prevalence may be biased. Furthermore, STI screening was offered to but not performed on all patients. Furthermore, repeat testing and the interval of such testing were, ultimately, decided by each individual patient.

Despite these limitations, there is value in assessing the local sex work environment and using this as the basis for public health interventions. Indeed, additional work must also be done to maximise the uptake of voluntary STI screening, particularly among HIV infected sex workers. This study suggests that STI prevention efforts in San Francisco must increasingly target sex workers who are African-American, male, and work independently of other sex workers. Moreover, anti-violence interventions should be an integral part of STI prevention. Our finding of decreased risk of STI among those individuals who have worked collectively with other sex workers is intriguing and warrants further study.

The St James Infirmary represents a novel collaborative effort between public health officials and the sex worker community. Through this unique model, sex workers have helped define public health priorities for their own community and public health officials have gained access to this hidden and stigmatised population.

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CORRECTION

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In the February issue of the journal there was an error in the paper by Hamlyn E, McAllister J, Winston A *et al* (Is screening for sexually transmitted infections in men who have sex with men who receive non-occupational HIV post-exposure prophylaxis worthwhile? *Sex Transm Infect* 2006;**82**:21–3). In reference 10, the initial of the first author was incorrect. The correct name is K Manavi.