

STI Global Update

Newsletter of the International Union against Sexually Transmitted Infections

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President's Column

Dear members of IUSTI and colleagues interested in STIs!

The year 2007 is quickly proceeding and its end is soon approaching. It is time to summarize our most recent activities in this year:

Our new logo is well established and accepted and sets an example for the new profile of the International Union against Sexually Transmitted Infections (IUSTI). The new IUSTI folder provides a summary on our aims and benefits for membership. Information on the regions and their activities is available on the newly designed homepage www.iusti.org.

We look back to 2 successful meetings in the year 2007:



King Holmes and Angelika Stary

1. The Seattle conference started with the **King K. Holmes 70th "Birthday Symposium"** at the University of Washington in honor of King Holmes. Excellent speakers presented overview lectures on different topics in order to celebrate the upcoming birthday of the incoming IUSTI president. I would like to comment on King's age with the following sentence: "Age is a question of mind over matter. If you don't mind, it doesn't matter".

The joint meeting **17th ISSTD - 10th IUSTI world Congress, July 29 to August 1**, organized by Hunter Handsfield and the local organizing committee in cooperation with IUSTI has been the big global STI event in this year. Approximately 1200 participants from all continents gathered in Seattle to discuss all aspects of STI-related science, clinical and epidemiological topics and the most recent developments in STI research. A special IUSTI symposium with very interesting contributions from all

5 regional branches reflected the different aspects of STI epidemiology, prevention and education and was well attended. As already announced in the last newsletter, the excellent scientific programme during the day and the social programme during the night kept many of us "sleepless in Seattle".

The **Executive Committee (EC)** had its annual meeting in Seattle to discuss the further strategy of our union. We had very fruitful discussions with consensus on important decisions concerning regional structures, change of the membership strategy, future world meetings and the members of the EC. Raj Patel was re-elected as Secretary General and has in addition taken over the task of a treasurer, Janet Wilson has been appointed as the newly installed Honorary Assistant Secretary, Northern America has a new Regional Director (Charlotte Gaydos) and Regional Chair (Jeanne Marrazzo), and Latin-America is now represented by Adele Benzaken and Patricia Garcia.



Closing ceremony at 23rd IUSTI Europe conference

2. The **23rd IUSTI-Europe conference on STIs and HIV/AIDS in Cavtat/Dubrovnik**, was organized by Mihael Skerlev (Misko), and was the very remarkable and highly successful IUSTI meeting of the European Branch in this year. With more than 600 participants it was very well attended – particularly considering the close timing with the joint meeting in Seattle. Due to the efforts of the scientific chair and committee the scientific programme was very attractive and the positive atmosphere among the participants during the meeting reflected the enthusiasm and friendship of our STI colleagues. On behalf of the Executive Committee I want to express my special thanks to Misko as the responsible local organizer, to Derek Freedman as the chair of the scientific committee, and to the regional officers for their excellent contribution to a successful IUSTI Europe event in the beautifully located congress venue of Cavtat close to Dubrovnik.

At both conferences we used the opportunity to provide information about our organisation and IUSTI

events using the IUSTI folder and conference announcements. The well presented *IUSTI Booth* at the conferences in Seattle and Cavtat was frequently visited by conference participants and provided the option to directly sign the membership application form and get in contact with IUSTI delegates.

I want to thank all colleagues contributing to the success of IUSTI.

Angelika Stary

IUSTI world president

IUSTI News

Holmes Chair in STDs and AIDS

The University of Washington in Seattle is seeking \$1.5 million to endow a Holmes Chair in STDs and AIDS, and thereby ensure the future of this important centre of excellence in STD research. There can be few individuals who have made a greater contribution to the field of STD research and practice than King Holmes and those who wish to contribute to the appeal can find further information at: <http://www.iusti.org/sti-information/holmes.htm>.

IUSTI website



Home

The International Union against Sexually Transmitted Infections (IUSTI) was founded in 1923 and it is organized on both a global and regional basis. It is the oldest international organisation with the objective of fostering international cooperation in the control of sexually transmitted infections including HIV/AIDS.

IUSTI is concerned with the medical, scientific, social and epidemiological aspects of sexually transmitted infections and their control.

IUSTI is on the Roster of the United Nations Economic and Social Council. It is an Official Non-Government Organisation in Consultative Status with the World Health Organisation. IUSTI organizes frequent international and regional conferences on sexually transmitted infections and, in collaboration with the International Journal for STD and AIDS, publishes expert [clinical guidelines](#) for their management.

IUSTI is Charity Nr 1113234 registered in the United Kingdom.

Forthcoming Conferences and Meetings:

11-14 October, 2007,
[23rd Conference of IUSTI - Europe on Sexually Transmitted Infections](#)
Dubrovnik, Croatia

3-6 February 2008
[15th IUSTI-Asia-Pacific Congress](#)
Dubai, UAE

July 1-4 2008
[6th meeting, European Society for Chlamydia Research](#) (non IUSTI meeting in Denmark)

4-6 September 2008
[24th Conference of IUSTI Europe](#)
Milan, Italy

The IUSTI website now conforms to the new IUSTI visual identity but there is clearly much more to do. The first priority is to provide a web-based facility for IUSTI membership applications and renewals incorporating convenient on-line credit / debit card payment. For payment, users will be referred via an encrypted link to a commercial secure payment system. Importantly, no credit card details will be entered or held on the IUSTI web server. Once the credit card transaction is approved, members will automatically be emailed with confirmation of their successful membership renewal. It is expected that this system will be in place by the end of the year. In conjunction with this it is planned to develop a new privacy policy to ensure that all relevant data protection standards are being met. This in turn will lay the foundation for a secure membership services area on the web site. Initial useful ideas for the IUSTI website have been received from members of the web consultation group, including ideas for "what's new" and "contact us" sections. I will be delighted to receive ideas from members concerning the website.

There have been problems with incomplete links to IUSTI conference web sites. Regional directors and conference organisers are asked to email the relevant links to webmaster@iusti.org as soon as they become available.

Michael Ward

Research Review

Syphilis: a continuing clinical challenge

During the 1970s, prior to the AIDS era, The New York Hospital and Memorial Sloan Kettering Cancer Center (MSKCC) performed routine serologic tests for syphilis on all patients upon admission. Positive serologic tests were evaluated by physician and nurse epidemiologists in real time. Over an 8-year period, 20 patients with primary or secondary syphilis were admitted to the hospital with incorrect diagnoses. In 19 of the 20 patients, a positive admission screening test for syphilis first alerted clinicians to the correct diagnosis.

Twelve of the twenty patients were admitted to surgery. At The New York Hospital, six patients with rectal chancres had diagnoses that included rectal abscess, fistula or hemorrhoids. Three of them were excised. One patient with a primary chancre and left inguinal adenopathy underwent surgical exploration for a possible incarcerated inguinal hernia. A patient on the urological service with a primary chancre and secondary lesions on the foreskin, was circumcised to remove chronic foreskin lesions. On otorhinolaryngology, a patient with meningeal (8th nerve) signs of secondary syphilis without skin lesions was treated for Meniere's Syndrome. Two patients with rectal chancres and secondary lesions admitted to MSKCC were evaluated for cancer. One who was thought to have malignant lymphoma underwent staging for radiation and/or chemotherapy. The other was considered for radical surgery. A young woman with a primary chancre on her tongue was referred to MSKCC for possible radical surgery to remove her carcinoma.

On the medical service, three people with hepatic signs of secondary syphilis were treated for hepatitis. One of them did not have skin lesions. Three patients were admitted to neurology. A patient with headache, secondary lesions and papilledema was evaluated for intracranial neoplasm. A patient with a rectal chancre, skin lesions of secondary, meningeal signs, and carcinomatous meningitis was admitted with a diagnosis of only carcinomatous meningitis. The third patient, who had secondary syphilis and optic neuritis, was treated for multiple sclerosis. Finally, a woman with a vaginal chancre was scheduled for a radical vulvectomy on the gynecology service to treat her presumed carcinoma.

Within the past year, I was asked to consult on two patients who were diagnosed with syphilis because their physicians did not understand how to interpret serologic tests. The first was a neonate who had a positive RPR from cord blood. The pediatricians did an emergency lumbar puncture, which was normal,

and started the child on intravenous penicillin. In fact, this represented passive transfer of antibody across the placenta from a mother who had been adequately treated in the past to a child who had no signs or symptoms of syphilis. Thus, treatment was discontinued. The second case was a single woman in her thirties with minimal sexual experience who complained to an otorhinolaryngologist of dizziness. An RPR was negative, but an FTA-ABS was marginally positive. Although she had no signs, symptoms or history of syphilis, he insisted that her symptoms were all due to syphilis and recommended immediate treatment with long-acting penicillin. She came to see me, emotionally distraught from the social stigma and reluctant to accept treatment for a disease that she did not believe she had. A panel of treponemal tests performed in the CDC's reference laboratory documented that she had never been infected with *T. pallidum*.

As syphilis becomes a more uncommon disease in most populations, physicians will become increasingly unfamiliar with its clinical manifestations and the interpretation of serologic tests. The opportunities to make an incorrect diagnosis will increase, which could result in serious adverse complications for patients. Therefore, it is especially important to continue to develop appropriate educational programs for medical students and young physicians.

Drusin LM, Homan WP, Dineen P: The Role of Surgery in Primary Syphilis of the Anus. 1976 *Annals of Surgery* 184:65-67.

Drusin LM, Singer S, Valenti AJ, Armstrong D: Infectious Syphilis Mimicking Neoplastic Disease. 1977 *Arch Intern Med* 137:156-160.

Drusin LM, Topf-Olstein B, Levy-Zombek E: Epidemiology of Infectious Syphilis at a Tertiary Hospital. 1979 *Arch Intern Med* 139:901-904.

Lewis Drusin

Regional Reports

Europe

It is extremely pleasing to be able to report that the 23rd IUSTI-Europe Congress on Sexually Transmitted Infections, which took place in Cavtat near Dubrovnik in Croatia in October 2007, managed to match the extremely high standard set by this series of meetings in recent years - in Vienna, Mykonos and, last year, in Versailles. All credit must be given to the Chairman of the International Scientific Committee (ISC), Derek Freedman (from Ireland) who managed to put together an innovative and fascinating programme which was truly as good as any STI congress in recent years. Enormous praise and gratitude is also due to Mihael Skerlev from Croatia, who as the local organiser and Congress President managed to put on such a fantastic conference. There were 550 registrations.



Marco Cusini (Italian national representative and Congress President for IUSTI-Europe Milan 2008); Claudia Heller-Vitouch (IUSTI-Europe Secretary and Chair of the International Scientific Committee for Milan 2008); Mihael Skerlev (Congress President IUSTI-Europe Dubrovnik 2007); Branka Marinovic (Conference Secretary, Dubrovnik); Derek Freedman (Chair, International Scientific Committee, Dubrovnik).

For those people like myself, whose first visit it was to Croatia, it was also extremely pleasing to be able to visit Dubrovnik (the ancient Ragusa) which is known as "the pearl of the Adriatic", and which is a UNESCO-designated world heritage site. The meeting was very pleasantly rounded off by a gala dinner held in the Ravelin Fortress adjacent to the old walls of Dubrovnik. The IUSTI-World President, Angelika Stary, thanked Professor Skerlev for his efforts, and awarded him the IUSTI silver medal in recognition of his achievements.

The IUSTI-Europe Board took the opportunity of the Cavtat congress to hold a most productive business meeting.

Some important decisions were taken at this meeting, in particular –

- That the 2010 IUSTI-Europe Congress will take place in Tbilisi in Georgia in 2010. The Congress President will be Josephe Kobakhidze, who is the national representative for Georgia on the Board. This will be the first major international STI meeting held in a former Soviet Union country, and should therefore be an historic event. At the time of writing it is very much hoped that the IUSTI-World Executive Committee will agree to designate this as a world meeting.
- The 2011 Congress will be held in Riga, Latvia. The Congress President will be Andris Rubins, the Latvian national representative.
- The Board voted unanimously to move to establish IUSTI-Europe as a not-for-profit society registered in Estonia, in order to regularise its status and its financial affairs. It is hoped that this work will be completed in the next twelve months.

In the meantime, we look forward with great excitement to the 2008 IUSTI-Europe Congress, which will take place in Milan, Italy, between 4-6

September 2008. Please visit the website for further information (www.oic.it/iusti-europe2008). The Congress President will be Marco Cusini (Italian national representative), and the Chair of the ISC is Claudia Heller-Vitouch, who is also the secretary of IUSTI-Europe.

Work on updating the European STD management guidelines continues. A new guideline on proctitis has been produced and published (*International Journal of STD & AIDS* 2007; **18**: 514-520).

The guideline on the management of pelvic inflammatory disease has been updated and published (*International Journal of STD & AIDS* 2007; **18**: 662-666).

Work continues on updating the guidelines on: syphilis; gonorrhoea; chlamydia; HIV testing; urethritis. All final and draft guidelines can be accessed on the IUSTI website. Any suggestions for the revision or development of new guidelines, or offers of help with authoring guidelines, would be gladly received by me (Keith.W.Radcliffe@hobtpct.nhs.uk).

The Guidelines Editorial Board now has official representatives from the European Dermatology Federation (EDF), the European Centres for Disease Prevention and Control (ECDC), the European Office of the World Health Organisation (WHO-Europe) and the Union of European Medical Specialities (UEMS).

Keith Radcliffe

North America



Charlotte Gaydos – new Regional Director for North America

New CDC Treatment guidelines

The new 2006 Centers for Disease Control (CDC) and Prevention treatment guidelines are available at: <http://www.cdc.gov/std/treatment/2006/toc.htm>

New Guidelines for Screening Males for Chlamydia

The CDC had published a meeting/workshop report on the web and sent a Dear Colleague letter about testing men for chlamydia. For the purposes of state and local program activities, the following guidance is provided to assist with decisions about which populations of males to screen for Chlamydia trachomatis (Ct) and how to best screen.

- Among males, those <30 years of age entering jails should be the highest priority for Ct screening
- Males attending sexually transmitted disease (STD) clinics should be screened for Ct

- Males with Ct infection should be re-screened at 3 months for repeat Ct
- Urine is the specimen of choice for screening asymptomatic men for Ct
- Nucleic acid amplification tests (NAATs) are the test of choice. The leucocyte esterase test is not recommended for screening males for Ct
- Pooling of urine specimens should be considered for Ct testing in low prevalence settings to conserve resources
- Partner services should be offered to partners of males with Ct

The report is available at:

<http://www.cdc.gov/std/chlamydia/ChlamydiaScreening-males.pdf> .

Expedited Partner Therapy for Chlamydia and Gonorrhea

An alternative approach to assuring treatment of partners is expedited partner therapy (EPT). EPT is the delivery of medications or prescriptions by persons infected with an STD to their sex partners without clinical assessment of the partners. Clinicians (e.g., physicians, nurse practitioners, physician assistants, pharmacists, public health workers) provide patients with sufficient medications directly or via prescription for the patients and their partners. After evaluating multiple studies involving EPT, CDC concluded that EPT is a “useful option” to further partner treatment, particularly for male partners of women with chlamydia or gonorrhoea. In August 2006, CDC recommended the practice of EPT for certain populations and specific conditions. For more information see report at:

<http://www.cdc.gov/std/ept/legal/introduction.htm>

Vaccine for Human Papilloma Virus

In 2006, a vaccine to prevent infection with four types of HPV (6, 11, 16 and 18) was approved by the Food and Drug Administration (FDA) for use in females aged 9 – 26. HPV 6 and 11 cause most genital warts in the US and HPV 16 and 18 are “high risk” types that cause up to 70% of all cancers of the cervix. Another vaccine to prevent “high risk” HPV (16 and 18) is expected to be approved in 2007. In the United States, there continues to be controversy over the implementation of HPV vaccine. Although approved by the CDC Advisory Committee on Immunization Practices and major specialty and primary care organizations, and approved for payment by the major insurers, implementation of universal vaccination mandates at the State level have met with resistance. The most prominent example was in Texas, where the governor proposed mandatory HPV vaccination and was rebuked by the state legislature. Surveillance data released by CDC has demonstrated that approximately 1/6 of women tested are infected with HPV

Gonorrhoea Resistance: Fluoroquinolones No Longer Recommended for Treatment of Gonococcal Infections

In early 2007, the CDC made major recommendations for gonorrhoea treatment which

removed quinolones as first-line therapy. Ceftriaxone and other third-generation cephalosporins are now the primary therapy. This was in response to the increased levels of QRNG observed in the National Gonorrhoea surveillance system. The information was widely disseminated and appears to have been implemented by most clinics and private practitioners. There are major concerns over management of allergic patients as well as anxiety over the lack of any real alternatives to the cephalosporins, if resistance develops. See report at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5614a3.htm?s_cid=mm5614a3_e

Abstinence-only for prevention of STDs

Several reports have been published by federal health agencies which indicate that the Government's abstinence-only policy, which currently receives almost \$200 million dollars annually, is a failure. Nearly all reports demonstrate that coital debut is modestly delayed, but when it occurs, contraception and condoms are not used, resulting in higher disease and pregnancy rates.

Syphilis

The CDC will be reporting that persons with HIV who are coinfecting with syphilis may have neurosyphilis rates subsequently as high as 4%. This has resulted in call for increased and more aggressive screening-post therapy, of persons with syphilis.

ISSTD/JUSTI The major ISSTD/JUSTI meeting was held in Seattle in August 2007. Over 1,200 delegates attended, with nearly 700 abstracts. The site of the next ISSTD 2009 will be in London 28 June-1 July 2009 in conjunction with the British Association for Sexual Health and HIV (BASHH). www.isstdlondon2009.com. There will also be a May 7-10 2008 meeting of the BASHH-ASTDA, 3rd joint conference in Brooklyn NY, "Converging Approaches in STI Control and Reproductive Health". See www.bashh.org.

Charlotte Gaydos

Africa

Both associate and full membership numbers have continued to rise during the course of 2007. The joint ISSTD-IUSTI meeting in Seattle this year presented a good opportunity to increase the African membership. Several pieces of research were presented from Africa at this joint ISSTD-IUSTI meeting and several new friendships and relationships were forged among IUSTI-Africa members.

The Region, whilst facing an HIV epidemic of huge proportions, is awaiting the roll out of the World Health Organisation's (WHO) Global Strategy for the Prevention and Control of Sexually Transmitted Infections

In July 2007, the IUSTI-Africa region launched a newsletter for its new members. Topics covered included country reports from Benin and Nigeria, an

STI microbiological surveillance report from South Africa, a research review on the male circumcision trials and news about the WHO's Global Strategy. Further information is available at the IUSTI website (www.iusti.org) or from iusti-africa@nicd.ac.za. Preparations for ICASA 2008 meeting in Dakar, Senegal, are on-going and a second stakeholders' meeting is planned for January 2008.

David Lewis

Latin America

The situation in Latin America continues to be very difficult for STD control. Available funding is low (100 times lower than for AIDS) and projects from UNAIDS and the Global fund either do not designate funds for STD's or have only very limited funds.

The lack of support and coordination for central programmes results in poor notification of STI cases. The groups working on STD's are isolated and rely mostly on volunteers. Also access to new technologies is limited to cities and larger centres. An increase in syphilis cases has been identified and congenital syphilis remains endemic in the region. Latin America also has only a limited number of health care personal trained in STI management, research and epidemiology.

Union Panamericana Contra las Infecciones de Transmision Sexual (IUSTI Latin America) organises postgraduate courses in Buenos Aires with the help of OPS and a number of courses have also been organised in Uruguay and Colombia. Again financial support is limited and the lack of sponsorship from medical companies makes it difficult to organise larger events. International symposia were however planned in Buenos Aires and Uruguay. IUSTI Latin America in Chile works closely with the national authorities in developing appropriate STD initiatives, including improved surveillance of congenital syphilis. In Colombia Dr. Beatriz Orozco has edited a book on STDs for use as a university text. A group which unites representatives of different countries has been constituted in Brazil.

In summary, STDs are increasing in the Americas but this has neither lead to effective prevention strategies by politicians nor to a change in behaviour in the population. Appropriate health education is needed combined with specific plans for STI control in each country reflecting its geo political status. International agencies need to support studies which assess the true prevalence of disease, measure trends and develop effective interventions.

Antonio Parisi

Asia-Pacific

Training of Sexually Transmitted Infections Specialists and Status of the Specialty in Asia Pacific Region

This report was presented at 17th ISSTD and 10th IUSTI World Congress. It comprises an email survey of 102 members in the list of the IUSTI AP Branch

Committee. Responses received from 27 key opinion leaders from 18 countries and territories as follows Australia (7 respondents), Brunei, China, HK SAR, Fiji, India (3 respondents), Japan, Laos, Myanmar, New Zealand, Philippines (2 respondents), Singapore, South Korea, Sri Lanka, Syria, Thailand, UAE, and Uzbekistan.

The survey was conducted from 16 May to 18 June 2007. The questionnaire was organised into 5 sections - Training in STI and Accreditation of STI Specialists, Professional Development and Clinical Governance, Clinical Services, STI Academic Activities, 3 main challenges of STI in your country.

Most of respondents were medical doctors (24), 9 were administrators, 3 were public health officials, 1 was a laboratory specialist, and 7 were academics. Most of the clinicians (15) were in government practice, 7 were in private practice, and 6 were in academic institutions.

STI is included in the undergraduate curriculum in 15 countries, as part of dermatology in 7, microbiology or infectious disease in 4, in the obgyn module in 3, as part of venereology/sexual health in 2 countries, in family medicine 1. The total number of lectures/tutorials ranged from 1 hour to 10 hours (Melbourne). Three countries do not have STI in undergraduate curriculum.

Clinic attachment for medical students ranged from 1 day (Newcastle, Gold Coast, HK, Myanmar, Singapore, and Thailand) to 4 days (Melbourne, Sydney). When combined with dermatology it ranged from 14 days (Brunei, China, Philippines, New Delhi) to 30 days (Punjab).

STI postgraduate training is provided as part of sexual health medicine in 4 countries (Australia, NZ, Fiji, Sri Lanka), as part of dermatology training in 8 (China, HKSAR, India, Philippines, Singapore, Syria, Uzbekistan), as part of obgyn in Thailand & Laos, as part of ID in Brunei and the Philippines. There is no postgraduate STI training reported in Fiji, Japan, Myanmar, and South Korea. The length of training in Australia/NZ/Sri Lanka was from 3 to 5 years, and 3 years in India/China /Singapore (with dermatology)

The number of specialists in STI trained each year at National level is from 1 to 3 in Brunei, Fiji, HK SAR, Myanmar, NZ, Singapore, South Korea, Syria, UAE; from 4 to 6 in Laos, Philippines, Sri Lanka, Thailand; and more than 10 in Australia, China and India.

STI is part of dermato-venereology in China, HK SAR, India, Philippines, Singapore, Syria, Thailand, UAE, Uzbekistan; a separate medical specialty in Australia, Fiji, NZ, Sri Lanka; part of Infectious Diseases in Brunei, Myanmar, Philippines, Thailand; part of ObGyn in Laos, Thailand; and part of urology in South Korea.

The majority of countries (14 out of 18) had an organization or professional body that looked into the development of STI specialty. Most respondents reported regular CME programmes in STI in their institution/hospital for specialists as well as primary care physicians. The majority of countries had regular epidemiologic reports and treatment guidelines. India and Australia had national STI journals. Brunei, Syria, UAE did not have regular STI reports.

The 3 main STI clinical service providers were STI/Sexual Health clinics (11 countries), general practitioners (9) and government primary health clinics (7). There was a professorial chair(s) in STI in 9 countries - Australia, China, India, Laos, Philippines, South Korea, Sri Lanka, Thailand, and Uzbekistan.

Compared with 10 years ago STI research activities was thought to be increasing in 11 and decreasing in 3 countries; the number of STI scientific publications was thought to be increasing in 9 and decreasing in 4 countries; collaboration between clinicians and public health experts was thought to be increasing in 11 and decreasing in 1 country. Collaboration between clinicians and social scientists was thought to be increasing in 9 and decreasing in 1 country; collaboration between clinicians with community groups was deemed to be increasing in 9 and decreasing in 1 country. Compared with 10 years ago political commitment to STI/HIV control programmes was thought to be greater in 10 countries and decreasing in 2 countries; funding for STI programmes was higher in 10 and lower in 5 countries.

The main challenges facing STI in Asia Pacific countries are in the professional/training field – some of the comments were – lack of specialist recognition, aging specialists, decreasing number of trainees, competition with better paid specialties, retaining quality trainees, difficulty of the field to survive as a separate specialty, retaining importance as part of dermatology, STI retaining importance vis-a-vis HIV infection.

Political and governmental factors were the next commonest reported challenges viz. STI not on national government's priority list, lack of political interest in STIs, inadequate awareness of STI being a public health issue, inadequate funding for development of this specialty. Biomedical issues were the next category e.g. increases in viral STIs/HIV infection, development of new drugs, STI/HIV in adolescent population and MSM.

Social and public attitudes were the next category viz. overcoming stigma, cultural reluctance to accept the burden of disease in the population, lack of support from the religious bodies to be party in prevention message communication. Infrastructure inadequacies were named by only a handful of respondents.

I would like to thank all who took the time to respond to the survey. The results make interesting reading and provide a snapshot of the state of our specialty in the Asia Pacific region.

Roy Chan

Summary of Proceedings of the IUSTI Global Challenges Symposium (ISSTD 2007/10th IUSTI World Congress)

Challenges for Africa

The talk by the IUSTI-AFRICA Regional Director addressed the following issues:

- the burden of STIs and HIV in Africa
- the WHO's Global Strategy for the Prevention and Control of STIs: 2006-2015 and a discussion of key points in the action plan of this strategy
- a description of available WHO-UNFPA Strategic Partnership Programme training manuals that are being used in field trials in 8 African countries
- clinical STI surveillance was discussed using a South African example of Gauteng province
- microbiological surveillance initiatives in the Region were discussed
- the rise in the prevalence of ciprofloxacin resistant gonococci in Southern Africa was described
- the decline in chancroid and maternal syphilis (RPR screening) was seen as a success related to syndromic management and possibly other factors, but the need to improve prevention efforts for congenital syphilis, which still occurs at unacceptably high rates in Africa and for which a cost-effective intervention is available, was highlighted
- ABC campaigns and the role of ARVs was discussed
- the need to move away from single dose nevirapine regimens for PMTCT programmes was stressed, in order to avoid future drug resistance for the mother and baby
- there is a need for Governments in Region to discuss HIV more openly in an attempt to reduce stigma
- the importance of gender-based approaches to HIV care and prevention was discussed
- the human rights of sex workers, men who have sex with men, and adolescents were raised as important areas for attention in national sexual health programmes

David Lewis

The Latin American Region and STIs

The Latin American region includes the territories in the Americas where the romantic languages like Spanish, Portuguese, French and creoles are spoken. This includes more than twenty countries and 4 dependencies from South America and Central America plus other countries like Haiti, Martinique and Guadeloupe in the Caribbean, and the French Guiana. Our geography is quite heterogeneous ranging from Amazonian rainforests to Andean regions and deserts. And there is a variety of ethnic backgrounds. But in essence we are not so different

and we share the problem of having to deal with public health threats like sexually transmitted infections (STI).

Historically, STIs in Latin America, as in other parts of the world, have been managed mainly by venereologists, but recently there is a growing trend for a broader range of professionals to be involved in the care of these diseases. Gynecologists, internal medicine, infectious diseases specialists, midwives and male midwives are becoming more involved in the care and public health issues surrounding STIs and there is increasing recognition of the role of other allied professions e.g. pharmacy workers.

More than thirty years ago the first Latin American Union against STD and AIDS (ULACETS) was founded and had a very important role in training and organizing the first Latin American Congresses on STIs, bringing together specialists from different countries. In 2003 with the purpose of promoting more dynamism, ULACETS switched name to UPACITS (Pan-American Union against STIs), but no other major changes occurred. A new effort to strengthen the response of Latin America against STIs brought together a group of health professionals in October 2003 who formed the foundation of the Latin American and Caribbean Association for the Control of STIs (ALAC) with the main objective of promoting development in prevention, health education, diagnosis, treatment and research to improve the control of STIs and integrate diverse specialties and health professionals.

Research is an important tool for the control of STIs and there are several different groups working around region. In Peru, as an example, through research done by the Epidemiology of STI/HIV group from the Universidad Peruana Cayetano Heredia, we have been able to determine the magnitude, distribution and determinants of STIs in urban and rural settings; to identify issues in the diagnosis and treatment of those diseases; and we are testing prevention interventions evaluating effectiveness and population level impact. Together with other ALAC members we are now discussing the need for research on STI prevention within our country's borders as a group effort and we hope to start a project in the near future.

Patricia J García

Reproductive Health Policy in the US

In the US, health is a major political issue. Although many have the expectation that government will satisfy physical, economic and psychological needs, there are countervailing political forces which emphasize lower government investment, in favour of the private sector. Interestingly, over the past 7 years of the Bush Administration, this "libertarianism" has been limited to the financial investment domain. In terms of reproductive health, social conservatives have promoted an interventionist agenda, and have widely implemented programs such as "abstinence-only" education programs to further these goals. However, this alignment is beginning to fray.

Public health by definition is a political process and therefore there is inherent tension in implementing public health in a political environment where multiple view points have an impact. Scientific evidence may conflict with social views about affected populations. Furthermore, the political structure of the United States encourages minority views which also tend to polarize public health issues. In particular, there have been multiple attempts at condom deligitimization, with efforts by Congress (at least until the recent mid-term elections) to impose warning labels on condoms and de emphasize condom use in lieu of abstinence only.

Effective targeting of research and development of data showing the effectiveness of condoms has been instrumental in de-fanging this argument. Similarly, there has been a heavy promotion of abstinence only programs following federal guidelines promoted by the United States education department which have promoted "Abstinence or sex within marriage is the expected standard and is the only method to avoid pregnancy and STDs." This has been accompanied by a substantial rise in abstinence only funding to the point where in 2005, abstinence only funding exceeded STD prevention funding; a trend which has continued.

After a hiatus of approximately a year or two, the STD and family planning community pointed out that delayed coital debut is actually part of comprehensive education. This was accompanied by the development of longitudinal data demonstrating that a variety of abstinence programs actually resulted increased STD instances and lack of efficacy data, which is currently resulting in push-back by many states and other groups interested in effectiveness. All of these developments and counterarguments have had substantial effect. We have begun to see "pushback" from local and state governments regarding federal mandates for ineffective abstinence programs. Congress has begun to challenge the large investment in these programs despite the data to the contrary.

The final area of substantial interest in reproductive health has been HPV vaccine. Initially, during the original FDA hearings, there was concern over the promotion of HPV vaccine by their religious right. Interestingly, this opposition to the HPV vaccine was de emphasized because of the overwhelming evidence of efficacy. In contrast, most of the debate in this area has been related to provision and access, and whether government should be mandating HPV vaccine. This has resulted in a substantial debate at the state level, mostly regarding HPV funding and mandates for HPV.

In terms of policy successes, we look at four successful HIV interventions where there were structural interventions which promoted success. These were the Uganda ABC program, the Thailand 100% condom promotion program of the early and mid 1990s, the United States Syphilis elimination project, and the tremendous decrease in STDs in gay men in the 1980s. If we look at each of these interventions, we find a number of consistent themes:

1. There is no one magic bullet

2. Each of the interventions had a multifactor approach.
3. Each of the interventions impacted behaviors that have involved contact with core group members or high risk activity.
4. Specific changes in sexual behavior were difficult to identify as rational for effectiveness.
5. These were all multifactoral which included voluntary counseling and testing, behavioral skills building, STI control and condom promotion.
6. There was high level political support
7. They were non judgmental

Each of the interventions that were successful had strong political and public health leadership which clearly addressed the community.

As scientists and clinical researchers we need to become more activist. We need to increase our visibility in policy issues emphasizing that science and the evidence base, and attempt to deligitimize advocacy based on supposition or non evidence belief. We need to be vigilant on scientific integrity. We need to capitalize on our professional credibility especially in the clinical realm and I suggest that we move the debate away from STDs towards a concept of sexual health which has been largely promoted in the United Kingdom and Western Europe.

Jonathan Zenilman

Conference Update

IUSTI Events:

15th IUSTI-Asia-Pacific Congress

Dates: February 3-6, 2008

Location: Dubai, UAE

Website: <http://www.iusti.ae/>

24th Conference on sexually transmitted infections and HIV/AIDS - IUSTI Europe 2008

Dates: September 4-6, 2008

Location: Milan, Italy

Website: www.iusti.org

11th IUSTI World Congress

Dates: November 9-12, 2009

Location: Cape Town, South Africa

Website: www.iusti.org

Other STI or Related

Meetings/Congresses/Courses:

International Conference on Opportunistic Pathogens in AIDS

Dates: January 27-29, 2008

Location: New Delhi, India

Website: <http://www.icopa-india.org>

15th Conference on Retroviruses and Opportunistic Infections

Dates: February 3-6, 2008

Location: Boston, USA

Website: <http://www.retroconference.org/2008/>

3rd Africa Conference on Sexual Health and Rights

Dates: February 4-7, 2008

Location: Abuja, Nigeria

Website: <http://africalsexuality.org>

2008 STD Prevention Conference: Confronting Challenges, Applying Solutions-ASTDA/CDC

Dates: March 10-13, 2008

Location: Chicago, USA

Website: <http://www.cdc.gov/stdconference/>

BHIVA Annual Conference

Dates: April 23-25, 2008

Location: Belfast, UK

Website: www.bhiva.org

ASTDA-BASHH Joint Meeting

Dates: May 7-10, 2008,

Location: New York, USA

Websites: www.astda.org and www.bashh.org

EADV Spring Symposium

Dates: May 22 -25, 2008

Location: Istanbul, Turkey

Website: www.eadv.org/istanbul2008/

CHIVA Annual Conference

Dates: May 23, 2008

Location: Liverpool, UK

Website: www.chiva.org

NHIVNA Annual Conference

Dates: June 26-27, 2008

Location: Glasgow, UK

Website: www.nhivna.org/

XVII International AIDS Conference

Dates: August 3-8, 2008

Location: Mexico City, Mexico

Website: <http://www.aids2008.org>

EADV Congress

Dates: September 17-21, 2008

Location: Paris, France

Website: www.eadv.org

BHIVA Autumn Conference and BASHH/BHIVA OGM

Dates: October 9-10, 2008

Location: London, UK

Website: www.bhiva.org

15th International Conference on AIDS and STIs in Africa

Dates: December 8-11, 2008

Location: Dakar, Senegal

Website: <http://www.icasadakar2008.org/>

International Society for Sexually Transmitted Diseases Research 2009

Dates: June 28- July 1, 2009

Location: London, United Kingdom

Website: <http://www.isstdr.org/index.php?id=62>

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.

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Further information on the activities of IUSTI available at

www.iusti.org

Boehringer Ingelheim Ltd have provided an unrestricted grant to assist in the production and dissemination of this edition of *STI Global Update*