



INTERNATIONAL UNION AGAINST  
SEXUALLY TRANSMITTED INFECTIONS  
AFRICA

# IUSTI -AFRICA

## NEWSLETTER

JULY 2008

Issue # 3

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## News from the Regional Director

This 3<sup>rd</sup> issue of the IUSTI-AFRICA newsletter brings with it some important update information regarding 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 is currently replacing 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 be 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. Several potential changes were discussed and these are outlined in the WHO news section of this newsletter.

One important change in the revised WHO guidelines will hopefully be further promotion of Acyclovir episodic therapy for the management of genital ulceration. A randomised 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 at 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 our research section.

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. If you are aware of STI surveillance data in your country, I invite you to consider sharing these data with others in the surveillance section of this IUSTI-AFRICA regional newsletter. We would really like to hear from you.



David Lewis

## Control of genital herpes: new hope in the fight against HIV

Nicolas Nagot<sup>1</sup>, Sinead Delany-Moretlwe<sup>2</sup> and Philippe Mayaud<sup>3</sup>

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<sup>2</sup> Reproductive Health & HIV Research Unit, University of the Witwatersrand,  
Johannesburg, South Africa

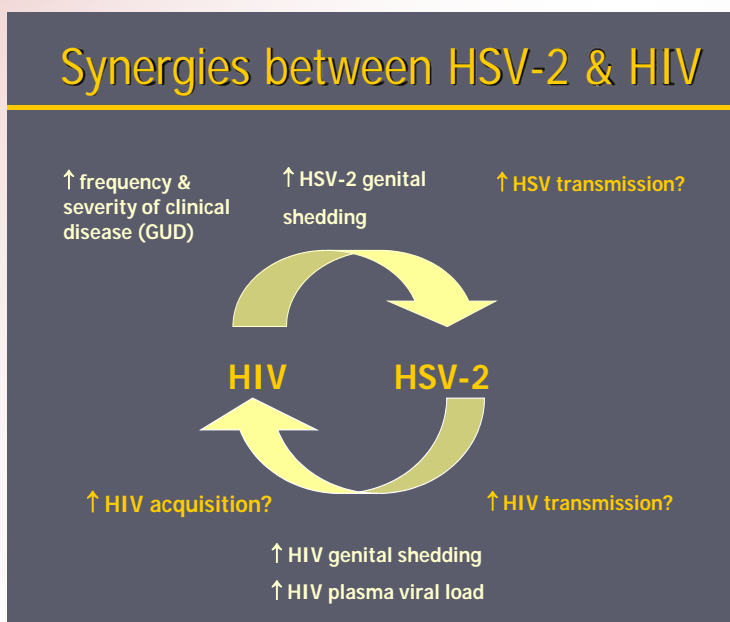
<sup>3</sup> London School of Hygiene & Tropical Medicine, London, UK



Dr Nicolas Nagot

Genital herpes caused by *Herpes simplex virus type 2* (HSV-2), is responsible for most cases of genital ulcer disease (GUD) in Africa: 79% of genital ulcers in Rwanda, 60% in Malawi, Lesotho or South Africa and 50% in Ghana and Central African Republic are due to HSV-2. This infection is back in the spotlights of HIV prevention and care because of its synergistic relationships with HIV. Recent meta-analyses of observational studies suggest that HSV-2 may enhance the risk of HIV-1 acquisition by about two- to three-fold, and that HSV-2 may increase the risk of HIV-1 transmission through increased HIV levels in the plasma and the genital tract in co-infected individuals. Several plausible biological mechanisms support the role of HSV-2. First, HSV reactivations can generate an influx of activated CD4+ T-lymphocytes in the genital mucosa and skin, which would enhance susceptibility to HIV. Second, HSV proteins have been shown to up-regulate HIV replication in vitro, mainly through a mechanism of reactivation of the HIV long terminal repeat (LTR), which would increase infectiousness. Third, recent ex vivo studies of the genital tract immune milieu have revealed that HIV-1 and HSV-2 coinfection results in depletion of the cervical immune cells responsible for the immune control of HSV-2 reactivation, leading to a vicious cycle of ever-increasing HSV-2 reactivations and HIV-1 replication.

Several randomised controlled trials have recently demonstrated that a reduction in HSV-2 reactivations through antiherpetic treatment could lead to substantial reduction in HIV-1 replication both at the plasma and genital levels. Control of HSV-2 infection would therefore represent a new and promising avenue for HIV prevention and care. Indeed, it is conceivable that sustained reductions in plasma HIV-1 RNA may lead to some clinical benefit in terms of HIV disease progression.



Currently, HSV control relies on public and patient education, use of condoms and the use of specific HSV-2 antiviral drugs that can be taken orally such as aciclovir, which is available in relatively cheap generic formulation; valaciclovir, a pro-drug of aciclovir with longer half-life requiring fewer doses, which is currently expensive but will soon be off-patent (2009); and famciclovir, a very expensive drug of similar efficacy.

These drugs can be used in two different strategies:

- Treatment of clinical episodes (GUD) using a 5 to 7 day regimen (i.e. episodic therapy).
- Prevention of clinical recurrences in patients who experience frequent/bothersome ones, using continuous treatment (i.e. suppressive therapy) for periods of at least 6-12 months.

While episodic therapy may be useful in shortening the duration of clinical recurrences, or if taken early, in aborting them, it has been shown to have no effect on their frequency. Suppressive therapy, on the other hand, has the advantage of reducing both the frequency of clinical recurrences and asymptomatic viral genital shedding. By this mechanism, HSV suppressive therapy has been shown to also reduce viral transmission between HSV-discordant couples. With HIV prevention as an outcome, both strategies have been tested in recent clinical trials.

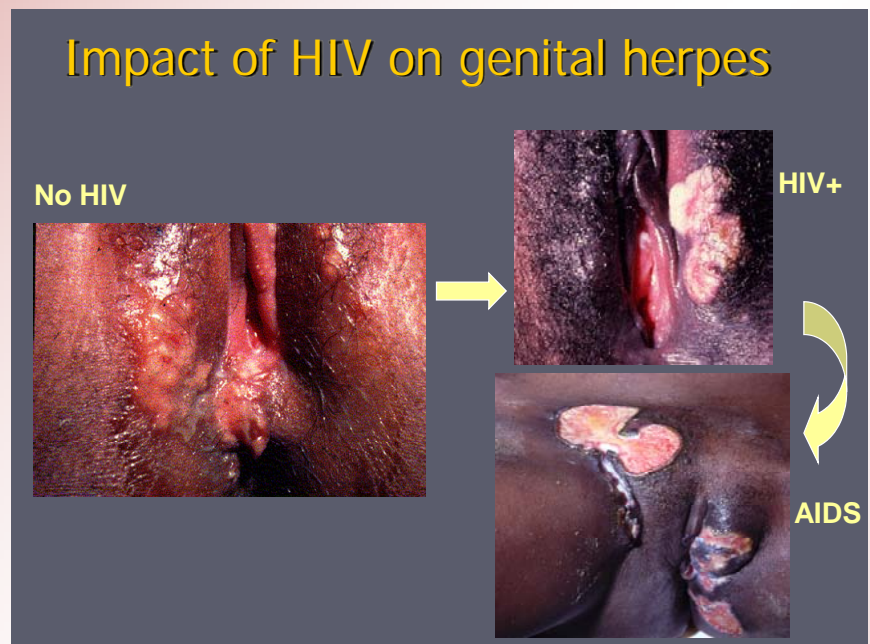
## Episodic therapy trials

Randomised placebo-controlled trials of herpes episodic therapy can be labelled 'pragmatic' trials. They were designed to evaluate the clinical and virological benefits of adding aciclovir to current GUD syndromic management guidelines that usually include syphilis and chancroid treatment in Africa. Although additional use of aciclovir had been recommended for a while by the World Health Organisation (WHO), it has seldom been implemented in Africa because of its perceived high costs and lack of substantial clinical benefits. Accordingly, the results of these trials, which were conducted in South Africa, Malawi, Ghana and the Central African Republic have shown relatively little impact on ulcer healing among HIV-infected patients. There was a moderate impact in South Africa, 1 or 2 days shorter duration, if the patients presented early. The impact on HIV was disparate, with decreased lesional or genital shedding among men and no impact on cervico-vaginal shedding in women. One of the important findings in these trials was the observation that over 50% of patients were HIV-infected, and in the majority of cases, unaware of their serostatus. This underscores the opportunity to offer HIV diagnosis and access to HIV management services to patients attending STI clinics, particularly those with GUD.

## Suppressive therapy trials

HSV suppressive therapy has been evaluated in randomised placebo-controlled trials aiming to prove the concept that HSV reactivations and HIV replication were causally related. The trials were conducted among dually HSV-2 and HIV-1 infected women in Burkina Faso, South Africa, Thailand, and among men who have sex with men in Peru. Researchers used virological endpoints (cervico-vaginal, rectal or plasma HIV-1 RNA) as trials outcomes. In contrast to episodic therapy trials, all trials have shown a consistent and concordant impact of valaciclovir (1 g daily) or aciclovir (800 to 1200mg daily) (used for relatively short periods of 2 to 3 months) in reducing genital and plasma HIV-1 RNA replication. One trial conducted among high-risk women in mining areas of Northern Tanzania did not show any significant impact on HIV-1. However, this trial used aciclovir for a longer period (2 years) with infrequent measurement of viral endpoints. Unfortunately, the researchers were also unable to demonstrate any impact on genital HSV-2, which they attributed to the overall poor compliance from study participants. This study inadvertently demonstrates the importance of careful operational research in aspects of adherence maintenance before such interventions could be possibly rolled out.

Other ongoing large multicentric trials, which include African sites, will evaluate the impact of long term (1-2 years) suppressive therapy on HIV transmission among HIV-serodiscordant couples in whom the HIV and HSV-2 infected subject will receive the study drug, and HIV seroconversion will be measured in the untreated partner. Two other trials are measuring the impact of aciclovir on HIV acquisition among HSV-2 infected but HIV-1 seronegative individuals. Finally, trials are planned to determine the impact of long-term suppressive therapy on HIV disease progression, as measured by CD4 count decline, among patients not eligible for antiretroviral therapy initially. These trials will address the important question of clinical HIV benefit of HSV treatment in patients who are frequently co-infected (up to 80%) with HSV-2.





## Looking ahead

The coming years will yield considerably interesting data from the large ongoing multicentre trials. It will then be possible to determine whether the hopes raised by the earlier proof-of-concept trials are translated into tangible epidemiological and clinical benefits. Successful results may in turn lead to further operational and economic research to determine the most suitable target groups and most cost-effective modalities of intervention delivery to reap the maximum public health impact.

However, the already accumulated knowledge leads us to recommend that greater efforts should be made to raise awareness of herpes infection among health practitioners, their patients and the community at large. In particular, HIV-infected patients should receive better advice and counselling regarding genital herpes, and where feasible, HSV-2 should be detected and managed as part of the HIV care package. Probably one of the greatest hurdles to greater adoption of HSV therapy could, however, remain health practitioners themselves, who need to be better informed, convinced and supported in changing their management approaches for HIV-infected patients. HSV therapy would provide relief to patients and possibly protection to their sexual partners, thereby effectively linking HIV prevention and care. STI practitioners should also not miss the tremendous opportunity to offer HIV detection and access to HIV care to their patients presenting with GUD.

Finally, research to develop an HSV vaccine should rank high on the international research agenda for the prevention of HIV and HSV-2. Such a vaccine would represent probably a more acceptable, effective and long-lasting form of HSV-2 control.

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**EMNOSTIC**, the **Eastern Mediterranean Network Of Sexually Transmitted Infections Control**, is a non-governmental, non-profit and non-partisan network of experts in the control of Sexually Transmitted Infections (STI). Its mission is to support the countries of the Eastern Mediterranean Region in assessing and formulating a response to the challenges related to STI. It aims to achieve its goals through sharing information and knowledge, supporting educational programmes and fostering networking, debates and discussion on STI.

#### Objectives:

1. Advocating for the development and/or strengthening of national responses to STI in the region.
2. Providing technical support and training to strengthen national responses to STI.
3. Facilitating exchange of experience and information within and beyond the region (including other similar networks).

#### Main areas of work:

- Exchange of information and experience by identifying publications, activities, events, meetings and training related to STI and reproductive health and disseminating information using e-mail, newsletters and EMNOSTIC website [www.emnestic.org](http://www.emnestic.org).
- STI situation assessment using WHO assessment tools with the aim of making available epidemiological data on STI in the region.
- Technical assistance provided to countries by STI experts from the region whose details are gathered in an updated database. Experts, not necessarily members of EMNOSTIC, could be requested to assist countries in planning and implementing projects or programmes for STI prevention and control.

*Interested professionals can apply to be included in the database by filling out a form available on the EMNOSTIC website ([www.emnestic.org](http://www.emnestic.org)) or by contacting the Secretariat Coordinator.*

#### How to join EMNOSTIC?

Membership is open to all individuals who are committed to prevention, care and control of STI in their countries and to STI experts from governmental and nongovernmental institutions and organizations. Membership is subject to approval by the Executive Committee.

*STI professionals willing to join EMNOSTIC can apply online ([www.emnestic.org](http://www.emnestic.org)) or contact the Secretariat Coordinator:*



**Dr Amira Medimagh**  
**Tel: +216 71 960 026**  
**Mob: +216 98 335 222**  
**Fax: +216 71 964 558**  
**e-mail: [amira.medimagh@emnestic.org](mailto:amira.medimagh@emnestic.org)**

For more information about EMNOSTIC, please visit the website: [www.emnestic.org](http://www.emnestic.org) or contact the secretariat.



Prof. Aïssatou Gaye-Diallo

## Sexually Transmitted Infections in Senegal: National survey done in 2006 among 639 pregnant women and 605 sex workers in the 11 regions.

Gaye-Diallo A., Niang Diallo P.A., Badiane M., Ndoeye I.,

Wade A.S., Diop I., Lalou R.,

Diakhaté-Doucouré M., Guèye-Ndiaye A.,

Touré-Kane N.C., Guèye-Gaye A., Mboup S.

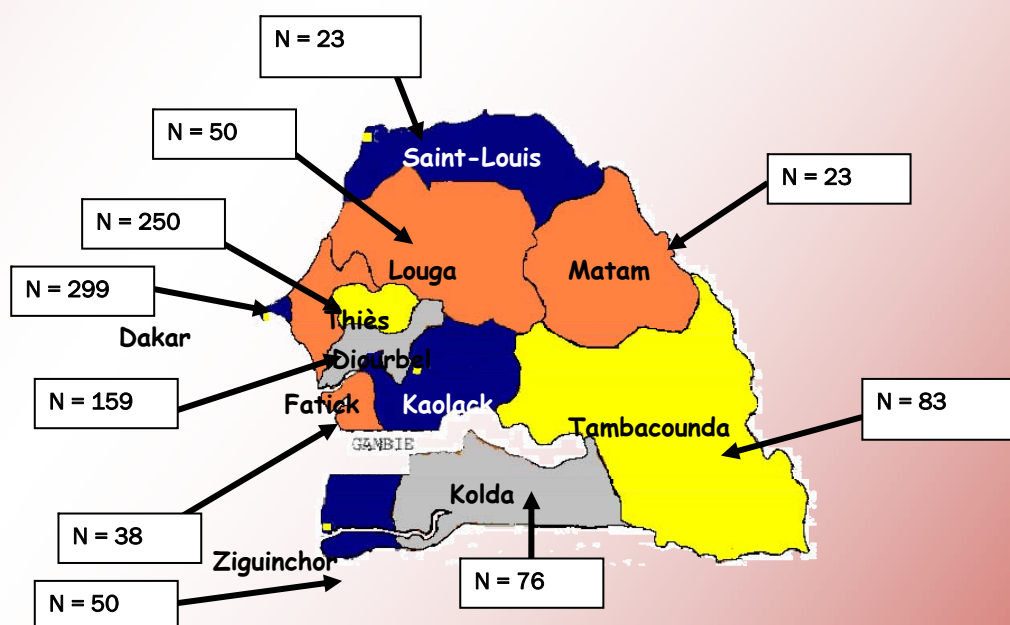
Sexually transmitted infections (STI) are without any doubt a priority in public health. The high frequency of classical STI (syphilis, gonococcal and chlamydial infections, chancroid, trichomoniasis) and their own complications are enough to make them a complete public health issue. That is why the Senegalese National Council of Fight against AIDS in collaboration with the Division of fight against AIDS and Sexually Transmitted Infections, the “ French Cooperation”, the Global Funds and the USAID have launched, in 2006, a big campaign of surveillance of these infections among target groups (soldiers, policemen, fishermen, truck drivers, sex workers and pregnant women).

This study involved the part of this survey targeting only pregnant women and sex workers. It aimed to analyze the results of biological tests performed in the two groups. A total of 1244 women divided into 639 pregnant women (who came to consult in health care centres) and 605 sex workers (registered or clandestine).

It was a survey of behavioral surveillance (not included in our study) combined to a biological survey (subject of our study). The survey covered the full national territory, the 11 regions of then. The greatest recruitment for both target groups has taken place in Dakar region with 299 women enrolled, followed by Thiès region with 250 enrollments. The smallest recruitment was in Matam with only 23 pregnant women enrolled.

Only 3 of the 605 sex workers were less than 18 years old (0.49% of sex workers were 17 years old) while, among pregnant women, 34 women were 17 years old and less. The oldest of pregnant women were 47 years old.

The peak of age range for pregnant women was between 21 and 30 years while the majority of sex workers have an age range between 31 and 40 years.



Distribution of study population as per region



Biological tests involved vaginal secretions for vaginal candidiasis, *Trichomonas vaginalis* vaginitis and bacterial vaginosis testing. We have also tested participants' blood samples for indirect diagnosis of syphilis, *Chlamydia trachomatis* infection, genital herpes and HIV infection.

For vaginal specimens, the self administered sampling method was used. Blood specimens were taken in the elbow fold.

The specimens were tested at the bacteriology-virology laboratory of Aristide le Dantec hospital according to standard operating procedures of the service.

The prevalence of vaginal candidiasis was 24% in the study population, 90% of these women had a vaginal discharge and 47.6% complained of itchiness. Pregnant women (29.5%) were more affected than sex workers (18.3%) with a significant association of the pathology with the pregnant woman status.

The prevalence of bacterial vaginosis was 39% in the study population, 32.3% among pregnant women and 47.2% among sex workers. The particularity noted is an association of the pathology with a local inflammatory reaction (more than 5 leucocytes per microscopic field): All the participants with local inflammatory reaction had also a bacterial vaginosis.

In this study, vaginosis has been correlated to the sex worker status with a significant relative risk. More, the prevalence of bacterial vaginosis per region was higher among sex workers in all the regions.

As per distribution within regions, Dakar region was the most affected with 24.1% of diagnosed cases.

*Trichomonas vaginalis* vaginitis have a prevalence of 7.4% in the general population, it is not correlated to a particular status. Independently of the considered region, pregnant women were more affected.

Regarding chlamydial infection, with a prevalence of 44.9%, almost half of the tests performed have shown *Chlamydia trachomatis* infection presence.

However we have noticed that no sign of *Chlamydia trachomatis* infection was identified in Saint-louis, Matam, Tambacounda and Kolda regions. In the other regions, prevalence have reached up to 84 % in the group of sex workers.

Syphilis has a frequency of 7% in the study population. Prevalence rates in our target groups were 2.1% among pregnant women and 11.5% among sex workers. We have noted that for five regions (Thies, Diourbel, Fatick, Ziguinchor and Tambacounda) no pregnant woman had anti-treponemal antibodies.

Regarding HSV-2 infection, almost half of the study population has been in contact with the type 2 herpetic virus (49.8%). This rate reached almost 100% in the sex workers group in all the regions.

HIV infection prevalence is 0.8% in the pregnant women group but reaches 19.9% among sex workers. This confirms the concentrated characteristic of HIV infection outbreak in Senegal. Among pregnant women, prevalence varies significantly with the region considered (e.g. 0.6 for Dakar and 4.3 for Ziguinchor). The highest rate for sex workers was registered in Tambacounda (35.5%).

Regarding co-infections, we have noted 94.4% of HIV/HSV-2 association and 57% of HIV/Bacterial vaginosis association. Genital herpes was associated to bacterial vaginosis to a rate of 47.4%. There was no significant association of *Trichomonas vaginalis* vaginitis with HIV nor with HSV-2 infection.

This study has allowed a comparison of Senegalese results with results from African and western literature.

It suggests also some future orientations for management and research regarding sexually transmitted infections:

- Analysis of bacterial vaginosis characteristics, especially the link with the inflammatory reaction and symptoms such as itchiness, vulva irritation and dyspareunia.
- Prospective study on genital herpes; respective contribution of HSV-1 and HSV-2; Characteristics of genital herpes in Senegal.
- Study of co-infections HIV/HSV-2; HIV/Bacterial vaginosis and HSV-2/Bacterial vaginosis.

This study underlines also the importance of decision makers in the perpetuation of sexually transmitted infection surveillance. The microbiological aspect of the combined behavioral and biological national surveillance survey of sexually transmitted infections should be done in a sentinel way.

### 13<sup>th</sup> Regional Dermatology Training Centre International CME Conference

The 13<sup>th</sup> Regional Dermatology Training Centre (RDTC) International CME Conference and Graduates' Reunion was held in Moshi, Tanzania between 16<sup>th</sup>-19<sup>th</sup> January this year.

The four day conference was composed of sequential symposia addressing various dermatological topics, such as the swollen limb, leprosy, genodermatoses and epidemiology of skin diseases, as well as cutaneous manifestations of HIV/AIDS and STIs. The Regional Director delivered a lecture on 'STIs: topical issues for Africa'.

The conference was attended by about 100 African graduates and trainees in dermato-venereology from across the continent. The numbers were less than expected due to the post-election violence in Kenya which resulted in closures of borders and prevented many Ugandan and Kenyan delegates from attending. The Moshi Urban Youth and Culture Group presented a series of poignant sketches about the stigma associated with albinism in African culture.

Several new IUSTI-Africa members were recruited, and both the Michael Waugh prize for best STI presentation, and the Terence Ryan Prize for the best dissertation in Health Sciences Research, went to Dr. Christabel Akiso Mayienga from Kenya.



**Figure 1.**

*The Regional Dermatology Training Centre, Moshi*

**Figure 2.**  
*The Moshi Urban Youth and Culture Group musicians*



**Figure 3.**

*Professor Henning Grossmann presenting the Michael Waugh STI prize to Dr. Christabel Akiso Mayienga*



## News from the World Health Organisation (WHO)

### Revision of the WHO's Syndromic Management Guidelines

The Regional Director participated in the group chosen by the WHO to review and make suggestions for changing of the STI syndromic management guidelines. The international revision task team met over a period of one week in April at the Grand Hotel Suisse in Montreux, Switzerland. The Regional Director presented an overview of gonococcal antimicrobial resistance reports over the past 10 years on the African continent. Some data were unpublished and shared through ministries of health and individual researchers.

Key changes recommended for WHO to consider in revising the existing guidelines were the replacement of ciprofloxacin by cephalosporins as first line agents for the management of presumptive gonococcal infection, the introduction of acyclovir as first line therapy for genital ulceration (in addition to the current benzathine penicillin and erythromycin regimens), the introduction of a risk assessment component in the vaginal discharge algorithm and the creation of a flow chart for proctitis/rectal discharge.

The recommendations of the task team will hopefully result in the creation of updated and improved STI syndromic management guidelines soon.

## Update on World IUSTI Congress 2009

An exciting opportunity to move the World IUSTI 2009 Congress from the Cape Winelands to the world-famous Waterfront in Cape Town has presented itself. The Congress will now take place at the Board of Executives Conference Facility under the shadow of Table Mountain. Delegates will be able to take full advantages of many of the recreational opportunities provided by South Africa's Mother City.

The Congress now has its own website and you will be able to read more about the conference at [www.iusti.co.za](http://www.iusti.co.za)



**Figure 1**  
Cape Town Waterfront

# Forthcoming Events



## Conferences in Africa:

15th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) 2008:  
Dakar, Senegal: 3 - 7 December 2008: [www.icasadakar2008.org](http://www.icasadakar2008.org)

International AIDS Society Conference  
Cape Town, South Africa, 19 - 22 July 2009: [www.ias2009.org](http://www.ias2009.org)

11th IUSTI World Congress - Africa 2009:  
Cape Town, South Africa: 9 - 11 November 2009: [www.iusti.co.za](http://www.iusti.co.za)

## International conferences:

6th meeting, European Society for Chlamydia Research  
Aarhus, Denmark: 1 - 4 July 2008: [www.chlamydia.au.dk/english](http://www.chlamydia.au.dk/english)

XVII International AIDS Conference:  
Mexico City, Mexico: 3 - 8 August 2008: [www.aids2008.org](http://www.aids2008.org)

17th EADV Congress:  
Paris, France: 17 - 21 September 2008: [www.eadv.org](http://www.eadv.org)

25th International Papillomavirus Conference:  
Malmo, Sweden: 8 - 14 May 2009: [www.hpv2009.org](http://www.hpv2009.org)

International Society for Sexually Transmitted Diseases Research:  
London, United Kingdom: 28 June - 1 July 2009: [www.isstdr.org/index.php?id=62](http://www.isstdr.org/index.php?id=62)

## IUSTI conferences:

24th IUSTI-Europe Conference:  
Milan, Italy: 4 - 6 September 2008: [www.oic.it/iusti-europe2008](http://www.oic.it/iusti-europe2008)

### IUSTI-Europe 2010

Tbilisi, Georgia (in planning) - Contact: *Josephe Kobakhidze*

### ISSTD / IUSTI North America 2011

Joint Meeting, (in planning) - Contact: *Charlotte Gaydos*

### IUSTI-Europe 2011

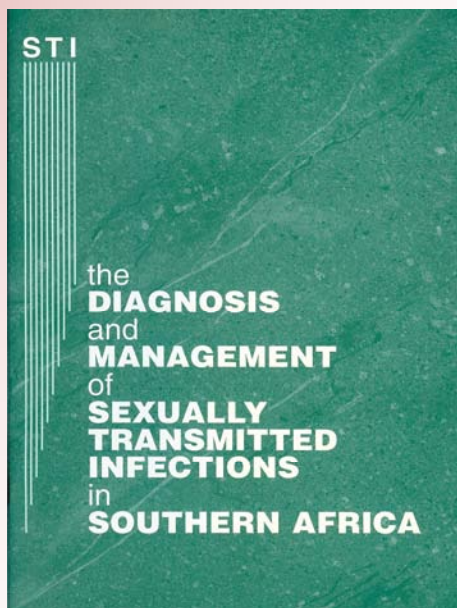
Riga, Latvia (in planning) - Contact: *Andris Rubins*

### 12th IUSTI World Congress

New Delhi, India: 2-5 November 2011 - Contact: *Somesh Gupta*

# The Diagnosis and Management of Sexually Transmitted Infections in Southern Africa.

**Authors:**  
**Ron Ballard**  
**Ye Htun**  
**Glenda Fehler**  
**Graham Nielsen**



**72 pages**  
**Paperback**

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## INTRODUCTION

- a rapid reference for health workers who may encounter diagnostic problems in this particular disease area;
- to emphasize the role which laboratory investigations can play in the establishment of a definitive diagnosis in cases of STI;
- to provide a rational basis for the treatment of these diseases in southern Africa.

## FEATURES

- 79 colour plates and 10 treatment flowcharts
- Suitable for the health worker, medical student, medical officer and/or post graduate student
- Use as a teaching/training guide

## CONTENTS

- Disease specific management of STIs- *Gonorrhoea, Syphilis, Genital herpes, Chancroid, Genital warts, Pubic lice*, etc.
- Syndromic management of sexually transmitted infections - *Mixed infections, Syndromic management flowcharts, STIs in gay men*, etc.

## For orders, please contact:

Aulette Goliath

STI Reference Centre, South Africa

Tel: + 27 11 555 0468 Fax: +27 11 555 0470

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*Online membership registration on the website [www.iusti.org](http://www.iusti.org) is temporarily inaccessible due to on-going initiatives to improve the IUSTI website for members.*

There are three types of membership for IUSTI- AFRICA:

- a) **Full Membership of IUSTI-AFRICA** is open to individuals who have a professional interest in the study, prevention and control of sexually transmitted infections. A medical qualification is not a requirement for full membership. Full membership of IUSTI requires a nominal fee of **40 EUROs every 2 years**. Full members of the union will be entitled to the privileges of membership, which include a reduction in registration fees at most IUSTI regional and world meetings. The membership fee has been set so that it will be attractive to anyone who participates regularly in IUSTI events. We anticipate that any member who attends at least one meeting every two years would re-coup their membership dues.

Full members will also receive a substantial discount of 40% on a subscription to the Union's official journal, the International Journal of STD and AIDS. Subscribers also benefit from free access to the online version of the journal and archive dating back to 1996. To find out more about the journal visit <http://www.rsmppress.co.uk/std.htm>. To subscribe at the special IUSTI rate visit <http://www.rsmppress.co.uk/specialoffers/iusti.htm> or call the journals subscriptions department on +44 (0) 207 2902927/8.

Moreover, the database of full members will be available in an edited form to the World Health Organization (WHO) and on the web for individuals seeking to recruit experts to assist as advisers etc. in specialist STI work.

**There are two payment options for full membership:**

1. An electronic bank deposit – [for your currency conversion to South African Rand \(ZAR\)](#) ,  
please email: [iusti-africa@nicd.ac.za](mailto:iusti-africa@nicd.ac.za)

Payment can be done electronically or as a bank transfer into the following account;

**IUSTI Africa, Standard Bank Ltd, Jan Smuts Avenue, Rosebank, South Africa**

**account number: 006988407 sort code: 004205 swiftcode: SBZAJJ.**

Should you choose this option, please fax us a copy of deposit slip with your completed IUSTI-Africa application form.

2. Credit card payment (details to be completed on application form and faxed to us at Fax no: + 27 11 555 0470)

- b) **Associate membership of IUSTI-AFRICA** is open to individuals who would like to maintain a corresponding link with the IUSTI-Africa network. Associate membership is **FREE** and not linked to the payment of any membership dues. Associate members may participate in meetings of the Union without voting rights. As an Associate member of IUSTI-Africa, you will continue to receive the **IUSTI-Africa Newsletter**.
- c) **Organisational Membership of IUSTI-AFRICA** is also open to organizations, such as national organisations for the study of sexually transmitted diseases. The membership fee for organisations is **200 EUROs every two years**.

## Suggestions, Comments, Feedback ...

We welcome your suggestions and feedback on the newsletter. Please direct your comments to the:

Administrative Secretary at [iusti-africa@nicd.ac.za](mailto:iusti-africa@nicd.ac.za)

## NEWS IN BRIEF FROM THE OTHER IUSTI REGIONS

More detailed information is available in the IUSTI Global Update, available at [www.iusti.org](http://www.iusti.org)

### Asia-Pacific

The Asia-Pacific branch is spread over many countries within a huge region, but has been very active in the last 20 years. It has traditionally had a large and floating membership. The committee presently has members from its traditional core constituencies, but the Regional Director and Chairperson are particularly excited to see the two most populous nations, China and India, represented by Office bearers, together for the first time.

### Europe

The 24th IUSTI-Europe Congress is going to take place in the University of Milan in Italy between 4th-6th September 2008. Please visit the website for full information ([www.oic.it/iusti-europe2008](http://www.oic.it/iusti-europe2008)).

Work continues on European STI Guidelines. The following guidelines are currently in the process of revision: Syphilis, HIV testing, Gonorrhoea, Chlamydia, Urethritis, Tropical Genital Ulcerative Diseases and Genital herpes. The full published guidelines, and updates on work in progress, can be accessed at the IUSTI website ([www.iusti.org](http://www.iusti.org) then "IUSTI Regions", then "Europe", then "Guidelines").

### Latin America

The Latin American and Caribbean Association for the Control of Sexually Transmitted Infections (ALAC-ITS) is a scientific International association founded in 2003 with the purpose of gathering professionals from different areas with expertise from Latin America and the Caribbean (LAC) with the common interest of collaborating in activities related to services, training and applied research on the control of STIs.

In March 2008, representatives of the National STI programs from 19 countries, PAHO, WHO and members of ALAC-ITS met in Lima, Peru for the *"The Latin American ALAC-ITS Meeting: Latino American and Caribbean National STI Programmes' Workshop, Opportunities and Programmatic and Research Challenges in STIs in the Region"*. The objective of the meeting was to discuss the results of the survey and to propose a joint work plan 2008-2009 to address those issues. The final report of the meeting is available in ALAC-ITS web page: [www.alacits.org](http://www.alacits.org)

### North America

The BASHH/ASTDA meeting held in Brooklyn New York May 7-10, 2008 entitled "Converging Approaches in STI control and Reproductive Health" was very successful. With approximately 500 attendees from both the US and the UK, as well as many other countries, topics were provided in an integrated fashion bringing issues together for both HIV and STIs.

