



**IUSTI**  
INTERNATIONAL UNION AGAINST  
SEXUALLY TRANSMITTED INFECTIONS  
AFRICA

# IUSTI -AFRICA

## NEWSLETTER

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Issue # 1

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## Message from the Regional Director

Since I took over as Regional Director for IUSTI-AFRICA at the start of 2006, it has been my goal to develop an interactive newsletter about STIs for the African Continent. I am delighted to bring this newsletter to you and I hope that we will be able to continue doing this through your contributions.



**Professor David Lewis**

Special thanks for this issue go to Dr. Luc Béhanzin, IUSTI-Africa's country lead in Benin, and to Dr. Ayodele Ajayi and his colleague in Ibadan, Nigeria for their contributions. I also wish to express my gratitude to Mrs. Aulette Goliath, IUSTI-Africa's hard-working administrative secretary who has made production and distribution of this newsletter possible. Ms. Veerle Msimang has greatly assisted us by making this a bilingual newsletter through her French translation. Finally, at this launch of the first IUSTI-AFRICA newsletter, I would like to express my thanks to the National Health Laboratory Service, and the National Institute for Communicable Diseases within which I work, for their support in allowing us to base the IUSTI-AFRICA Regional Centre at the STI Reference Centre and for their vision concerning the importance of establishing and extending existing networks of excellence across Africa within the discipline of communicable diseases, including sexually transmitted infections.

I would particularly like to draw your attention to the surveillance report. I would like to see this as a regular feature but we can only do this if we get reports from other countries within Africa. Both clinical and microbiological surveillance reports are welcome and I encourage you to consider making a contribution to the newsletter. In this first newsletter, we raise the issue of rising ciprofloxacin resistance among gonococci isolated in South Africa. How much of a problem is it in other parts of Africa?

Finally, please look out for the soon-to-be published Global Strategy for the Prevention and Control of STIs (World Health Organization). This advocacy document, if used correctly and supported by Member states, has the potential to really make an impact on the severity of STIs and their complications in Africa. We focus very much on HIV/AIDS these days but we must not forget the large numbers of babies that die every year because of congenital syphilis on our continent. Data is simply missing on some other key complications, such as blindness due to gonococcal ophthalmia neonatorum and the extent of STI induced infertility.

We should work together to champion the right of all Africans to receive high quality STI care in our countries. If you are not already a signed up member of IUSTI, please do join us in the fight against STIs. The African Region is part of a larger International Union. We can be strong in union and weak in isolation. I encourage you to become either a full member (Euros 40 every two years) or an associate member (free of charge) of our Society, though membership of the IUSTI-AFRICA branch.

**Being a member will ensure that you stay on our mailing list and receive further newsletters. If you no longer wish to receive our newsletter, please email us on [iusti-africa@nicd.ac.za](mailto:iusti-africa@nicd.ac.za), so that we can remove you from our database.**

## Focus on African Countries: *Benin*



Contribution by : Dr Luc Béhanzin

Dr Luc Béhanzin,  
Coordinator of the sub-Project Care of High-Risk Groups In Francophone West Africa (CHIFWA), a component of the regional Project AWARE-HIV/AIDS funded by USAID/WA and coordinated by FHI-Cotonou, Benin.  
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In Benin, STIs constitute a public health concern as for all Sub-Saharan African countries. The *Programme national de lutte contre le SIDA et les IST* (PNLS-IST) [National Program to fight against AIDS and STIs] is the government body responsible for STI control in the country. After being neglected for a long time by national programs, it is only recently that STIs have begun to be really taken into consideration through the establishment of the Project «Appui à la lutte contre le SIDA en Afrique de l'Ouest», a CIDA-funded Project. The first STI algorithms were developed and adopted by the ministry of health in 1994 with support from this Project during its phase I, reviewed in 2000 during phase II and in 2006 in phase III (commonly referred to as Project SIDA 3). This phase III is in its last year of implementation. The Project SIDA-Benin was phased out in September 2006. The main strategy of this Project was to target and focus STI interventions on the commercial sex workers (CSWs) and their clients for an effective control of the STIs among these groups. With the assistance of this Project, Benin experienced a significant decrease in the prevalence of curable STIs as well as a significant fall in HIV prevalence among the sex workers in Cotonou, the country's economic capital which is the main intervention area of the Project. It should be noted that this Project, in fact, covers nine West African countries including Benin.

Since December 2006, Benin has new STI algorithms with the integration of the so-called new anti-STI agents such as fluconazole, azithromycin, acyclovir and others.

Under the aegis of the Project SIDA 3-Benin in its withdrawal phase, a special service for STIs was established by order of the Ministry of Health in June 19, 2006. This service, called the *Service de prise en charge des Infections Sexuellement Transmissibles (IST) et des Groupes à Haut Risque* [Service for the treatment and care of Sexually Transmitted Infections (STIs) and High-Risk Groups], is integrated into Benin's national STI programme (PNLS-IST). The tasks of this special STI service are to a) ensure the control of STIs among the general population including the high-risk groups, b) ensure the regular medical follow up of the CSWs, c) develop community-based STI/HIV/AIDS prevention activities among high-risk groups, d) ensure the supervision, and monitoring of STI treatment and care activities and interventions among high-risk groups, e) contribute to the epidemiological surveillance of STI/HIV/AIDS and

f) conduct operational studies. This ministerial order which strongly recommends the control of STIs among the CSWs is based on the presidential decree of April 4, 2006 which obliges the Government to take all necessary measures to make compulsory the medical monitoring of people with a high HIV transmission potential, namely CSWs, men who have sex with men, intravenous drug users and to encourage counseling and testing of HIV.

With the new STI algorithms, 100 care providers have already been trained during this first quarter 2007 and another training session is planned for 100 additional care providers in the second quarter.

The strategy of an Adapted Service (AS) for STI control among the CSWs is the strategy currently promoted in Benin, with financial support from MAPII Fund and the Global Fund. It is foreseen to establish six adapted services per demographic department in Benin for an effective coverage of this population. As this strategy owes its success to outreach activities among CSWs, it is envisioned through the MAPII Fund to enhance the recruitment of communities-based bodies intervening in this area for the successful referral of the CSWs to these adapted services. The treatment and care of the CSWs will be free of charge in each AS point according to national policy.

Benin will continue, with the assistance of the World Health Organization, to further integrate syndromic approach for STI management into the curricula of medical and paramedical schools, which started with support from the Project SIDA.

### Major challenges for Benin

- Preserving the achievements of the Project SIDA 3- Benin with their strengthening and extension
- Provision of condoms to the global population given that PSI intends to withdraw from the social marketing of condoms in Benin
- Supply of Azithromycin, Acyclovir, Podophyllin and/or Podophyllotoxin, particularly for the high-risk populations (e.g. CSWs)
- Lack of studies on the antimicrobial resistance of STI pathogens
- Improved reporting of STI cases
- Development of new algorithms in a poster format
- Real integration of the treatment and care of STIs in the minimum care package in all health centers
- Strengthening of the institutional and technical capacity of the *Service de prise en charge des IST et des groupes à haut risque* within PNLS-IST
- Opening of the PNLS-IST's STI Service to the scientific world.

# Focus on African Countries: Nigeria

Contribution by:

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University College Hospital, Ibadan, Nigeria.

## INTRODUCTION

Sexually transmitted infections (STIs) are of major public health importance in developing countries including Nigeria, the most populous nation in Africa and home to 140 million people belonging to more than 350 ethnic and linguistic groups.

The epidemiology of STIs in Nigeria is related to several factors including demographics and social conditions which affect the availability of sexual health education, diagnostic facilities and appropriate treatment. STIs have been shown to be prevalent in the 20 to 29 age group, although sexual activity typically begins between the ages of 9 and 19.<sup>1</sup>

**Dr A.A Ajayi** and colleagues work in the teaching hospital at the University College Hospital in Ibadan, Nigeria.

**Front view of:**  
The University College Hospital



Despite extensive research in the fields of sexual health and STIs, the full extent of the STI disease burden in Nigeria is not known as most people do not access formal healthcare sectors for STI treatment. Hence STIs tend to be under reported in developing countries, Nigeria inclusive.

## a) URETHRITIS, CERVICITS and VAGINITIS

### (i) Gonorrhea

The true prevalence of gonorrhea is difficult to establish in Nigeria, due to syndromic management of cases. Abuse of antibiotics is particularly rampant in the Nigerian setting, making recovery of *Neisseria gonorrhoeae* from surveillance cultures an uphill task, and creating the need for alternative means of diagnosis. A recent survey among commercial sex workers (CSW) in Ibadan reported a 16.6% prevalence of gonorrhoea among this group of women.<sup>2</sup>

Penicillin has long ceased to be the mainstay of treatment in Nigeria due to the high prevalence of penicillinase-producing *Neisseria gonorrhoeae* and ciprofloxacin is currently the first-line drug for treatment. A more recent study (unpublished) in Ibadan, however, found the prevalence of ciprofloxacin resistant *N. gonorrhoeae* to be 18.6%.

### (ii) Chlamydial and *Mycoplasma genitalium* infection

Diagnosis of *Chlamydia trachomatis* infection poses a great challenge due to failure of *Chlamydiae* to grow on cell-free media and thus requiring expertise and equipment for tissue culture that are not readily available in laboratories in Nigeria. Enzyme immunoassay and fluorescence antibody tests are expensive and hence not generally available except in research laboratories.

### (iii) *Mycoplasma genitalium* infection

*Mycoplasma genitalium* is responsible for approximately 10% of non-gonococcal urethritis in West Africa, with symptoms indistinguishable from those of *C. trachomatis* and *Trichomonas vaginalis*. In some studies, *M. genitalium* has been implicated as a cause of urethritis in men, accounting for 14% of all cases of non-gonococcal urethritis among men attending an STI clinic in Ibadan.<sup>3</sup> Routine diagnosis of this condition remains difficult as no commercial diagnostic tests are available.

### (iv) Trichomoniasis

In a study of West African men with urethral discharge, *T. vaginalis* was found to be the cause of non-gonococcal, non-chlamydial urethritis in 15% of cases<sup>4</sup>. Trichomoniasis was also a more frequent co-infection than Chlamydial infection among a subset of people with gonorrhoea. More recently, *T. vaginalis* was diagnosed in 45% of male partners of infected women in Ibadan.<sup>5</sup>

### (v) Bacterial Vaginosis

Studies have shown that between 20% and 51% of women in sub-Saharan Africa are affected by bacterial vaginosis<sup>6</sup>. In a recent study in Ibadan, it was found to be the second most common genital tract infection among female sex workers after candidiasis.<sup>2</sup> It is easily diagnosed using a combination of clinical and simple laboratory criteria and the first line regimen for treatment is metronidazole. Probiotics have been used to good effect in developed countries<sup>7</sup>, but are still at experimental stage in an ongoing clinical trial in Ibadan.

## b) GENITAL ULCERATION

### (i) Syphilis

Little recent data exist on the prevalence of *Treponema pallidum* as an aetiological cause of genital ulceration in Nigeria. Both the rapid plasma reagin (RPR) and the venereal disease research laboratory (VDRL) tests are regularly used for diagnosis in Nigeria and treponemal-specific confirmatory tests are lacking in many laboratories.

Sentinel surveys for syphilis and HIV have been conducted biennially in Nigeria since 1991. The sentinel population is women aged 15-49 years, attending antenatal clinics in public institutions in all states of the federation for the first visit during a

# Focus on African Countries: Nigeria

confirmed pregnancy. The unlinked anonymous method is adopted for the exercise, using routine screening for syphilis as the entry point. The sampling period for the survey is 10 weeks. The 2005 sentinel survey among pregnant women in Nigeria suggested that syphilis has increased relative to 2003 in most Zones, with a national prevalence of 1.5% (Figure 1).<sup>8</sup> The prevalence was highest in the South South Zone (2.3%) and lowest in the North Central Zone (0.5%) of the country.

Zone	No. of samples	No. positive	Prevalence (%)	95% Confidence
South South	5748	133	2.3	1.9 - 2.7
South West	6617	147	2.2	1.9 - 2.6
North East	5681	57	1.0	0.9 - 1.7
South East	5098	39	0.8	0.6 - 1.1
North West	6875	51	0.7	0.6 - 1.0
North Central	6901	34	0.5	0.3 - 0.7
Total	36920	461	1.5	1.1 - 1.8

**Figure 1: Prevalence of syphilis in Nigeria by zone, 2005**

**Source:** Federal Ministry of Health, National Syphilis Seroprevalence Sentinel Survey, 2005.

## ii) Chancroid

Existing studies in Nigeria indicate that chancroid may be common with prevalence ranging from 5.6% to 86% among sex workers<sup>9,10</sup>. Similar to other genital ulcerative diseases, it has been found to be significantly associated with increased risk of HIV infection. Diagnosis is usually clinical as culture is difficult.

## (iii) Lymphogranuloma venereum (LGV)

A sero-epidemiological study using a complement fixation test (CFT) and involving 5009 individuals resident in two large cities (Ibadan and Benin) in the Western Region of Nigeria, detected a sero-reactivity rate that ranged from 5.3% to 11.5% in Ibadan and 7.3% to 18.3% in Benin.<sup>11</sup> A more recent study in Ilorin found the sero-prevalence of LGV to be 12.5%.<sup>12</sup> Diagnosis is usually clinical as tests that detect chlamydial antigens or nucleic acid are expensive and therefore not generally available except in research laboratories.

## (iv) Granuloma Inguinale (Donovanosis)

This STI is uncommon in Nigeria and the rest of West Africa.

## (v) Genital herpes

In a study of the association of genital ulcerative disease (GUD) with HIV prevalence in Lagos State, a baseline seroprevalence rate of 59% for HSV-2 was detected among female sex-workers.<sup>10</sup> Chancroid and HSV-2 antibodies were also more common in HIV-infected sex workers. A

study among GUD patients in Ibadan<sup>13</sup> detected a prevalence of 4.6% for HSV by tissue culture (HSV-2 accounted for 3.3% and HSV-1 for 1.3% of cases, respectively).

Laboratory diagnosis of herpes simplex virus is largely beyond the means of most peripheral medical units in the tropics. In practice, therefore, the diagnosis has often to be made by exclusion and on clinical grounds. Treatment is with acyclovir.

## c) HIV/AIDS

HIV belongs to the lentivirus subfamily of retroviruses and is divided into HIV-1 and HIV-2. In a recent study of sex workers in Ibadan, HIV-1 was responsible for infection in 25.6% of cases, with dual infections to HIV-1/2 occurring in 2.8% of cases.<sup>14</sup> Subtypes G, C and circulating recombinant forms (CRF) were found to be the most prevalent clades among this high risk group.

The 2005 HIV sero-surveillance surveys in Nigeria showed that the national median HIV prevalence was 4.4%. The state HIV prevalence ranged from 1.6% in Ekiti State to 10% in Benue State<sup>15</sup>. Although HIV prevalence was generally higher in urban sites than in rural sites, the difference was not statistically significant.

## CONCLUSION

To stem the tide of STIs in Nigeria, it is crucial to involve all necessary stakeholders and reach out to the high risk groups who constitute the main reservoir of infection. This 'war' against the STI epidemic can only advance to the extent that we can incorporate community based strategies, through advocacy, in our interventions. There is a need for regular aetiological and antimicrobial resistance sentinel surveillance among STI clinic attendees to monitor the on-going effectiveness of current syndromic management algorithms.

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## IUSTI World News

IUSTI's World President, Prof. Dr. Angelika Stary (Austria), firmly believes that the strength behind IUSTI lies in its five Regions and is committed to seeing the growth of local membership and regional activity during her term of office. To improve communication between the regions, Professor Jonathan Ross (UK) has recently established STI Global Update, the official IUSTI world newsletter, which aims to provide an international perspective on the management and control of STIs. It is available to all IUSTI full and associate members free of charge.

Key news points from the February 2007 edition of STI Global Update include:

- IUSTI continues to organize successful regional meetings and looks forward to having the IUSTI 2009 world meeting in Africa (see flier in this IUSTI- Africa newsletter)
- The IUSTI 2007 world meeting is taking place in Seattle in July 2007 in collaboration with the International Society for STD Research (ISSTD)
- The Asia-Pacific Branch of IUSTI has a new Regional Director, Professor Roy Chan (Singapore) - all at IUSTI-AFRICA wish him well with his new position and acknowledge the hard effort put into strengthening this Region by his predecessor, Dr. Verapol Chandeying (Thailand)
- IUSTI has a new website at [www.iusti.org](http://www.iusti.org) - please let the webmaster, Professor Michael Ward know by email ([mew1@soton.ac.uk](mailto:mew1@soton.ac.uk)) about new services you would like to see on the web site, particularly related to issues facing Africa

## Rising prevalence of ciprofloxacin resistant gonorrhoea in South Africa

Contribution:

Professor David Lewis,

Sexually Transmitted Infections Reference Centre,

National Institute for Communicable Diseases, South Africa

### INTRODUCTION

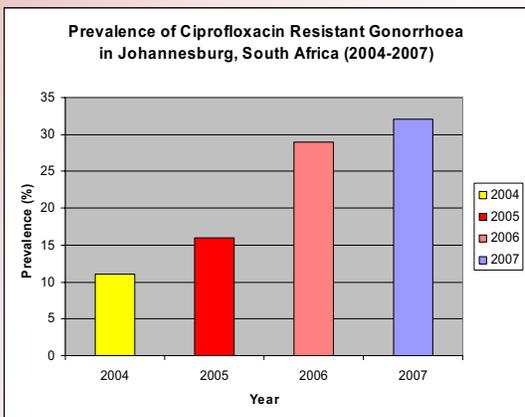
Quinolones, for example ciprofloxacin and ofloxacin, were recommended for the primary treatment of gonorrhoea from the late 1980s onwards, due to increasing gonococcal resistance to penicillin, spectinomycin and tetracyclines. Decreased susceptibility and resistance to quinolones have been increasing in prevalence worldwide, with the result that many countries have been forced to abandon this group of antimicrobial agents for the treatment of gonorrhoea. Within Africa, there are very limited microbiological surveillance data and, for many African countries, the extent of the problem is simply not known.

Quinolone resistant gonococci (QRNG) are those determined by laboratory testing to have a ciprofloxacin minimum inhibitory concentration (MIC) of greater or equal to 1 mg/L. The World Health Organisation (WHO) recommends a change in first-line therapy for gonorrhoea if less than 95% of patients can be reliably cured with the first-line antimicrobial agent.

Ciprofloxacin remains the first-line agent used to treat presumptive gonococcal infections in patients with sexually transmitted infection (STI) syndromes attending primary health care clinics in South Africa. These syndromes include the male urethritis syndrome (MUS) and scrotal swelling syndrome (SSW) in men as well as women with vaginal discharge syndrome (VDS) and lower abdominal pain (LAP) syndrome.

### SURVEILLANCE OF CIPROFLOXACIN RESISTANT GONORRHOEA AMONG MALES WITH URETHRAL DISCHARGE IN SOUTH AFRICA

A high level of ciprofloxacin resistant gonorrhoea in South Africa (22%) was first reported among isolates tested in Durban in 2003 by Moodley *et al.* (Int. J. Antimicrobial Agents 2004;24:192-193). More recent data on ciprofloxacin resistance in gonococci isolated in several provinces within South Africa were reported at the 1<sup>st</sup> Joint Congress of The Federation of Infectious Diseases Societies in Southern Africa in July 2005 by Koornhof *et al.*. A national survey undertaken in 2004 as part of South Africa's newly-established National STI Surveillance Programme, and co-ordinated by the STI Reference Centre at the National Institute for Communicable Diseases (NICD) in Johannesburg, demonstrated marked variation in ciprofloxacin resistance among several of South Africa's cities: 24% in Durban, 11% in Johannesburg, 10% in Umtata, 8% in Pietermaritzburg, 7% in Cape Town and 0% in Pretoria. Ciprofloxacin resistance data for 2005 were also presented in abstract form from Durban and Johannesburg at the 2005 FIDSSA Congress, both cities observing marked increases in resistance levels (Durban 42% resistance, Johannesburg 16% resistance).



**Figure 1:** Escalating resistance to ciprofloxacin in Johannesburg, South Africa

The NICD's STI Reference Centre has been testing gonococcal strains obtained by urethral culture from men with MUS over the period 2004-2006 in Esselen Street clinic in central Johannesburg. Over this three year period, the prevalence of QRNG rose from 11% to 29% (Figure 1). The STI Reference Centre has just completed a gonococcal resistance survey at Alexandra Health Centre, situated in the north-east of Johannesburg. At the end of the three month's survey, 47/148 (32%) of gonococcal isolates tested were resistant to ciprofloxacin (MIC  $\geq$  1 mg/L) by laboratory testing (Figure 2). There is also evidence of similar rises in other South Africa cities. In Cape Town, for example, the prevalence of ciprofloxacin resistance rose from 7% (17/232 isolates) in 2004 to 17% (18/103 isolates) in late 2006 and 28% (39/141 isolates) in early 2007.

### CONCLUDING REMARKS

Surveillance data presented above show that ciprofloxacin can no longer be relied upon to treat gonorrhoea in South Africa, at least. There is now an urgent need in South Africa to change first line therapy for presumptive gonococcal infection in the national syndromic management protocols in use at primary health care facilities, i.e. away from ciprofloxacin to another agent. Gonococci are still susceptible to cephalosporins and no confirmed resistant strains have been reported in South Africa to date. Patients with QRNG can be reliably treated with Ceftriaxone 250mg as a single intramuscular dose.

Spectinomycin still has activity against gonococci although this should be reserved for special situations, e.g. severe penicillin allergy, and is generally not available in South Africa. When it has been used in the past, resistance has occurred relatively quickly, limiting its usefulness in the longer term. It is possible that gonococcal infections will need combination therapy

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treatment in the future once resistance to cephalosporins develops as there are no other options at present for management of multi-resistant gonorrhoea.

## SHARE YOUR SURVEILLANCE DATA WITH COLLEAGUES IN AFRICA

It is IUSTI-Africa's wish to use this newsletter as a vehicle to disseminate and share microbiological aetiological and resistance surveillance data between countries on the African continent. In this newsletter, for example, Ajayi *et al.* report data from a recent (unpublished) survey in Ibadan (Nigeria) - ciprofloxacin resistant gonorrhoea accounted for 19% of gonorrhoea cases. Microbiological surveillance now forms a key pillar of the WHO's Global Strategy for the Prevention and Control of STIs: 2006-2015 which aims to increase quality of STI care worldwide (see article in this newsletter). If you know of microbiological surveillance data in your country and you wish to share it with colleagues in Africa, please send your report to the IUSTI-AFRICA Regional Director at [iusti-africa@nicd.ac.za](mailto:iusti-africa@nicd.ac.za)

## 15th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA)



Above: International Steering Committee Representatives after the June 2007 Press Conference

(left to right): Dr. Saladin Osmanov, Initiative for Vaccine Research/World Health Organisation; Dr. Craig McClure, International AIDS Society; Dr. Femi Soyinka, Society on AIDS in Africa; Professor Souleymane Mboup, Conference Chair/Society on AIDS in Africa; Ms. Bernice Heloo, SWAA International; Professor David Lewis, IUSTI-AFRICA/NICD (NHLS) South Africa; Professor Papa Salif Sow, Chair Scientific Programme Committee/CHU Fann

### AFRICA'S RESPONSE: Face the Facts

#### RÉSPONSE de l'AFRIQUE: Faire face aux réalités

Preparations for the 15<sup>th</sup> ICASA are now underway and the 1<sup>st</sup> International Steering Committee Meeting took place in Senegal on June 8<sup>th</sup> this year. IUSTI-AFRICA is represented on the steering committee by the Regional Director, who has been asked by Professor Papa Salif Sow, the Chair of the 15<sup>th</sup> ICASA Scientific Committee, to assist the committee with the STI component of the scientific programme. The IUSTI-AFRICA Regional Director, empowered by the WHO Global Strategy for the Prevention and Control of STIs, will do his best to ensure that STIs feature prominently in the conference programme alongside HIV/AIDS.

Senegal is the first country to hold a second ICASA conference, having chaired the 6<sup>th</sup> ICASA meeting back in 1991. Professor Souleymane Mboup, who chaired the ICASA conference in 1991, is also the Chairperson for the 2008 ICASA.

Professor Mboup, and his Vice-Chairs Dr. Ibra Ndoeye and Dr. Fathia Mahmoud, are committed to making the 2008 ICASA a success and IUSTI-AFRICA will do all it to support them in their roles. Professor Mboup's conference message states that the 15<sup>th</sup> ICASA will be defined by the principles of transparency, integrity, metamorphosis and excellence.

The conference will be held in Dakar, between 8-11 December 2008. The provisional venue will be the Conference Centre (Complexe OCI) currently under construction for the Islamic Conference Summit (to be held in March 2008). The venue has capacity for 5,000 delegates. The theme of the conference will be '**Africa's Response: Face the facts**'.

If there are any STI-related topics you think should be covered on the scientific programme at the conference, please write to the Regional Director at [iusti-africa@nicd.ac.za](mailto:iusti-africa@nicd.ac.za)

## Male Circumcision Trials in Africa

Contribution: Professor David Lewis, STI Reference Centre, South Africa

Male circumcision has been carried in Africa for thousands of years, as demonstrated by the practice of the Ancient Egyptians to carry out a complete circumcision with the foreskin totally removed (see Figure 1).



**Figure 1:** Statuette of Merire-hashetef as a young man (2,300 BC) showing his complete circumcision

The results of two randomized trials assessing the potential of male circumcision to prevent new cases of HIV infection were published in the *Lancet* in February 2007<sup>1,2</sup>. Both studies were performed in Africa, one in Uganda and the other in Kenya. The randomized trials come after a number of observational studies which indicated that uncircumcised men had a higher prevalence of HIV than circumcised men<sup>3</sup>. Importantly, they support the findings of the first randomized controlled trial of male circumcision in 18-24 year old men in Orange Farm, South Africa published by Bertran Auvert and colleagues in 2005<sup>4</sup>. The South African trial was stopped by its data and safety monitoring board when an interim analysis showed a 60% protective effect of circumcision in an intention-to-treat analysis. A 76% protective effect of circumcision was observed in a per-protocol analysis that adjusted for cross-overs.

The randomized trial in Rakai, Uganda, enrolled 4,996 uncircumcised HIV-negative men (aged 15-49) on the basis of agreement to undergo voluntary counselling and testing for HIV. Men were randomly assigned to receive immediate circumcision (2,474 men) or to have circumcision performed after 2 years (2,522 men). HIV testing was performed again at 6, 12 and 24 months after enrolment and the primary outcome was HIV incidence. Ronald Gray and colleagues based their analyses on a modified Intention-to-treat basis. They found that male circumcision had a 51% estimated efficacy in terms of protecting men against new HIV infection. Sociodemographic, behavioural and STI symptoms did not appear to influence the trend of protection against HIV in the circumcised group. The group reported 84 moderate or severe adverse events (wound dehiscence and infection) in the circumcision group (3.6%) but these all resolved with treatment. The trial was terminated by the NIAID on the basis of efficacy in December 2006.

The randomised trial in Kenya took place in Kisumu among a group of 2,784 men (aged 18-24). As in the previous study, men were randomly assigned immediate circumcision (1,391 men) or delayed circumcision at 2 years (1,393 men). HIV incidence was again the primary outcome in an intention-to-treat analysis and repeat HIV testing took place at 1, 3, 6, 12, 18 and 24 months. As was the case for the trial in Rakai, it was stopped prematurely in December 2006 after a third interim analysis showed efficacy. At 2 years, the HIV incidence was 4.2% (95% CI 3.0-5.4%) in the delayed circumcision group versus 2.1% (95% CI 1.2-3.0%) in the circumcised group. This translated into circumcision reducing the risk of acquiring HIV by 53% (95% CI 22-72%). The authors reported only 21 adverse events and all resolved quickly.

It is thus now clear that circumcision does partially protect men, at least in a randomized controlled trial setting, from acquiring HIV. The data on the protective effects of male circumcision were reviewed by a panel of experts at a WHO/UNAIDS Technical Consultation in March 2007<sup>5</sup>. This consultation recommended, among other things, the need to develop clear communication strategies to ensure that men opting for the procedure understand that male circumcision is only partially protective and that they therefore need to continue to use other effective methods for HIV prevention, such as condoms. Whether male circumcision is a practical or safe intervention to roll-out across continents such as Africa remains a topic of much debate, as many of IUSTI-Africa members will be aware.

### References:

1. Gray RH et al.. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet* 2007;**369**:657-666
2. Bailey RC et al.. Male circumcision for HIV revention in young men in Kisumu, Kenya: a randomised controlled trial. *Lancet* 2007;**369**:643-656
3. Weiss HA et al.. Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS* 2000;**14**:2361-2370
4. Auvert B. et al.. Randomised, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial. *PLoS Med*;**2**:1-11
5. WHO/UNAIDS Technical Consultation. New data on male circumcision and HIV Prevention: Policy and Programme Implications

The WHO's draft '**Global Strategy for the prevention and control of sexually transmitted infections: 2006-2015**' was presented to Member States at the 59<sup>th</sup> World Health Assembly in May 2006.

**The World Health Assembly endorsed the Global Strategy and urged member states to:**

- adopt and draw on the strategy in order to ensure that national efforts to achieve the Millennium Development Goals includes plan and action, appropriate to the local epidemiological situation, for the prevention and control of STIs, including mobilization of political will and financial resources for this purpose
- to include prevention and control of STIs as an integral part of HIV prevention, and of sexual and reproductive health programmes
- to monitor implementation of the national plans in order to ensure that populations at risk of STIs have access to prevention information and supplies, and to timely diagnosis and treatment

**The World Health Assembly also requested the WHO Director General to:**

- prepare an action plan, in collaboration with other organizations in the United Nations system, that sets out priorities, actions, a time frame, and performance indicators, for implementing the Strategy at global and regional levels, and to provide support for country-level implementation and monitoring of national plans for control and prevention of STIs
- to raise awareness , among Member States, of the importance of drawing up, promoting and funding supportive legislation, plans and strategies for prevention and control of STIs
- to provide support to Member States , on request, for adapting and implementing the Strategy in ways that are appropriate to the local epidemiology of STIs, and for evaluating its impact and effectiveness
- to report to the Health Assembly through the Executive Board, in 2009, 2012 and 2015 on the progress of implementing the strategy

IUSTI-AFRICA's Regional Director represented both the IUSTI-AFRICA Region and the IUSTI World President at the recent stakeholder's meeting, held recently at the WHO's Headquarters in Geneva (11-13 June, 2007), to discuss the Action Plan for the implementation of the Global Strategy. Africa was well represented with African country representatives from five Member States, including Dr. Joseph Aimé Bidiga (Burkina Faso), Dr. Anne Cécile Zoung-Kanyi (Cameroun), Dr. Felizbela Gaspar (Mozambique), Dr. Esmael Wabela (Ethiopia) and Dr. Aziza Bennani (Morocco). WHO STI Regional Advisors from Africa also attended - Dr. Benoit Soro (AFRO) and Dr. Hamida Khattabi (EMRO).

**The group examined and discussed in depth the seven main outcomes of the Strategy:**

- strengthening support components (guidelines, training, networks, commodities logistics, laboratory support, surveillance and research)
- provision of good quality STI care
- ensure a reliable supply of effective and safe medicines and commodities
- promotion of healthy behaviour
- review of policies, laws and regulations that affect STI prevention and care
- undertaking of advocacy at the global, regional and national levels
- advocacy for collaborative activities between key programmes



**Above:** Statue showing an African patient with onchocerciasis (river blindness) outside the World Health Organization in Geneva, Switzerland

Updates on the global strategy, particularly those relevant to Africa, will be presented in future IUSTI-AFRICA newsletters. If you would like to give IUSTI your thoughts on the Strategy document when it is published, write to Mrs. Aulette Goliath at [iusti-africa@nicd.ac.za](mailto:iusti-africa@nicd.ac.za)

## Forthcoming Events

### Conferences in Africa:

FIDSSA - 2nd Joint Congress, Cape Town, South Africa: 28 - 31 October 2007: [www.fidssa.co.za](http://www.fidssa.co.za)

Sexuality, Poverty and Accountability in Africa, Abuja, Nigeria: 4 - 7 February 2008: <http://africalsexuality.org>

15th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) 2008,

Dakar, Senegal: 8 - 11 December 2008: [www.saafrica.org/news.php#news\\_0](http://www.saafrica.org/news.php#news_0)

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

### International conferences:

17th ISSTD/10th IUSTI World Congress, Seattle, WA, USA: 29 July - 1 August 2007: [www.isstdr.org/index.php?id=38](http://www.isstdr.org/index.php?id=38)

Australasian Sexual Health Conference 2007, 8-10 October 2007, Jupiter's Casino, Gold Coast, Queensland, Australia.

23rd Conference of IUSTI—Europe, Dubrovnik, Croatia: 11 - 14 October 2007:

Contact: Dr. Mihael Skerlev [mskerlev@kbc-zagreb.hr](mailto:mskerlev@kbc-zagreb.hr)

15th IUSTI-Asia - Pacific Congress, Dubai, UAE: 3 - 6 February 2008: [www.iusti.ae](http://www.iusti.ae)

## IUSTI - AFRICA Membership

[www.iusti.org](http://www.iusti.org)

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.rsmprss.co.uk/std.htm>. To subscribe at the special IUSTI rate visit <http://www.rsmprss.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)

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

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



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## INTRODUCTION

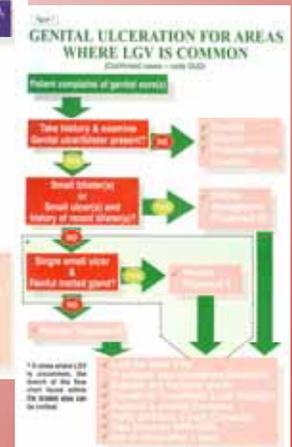
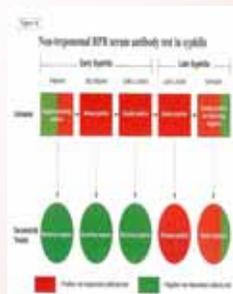
- a rapid reference for health workers who may encounter diagnostic problems in this particular disease area;
- to emphasize the role which laboratory investigations can play in the establishment of a definitive diagnosis in cases of STI;
- to provide a rational basis for the treatment of these diseases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

## FEATURES

- 79 colour plates and 10 treatment flowcharts
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- Use as a teaching/training guide

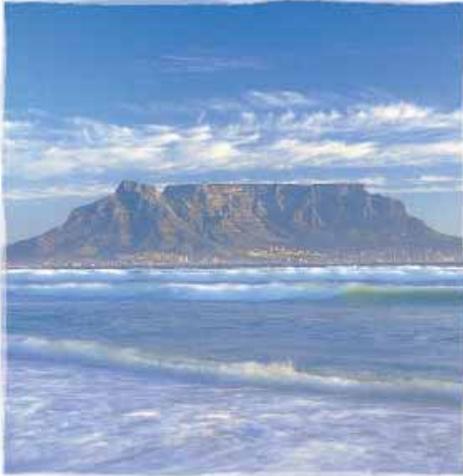
## CONTENTS

- 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:

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