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As we go to press, news is still emerging of the Guatemala syphilis scandal,¹ in which female sex workers, prisoners and mental hospital patients were deliberately infected with syphilis, and soldiers with gonorrhoea and chancroid. Unlike Tuskegee, this programme involved experimentation on an overseas population of a kind that—as acknowledged by its investigators—could not comfortably be attempted within US borders. Ethical guidelines have emerged and taken root alongside horror stories of experimentation, often with military collaboration. It is heartening then to hear of a different history—that of STI research in Africa. David Mabey, Francis Ndowa and Ahmed Latif² tell a story of scientific collaboration across and beyond the continent which created many landmark studies in STI control.

In the era of evidence based medicine, we are urged to base all our decisions on evidence and evaluate them accordingly. This can create challenges when, as so often, change is imposed from without. Menon-Johansson *et al* attempted to evaluate the impact of 'High Impact Changes' proposed by England's Department of Health for specialist genitourinary medicine clinics.³ Their study illustrates the challenge of evaluation through ecological data. The results nevertheless demonstrate the potential impact of text messaging and central booking services on follow-up rates and on the numbers screened for sexually transmitted infections. It is commendable to have assessed these changes, but we hope that evaluation plans will increasingly be built into policy driven service changes from start.

This month, several studies focus on testing. Huppert *et al* show that a self-administered point of care test for trichomoniasis was as accurately performed by adolescent women as by their clinicians.⁴ The study demonstrates the potential of such tests for vulnerable groups. The acceptability of non-invasive testing, and its impact on flow times within the clinic is confirmed in a randomised trial reported by Brown *et al*.⁵ A different screening innovation is described by Clark *et al*⁶—they explore the yield of testing for acute and recent HIV infection in a Peruvian population. This was four times as common among men who had sex with men, suggesting that this approach may be important in transmission prevention among

this group. Two further diagnostic studies address practical problems in testing. Scott *et al*⁷ assess the impact of a dual PCR test for herpes and syphilis, concluding that it improved turnaround and enhanced detection of syphilis, especially where it was unexpected. More relevant to the developing country setting is Castro *et al*'s work, which demonstrates the potential of a simultaneous treponemal and non-treponemal test for syphilis.⁸

We have a number of interesting and surprising studies of behaviour this month. White *et al*⁹ report a network simulation study which compared the impact of polygyny and gender symmetry among various levels of concurrency. The prevalence of STIs in the simulated scenarios was substantially lower for polygyny than for symmetric concurrency. Sánchez-Alemán *et al* problematise the view that delayed sexual debut is protective against STI in a study of Mexican college students.¹⁰ Here, delayed sexual debut was in fact a risk factor for HSV-2 acquisition, due to a subgroup with high partner numbers. The use of sexual and social network contacts to trace identify cases of HIV is interestingly explored by Yamazaki *et al*.¹¹

Yang *et al*¹² have taken on the challenge of studying the clients of female sex workers, demonstrating low rates of consistent use, and worrying prevalence of HIV, syphilis and hepatitis C. We also have reports of STI prevalence among Tunisian sex workers from Znazen *et al*,¹³ and of age specific HPV prevalence in young Dutch women.¹⁴

Finally, two papers attest to the continuing clinical burden of STIs, and the role of the sexual health service in reducing transmission—directly through clinical intervention, or through education for other services. Muldoon *et al* report delays in diagnosis for five cases of ocular syphilis¹⁵ with potential risk to sight and of onward transmission. And Harding's group¹⁶ remind us of the high burden of psychological and physical symptoms among HIV outpatients, demonstrating its association with unprotected sexual contact and with poorer treatment adherence.

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