Welcome to the tenth issue of HIV This Week! In this week’s issue there is something for everyone. You can learn more about young people (vago, vaguitas, street guys and fast girls; adolescents’ views on HIV testing), about the perverse effects of political interests and top-down programming on the effectiveness of prevention at community level; about gender issues (romantic attachment, women in Malawi who take their mat and go, women’s human rights and what the term ‘epidemiologically fathomable’ might mean); about a US population in which 64% believe HIV can be transmitted by mosquitoes or animal bites (!); and about rapid testing; India’s response to HIV; and tuberculosis/HIV collaboration in the context of universal access. In case you are wondering why there are three articles from late 2005 included in this issue, they are from the journal Culture, Health and Sexuality and were only indexed in Medline last week.

To find out how you can access a majority of scientific journals free of charge, please see the last page of this issue or check the HIV This Week blog on the UNAIDS website at http://hivthisweek.unaids.org.

We want to be as helpful to you as we can, so please let us know what your interests are and what you think of HIV This Week by sending a comment to hivthisweek@unaids.org or by posting one on the HIV This Week blog. If you would like to recommend an article for inclusion in HIV This Week, please let us know.

Don’t forget that you can find a wealth of information on the HIV epidemic and responses to it at http://www.unaids.org.

Cate Hankins
Chief Scientific Adviser
Charles Shey Wiysonge
Research Officer

1. Tuberculosis


Tuberculosis is the oldest of the world’s current pandemics with 8.9 million new cases and 1.7 million deaths occurring annually. The disease is among the most common causes of morbidity and mortality in people living with HIV. However, tuberculosis is more than just part of the global HIV problem; well-resourced tuberculosis programmes are an important part of the solution to scaling-up towards universal access to comprehensive HIV prevention, treatment, care, and support. Reid and colleagues review the impact of the interactions between tuberculosis and HIV in resource-limited settings; outline the recommended programmatic and clinical responses to the dual epidemics, highlighting the role of tuberculosis/HIV collaboration in increasing access to prevention, diagnostic, and treatment.
services; and review progress in the global response to the epidemic of HIV-related tuberculosis.

2. Gender


In much of HIV prevention literature, women are depicted as passive and ill-equipped to confront the epidemic without external support to enhance their status, autonomy, and negotiation skills. This paper critically evaluates this depiction, using data from in-depth interviews conducted with married couples in rural Malawi. It focuses on the extent to which married women perceive that they have the ability to protect themselves from infection and on the prevention strategies that they employ. Interview data suggest that women have identified a range of contextually appropriate ways to resist exposure to HIV. These strategies include sitting and discussing the dangers of HIV with their husbands; utilizing social networks for advice and as advocates; publicly confronting husbands' girlfriends; and divorcing men who do not adopt safer practices. These locally-formulated strategies are not likely to be followed consistently, and they may not be the most effective strategies in preventing husbands from straying or protecting women from contracting HIV. Their existence, however, demonstrates that rural Malawian women believe that they have some agency to protect themselves; and, they are in fact using locally appropriate strategies to do so.


Most unprotected sex occurs in close relationships. However, few studies examine relational factors and sexual risk among high-risk populations. Romantic Attachment Theory states that individuals have cognitive working models for relationships that influence expectations, affect, and behaviour. Kershaw and colleagues investigated the influence of attachment avoidance and anxiety on sexual beliefs (e.g., condom use beliefs, self-efficacy), behaviour (e.g., condom use, multiple partners, unprotected sex with risky partners), and sexually transmitted infections (STIs) among 755 high-risk, young pregnant women age 14-25 recruited from urban prenatal clinics. Attachment anxiety predicted sexual beliefs, condom use, and unprotected sex with risky partners controlling for demographic variables. Sexual beliefs did not mediate the relationship between attachment orientation and sexual behaviour. Current relationship with the father of the baby did mediate the effect of attachment anxiety on multiple partners and STIs. Results indicate the importance of including general relational factors, such as attachment, in HIV prevention.


Statistics never fail to shock. Almost 25 years after the first clinical evidence of AIDS was reported, more than 25 million lives have been lost to this pandemic and more than 40 million people are currently living with HIV. An increasingly large percentage of these individuals are women, as every region experiences the growing 'feminization' of the epidemic. After citing the reasons for women's vulnerability (i.e. gender inequality, lack of education, cultural attitudes to sex, poverty, and violence), Suman Mehta argues the potential role of
gynaecologists and obstetricians through integration of HIV into sexual and reproductive health services to strengthen the response to the epidemic. Among the key roles gynaecologists and obstetricians should play, she cites upholding women’s human rights including rights to healthcare, fighting for more and better resources and for the reduction of gender inequalities.


This paper examines the shifting nature of contemporary epidemiological classifications in the HIV epidemic. It first looks at assumptions that guide a discourse of vulnerability and circulate around risk categories. It then examines the underlying emphasis in public health on the popular frame of "vulnerable women" who acquire HIV through heterosexual transmission. Drawing on work on gender, sexuality, and intersectionality, the paper asks why a discourse of vulnerability is infused into discussions of heterosexually-active women’s HIV risks but not those pertaining to heterosexually-active men’s. The paper then moves to current surveillance categories that are hierarchically and differentially applied to women’s and men’s risks in the HIV epidemic. Here, the focus is on the way in which contemporary classifications allow for the emergence of the vulnerable heterosexually-active woman while simultaneously constituting lack of fathomability concerning bisexual and lesbian transmission risk. Lastly, theories of intersectionality, are used to examine current research on woman-to-woman transmission, and to suggest future more productive options.

3. Young people


Young people constitute a priority for sexual health research, policy and planning. Many studies, however, regard youth as a homogeneous group defined by developmental stages and their problems as inherent rather than factors resulting from structural vulnerability. Ethnographic data from this study provided strong evidence of the inappropriateness, in prevention interventions, of the concept of ‘young people’ as a group defined only by age and gender. When incorporating social resources and support into the analysis, specific segments of youth with diverse sexual practices and health seeking behaviours emerge. Thus, although most young people in urban areas show a similar level of HIV/STI knowledge, their exposure to risk varies according to their living conditions. Two population segments - "street guys" and "fast girls" - identified as vulnerable for sexual risk, are characterized. Both groups hang out on the streets, and most are involved in using alcohol and drugs, and/or practicing transactional sex. The authors conclude that this study provided evidence for the need of various approaches according to level of poverty and social vulnerability in order to develop more effective HIV and STI prevention programmes to meet the needs of young men and women in low-income areas.

4. HIV testing and counselling


Reduced HIV risk behaviour and increased use of care and support services have been demonstrated among adults accessing HIV voluntary counselling and testing (VCT). The
impact of VCT on adolescents is, however, not known. Focus group discussions were held with adolescents and parents in two South African townships to establish the perceptions of and needs for VCT among young people. Ecological theory informed the analysis. Adolescents had limited experience of VCT, were afraid of knowing their HIV status, and felt that testing was only for symptomatic individuals. Youth felt that they would disclose their HIV status to family members who they felt would be most supportive. Youth were afraid of stigma and discrimination; rarely referring to the community as a source of support. Discussions highlighted the inappropriateness of clinical facilities for youth VCT. The authors conclude with recommendations for youth-friendly VCT services.

Hutchinson AB, Branson BM, et al. A meta-analysis of the effectiveness of alternative HIV counseling and testing methods to increase knowledge of HIV status. AIDS 2006;20:1597-1604

Alternatives to conventional HIV counselling and testing (HIV-CT) have been used to improve receipt of HIV test results. Hutchinson and colleagues assessed the effectiveness of alternative HIV-CT methods on the receipt of HIV test results. They identified studies by a systematic search of the literature using English-language databases from 1990 to 2005. Studies were included if they used an alternative method for HIV-CT, reported the receipt of HIV test results and had a comparison group. Pooled effect sizes [risk ratios (RR)] were calculated using a random effects model. Seventeen effect sizes (k) were included n = 21 096). Alternative HIV-CT methods included rapid testing (k = 12), oral fluid testing (k = 2), home testing (k = 1), and telephone post-test counselling (k = 2). All alternatives except for oral fluid testing significantly increased receipt of results compared with conventional testing. In stratified analysis, rapid testing was most effective [RR, 1.80; 95% CI 1.46-2.22) followed by telephone post-test counselling (RR, 1.38. 95% CI, 1.24-1.47). Hutchinson and colleagues conclude that here is strong evidence that clients are substantially more likely to receive their HIV test results with rapid testing than with conventional tests or other alternatives. Therefore, to increase knowledge of HIV status, rapid testing is preferable in settings with low rates of return for test results.

5. Politics and prevention


In every country, health and prevention "come down" from the authorities responsible for this mission by way of planners, local authorities, and peer educators until it reaches the target population. International and national systems function on the premise of a top-down transmission, with little room for integrating local information that might provide a better understanding of the implementation process. This analysis is based on an empirical evaluative research of HIV prevention projects with sex workers in a remote area of northern Brazil. It illustrates how nursing socio-political analysis can reveal how political interests can have perverse effects by contaminating the group’s internal relations and with established partnerships, thereby weakening the impact of prevention programmes. These effects can seriously affect community relations and social practices, far beyond the technical division of work and political hierarchies in the socio-sanitary network.
6. Misconceptions


Ritieni and colleagues examined misconceptions about HIV among 454 Latino adults in California using data from a population-based telephone survey conducted in 2000. Common misconceptions concerning modes of HIV transmission included transmission via mosquito or animal bite (64.1%), public facilities (48.3%), or kissing someone on the cheek (24.8%). A composite misconceptions score was constructed. Correlations between the composite measure and other HIV-related beliefs were examined. Latinos with a higher level of misconceptions were more likely to report higher self-perceived risk of HIV infection, and discomfort with infected individuals in a school and in a food setting. Results from multiple linear regression analysis indicated that individuals 45 years and older, those who were interviewed in Spanish, and those with lower education or income levels had a higher degree of misconceptions. The results suggest the need for targeted education efforts to reduce HIV misconceptions among Latino adults in California.

7. Country response


India’s HIV epidemic is not yet contained and prevention in populations most at risk of HIV exposure (high-risk groups) needs to be enhanced and expanded. HIV prevalence as measured through surveillance of antenatal and sexually transmitted disease clinics is the chief source of information on HIV in India, but these data cannot provide real insight into where transmission is occurring or guide programme strategy. The factors that influence the Indian epidemic are the size, behaviours, and disease burdens of high-risk groups, their interaction with bridge populations and general population sexual networks, and migration and mobility of both bridge populations and high-risk groups. The interplay of these forces has resulted in substantial epidemics in several pockets of many Indian states that could potentially ignite sub-epidemics in other, currently low prevalence, parts of the country. The growth of HIV, unless contained, could have serious consequences for India’s development. India’s national response to HIV began in 1992 and has shown early success in some states. The priority is to build on those successes by *increasing prevention coverage of high-risk groups to saturation level, enhancing access and uptake of care and treatment services, ensuring systems and capacity for evidence-based programming, and building in-country technical and managerial capacity*. Editors’ note: UNAIDS has used the expression ‘populations at higher risk of HIV exposure’ or ‘most at risk populations (MARPs)’ in preference to the old stigmatising term ‘high risk groups’. Increasingly, UNAIDS is using the term ‘key populations’ to refer to vulnerable populations that are key to the epidemic’s dynamics and key to the response.

That was *HIV This Week*, signing off.
Editors' notes on journal access

For readers in all countries:
All abstracts in HIV This Week are freely available on the Web.

You can access a majority of scientific journals free of charge no matter where you are located, but for some journals you do need a subscription to access the full text of an article. Some journals are free to readers in all countries either through ScienceDirect or through the journal’s own website.

For articles available through ScienceDirect, you should follow the link http://www.sciencedirect.com/ to the ScienceDirect website. Then, type in the title of the journal for which you are searching.

Some journals are open access, available to readers in all countries: American Medical Association journals (http://pubs.ama-assn.org/), American Society of Clinical Oncology (2 journals), Australian Medical Association (1 journal), BioMed Central journals (http://www.biomedcentral.com/), BMJ journals (http://journals.bmj.com/), Canadian Medical Association (1 journal), Nature Publishing Group journals (http://www.nature.com/), Public Library of Science journal (http://medicine.plosjournals.org/) and Science (1 journal).

Other journals offer free access to full-text articles after a certain period of time (see lists at High Wire Press http://highwire.stanford.edu/lists/freeart.dtl and PubMed Central http://www.pubmedcentral.nih.gov/).

For residents of low- and middle-income countries: the Health InterNetwork Access to Research Initiative (HINARI)
HINARI, set up by the World Health Organisation (WHO) and major publishers, enables readers in low- and middle-income countries to gain access to one of the world’s largest collections of biomedical and health literature. Over 3400 journal titles are now available to health institutions in 113 countries, benefiting many thousands of health workers and researchers, and in turn, contributing to improved world health. More information on the HINARI programme and eligible countries is available at http://www.who.int/hinari/en/, e-mail: hinari@who.int.

Local, not-for-profit institutions in low- and middle- income countries may register for access to the journals through HINARI. Institutions in countries with GNP per capita below $1000 are eligible for free access. Institutions in countries with GNP per capita $1000-$3000 pay a fee of $1000 per year/institution.

For employees of UNAIDS or WHO:
If you work for WHO or UNAIDS, you can access a number of journals by going to the WHO library. You can also see the full list of journals you can access freely on the web (including usernames and passwords) by going to the WHO Library website, accessible through the home page of WHO intranet https://intranet.who.int/ under Information Resources. If you
work for UNAIDS, *HIV This Week* is also available on the intranet at the link https://intranet.unaids.org/HIVThisWeek/2007/index.htm.