Highlights from this issue

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Welcome to our first issue of 2014. UK readers will have followed with interest the recent publication of the 3rd National Survey of Sexual Attitudes and Lifestyles (Natsal—see natsal.ac.uk), which coincided with World AIDS day 2013. Population surveys however have their limitations—particularly in their ability to describe in useful detail minority sexual practices. These need to be explored through customised surveys using targeted recruitment, or through data collection systems of sufficiently large scale to capture useful numbers of these groups.

Two populations in which Natsal has limited power are men who have sex with men (MSM) and sex workers of both genders. Improving data quality in GUMCAD, the electronic records based surveillance system for genitourinary medicine in England, is enabling improving power and accuracy in the study of vulnerable minority populations. McGrath-Lone and colleagues[1] report on the sexual health of male sex workers in England—0.08% of all men attending clinics were coded as sex workers, and this group experienced high rates of sexually transmitted infections (STI). Data on behavioural risk factors are currently limited, but likely to improve with planned changes in surveillance. The STI and HIV transmission potential of sex work relates to levels of condom use, which varies enormously across the world. While rates of unprotected sex tend to be higher in developing countries, Eccles *et al*[2] report advertisements for unprotected sex by female indoor sex workers in the north of England. This was associated with lower hourly rates and the offer of anal intercourse. These findings have important implications for health promotion to this group.

Sex parties are also hard to study using population-based surveys, so Grov *et al*[3] used banner advertising on a website to recruit MSM for an online survey of sex party participation. MSM attending such parties reported high levels of many of risk characteristics, suggesting the need for the targeting of HIV and STI promotion activities for this group. Clinics and surveillance systems tend to assign infections to the highest risk activity or contact group, and in so doing can overlook the potential contribution of other practices to STI and HIV transmission. Recognising this challenge, Nash *et al*[4] undertook a cross-sectional survey of electronic health records of MSM in Melbourne exploring the contribution of practices other than anal sex to transmission of STI. They conclude that while urethral chlamydia was rarely transmitted through other routes, oral sex and other practices in which condoms are either not used or not useful make an important contribution to transmission of primary syphilis and urethral gonorrhoea. This is particularly important given the high rates of asymptomatic infection reported in this group, as reported by Duareva-Vizule *et al*[5] and under-testing of affected anatomical sites.[6]

What should be provided within a sexual health service? With many shifts in commissioning and the structure of sexual health services, there is a growing need to use audit in assessing the value of services. In this month's educational article, Sonnex[7] explores the use of colposcopy in the assessment of common gynaecological complaints in the genitourinary clinic setting. Burton *et al*[8] report on the use of text reminders to encourage re-attendance —by contrast with other studies, they find little effect in their setting, which already had a high re-attendance rate.

Prevention needs to be epidemiologically driven. Sometimes this can be relatively straightforward, as we see in a reassuring report from the Netherlands suggesting a good degree of hepatitis B control has been achieved amongst MSM by vaccination levels of 50%.[9] However in this month's Programme Science article[10] Mishra *et al* emphasise the importance of distinguishing between the sources of HIV transmission, and the distribution of new diagnoses. They suggest that interventions are likely to be more effective when directed by transmission source than by the distribution of new diagnoses.

Other papers include a report on successful quality assurance for point of care testing in the Brazilian Amazon,[11] suboptimal adherence to antibiotic treatment in urethritis,[12] the distribution of pathogens in paraurethral gland infection,[13] *Gardnerella vaginalis* in lactobacillus predominant vaginal flora,[14] susceptibilities of ureaplasmas and mycoplasmas,[15] preferences for microbicides,[16] antenatal care in Ecuador[17] and HPV detection in adolescent women.

Competing interests None.

Provenance and peer review Commissioned; not peer reviewed.

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