-2015* was presented for endorsement to the Regional Committee for the Eastern Mediterranean in October 2008. In the Americas, the *Regional Strategy and Plan of Action for Cervical Cancer Prevention and Control* was presented to their Regional Committee in September 2008. Finally, regional action plans for prevention and control of STIs for the European and African regions are in preparation and should be finalized during the course of 2009.

WHO has undertaken other activities to promote the implementation of the strategy. An international consultation was held in Geneva (WHO Headquarters) to inform on guidance regarding strengthened, but more focused surveillance of sexually transmitted infections. An updated WHO guide for surveillance will be published in early 2009. Other areas of work that have had consultations to update recommendations are in clinical management of sexually transmitted infections and programmatic issues such as which interventions and which populations should be targeted for the control of sexually transmitted infections to prevent the transmission of HIV infection. Additionally, a revised version of the training modules for the management of sexually transmitted infections, with an interactive CD-ROM version, has been published and disseminated. A publication with recommendations on the use of periodic presumptive treatment of sexually transmitted infections, particularly among sex workers has also been published.

The revisions covering the management of sexually transmitted infections are worth highlighting. The revised *Guidelines for the Management of sexually transmitted infections* will include changes in the management of genital ulcer diseases to reflect the observation that the predominant etiology globally is now herpes simplex virus infection. Secondly, recommendations for treatment of *Neisseria gonorrhoeae* will change due the observed widespread resistance in *Neisseria gonorrhoeae* to fluoroquinolones. The new guidelines will also now include treatment recommendations for anogenital infections. Thus, it will be important that countries study these revisions and recommendations and adapt their respective national guidelines accordingly.

The other important area of work has been operational research to strengthen cervical cancer prevention programmes in a number of countries, mainly in Africa. The objective is to assess the acceptability and feasibility of implementing a cervical cancer prevention programme with the "see and

treat" approach based on visual inspection with acetic acid followed by cryotherapy. Between December 2006 and May 2008 about 11 421 women have been screened, with 1 279 VIA-positive (11.2%). Of 1 030 women eligible for cryotherapy, 640 (62.1%) received cryotherapy treatment. Generally, it has been found that the procedure is highly acceptable to women. The constraints to scaling-up are the attrition rate of close to 40% of eligible women not receiving cryotherapy because of shortage and breakdown of cryotherapy equipment and loss to follow-up between screening and treatment. Therefore, future plans include a market survey to come up with minimum requirements for cryotherapy units for use at primary health-care level and the development of a comprehensive list of manufacturers with equipment with acceptable specifications who are willing to offer preferential pricing for the public health sector, who can train local technicians in maintenance or can offer after-sales service.

Related to the cervical cancer prevention, WHO has been working with international partners to explore mechanisms to introduce the human papillomavirus vaccines into vaccination programmes in resource-constrained settings. An online Human Papillomavirus Vaccine Global Community was launched in 2008 as a forum to exchange knowledge of and resources for human papillomavirus vaccines (http://hpv-vaccines.net/).

Finally, WHO, with organizations of the United Nations system, convened a consultation on *Men who have sex with men and the prevention and treatment of HIV and other sexually transmitted infections* in Geneva in 2008, and highlighted the urgency of scaling up interventions and strengthening surveillance within this population.

Francis Ndowa and Julia Samuelson

Regional Reports

Latin America

The Latin American and Caribbean Association for the Control of STI (ALAC-STI) is an international scientific organization, aimed at bringing together professionals from different specialities from the countries of the region, who are interested in collaborating on activities related to services, training and research applied to the control of STI. During a recent meeting the members agreed on the need to carrying out a review of programs in the Latin America and Caribbean region. A survey was designed to obtain information directly from national STI programs and was sent to 20 countries. Only Haiti failed to respond. The survey included queries about the epidemiology of STIs, organizational aspects of the programs, integration of the programs into primary care, national policies for managing cases and use of syndromic management, provision of free services, medicines and laboratory tests, existance and functioning of epidemiological surveillance systems, training in STI management, research in STI aspects and external funding.

Results from 19 countries (Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Uruguay and Venezuela) were analized.

All the countries in the region reported that STIs were prevalent diseases and that their STI programs are integrated to some degree into primary care services. Syndromic management is an accepted policy for the management of STI cases in the public sector in all countries, and in several of them it is also used in the private sector. The public sector offers treatments for STI patients free of charge in 84% of the countries surveyed; free laboratory tests in 68%, free provision of condoms in 79%, free counseling in 95%, and free HIV testing in 63%.

The majority (16/19) of the countries have systems for referral and management of partners and most report having screening services and treatment for at least one vulnerable sub-group, with sex workers being the group for which these services are most consistently available.

A considerable number of countries reported the availability of national training courses on syndromic management and counseling, and all agreed on the need for regional courses, either regularly or periodically, to further increase the scientific and technical knowledge of those working with the programs. All agreed on the need to develop intervention programs for the prevention and control of STI in priority border areas.

This survey has provided information that should be used for the benefit of all the countries in the region, to share best practice, to improve prevention activities and to develop collaborations between countries to better address STIs.

Patty Garcia

Europe

I am delighted to be able to report that our recent 24th Congress, held in Milan between 4th–6th September 2008, was an enormous success. The scientific content was of the highest possible standard. Although a European meeting in name, there is no doubt that this series of European congresses have now become *de facto* world meetings, both in their size and quality. 600 delegates attended this meeting - a remarkable number. It was held in the University of Milan, a most pleasant and attractive setting conveniently located in the heart of the city. Most of the delegates were able to stay in hotels only a few minutes walk away, which made for a very pleasant experience.

The opportunity was taken to hold IUSTI business meetings in a venue located just outside Milan in the two days prior to the congress itself. This allowed meetings of the IUSTI World Executive, the IUSTI Europe Board and the European STI Guidelines Editorial Board to take place.

A number of awards were made at this meeting.

IUSTI silver medals were awarded to the congress president, Dr Marco Cusini, and to Dr Andreas

Katsambas. IUSTI bronze medals were awarded to those individuals presenting the best posters at the meeting. These were: Dr H Patel (United Kingdom) for, "A comparison of the Newmarket and Biokit total antibody EIA test for the detection of treponemal antibody"; Dr M Seita (Canada) for, "Male sex workers: are we ignoring a risk group in Mumbai, India?"; Dr A Khryanan (Russia) for, "Prevalence of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* and sexual behaviour among female university students in Novosibirsk, Russia". Prizes were also awarded to the best young presenters of free oral communications: Dr M Cole (United Kingdom) for "*Neisseria gonorrhoeae* resistance patterns" and Dr L Ferrara (Italy) for "A network for prevention, control, diagnosis and treatment of sexually transmitted infections in Piemonte".

On behalf of the Board of IUSTI Europe I would like to express our admiration and gratitude to all those who made the meeting such a success, in particular to Dr Marco Cusini and to Dr Claudia Heller who was the Chair of the International Scientific Committee.

As mentioned above, an IUSTI Europe Board meeting was held at which important decisions were taken. These included confirming the decision to go ahead and register IUSTI Europe as a non-profit association in Estonia, and to establish a European Medal of Merit; to be awarded by IUSTI Europe to individuals that have made an outstanding contribution to the field within Europe.

There will be no separate IUSTI Europe congress in 2009, as we are encouraging participation at the ISSTDR meeting to be held in London that year. We will take the opportunity to hold an IUSTI Europe Board meeting in association with that meeting for the conduct of business.

In 2010, the IUSTI Europe Congress will take place in Georgia. This was discussed at the Board meeting in Milan, and obviously some concerns were expressed about the security situation in that country giving the recent shocking events. However, after careful deliberation the Board felt that the situation will have stabilised long before that meeting is due to take place and therefore confirmed their wish for it to go ahead. This will be a landmark event, being the first time that a major international STI meeting has been held in a former Soviet Union country.

As mentioned above, a meeting of the European STI Guidelines Editorial Board also took place immediately before the Milan meeting. This was supported by the European Centres for Disease Control.

Progress was reviewed on revisions of the original European guidelines published in 2001. A number of guidelines are being revised at present: syphilis; gonorrhoea; chlamydia; HIV testing; tropical genital ulcer disease; genital herpes. In the last 12 months two guidelines have been produced – a new guideline on proctitis published in August 2007, and a revision of the guideline on pelvic infection, published in October 2007, and subsequently further revised in a minor way.

The Editorial Board also discussed its work programme for the forthcoming 12 months.In addition to completing the revisions already commenced as described above, it was also decided to revise the guidelines on vaginal discharge, pediculosis pubis and scabies.

As always, I would be delighted to hear from anybody with suggestions to make about the European STI Guidelines, whether suggestions for new guidelines or revisions of existing ones, or from individuals interested in becoming involved as editors or authors. Please contact me at Keith.W.Radcliffe@hobtpct.nhs.uk

Keith Radcliffe

North America

North America IUSTI was well represented at the European IUSTI held in Milan, Italy, Sept. 4-6, 2008. Active participants and presenters at the meeting included Drs. Sevgi Aral, Max Chernesky, John Douglas, Dennis Ferrero, Kevin Fenton, Charlotte Gaydos, Hunter Handsfield, Frank Judson, King Holmes, Kees Rietmeijer, Richard Sweet, Julius Schachter, and Thomas Quinn. It was a wonderful meeting and we thank Marco Cusini, Conference President, and Claudia Heller-Vitouch, Chair of the Scientific Committee.

Julius Schachter, Sevgi Aral and Tom Quinn at European IUSTI Conference, Milan

New Edition of STD Book. The new edition of the widely used reference book for STDs was published in the spring of this past year: *Sexually Transmitted Diseases, 4th Edition,* eds. KK Holmes, PF Sparling, WE Stamm, P Piot, JW Wasserheit, L Corey, MS Cohen and HD Watts, (McGraw-Hill, New York, 2008). This book has been heralded as bringing STDs and associated social and population-level issues up-to-date and has created an excellent resource for clinicians world-wide. Earlier this year, the textbook received a 5 star rating from *Doody's Journal*, a resource journal for librarians. This 2,166 page edition is highly recommended for all researchers, public health officials, and clinicians in the field of STDs.

Syphilis News from the CDC's Morbidity and Mortality Weekly Report (Aug 15, 2008): Syphilis Testing Algorithms Using Treponemal Tests for Initial Screening New York City 2005-6. Four New York City laboratories that routinely conduct syphilis testing using EIA treponemal screening tests provided their testing algorithms, test volume, and test results for a

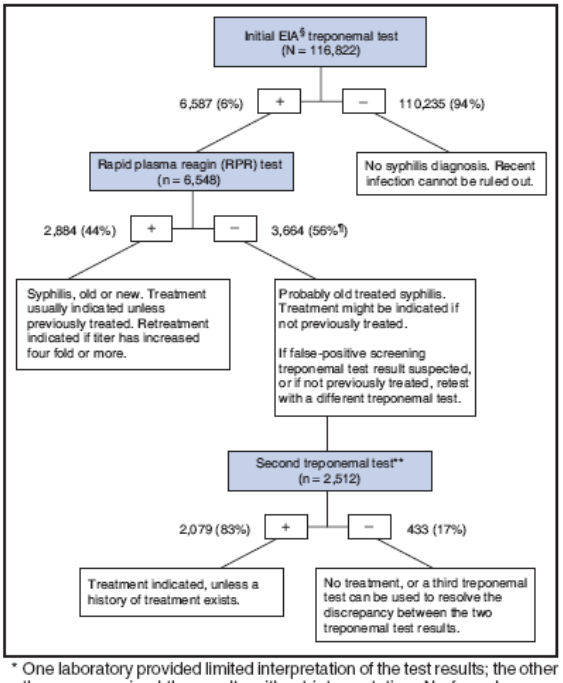
convenience sample of specimens. No further testing was done on specimens that were nonreactive with the treponemal screening EIA. Specimens considered reactive by EIA test were next tested with a rapid plasma reagin (RPR) test. At two laboratories, specimens that were reactive with EIA and nonreactive with RPR were retested using a different treponemal test: *Treponema pallidum* particle agglutination (TP-PA) or fluorescent treponemal antibody (FTA-ABS). At a third laboratory, specimens that were reactive to both the EIA test and the RPR test were retested using a different treponemal test (i.e., FTA-ABS or TP-PA). At the fourth laboratory, no further testing was done after the EIA and RPR tests. Of the 116,822 specimens included in the convenience sample, 6,587 (6%) were initially reactive to the EIA test (Figure). When 6,548 of the EIA-reactive specimens were tested with an RPR test, 2,884 (44%) were reactive and 3,664 (56%) were nonreactive to the RPR test. Further testing with FTA-ABS or TP-PA tests on 2,512 of the specimens reactive to the EIA test but nonreactive to the RPR test found 2,079 (83%) specimens reactive to the second treponemal tests (i.e., FTA-ABS or TP-PA). In addition, the one laboratory that performed TP-PA testing on specimens that were reactive to both the EIA and RPR tests found 78 of 80 (98%) specimens were reactive to the TP-PA test. Test results that would not have been identified by the traditional algorithm were obtained for 3% of the specimens tested for syphilis.

When results are reactive to both treponemal and RPR tests, persons should be considered to have untreated syphilis unless it is ruled out by treatment history. Persons who were treated in the past are considered to have a new syphilis infection if quantitative testing on an RPR test or another nontreponemal test reveals a four fold or greater increase in titer (health departments maintain registries of past positive tests). When results are reactive to the treponemal test but nonreactive to the RPR test, persons with a history of previous treatment will require no further management. For persons without a history of treatment, a second, different treponemal test should be performed. If the second treponemal test is nonreactive, the clinician may decide that no further evaluation or treatment is indicated, or may choose to perform a third treponemal test to help resolve the discrepancy.

If the second treponemal test is reactive, clinicians should discuss the possibility of infection and offer treatment to patients who have not been previously treated. Unless history or results of a physical examination suggest a recent infection, such patients are unlikely to be infectious and should be treated for late latent infections, even though they do not meet the surveillance case definition. Treatment can prevent severe (i.e., tertiary) complications that can result from untreated syphilis, although the probability of such complications occurring without treatment, while unknown, likely is small.

Reversal of the traditional syphilis screening sequence has been driven by economics. For high-volume laboratories, an automated treponemal test can be less expensive than using an RPR test for the initial screening. An important consequence of this reversal is the identification of a combination of reactive and nonreactive test results that would not otherwise have been identified. The clinical interpretation of these results was complicated by the lack of standardized follow-up testing algorithms among the four laboratories, and by the lack of an evidence base with which to judge the merits of each algorithm. Consequently, use of a reversed sequence of syphilis testing might result in overdiagnosis and overtreatment of syphilis in some clinical settings. The recommendations in this report might not be appropriate in countries with different patterns of seroreactivity, systems of health care, and epidemiology of disease. Furthermore, additional analyses are needed that further elucidate the use and total costs of these alternative screening approaches for syphilis, given the anticipated increase in use of treponemal tests for screening in the United States.

FIGURE. Composite results of syphilis testing algorithms using treponemal tests for initial screening and likely interpretations* — four laboratories, New York City, October 1, 2005–December 1, 2006†



* One laboratory provided limited interpretation of the test results; the other three summarized the results without interpretation. No formal recommendations exist regarding the interpretation of results derived from testing algorithms using treponemal tests as the initial test.
† Using a convenience sample of 116,822 specimens. The four laboratories used different testing algorithms. Data shown are a composite of results from all four laboratories.
§ Enzyme immunoassay.
¶ Reactive with EIA treponemal test but nonreactive with RPR test.
** Using *Treponema pallidum* particle agglutination or fluorescent treponemal antibody tests.

We welcome new members from North America. Please log onto www.IUSTI.org and join our unique international colleagues who work in the STI field. Other Regions which play an integral part of Worldwide-IUSTI include: IUSTI-Europe, IUSTI-Latin America, IUSTI-Africa, and IUSTI-Asia Pacific. Associate membership is free and full membership is inexpensive and dues can now be paid through the website electronically. Membership is open to

individuals with a professional interest STIs. We have a lot of work to do in diagnosing, treating, and preventing STIs in North America.
Charlotte Gaydos

Asia-Pacific
Australia: Historically, Sydney has been at the epicentre of the HIV epidemic in Australia – with the great majority of new infections among men who have sex with men (MSM). However, over recent years new HIV infections in Sydney have remained fairly static, if not decreasing, while increasing sharply among MSM in Melbourne and Brisbane. The entire June 2008 issue of *Sexual Health* was dedicated to exploring the possible reasons for the differences between these three cities.
In the summary paper (Fairley CK, et al. *Sexual Health* 2008; 5: 207-210) the most logical conclusion was that the continued high-level and coordinated investment in HIV prevention in New South Wales (Sydney is the main city) was in stark contrast with the disinvestment that had occurred in the other states. The result was increases in high risk behaviour in Melbourne and Brisbane, but not in Sydney. The continued expenditure in New South Wales had proven to be highly cost-effective.
This national-scale 'natural experiment' in HIV prevention should serve as an illustration that apparent success cannot be taken for granted. Successful programs demand ongoing funding.

India: The 32nd National Conference of Indian Association for the Study of Sexually Transmitted Diseases and AIDS (ASTICON 2008) was held at Kodaikanal, Tamilnadu. Co-organised by Department of STD, Madurai Medical College, Madurai, it was attended by approximately 300 delegates and included topics of current interest and guest lectures which were delivered by distinguished speakers from India and abroad. Dr V Harindra, Consultant Physician, Department of GU Medicine, St. Mary's Hospital, Portsmouth, UK spoke about "ARV Therapy in HIV Infection"; Dr. Verapol Chandeying from Thailand delivered a talk on "Approach to the problem of abnormal vaginal discharge" ; Dr. Chavalit (Thailand) spoke about "STD prevention and control in the light of AIDS endemics; "Diagnosis of asymptomatic infections of Chlamydia and Gonococcus" was discussed by Dr. V.S. Dorai Raj, Former Director & Professor, Institute of Venereology, Madras Medical College, Chennai. Dr. N. Usman, Consultant at Rajiv Gandhi National Institute of Youth Development, Chennai discussed "Knowledge and Practice of Youth towards STI/HIV/AIDS in Tamilnadu". There was discussion about "Prostitution in India and its role in the spread of HIV infection" by Devinder Mohan Thappa, from JIPMER, Pondicherry. Dr R Basu Roy from UK spoke on "Reflections on HIV/AIDS".
The State AIDS Control Society (SACS), Chandigarh conducted a 2-day training for Medical Officers of 18 STI Clinics in the city which are providing medicines. This training was to implement the Enhanced Syndromic Management for RTIs and STIs as per National AIDS Control Organisation (NACO) Operational and Technical Guidelines. The training was held on 5th and 6th August, 2008.
Basil Donovan and Sunil Sethi

Africa
There have been some important changes in the management of STIs on the African continent. With the appearance of ciprofloxacin resistance in Southern Africa, South Africa has now taken the lead among its neighbours and has now replaced single dose ciprofloxacin (500mg) with single dose cefixime (400mg) as the first line therapy to treat presumptive gonococcal infections in the syndromic management flowchart algorithms for the urethral discharge and vaginal discharge syndromes. Single dose intramuscular ceftriaxone (250mg) will be given in place of cefixime for complicated STIs that may be due to *Neisseria gonorrhoeae*, namely pelvic inflammatory disease (lower abdominal pain syndrome) and epididymo-orchitis (scrotal swelling syndrome). It will be important for other African countries, which may still able to use ciprofloxacin, to regularly monitor the prevalence of ciprofloxacin resistant gonococci through periodic microbiological surveillance activities.
The World Health Organisation (WHO) has recently undertaken a consultation with international experts to review the current WHO STI syndromic management guidelines. This will be of key importance to the African Region, where such a STI management strategy is practiced. One important change in the revised WHO guidelines will hopefully be further promotion of acyclovir episodic therapy for the management of genital ulceration. A randomized placebo-controlled double-blind study was recently completed among men with genital ulceration in South Africa and assessed the benefit of adding acyclovir to antimicrobial therapy for chancroid and syphilis. Even though patients presented relatively late, a significant benefit in terms of ulcer healing was seen in those receiving acyclovir. There was also a decrease in HIV-1 RNA shedding in those men taking acyclovir. Within South Africa, approximately 60-70% of genital ulcers are now due to genital herpes and 70% of patients with genital ulceration are co-infected with HIV. The South African Department of Health's new STI treatment guidelines now recommend the use of acyclovir, in addition to benzathine penicillin and erythromycin, as first line therapy for genital ulceration. A further discussion of recent trials in Africa and the management of genital herpes in the context of HIV is the subject of the research section of the July 2008 IUSTI-Africa newsletter available on the IUSTI website.
The WHO's global strategy to improve STI management in Africa emphasises the importance of aetiological and antimicrobial resistance surveillance in order to optimise treatment regimens for STI syndromes. This component of the syndromic

management approach remains very weak in Africa. Over the next few years, it will be important to strengthen surveillance in order to strengthen public health approaches to reduce the transmission of both STIs and HIV/AIDS. A meeting of the International Collaborative Group on Gonococci was held in Rotterdam in September and plans are underway to establish a global gonococcal antimicrobial susceptibility surveillance programme which will include the African Region.

Botswana's HIV Clinicians' Society held a very successful 2nd International AIDS Conference in Gaborone between 17-20 September. The first day was dedicated to AIDS Prevention and included talks about the importance of concurrent partners, male circumcision and alcohol, among other drivers of the HIV/AIDS epidemic. The Regional Director gave a talk on the impact of STI treatment on HIV prevention and stressed the importance of focusing on HIV transmission rather than acquisition as a measure of the impact of STI management on HIV prevention.

Finally, preparations are well underway for the 15th ICASA to be held in Dakar, Senegal from 3-7 December. The conference's theme is 'Africa's response: Face the Facts" and IUSTI-Africa is a co-organiser for the event. Further information is available at the conference website: www.icasadakar2008.org.

David Lewis

Conference Update

IUSTI Events:

11th IUSTI World Congress
Dates: November 9-12, 2009
Location: Cape Town, South Africa
Website:
http://www.iusti.org/regions/africa/default.htm#saconf

25th Conference on Sexually transmitted infections and HIV/AIDS- IUSTI Europe 2008
Dates: To be announced
Location: Tbilisi, Georgia
Contact: Dr. Joseph Kobakhidze
devcokobakhidze@yahoo.com

12th IUSTI World Congress
Dates: November 2-5, 2011
Location: New Delhi, India
Website: www.iusti2011.org

13th IUSTI World Congress
Dates: 2012
Location: Melbourne, Australia
Contact: Prof. Christopher Fairley, E-mail:
cfairley@bigpond.com

Other STI or Related Meetings/Congresses/Courses:

15th International Conference on AIDS and STIs in Africa
Dates: December 03-07, 2008
Location: Dakar, Senegal
Website: http://www.icasadakar2008.org/

Prevention of HIV/AIDS
Dates: March 22-27, 2009
Location: Keystone, Colorado, United States
Website: http://www.keystonesymposia.org/9x3

12th Bangkok International Symposium on HIV Medicine
Dates: January 14- 16, 2009
Loaction: Bangkok, Thailand
Website: http://www.hivnat.org

Infectious Diseases: Adult Issues in the Outpatient and Inpatient Settings
Dates: March 23-27, 2009
Location: Sarasota, Florida, USA
Website:
http://www.ams4cme.com/www/LiveSeminars/SEMLA-2320090323.aspx

SA AIDS Conference 2009
Dates: March 31- April 3, 2009
Location: Durban, KwaZulu Natal, South Africa
Website: http://www.saaids.com

AIDS Scenarios Workshop
Dates: April 22, 2009
Location: London, United Kingdom
Website:
http://www.scenariodevelopment.com/AIDSScenarios

6th Spring Symposium of the European Academy of Dermatology and Venereology
Dates: April 23-26, 2009
Location: Bucharest, Romania
Website: www.eadv.org

5th European Conference on Clinical and Social Research on AIDS and Drugs
Dates: April 28-30, 2009
Location: Vilnius, Lithuania
Website: http://www.aidsvilnius2009.com

18th Annual HIV Conference of the Florida/Caribbean AIDS Education and Training Center
Dates: May 1-2, 2009
Location: Orlando, Florida, United States
Website: http://faetc.org/conference/

25th International Papillomavirus Conference
Dates: May 8-14, 2009
Location: Malmo, Sweden
Website: http://www.hpv2009.org/

American Conference for the Treatment of HIV (ACTHIV)
Dates: May 15, 2009
Location: Denver, Colorado, United States
Website: http://www.acthiv.org

Neisseria Vaccines 2009, International Workshop on Neisseria Vaccines
Dates: May 17-22, 2009
Location: Varadero, Matanzas, Cuba
Website: http://www.sci.sld.cu/neisseria/neisseria.htm

10th International Congress of Dermatology
Dates: May 20- 24, 2009
Location: Prague, Czech Republic
Website: http://www.icd2009.com/

International Society for Sexually Transmitted Diseases Research
Dates: June 28 - July 1, 2009
Location: London, United Kingdom
Website: http://www.isstdrlondon2009.com/

International AIDS Society 2009
Dates: July 19-22, 2009
Location: Cape Town, South Africa
Website: www.ias2009.org

18th European Academy of Dermatology and Venereology Congress
Dates: October 7-11, 2009
Location: Berlin, Germany
Website: www.eadv.org

12th European AIDS Conference/EACS
Dates: November 11-14, 2009
Location: Cologne, Germany
Website: http://www.eacs-conference2009.com/

Somesh Gupta

STI Global Update is published by the International Union against Sexually Transmitted Infections. Its aims are to provide an international perspective on the management and control of sexually acquired infections. Regular contributions from the regional directors of IUSTI and feedback from conferences is supplemented by short reviews of relevant topics and input from the Center for Disease Control (US), Health Protection Agency (UK) and the World Health Organisation.
Prof. Jonathan Ross, Editor
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