

Brief Encounters

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GUIDELINES

Raging hormones coupled with breakdown of family and social restraints lie behind the risk taking behaviour of the young. It is good to have guidelines for managing STIs in children and adolescents. They let the clinician off the hook. But guidelines are as good as the evidence available—and often that is not much.

See pp 314 and 324

KIDS ARE SO GROWN UP

Young people don't care if you look uncool, nor are they put off by sharing waiting rooms with grown ups. Have the right attitude, open outside school hours, and allow walk ins and you have yourself an adolescent clinic. Sexual health services for the young is within all our grasps.

See p 342

STIGMA NOT SHAME MATTERS

Stigma about STIs, but not shame, may influence health care seeking behaviour. African American youths who felt stigma about STIs expected a negative reaction to disclosing their sexual behaviour to health care workers. Stigma also effected their previous STI related health care. That may be why young people with STIs are less likely to reattend for follow up. Or take their treatment.

See pp 334 and 349

SNAKE BITE REMEMBERED

"Those bitten by a snake fears a black and white thread" so goes a Persian saying. Young females diagnosed with a non-viral STI appear to change their behaviour, at least over the next three

months. According to Fortenberry and colleagues, many went back to a previous partner, perhaps as a safe option. Reinfection rates of *Trichomonas vaginalis* are, however, very high in low income African American females. Crosby and colleagues found that infection was strongly associated with marijuana use, older sex partners, non-steady partner, and delinquency. No surprises there. But is there also a role for stigma?

See pp 360 and 365

FAREWELL INNOCENT KISS

The proverbial aunt kissing her pretty little niece used to get the blame for passing on herpes simplex type 1 virus down the generations. Now that aunts kiss less, and boys and girls kiss more—in more varied sites, and at a younger and younger age—HSV-1 has lost its innocence as well. It too behaves like an STI.

See pp 346

SWEDES LIKE US

We all used to envy the Swedes their wraparound sexual knowledge. No longer. Edgarth blames the economic downturn of the 1990s on education budget cuts, reduced sex education in schools, rising truancy, drug use, smoking, and abortion rates and a 60% increase in chlamydia. In the UK, however, sex education in schools did not lower a single petticoat.

See pp 318 and 352

POOR BOYS

Boekeloo and colleagues found that most clinicians and one third of other health care workers are unwilling to screen males for chlamydia because of perceived difficulties. However, Van Leeuwen and colleagues found that ability to test for chlamydia and gonorrhoea in urine allows for the screening of out of reach groups with little extra effort and an unsurprisingly high pickup rates.

See pp 357 and 369

GLOOMY EUROPE

STIs are low on the European medico-political agenda. The first survey of STI prevention policies across Europe is gloomy. Apart from the UK and some Scandinavian countries there are no national STI control programmes. In Eastern Europe and the republics of the former Soviet Union, economic and social upheavals have greatly weakened public health strategies.

See pp 320 and 380

HEPATITIS VACCINATION

We know so little about uptake of hepatitis vaccination in men who have sex with men. Now that this has been taken up as a national target in the UK Department of Health Sexual Health Strategy the absence of empirical research in this field is lamentable.

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