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SEXUALLY TRANSMITTED INFECTIONS
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News from the Regional Director

This October issue of the IUSTI-Africa newsletter has a number of reports from STI/HIV conferences and training sessions held in the African Region over the past 12 months. It is heartening to see such high quality and well attended events taking place in so many African countries, as exemplified by those highlighted in this issue from Botswana, Senegal, Tanzania and Zimbabwe. South Africa was also the venue for the 2009 International AIDS Society meeting. This November will see the first IUSTI meeting in Africa for 10 years. Preparations for the 11th IUSTI World Congress are well underway and the meeting promises to be global in both scientific content and delegate attendance.



As well as educational activities, this year has seen several important research publications emanating from research in Africa. Among these was the press release in May outlining the main outcomes of the Partners in Prevention HSV/HIV Transmission study (described in further detail below) and the publication of the results of a randomised trial of acyclovir versus placebo as an addition to conventional bacterial treatment for genital ulceration in South Africa (Gabriela Paz Bailey *et al.*, Journal of Infectious Diseases). This latter study showed clinical benefit in terms of enhanced ulcer healing as well as evidence of decreased HIV shedding from genital ulcers among those patients receiving acyclovir. In this issue, Professor Bertran Auvert summarises the findings to date from the roll out of male circumcision in Orange Farm, South Africa. The Orange Farm research site has become a role model for scaling up male circumcision in several African countries as a means to reduce the risk of HIV acquisition.

Several African countries have already revised, or are considering revision of, their national syndromic management treatment guidelines for presumptive gonorrhoea in the light of documented rapidly rising prevalence of quinolone resistant *Neisseria gonorrhoeae* (QRNG) infections. Previous issues of this newsletter have focused on significant rises in isolation of QRNG in South Africa and, in this current issue, a surveillance report from Kenya reports a similar picture. The global issue of multi-resistant gonococcal infections was discussed at length at a technical consultation organised by the Southern African Development Community (SADC) in Zambia this September, where new regional treatment guidelines were drafted in the context of a framework for STI management and prevention.

The continuing success of the IUSTI-AFRICA newsletter does depend on the enthusiasm of, and contribution from, our members. If you perform research in Africa or would like to write an article about STI/HIV issues in an African country, then please send your contribution to Mrs. Aulette Goliath at iusti-africa@nicd.ac.za. If you are not yet an IUSTI member, do consider becoming a part of the growing IUSTI-Africa community. The African Region has been the most successful IUSTI region in the past 2-3 years in terms of membership growth and is now firmly established as a functional and dynamic IUSTI region in its own right. If you are already a member, do encourage any colleagues working in the field of STI/HIV to join up. Full details on how to become a member of IUSTI-Africa are at the back of this newsletter.

I look forward to meeting some of you at next month's World IUSTI Congress in Cape Town, South Africa.

David Lewis

Time to Change Antibiotic Treatment of Gonococcal Infections

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In sub-Saharan Africa, the prevalence of gonorrhea among adults is estimated at 2-3%, with incidence rates estimated at 58 cases per 1000 males and 65 per 1000 females [1]. Among those who are accurately diagnosed with infection, appropriate antibiotic treatment is curative.

Subsequent to chromosomally-mediated penicillin and tetracycline resistance emergence to *N. gonorrhoeae* (NG) in the early 1990s, fluoroquinolones became the recommended therapy for gonococcal treatment in the United States. In the 1980s, rising rates of fluoroquinolone resistance were detected in Pacific and Asian countries, and quickly spread to the United States. By 2007, over 5% of U.S. isolates were fluoroquinolone resistant, and since 2007, the Centers for Disease Control and Prevention (CDC) no longer recommends fluoroquinolones for gonorrhea treatment in the U.S. [2]. The CDC currently recommends 125mg IM ceftriaxone or 400mg oral cefixime for uncomplicated gonorrhea treatment [2]. The wholesale price of these antibiotics is 2-5 times that of ciprofloxacin. The cost implications of alternative treatment regimens for gonorrhea are substantial considering the burden of disease, and rising rates of antibiotic resistance. The rising cost of newer antimicrobials may represent a heavy financial burden in resource restricted settings.



Left to Right:

Lawrence Agunda, Edith Nyagaya, Prof. J.O. Ndinya-Achola and Ruth Murugu in the lab in Kisumu, Kenya

The prevalence and type of antibiotic resistance for gonorrhea varies geographically. For example, resistance to CDC-recommended doses of ciprofloxacin and ofloxacin (both fluoroquinolones) exceeds 40% in some Asian countries [3], but is less than 5% in Australia and New Zealand [1]. It is suspected that fluoroquinolone resistance in Africa is low, but there is limited systematic data collection and analysis [1]. This information is vital for appropriate treatment and for interrupting transmission. In Kenya, national guidelines for the management of urethral discharge syndrome include treatment with a stat dose of ciprofloxacin or norfloxacin, plus a 7-day course of doxycycline.

Objective and Methods

We measured the prevalence of quinolone resistance among men attending an STI clinic in Kisumu, Kenya over a 4-month period. For isolation of *N. gonorrhoeae*, urethral swabs were inoculated directly onto chocolate agar. The inoculated culture plates were incubated at 35°C in a moist atmosphere containing 5% CO₂ for 24 to 48 hours. Antibiotic susceptibilities were determined for cefixime, ceftriaxone, ciprofloxacin, norfloxacin, and azithromycin using antibiotic disc diffusion which is an appropriate methodology for the laboratory in Kisumu. Antimicrobial disks with

10µg of norfloxacin were used for that antibiotic. Inhibitory zones were measured, and susceptible and resistant values interpreted according to criteria recommended by package inserts. A subset of 19 isolates selected to represent both norfloxacin susceptible and resistant isolates were also tested by agar dilution (which requires a higher level of expertise than available in Kisumu) at the National Microbiology Laboratory in Winnipeg, Canada. This was done to independently evaluate the existence of resistance using rigorous methodology, rather than to validate the disc diffusion methodology.

Results

From March 18 – July 27, 2009, there were 412 male client visits, and 103 (25%) had urethral swabs obtained and cultured for NG. Urethral swabs were obtained from men who had a current complaint of urethral discharge or urethral discharge on examination. Among the 103 men tested for NG, 90 (87%) were positive. The prevalence of norfloxacin susceptibilities were analyzed among these 90 men using disc diffusion.

	Antimicrobial Susceptibility Results	
	Sensitive, n (%)	Resistant, n (%)
Norfloxacin	76 (84.4)	14 (15.6)

Overall, the prevalence of norfloxacin resistance was 15.6% [95% confidence interval 8.8-24.7%]. The agar dilution testing of the 19 isolates showed 8 sensitive isolates with a Minimum Inhibitory Concentration (MIC) of 0.004 µg/ml, and 11 resistant isolates with MICs of 2.0-4.0 µg/ml. All isolates were sensitive to cefixime, ceftriaxone, and azithromycin, by both disc diffusion and agar dilution testing.

Discussion

We found a high prevalence of quinolone resistance among men with culture-positive *Neisseria gonorrhoeae* attending our STI clinic in Kisumu, Kenya, between March and July 2009. Overall, 15% of all isolates were resistant. These results confirm the existence of quinolone resistance in western Kenya, and suggest that prevalence may be greater than an acceptable level (5%, as per CDC [1]) for continued treatment with ciprofloxacin or norfloxacin.

It is likely that NG resistance levels would be similar in other settings in Kenya, but these results should be confirmed through expanded surveillance in other Kenyan districts. If confirmed, then it would be advisable to change treatment guidelines for *N. gonorrhoeae*, and for the management of urethral discharge.

Citations

- 1 Tapsall J. Antimicrobial resistance in *Neisseria gonorrhoeae*. World Health Organization 2001. From http://www.who.int/drugresistance/Antimicrobial_resistance_in_Neisseria_gonorrhoeae.pdf. Accessed on December 15, 2008.
- 2 Centers for Disease Control and Prevention. Update to CDC's *Sexually Transmitted Diseases Treatment Guidelines, 2006*: Fluoroquinolones No Longer Recommended for Treatment of Gonococcal Infections. *MMWR* 2007;56(14):332-336.
- 3 World Health Organization (WHO) Western Pacific Region Gonococcal Antimicrobial Susceptibility Programme (GASP) Report- 2000. *Commun Dis Intell* 2001; 25:274-277.

We would like to acknowledge the contributions of the following individuals who are in the lab in Kisumu, Kenya: Edith Nyagaya, Ruth Murugu and Lawrence Agunda.

SADC Sexually Transmitted Infections Framework

Professor David Lewis, IUSTI-Africa Regional Director

In 2006, the Southern African Development Community (SADC) secretariat developed a draft framework, guidelines, norms and standards for prevention and management of STIs to assist in co-ordinating the regional response. The initial document was created with input from a consultant and the experience of four countries involved in the cross-border initiatives funded through the SADC/DFID STI/HIV and AIDS Project (Botswana, Lesotho, Namibia and Swaziland). The finalisation and approval of the Framework coincided with the end of the SADC/DFID Programme, which meant that funds were not available for packaging and dissemination of the final product.

New funding, available through the African Development Support for Communicable Diseases, has been recently made available for finalisation and dissemination of the Framework. In view of recent developments in HIV prevention (male circumcision), the increasing realisation of the importance of men-who-have-sex-with-men (MSM) in terms of the HIV epidemic through heterosexual bridging, and the increasing prevalence of multi-drug resistance gonorrhoea and the loss of quinolones, such as ciprofloxacin, as effective agents to treat gonococcal infections, it was felt necessary to review and revise the existing draft Framework.

Accordingly, an ad hoc technical meeting to review the draft SADC Regional STI Framework took place in Livingstone between 22-25 September 2009. The meeting was attended by country representatives from Botswana, Lesotho, Malawi, Namibia, Seychelles, Tanzania, Zambia and Zimbabwe, as well as a consultant (Dr. Swati Sadaphal, USA), technical advisors from the National Institute for Communicable Diseases of the National Health Laboratory Service (IUSTI-Africa Regional Director, South Africa) and Population Services International (Dr. Voahirana Rajoela, Masagascar), the STI lead for WHO-Afro (Dr. Benoit Soro) and members of the SADC secretariat. The technical team will meet again in December to review the revised Framework to be produced by the consultant, and it is anticipated that the finalized Regional STI Framework will be disseminated in the first half of 2010.



The technical team and SADC secretariat staff

The Bophelo Pele male circumcision project in Orange Farm

Professor Bertran Auvert, ANRS (France)

Orange Farm is a semi urban area of 25 km² in the south of Johannesburg (South Africa). Orange Farm has a population of about 150,000 inhabitants. The Bophelo Pele project, funded by the Agence Nationale de Recherches sur le SIDA (ANRS, France), aims to offer free and safe male circumcision to all adult men of this community. This project started after an initial community mobilisation in 2007.

General information on male circumcision is delivered to male and female residents of Orange Farm using local radio announcements, pamphlet distribution to every household and community meetings. Men willing to undergo circumcision, as well as women, are welcome in outreach centres located throughout the community where they receive risk reduction counselling, detailed information on male circumcision, and are offered HIV screening using rapid tests and an immediate CD4 count if they test positive for HIV infection.



Men are circumcised at least three days after counselling within the Bophelo Pele male circumcision centre located in the township. Treatment of symptomatic sexually transmitted infections is provided when necessary. Male circumcisions are performed in a room equipped with seven beds separated by curtains. Cost has been reduced to ZAR 300 per circumcision by using the forceps guided circumcision method with a surgical disposal kit, monopolar electrocautery and by optimizing the use of personnel. A surgical team is composed of one surgeon to apply the forceps, cut the foreskins, control the bleeding and supervise staff, as well as five nurses to administrate local anaesthesia, assist during surgery and complete the suturing. With this team composition, six to ten male circumcisions can be performed per hour, with an average surgeon time of seven and a half minutes per male circumcision and a total procedure time of 20 minutes. After surgery, participants receive oral and written post-operative instructions.

Follow-up visits are conducted in a private room at the surgical centre, on days 2 and day 7 after surgery. Participants missing a follow-up visit receive phone reminders. Patient bookings for male circumcision range from 30 to 100 per day.

After more than 7000 male circumcisions, no death



The Bophelo Pele male circumcision centre in Orange Farm

nor permanent injury due to adverse events were observed. However, eight (0.14%) participants were hospitalised for adverse events. The total complication rate, including minor complications such as pain, bleeding, local infection and swelling, is 2.7%. External quality control using the WHO Quality Assessment Toolkit is organised regularly.

The Bophelo Pele project is tailored to be a safe and cost efficient model for rolling out surgery on a large scale as a public health intervention in a semi-urban setting where a high volume of surgeries is required. This project demonstrates that the roll-out of adult MC can be done safely and inexpensively according to international recommendations.



The surgical ward at the Bophelo Pele Male Circumcision

Partners in Prevention HSV/HIV Transmission Trial

Professor David Lewis, IUSTI-Africa Regional Director

The results of the Partners in Prevention HSV/HIV Transmission trial were released in a University of Washington Press release on 8 May, 2009. This important trial, led by a team of researchers from the University of Washington in Seattle, and funded by the Bill and Melinda Gates Foundation, was conducted at 14 clinical trial sites in seven African countries, namely Botswana, Kenya, Rwanda, South Africa, Tanzania, Uganda and Zambia. An estimated 50,000 couples were screened in order to recruit the 3,408 HIV discordant couples to the study. This study, which began recruitment in November 2004 and ended follow-up in October 2008, is particularly relevant for Africa, where the majority of new HIV infections occur among heterosexual HIV discordant couples.

Most people infected with HIV through sexual exposure also have HSV2 infection, the latter typically occurring before HIV infection. HSV2 remains in the body, as a latent infection in the dorsal root ganglia, and HSV 2 infectious particles are shed intermittently in many infected individuals, often without clinical blistering or ulceration. Numerous studies have highlighted the strong association between HSV2 genital infection and HIV infection, so-called 'epidemiological synergy'. Previous studies have shown the effectiveness of suppressive acyclovir in decreasing both HSV2 and HIV genital tract shedding. These previous studies, however, did not measure whether this reduction in genital tract HIV shedding will translate into decreased HIV transmission, hence the need for the Partners in Prevention HSV/HIV Transmission trial. The objective of this randomised placebo-controlled trial (RCT) was to determine if suppressive acyclovir given to HIV-HSV 2 co-infected patients would decrease transmission of HIV to HIV-uninfected sexual partners in comparison to placebo.

A total of 3,408 enrolled HIV and HSV-2 co-infected participants with HIV seronegative regular sexual partners received daily treatment with either acyclovir (400 mg twice daily) or placebo. Acyclovir suppressive therapy reduced the frequency of genital ulcers by 73% and the mean HIV plasma viral load by 40% compared to the placebo arm. However, these effects were not sufficient to reduce the risk of HIV transmission. In the primary analysis of HIV transmissions determined by laboratory testing to have occurred within the couple, and not acquired from an outside partner, there was not a significant difference in the number of transmissions in the acyclovir arm compared to those participants receiving placebo.

The study did, however, show a significant benefit in terms of acyclovir slowing HIV disease progression by 17% compared to placebo. In this analysis, disease progression was measured by reduction in CD4 count to less than 200, starting of antiretroviral (ARV) therapy or death. The use of suppressive acyclovir may therefore prove to be a useful strategy to prolong the time HIV-infected individuals can remain off ARVs.

The results of this trial, which failed to show any benefit from suppressive acyclovir therapy in terms of HIV transmission to an HIV seronegative partner, follow other recently published clinical trials in Africa and other parts of the world, which failed to show a protective benefit for HIV acquisition in HSV 2 seropositive and HIV seronegative women and men-who-have-sex-with-men (MSM). Further analysis of the data of these RCTs is required to try and understand the results in the light of the strong epidemiological evidence for a cofactor role of HSV2 in HIV transmission.



Couple counselling site for the Partners in Prevention HSV/HIV Transmission trial



Laboratory technologist processing blood specimens in the trial

The information in this article was made available in the University of Washington Press Release, 8 May 2009. For further media information, contact Clare Hagerty clareh@u.washington.edu or Mary Guiden mguiden@u.washington.edu at the University of Washington, USA.

The 2nd Botswana International HIV Conference

Dr. Victoria Nakimbugwe

From 17-20 September 2008, the Botswana HIV Clinicians Society hosted the 2nd Botswana International HIV Conference, themed **“Bold New Steps”**, at the Gaborone International Convention Centre at the Grand Palm Hotel. The conference boasted a rich programme that tackled a broad range of topics of great applicability to all serving in the field of HIV. The conference was officially opened Botswana’s Vice President Lt. Gen. Mompoti Merafhe who re-affirmed the Botswana government’s commitment to the battle against HIV/AIDS. His Excellency Festus Mogae, the former president of Botswana, accepted an Honorary Life Membership of the Southern African HIV Clinicians Society (parent body of the Botswana HIV Clinicians Society) in recognition of his sterling efforts at combating HIV during his term of office. The Conference featured a host of renowned local and international experts in the field who shared the very latest, pertinent information to conference delegates from several African countries, including Botswana, Lesotho, Mozambique, Namibia, South Africa, Zambia and Zimbabwe.

Summary of the Conference’s Symposium on HIV Prevention Strategies

Dr. Max Essex, of the Botswana–Harvard partnership, discussed the role of antiretroviral (ARV) therapy in prevention of HIV transmission and concluded that given the disproportionately high prevalence of HIV-1C in southern Africa and the disappointing results, to date, with various biomedical preventive measures, including vaccines and microbicides, it would be logical to harness ARV agents for prevention of high viral load transmission (PHVT) at the community level in this setting.

Dr. Thomas Rehle, of the Human Sciences Research Council in South Africa addressed the advances in HIV surveillance with a focus on ways to measure the impact of HIV prevention programmes and concluded that because incidence measures are generally more reliable than prevalence estimates for assessing current HIV-transmission dynamics and the impact of HIV prevention programs, then laboratory-based HIV incidence estimation from representative cross-sectional surveys is the method of choice for national HIV incidence surveillance and that assay-based HIV incidence analysis needs to account for ART-related misclassification.

Dr. Daniel Halperin, Harvard University School of Public Health, spoke on new directions in HIV prevention citing the evidence from numerous randomized trials and observational studies done in Africa. He emphasised that more data are needed for strategies/interventions that may have population-level prevention impact, including condom social marketing targeting youth/the general population, VCT and its impact on behaviour change among both those testing positive and negative, abstinence-based programs for youth, the introduction of safe & affordable male circumcision services and enhanced monitoring and evaluation activities in order that we can adequately measure the impact of major new initiatives. He dismissed the utility, in terms of prevention at population-level, of condom promotion for regular partnerships, especially among married couples, and syndromic management (presumptive antibiotic treatment) of vaginal discharge.

Dr. John Krieger, University of Washington, presented compelling evidence that safe male circumcision has a role in curbing the HIV epidemic with a systematic review of existing research on the subject and concluded that it is an approach that is applicable today and called for thoughtful technical implementation of the intervention especially given that its impact goes beyond HIV alone, that it is not too highly technical, and that the skill is transferable with good training. Dr. Ali Salim Ali briefly highlighted Botswana’s progress with the plan to adopt safe male circumcision as an additional strategy for HIV prevention and to have rolled out a nationwide campaign by 2012.

Professor Leickness Simbayi, Human Sciences Research Council in South Africa, explored positive prevention in which people living with HIV and AIDS would be targeted for HIV prevention with reference to the experience they have had at the social aspects of HIV/AIDS and health research programme. He concluded that theory-based behavioural interventions can reduce transmission risks in HIV-infected adults, that both healthy relationships and options for health have proved useful and highly adaptive, that the growing population of people living and thriving with HIV infection demands expanding positive prevention services, that positive prevention should be part of a comprehensive HIV prevention strategy.

Professor David Lewis, from the National Institute for Communicable Diseases in South Africa and IUSTI-Africa’s Regional Director, discussed better management of STIs, specifically addressing strategic approaches and current challenges to HIV prevention. He detailed the intimate relationship between HIV and various STIs especially HSV-2, gonorrhoea, chancroid and several other bacterial STIs.

On behalf of Rev. Jim MacDonald, Dr. Samba Nyirenda the co-founder of Safe Haven Counselling Services, Francistown,



2nd Botswana International HIV Conference

prevention, bringing to the forefront the existing loop holes in Botswana's system (regarding HIV and discrimination among others) and relaying some of the organization's recent activities.

Ms. Alla Tshetsanyana Moyo, with UNFPA, discussed the cause/effect link between gender based violence (GBV) – a bona fide public health concern - and HIV outlining as she did the subpopulations at high risk as well as practical interventions that could be put in place to address GBV. She updated the audience on the progress Botswana had made on this front to date through a multi-sectoral response and this included; improved efforts in primary, secondary and tertiary prevention, passing of legislation with the Domestic Violence Act, development of a GBV health sector policy framework and availing psycho-social support and protection to victims/survivors.

Dr. Mark Wainberg, McGill University AIDS Centre in Canada, discussed the disappointing results that microbicide research had generated to date and then touched on future prospects. He floated the possibility of using topical ARVs, specifically RT Inhibitors (e.g. Tenofovir gel, TMC-120) and Integrase Inhibitors, for prevention and left the audience with the thought that while these might be effective, there might be repercussions as far as resistance should transmission occur.

Mr. Richard Matlhare, of Botswana's National AIDS Coordinating Agency (NACA), singled out the practice of entertaining multiple and concurrent sexual relationships by both men and women with low consistency in condom use and in the context of low levels of male circumcision, as a key driver of the epidemic in Botswana. He delineated several factors that facilitated the practice and pointed out that NACA was committed to prioritising it as part of the minimum prevention package which includes HIV testing and counselling, prevention of mother to child transmission, prevention of blood borne infections, management of STIs and prevention of sexual transmission of HIV.

Ms. Yasmin Halima, a consultant with the AIDS Vaccine Advocacy Coalition (AVAC) tackled the controversial subject of pre-exposure prophylaxis (PrEP) discussing the challenges that have been met in the research, policy and implementation of this potential prevention tool. She highlighted the advances in PrEP research, gave an update on clinical trials and pointed out the caveats of current research, recounted the challenge of translating results from trials and discussed the profile policy, advocacy and investment in PrEP. Finally, she made a case for PrEP based on the facts that only 31% of those who need therapy receive it worldwide and approximately six new individuals became infected with HIV for each person started on HAART in 2006.

This is an abbreviated version of the web-based conference report prepared by Dr. Victoria Nakimbugwe, ex-secretary of the Southern African HIV Clinician Society. Dr. Nakimbugwe's full official conference report is available at <http://www.botshiv.org.bw/conference.php>

15th International Conference on AIDS and STI in Africa (ICASA)

Professor David Lewis, IUSTI-Africa Regional Director

The 15th International Conference on AIDS and STI in Africa (ICASA) was held in Senegal, in the capital city of Dakar, from 3 – 7 December 2008, under the Presidency of Professor Souleymane Mboup. This proved to be one of the largest conferences to ever be held in Africa, with approximately 10,000 delegates. The theme for the 15th ICASA was 'Africa's Response: Face the Facts'. His Excellency, President Abdoulaye Wade, presided over the opening ceremony, at which Angelique Kidjo and Youssou Ndour sang the official ICASA 2008 song. President Wade remarked that the response to HIV must rest on the three pillars of prevention, treatment and research. He highlighted the previous efforts in Senegal to fight HIV/AIDS from 1986, including prevention campaigns and provision of free antiretroviral (ARV) drugs as early as 1998, making Senegal one of the first African countries to offer ARVs. Professor Mboup stated that the conference would be characterised in particular by the integration of three programmes: leadership, community and scientific – this goal was met. There were 250 sessions, in the form of plenary sessions, parallel sessions, skills



Senegalese dancers outside the conference venue on the opening day



The main auditorium at the 15th ICASA

some African countries, this has resulted in fewer people becoming newly infected with HIV and fewer people dying. There were several key meetings and events in the last 25 years related to the history of HIV/AIDS on the continent, such as the Abuja Declaration on HIV in 2001, the creation of the Drug Access Initiative, and the launch of Africa's first national AIDS treatment programme in Botswana. High quality scientific research undertaken in Africa has made a major contribution to

building workshops, non abstract-driven sessions and special sessions. The conference venue contained a village where political, religious and traditional leaders, scientists and community members could gather to exchange knowledge. In order to prepare for such a large conference, a 72-strong international steering committee was established and met on several occasions in the two years before the conference took place. IUSTI-Africa was represented on this steering committee through the Regional Director.

Dr. Peter Piot, former UNAIDS Executive Director, reviewed the history of AIDS in Africa, highlighting the fact that emerging political leadership and civil society activism have recently helped to remove the silence and denial that surrounded the epidemic in the 1980s and early 1990s. In

the global AIDS effort. Examples of such research findings are the discoveries of HIV-2 and simian immunodeficiency virus, the genetic heterogeneity of HIV, mechanisms and prevention of heterosexual and perinatal transmission, the use of co-trimoxazole to treat and prevent opportunistic infections in immunosuppressed individuals, and the now proven benefits of male circumcision in reducing HIV transmission. There still remain several key challenges, as outlined by Dr. Piot, which include sustaining political commitment and funding, expanding coverage of access to antiretroviral treatment, intensifying HIV prevention, increasing technical and community capacity, and connecting the AIDS response with other public health and development efforts.

Several of the First Ladies of Africa met at the 15th ICASA to give support to HIV prevention and treatment efforts, including Madame Lobbo Traore Toure (Mali), Madame Jeannette Kagame (Rwanda) and Her Royal Highness, Princess Lalla Salma (Morocco). The First Ladies shared their experiences of the HIV response through regional organizations such as the Organization of African First Ladies Against AIDS (OAFLA) and Synergies Africaines, as well as in their own countries through national organizations. In 2007 the OAFLA launched the “Save the Unborn Child First Ladies Campaign” in the 50 OAFLA member countries. This campaign focuses on the prevention of HIV transmission from mother to child. The prevention of new infections among young people, and protection of children affected by HIV from stigma were the aims of the “Treat every child as your own” campaign launched by OAFLA in 2005. Professor Souleymane Mboup presented Princess Lalla Salma, spouse of King Mohammed VI of Morocco, with the prize of the 15th ICASA 2008 in recognition of her commitment to the fight against AIDS.

An area of emerging research concerned men-who-have-sex-with-men (MSM). Several MSM studies, including research from South Africa, Malawi, and Nigeria were presented. These presentations highlighted the enhanced risk of MSM individuals to STI/HIV infection, as evidenced by high HIV prevalence compared to ‘background populations’, and the role of bisexual men in heterosexual bridging to the MSM community through concurrent partnerships with individuals of both sexes. Homosexuality remains punishable by imprisonment in many African countries, and by death in a few. Criminalisation of MSM sexual orientation results in individuals taking higher risks in their sexual encounters and results in poor local intelligence on HIV epidemics. The lives of African MSM are characterized by denial, violence, and stigmatization. HIV programmes in many countries remain heavily heterosexual and female focused and more recognition of MSM as a risk group is needed.



Recruiting new members at the IUSTI-Africa stall

IUSTI–Africa was also represented at the 15th ICASA for the first time with a stall, which was staffed by Mrs. Aulette Goliath, the organisation’s administration secretary, with assistance from two STI Reference Centre staff (Sr. Martha Sello and Mr. Frans Radebe) and the IUSTI Regional Director. Over 100 new members for IUSTI-Africa were recruited. Our congratulations go to Professor Mboup and his team for making this conference such a success.

Acknowledgement: This article was made possible with information available from the 15th ICASA website.

18th meeting of the International Society for STD Research (ISSTDR)

Professor David Lewis, IUSTI-Africa Regional Director

The 18th meeting of the International Society for STD Research (ISSTDR) was held in London from 28 June – 1 July 2009, under the Presidency of Professor Catherine Ison (London, UK). The meeting was held in association with the British Association for Sexual Health and HIV. The meeting took place within the Queen Elizabeth II Conference Centre, a few hundred metres from the Houses of Parliament. The ISSTDR meetings have been held regularly over the last 30 years, mostly every two years, and have become the most important forum for presentation and discussion of recent findings in this field. The most successful aspect of these meetings has been their ability to attract healthcare scientists from a range of disciplines including clinicians, epidemiologists, microbiologists, and social scientists and to promote networking. ISSTDR has always encouraged young scientists in the field and was a particular focus for this meeting. In these regards, the London meeting was very successful, attracting approximately 1,400 delegates from around the world.



The House of Parliament, London

STI/HIV tests, congenital syphilis, 'safe in the city' (a waiting room intervention video for STI patients, the SHAZ project which focuses on economic livelihoods and STI/HIV prevention for orphan girls in Zimbabwe, HPV vaccination, chlamydial control, the PREVEN urban community randomised trial in Peru and, finally, a symposium on HIV care.

Within the main scientific programme, there were several oral presentations from Africa countries, including Bénin, Kenya,

The theme for London meeting was 'Scanning the Horizon' and the programme had five tracks, namely biology and detection (basic science and diagnostics), treatment and care, transmission dynamics, population interventions and a fifth cross-cutting track, covering topical issues. There were satellite symposia on *Haemophilus ducreyi* (chancroid) pathogenesis, the role of emergent properties and structural patterns in the epidemiology and prevention of disease, new diagnostic



Precious Magooa (South Africa) spoke about molecular detection of quinolone resistant gonococci

Malawi, South Africa, Tanzania and Zimbabwe. Several oral presentations were made by African delegates, including Ms. Precious Magooa, from Johannesburg, who presented a molecular analysis of quinolone resistant gonococci isolated in South Africa and Dr. Mapanje, from Lilongwe, who presented important data on the continued susceptibility of *Neisseria gonorrhoeae* strains to gentamicin, despite 14 years continued use as first-line therapy in the public health care sector of



Dr. C. Mapanje (Malawi) spoke about continued effectiveness of gentamicin to treat gonorrhoea

Malawi for presumptive treatment of gonorrhoea. The rising prevalence of multi-drug resistant gonorrhoea was a major theme at the meeting, and the IUSTI-Africa Regional Director gave a plenary on this topic on the last day.

Update on the forthcoming 11th IUSTI World Congress

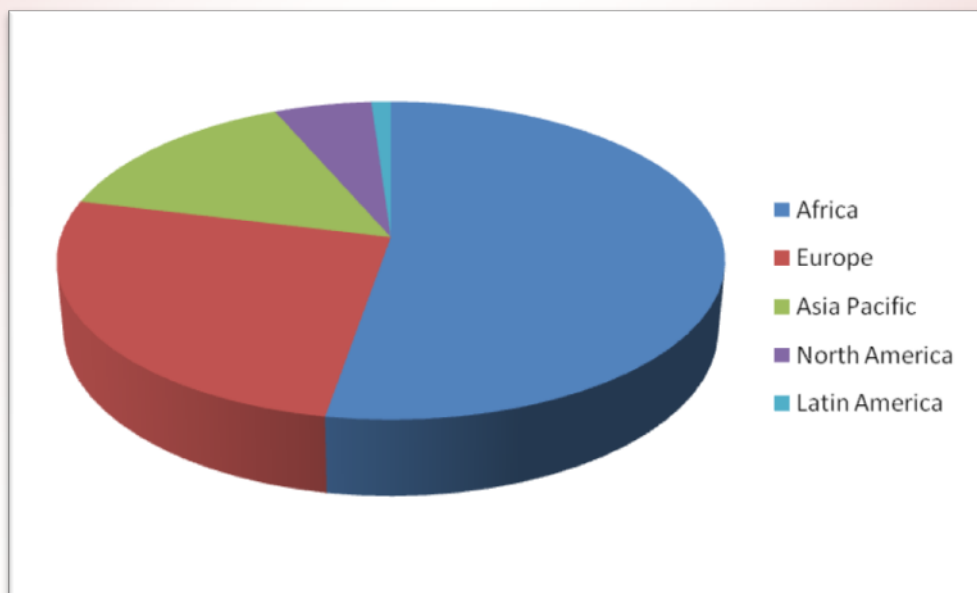


David Lewis, IUSTI-Africa Regional Director

The 11th IUSTI World Congress will take place in Cape Town, South Africa from 9th to 12th November 2009. This is the first IUSTI meeting in Africa for 10 years and will focus on both traditional STIs and HIV from clinical, public health, behavioural and laboratory aspects. The conference has proved very popular and registrations are now closed. It is expected that approximately 330 delegates will attend the meeting, which will be held on the Waterfront in Cape Town at the Nedbank (former Board of Executives) building.

On the opening day, the IUSTI North America branch will offer a free half day update course on STI/HIV with four internationally respected US scientists presenting on a variety of topics. The course has been put together and organised by Dr. Charlotte Gaydos, the Regional Director for North America. Three satellite symposia follow on from this, organised and supported by Abbott Molecular, Siemens Healthcare Diagnostics and the Public Health Agency of Canada. The three symposia will cover challenges and new approaches in managing STIs, innovations for infectious diseases management and sexual health promotion. The opening ceremony takes will take place in the late afternoon, at which Dr. Francis Ndowa (WHO) will discuss the global burden of STIs followed

by the opening lecture, given by Professor David Mabey from the London School of Hygiene and Tropical Medicine. Professor Mabey will discuss what we have learnt from STI/HIV research in Africa.



Above: Distribution of free oral and poster presentations by IUSTI Region (N = 184)

During the remaining 3 days of the Congress, there will be 7 plenary lectures, 44 symposium talks in 13 themed symposia, 48 oral presentations and 139 posters. Among the 184 free oral and poster presentations, just over 50% have been submitted by Africans as illustrated in the pie chart. There are substantial contributions expected from both the European and Asia Pacific Regions too. The strong presence of delegates from African and Asia Pacific Regions was made possible through the generosity of a number of organisations and persons to the scholarship fund, namely

Conferences: *South Africa*

the National Institutes of Health (USA), PEPFAR (GAP South Africa), WHO, the Wellcome Trust (UK), GenProbe (USA), Diagnostics for the Real World (USA/UK) and the Society for the Study of Sexually Transmitted Diseases in Ireland.

The plenary sessions will cover rapid diagnostic tests for STIs, prevention of mother to child transmission of HIV, biological drivers of the HIV epidemic, sexual networks and the internet, male circumcision, HIV vaccines and how to use information technology (IT) in novel ways to improve STI/HIV clinical practice. The symposia will cover men-who-have-sex-with-men, STI bacterial typing, STI/HIV public health interventions, HIV treatment approaches, condoms, STI/HIV behavioural interventions in Africa, roll out of rapid tests for syphilis screening of pregnant women, updates in STIs and IT, challenges to effective STI syndromic management, HPV vaccination and HPV clinical disease, commercial sex work, STI treatment as a component of HIV prevention, and finally IUSTI global challenges. The conference will conclude with a closing lecture by Professor King Holmes from the University of Washington (Seattle, USA) on emerging multi-component STI/HIV prevention strategies. Professor Holmes will take over as IUSTI World President from Professor Angelika Stary at the end of the meeting.



Above: The Conference Venue at the Cape Town Waterfront with Table Mountain in the background

14th Regional Dermatology Training Centre Annual Continuing Medical Education Conference and Graduate's Reunion

Professor David Lewis, IUSTI-Africa Regional Director

The 14th Regional Dermatology Training Centre (RDTC) Annual Continuing Medical Education Conference and Graduate's Reunion was held in Moshi, Tanzania from 14 – 17 January 2009. This annual training event remained as popular as ever, with well over 100 delegates from several African countries. The conference was opened and chaired by Professor John Masenga of the RDTC. The teaching faculty consisted of dermatology specialists from several European countries and Africa, whilst the IUSTI-Africa Regional Director assisted with delivery of the HIV/STI teaching component. The sessions covered dermatosurgery and skin cancer, leprosy, fungal infections and leishmaniasis, STI/HIV infections, lymphoedema and varicose veins, ulceration and wound healing, pharmacology and therapeutics, immunology including allergic reactions, career experiences in dermatology, as well as postgraduate and student presentations.



John Masenga opening the conference



Dr. Pierre Yassa, (right), IUSTI-Zambia country lead, with two new IUSTI-Africa recruits



Delegates at the conference



The IUSTI-Africa Regional Director presenting Dr. Godfrey Muriu with the Michael Waugh prize



Youth performing their play on slavery

The Michael Waugh prize for the best Health Sciences dissertation in the field of STI/HIV was awarded to Dr. Godfrey Muriu from Kenya, whose dissertation focused on HIV counselling and testing. Several new IUSTI-Africa members were recruited during the meeting. As with the previous year's conference, faculty were invited to a performance on slavery in history and modern times by the Moshi Urban Youth and Culture Group.

Update Course on Sexually Transmitted Infections

Professor David Lewis, IUSTI-Africa Regional Director

A two day course was held in Harare, Zimbabwe, for doctors and nurses from 28-29 September 2009. The training was made possible by the efforts of the Zimbabwe Community Health Intervention Research Project (Zichire), which co-ordinated the running of the course. The course was supported by the University of Zimbabwe's Department of Community Medicine, the Department of Obstetrics and Gynaecology of the University of San Francisco School of Medicine, Battelle Centers for Public Health Research and Evaluation and the University of Washington's Department of Global Health. The course was opened by Dr. Gerald Gwinji, Permanent Secretary of Health in Zimbabwe. Invited speakers came from the USA, South Africa and Zimbabwe and included Dr. Mike Chirenje (Zimbabwe), Dr. Owen Mugurungi (Zimbabwe), Dr. Hunter Handsfield (Seattle, USA), Dr. Kees Rietmeijer (Denver, USA), Dr. Kasprzyk (Zichire and Seattle, USA), Dr. Montaña (Zichire and Seattle, USA), Dr. Karin Hatzold (PSI, Zimbabwe) and Professor David Lewis (IUSTI-Africa, Johannesburg, South Africa).

The course was very well attended with 107 individuals, mainly doctors and nurses, and this was a credit to the hard work and excellent organisation of the Zichire team. The topics covered included the following:

- ◆ The current status of HIV/AIDS prevention in Zimbabwe
- ◆ STI/HIV epidemiology in sub-Saharan Africa and Zimbabwe
- ◆ Aetiology of STI syndromes in Zimbabwe
- ◆ Genital ulceration
- ◆ Urethral discharge and complication in men
- ◆ Vaginal discharge, cervicitis and complications in women
- ◆ Genital dermatology
- ◆ Primary HIV and common HIV/AIDS clinical presentations
- ◆ Human papillomavirus infections and cervical cancer
- ◆ Male circumcision
- ◆ Barriers and microbicides
- ◆ STI/HIV interactions and STI management for HIV prevention
- ◆ Antiretroviral therapy, post-exposure and pre-exposure prophylaxis
- ◆ HIV/AIDS prevention in Zimbabwe: role of Community Popular Opinion Leaders

Over 60 delegates registered as IUSTI-Africa associate members during the two days of the course.



Delegates on the training course



Zichire staff enjoying the post-course tea party

Online membership registration on the website at www.iusti.org

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

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