Helen Ward, Rob Miller, *Editors*

PRIMARY CARE AND STIs

The National Strategy for Sexual Health and HIV proposed moving much care for STIs from the GUM clinic setting into primary care, as yet there are few data on the feasibility and acceptability of this new "point of delivery" for STI management. Cassell *et al* carried out a cross sectional survey of new patients attending an outer London GUM clinic. Of all attendees with an STI 39.9% had already seen a GP for their current problem, before they attended the GUM clinic. Duration of symptoms was significantly longer in those who had seen a GP first compared to those who went straight to the GUM clinic. Of those who had not seen a GP first a third cited the convenience of GUM clinic access or difficulties in accessing primary care services as a factor in their health care interaction. By contrast only 3% mentioned embarrassment as being a reason for not seeing their GP with their STI. Clearly primary care is already an important setting for the management of STIs. The delays in starting treatment for STIs because patients first access care through their GP and the barriers to access of primary care need to be addressed when planning future services for management of STIs.

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COMMISSIONING HIV SERVICE—NOT MERELY NEW RULES—A DIFFERENT GAME ALTOGETHER

The NHS plan, the National Strategy for Sexual Health and HIV, and the abolition of the special funding arrangements for NHS services, together with the devolution of commissioning to Primary Care Trusts (PCTs) have resulted in HIV services being thrust into the mainstream of the NHS. Huxter identifies the need for clinicians, managers, and those living with HIV to engage with the Regional Specialised Commissioning Groups in order for HIV services to be planned and delivered to agreed standards. He advises that HIV care providers will need to be increasingly well informed, not just about how commissioning works locally, but also by identifying who they need to influence within the local PCT. By influencing the PCTs, which act both as Commissioners and providers, HIV will continue to be regarded by them as important. Huxter's suggestions for models of commissioning are tempered by the advice that this is not the same old game "merely played by new rules—it is a different game altogether."

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SEXUAL ILL HEALTH—HEALTH OF THE NATION?

The editorial by Adler makes for depressing reading. Ten years on from publishing *The Health of the Nation: a strategy for health in England* it is clear that the strategy has not delivered its promises. Rather than improving the sexual health of the nation things are if anything worse now than they were 10 years ago. Adler catalogues the failures—over the last five years there have been rises in all STIs, teenage pregnancy rates remain unchanged since 1992, and there is an expected doubling in prevalent HIV cases between 1997 and 2005. Together with changes in sexual behaviour (younger age of first intercourse and increase in lifetime partners and concurrent partnerships), pressure on GUM services, and delays in access these factors all contribute to "driving" the STI epidemic. Adler points out that while the recent sexual health and HIV strategy outlines plans for better prevention and treatment services these will be impossible to deliver—given the lack funding and the fact that sexual health is not an NHS or political priority. Until it is, "further failure will follow further failure".

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A FAILURE OF PUBLIC HEALTH

"Even one case of congenital syphilis is a sentinel public health event" writes Tikhonova. In the Russian Federation the incidence of congenital syphilis has increased 26-fold in the 1990s. The authors report factors associated with delivering an infant with congenital syphilis among a group of pregnant women with syphilis. Between 1995 and 1999, 544 cases of congenital syphilis were identified. Women with no prenatal care or a late first screen for syphilis were at increased risk, factors that are clearly modifiable. Given the increase in syphilis in many parts of Europe and former Soviet countries, this article reminds us of the need for systematic screening of pregnant women early in pregnancy. To achieve this means investment in accessible prenatal care for all.

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WHO GETS GONORRHOEA AGAIN?

A significant number of people with gonorrhoea have had it before. A retrospective cohort study in Baltimore found a reinfection rate of 4.28 per 100 person years. Being male, young, having more sex partners, and having a sex partner who sold sex were independent risk factors for reinfection. Injection drug use, and initially attending as a contact were found to be protective. In women, reporting "any" rather than "none" for condom use was found to be a risk factor, but this was probably due to residual confounding with numbers of sex partners and commercial sex, both of which are associated with increased condom use. The significance of the finding is the identification of factors predictive on reinfection that could be used to focus enhanced interventions, so long as we can identify interventions that work.

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