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Highlights from this issue

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Throughout human history, military conflict and the presence of armies have been associated with higher rates of STI. This relates to many drivers of increased transmission – displacement and migration of populations, growth of sex work and sexual violence to name but a few. However times are changing, at least in the standing military populations of developed countries. In this month's issue, Harbertson *et al* report on the sexual behaviour and STI experience of recently deployed shipboard US military personnel.¹ The picture is complex, and is discussed in an accompanying editorial by Joel Gaydos and colleagues² which reflects on the implications for providers and policymakers. Their recommendations focus on the need for all military medical practitioners to be able to take travel and sexual histories. An interesting model of military sexual health care is presented by Desai *et al*,³ who describe the re-organisation of sexual health care for UK military overseas. The service for British forces in Germany was reconfigured into a nurse-led model – the authors describe the new hub and spoke service and compare its performance to the previous model of care.

Chemsex – sex under the influence of psychoactive substances – continues to be a hot topic, as you will see if you follow us on Twitter @sti_bmj. This month we publish in print a study by Bourne⁴ which describes the risk propensity of chemsex episodes compared with other sexual encounters among British men who have sex with men (MSM). This report has had extensive coverage in the press and was discussed in the *BMJ* – you can listen to the authors' podcast on our website at sti.bmj.com. The transmission risks that cluster with chemsex are demonstrated in Gilbert *et al*'s study⁵ which describes the epidemiological and behavioural features of an outbreak of *Shigella flexneri* 3a in England and Wales. A high proportion of those affected were HIV positive, and sex parties organised through social media were a common experience. In this month's BASHH column, Clutterbuck reflects on the role of the BASHH MSM special interest group in responding to the emerging and changing health needs of our MSM community, emphasizing particularly the importance of integrated and contraceptive focussed services to have capacity to respond to the needs of MSM.

African communities, at home or in diaspora, are a strong theme this month. In a qualitative study⁶ De Jesus *et al* describe the differing attitudes and experiences to HIV

testing of African-American and East African women in the US, emphasizing the implications for targeted testing and screening. Adebajo and colleagues explore differing approaches to the offering of HIV testing to MSM and drug using men in Nigeria, and report improved results with peer led counselling and testing.⁷ The role of heterosexual anal sex in sexual risk is often overlooked, so it is good to see Mtenga *et al*'s qualitative study of practices and beliefs about anal sex in rural Tanzania, which raises some important issues for sex education and health promotion.⁸ Finally Heaton *et al* describe the impact of the US PEPFAR (President's Emergency Plan for AIDS Relief) on HIV prevention and treatment in Africa.⁹

Innovative approaches to partner notification and the use of near patient testing are closely intertwined, and bound up with the increasingly wide range of settings where STIs are diagnosed. Estcourt *et al*¹⁰ describe a pilot randomised controlled trial of accelerated partner therapy for people with chlamydia diagnosed in primary care. This was a challenging study, and the authors reflect on the need for service level randomisation if robust evaluations of such interventions are to be achieved. In terms of our readiness to offer quick answers to index patients and partners, Brook's state-of-the-art review of currently available rapid tests for chlamydia will provide a helpful overview for the many clinicians who are seeking to configure efficient and safe patient pathways.¹¹

The HIV cascade is increasingly seen as the key measure of health system response to HIV – this month we report a study from the Netherlands which reports generally good linkage to care, but still some significant delays in newly diagnosed individuals.¹² The serology of STIs is explored in two studies on *Trichomonas vaginalis*¹³ and *Mycoplasma genitalium*.¹⁴

Finally, we have the answer to two big questions: were the Olympic and Paralympic games associated with increased clinic attendances?¹⁵ And is the incidence of STI greater in big cities?¹⁶

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