1. Male circumcision


A randomized controlled trial (RCT) has shown that male circumcision (MC) can reduce sexual transmission of HIV from women to men by 60% (95%CI 32%-76%). Williams and colleagues explore the implications of this finding for the promotion of MC as a public health intervention to control HIV in sub-Saharan Africa. Using dynamical simulation models the authors consider the impact of MC on the relative prevalence of HIV in men and women and in circumcised and uncircumcised men. Using country level data on HIV prevalence and MC, they estimate the impact of increasing MC coverage on HIV incidence, HIV prevalence, and HIV-related deaths over the next 10, 20, and 30 years in sub-Saharan Africa. Assuming that full coverage of MC is achieved over the next 10 years, Williams and colleagues consider three scenarios in which the reduction in transmission is given by the best estimate and the upper and lower 95% confidence limits of the reduction in transmission observed in the RCT. MC could avert 2.0 (1.1-3.8) million new HIV infections and 0.3 (0.1-0.5) million deaths over the next 10 years in sub-Saharan Africa. In the 10 years after that, it could avert a further 3.7 (1.9-7.5) million new HIV infections and 2.7 (1.5-5.3) million deaths, with about one quarter of all the incident cases prevented and the deaths averted occurring in South Africa. The authors show that a) MC would increase the proportion of infected people who are women from about 52% to 58%; b) where there is homogenous mixing but not all men are
circumcised, the prevalence of infection in circumcised men is likely to be about 80% of that in uncircumcised men; c) MC would be equivalent to an intervention, such as a vaccine or increased condom use, that reduces transmission in both directions by 37%. This analysis is based on the result of just one RCT, but if the results of that trial are confirmed Williams and colleagues suggest that MC could substantially reduce the burden of HIV in Africa, especially in southern Africa where the prevalence of MC is low and the prevalence of HIV is high. While the protective benefit to HIV-negative men would be immediate, the full impact of MC on HIV-related illness and death would only be apparent in 10-20 years.

2. Gender and HIV


Gender, as a structural factor, organises social relations, shaping opportunities and constraints surrounding sexual interactions between women and men. The structure of gender relations is also fundamental to the acceptability and use of women-initiated methods for preventing HIV and (other) sexually transmitted infections (STI). New methods are now available, and others are being developed, that could enable women to take the initiative in preventing STI. However, attempts to capitalise on “female-controlled” preventive methods thus far have met with limited success. Female-initiated methods were introduced to intervene in the state of gender relations and assist women who are disempowered vis-à-vis their male partners. Paradoxically, however, Mantell and colleagues underscore that it is the very structure of regional and local gender relations that shapes the acceptability (or lack of acceptability) of these methods. This paper specifically addresses how the structure of gender relations - for better and for worse - shapes the promises and limitations of widespread use and acceptance of female-initiated methods. The authors draw on examples from around the world to underscore how the regional specificities of gender (in)equality shape the acceptance, negotiation, and use of these methods. Simultaneously, Mantell and colleagues demonstrate how the introduction and sustained use of methods are shaped by gender relations and offer possibilities for reinforcing or challenging their current state. Based on their analyses, the authors offer key policy and programmatic recommendations to increase promotion and effective use of women-initiated HIV/STI protection methods for both women and men. The recommendations include considering the state of local and regional gender relations to tailor promotional strategies and messages for female-initiated disease prevention methods, engaging men in the promotion of female-initiated methods, recognising that female-initiated methods for HIV/STI prevention do not exist in a gender-neutral landscape (even though they have been uncritically infused with ideologies of female empowerment, autonomy, and personal choice), balancing the need to draw strategically upon masculine ideologies that will protect women and men from HIV/STIs with the risk that programmatic decisions may perpetuate gender inequality, and realising that the structure of gender relations can shape the acceptability and use of female-initiated methods. Conversely, female-initiated methods could contribute to shifting the state of gender relations.
3. Condoms


Liao and colleagues evaluated a two-phase HIV and (other) sexually transmitted infections prevention programme for female sex workers in a resource-limited rural town in Hainan Province, China. The primary strategy, undertaken from 1997 to 2000, was a condom promotion campaign conducted through outreach to sex workers. Four serial cross-sectional surveys were carried out before and after the programme. Over a period of 2 years, reported condom use during the most recent sexual encounter increased from about 50% to more than 70%; and condom use in more than 50% of sexual acts during the past 6 months increased from less than 40% to near 80% of respondents. Controlling for education, ethnicity and age, reading of educational materials (the intervention variable) was a significant contributor to a higher knowledge score, motivation to use condoms, and reported condom use. This study demonstrates that outreach to female sex workers, if appropriately tailored to local settings, can increase condom use in a resource-limited rural area.

4. HIV testing


Warwick describes how the ART programme in Botswana has influenced the willingness of the community of Tutume District, Botswana to come forward for HIV testing. A retrospective review of Tutume Primary Hospital records was performed for three different periods: prior to the national ART programme, once ART was available in limited centres, and once ART was available locally. There was a five-fold increase in the number of HIV tests performed once treatment became available locally, primarily due to increased uptake by women. The author concludes that access to free ART increases the HIV testing rate of previously reluctant communities.

5. Young people


In this study, Olshen and colleagues sought to describe the use of HIV post-exposure prophylaxis (PEP) in adolescent survivors of sexual assault and to explore barriers to PEP completion in this population. The authors conducted a chart review of two academic medical centres in Boston, Mass, between 01 July 2001 and 30 June 2003. The study participants were adolescents presenting to the paediatric emergency departments of the two centres within 72 hours of a penetrating sexual assault. Of 177 charts reviewed, adequate documentation of the sexual assault and medical management was available for 145 patients (96% female, 38% black, 14% Hispanic). The authors found that many patients were uncertain regarding their exposures: 27% were unsure whether a condom had been used, 54% were unsure whether ejaculation had occurred, and 21% had blacked out during the assault. One hundred ten (76%) received PEP. Of the 97 patients referred for follow-up at the academic centres, 37 returned for at least 1 visit and 13 completed a 28-day course of PEP. Sixteen (46%) of those taking PEP who returned for follow-up developed an adverse
reaction to medication. Forty-seven percent of adolescent sexual assault survivors had carried a psychiatric diagnosis before the assault; adherence to PEP was lower among these adolescents. In conclusion, Olshen and colleagues observed low rates of PEP completion among adolescent sexual assault survivors. Potential difficulties of using PEP in this population include uncertainties regarding exposure, high rates of psychiatric co-morbidity, and low rates of return for follow-up care.

6. Greater involvement of people living with HIV.


Participatory, community-based research is relatively new to mainstream medical research, but it is not new to health research. Participation in research is often conceptualised as a continuum in which different levels of participation imply different amounts of community control over the process and outcomes. At one end lies the conventional research situation in which community members are passive participants in the research process and have little influence over the process or outcome. At the other end lies a far more empowering situation in which community members work as equal partners to define and execute the research as well as to determine its applications. Theoretically, participatory research is situated at this far end of the continuum. Chung and Lounsbury present a case study of a participatory process that was used to understand the needs of persons living with HIV in a US state. The case illustrates that participation in a community-based research project is a dynamic phenomenon that must be negotiated among an evolving web of roles and relationships. Using a continuum to model the multiple modes of community participation, the authors follow the changing nature of participation over the course of a single project. Their analysis illustrates the different levels of participation given by the continuum as well as the dynamic nature of participation. A shared understanding of participation evolves as the roles and relationships of those involved are negotiated and renegotiated. However, lack of reflection over power differentials can lead to disempowering outcomes even after achieving a seemingly participatory process. In conclusion, Chung and Lounsbury say, this case reveals that failing to resolve divergent assumptions about power and purpose can lead to fissures that are difficult to overcome.

That was HIV This Week, signing off.

Editors’ notes on journal access

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