Welcome to the thirty-second issue of HIV This Week! In this issue, we learn why understanding resilience is as important as understanding vulnerability (the role of community safety nets; equity, social cohesion, solidarity and inclusion; and the social dynamics of orphan care), basic science (promising first steps in gene therapy for advanced immunodeficiency; Vitamin A deficiency and supplementation: what does it mean and should you top up?), epidemiology (faster disease progression with sub-type D in Kenya), gender (higher age at marriage and HIV risk in sub-Saharan Africa; empowering adolescent girls in Brazil to reinforce social norms favouring women's participation in condom purchase and use; gender-specific analyses of determinants of intended condom use in South Africa), stigma (Thai nursing students views of people who inject drugs), mother-to-child transmission (birth outcomes improve in the midst of overall worsening of pre-term delivery and low birth weights in the US; high HIV prevalence among pregnant women in north west Trinidad), men who have sex with men (the challenge of ostracism in Nigeria), traditional medicine (ethical and regulatory issues in Africa), sex work (problems replicating Sonagachi in Ria), women and girls (the mediating effects of mother-adolescent communication on sexual behaviour), partnerships (Roll Back Malaria and NEPAD) and harm reduction (broadening the framework for a successful approach to injecting drug use).

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.

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1. Resilience


Safety nets are mechanisms to mitigate the effects of poverty on vulnerable households during times of stress. In sub-Saharan Africa, extended families, together with communities, are the most effective responses enabling access to support for households facing crises. This paper reviews literature on informal social security systems in sub-
Saharan Africa, analyses changes taking place in their functioning as a result of HIV and describes community safety net components including economic associations, cooperatives, loan providers, philanthropic groups and HIV initiatives. Community safety nets target households in greatest need, respond rapidly to crises, are cost efficient, based on local needs and available resources, involve the specialized knowledge of community members and provide financial and psycho-social support. Their main limitations are lack of material resources and reliance on unpaid labour of women. Changes have taken place in safety net mechanisms because of HIV, suggesting the resilience of communities rather than their impending collapse. Studies are lacking that assess the value of informal community-level transfers, describe how safety nets assist the poor or analyse modifications in response to HIV. The role of community safety nets remains largely invisible under the radar of governments, non-governmental organizations and international bodies. External support can strengthen this system of informal social security that provides poor HIV-affected households with significant support. Editors' note: Vulnerability is much studied but relatively little is known about community resilience and how to better foster and support it. What forms does solidarity take and why is it more likely to be expressed in some communities and not in others? How can men be encouraged to become involved as much as women in creating and maintaining social safety nets? Understanding the mechanisms and manifestations of resilience is as key to the response to HIV as understanding the origins and underpinnings of vulnerability.


The HIV epidemic feeds on, and worsens, unacceptable situations of poverty, gender inequity, social insecurity, limited access to healthcare and education, war, debt and macroeconomic and social instability. The number of people living with HIV and AIDS continues to increase in several regions, most markedly in sub-Saharan Africa, the Pacific, Eastern Europe and Central Asia. The persistent nature of the epidemic and its increasing incidence in less powerful, more economically marginalised communities signals a need for a critical review of past policy and practice, particularly where this has left unchanged or worsened the risk environments that lead to new infection. Available evidence suggests that the caring and consumption burdens of AIDS have largely been met by households, limiting the capacities for future caring and mitigation of impact. Social cohesion or the collective networking, action, trust and solidarity of society, plays a positive role in reducing risk and dealing with vulnerability but is itself negatively affected by AIDS. This paper introduces the programme of work reported in this supplement of AIDS Care with an analysis of background evidence of community responses to HIV. It explores how interventions from state institutions and non-governmental organizations (NGOs) support and interact with these household, family and community responses. How far is risk prevention reliant on individuals' limited resources and power to act, while risk environments are left unchanged? How far are the impacts of AIDS borne by households and extended families, with weak solidarity support? Where are the examples of wider social responses that challenge the conditions that influence risk and that support household recovery? Through review of literature, this background paper sets out the questions that the studies reported in this supplement have, in various settings, sought to explore more deeply. Editors' note: This supplement of AIDS Care focuses specifically on community responses to HIV, the resilience-vulnerability continuum, equity-inclusion and the nature of social solidarity.
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The astounding rise in the number of orphans due to the HIV epidemic has left many Ethiopian families and communities with enormous childcare problems. Available studies on the capacity and sustainability of the extended family system, which culturally performs the role of care for children in need, suggest two competing theories. The first is grounded in the social rupture thesis and assumes that the traditional system of orphan care is stretched by the impact of the epidemic, and is actually collapsing. By contrast, the second theory counter-suggests that the flexibility and strength of the informal childcare practise, if supported by appropriate interventions, can still support a large number of orphans. Based on a seven-month period of child-focused, qualitative research fieldwork in Ethiopia involving observations; in-depth interviews with orphans (42), social workers (12) and heads of households (18); focus group discussions with orphans (8), elderly people and community leaders (6); and story-writing by children in school contexts, this article explores the trade-offs and social dynamics of orphan care within extended family structures in Ethiopia. It argues that there is a rural-urban divide in the capacity to cater for orphans that emanates from structural differences as well as the socio-cultural and economic values associated with children. The care of orphans within extended family households is also characterised by multiple and reciprocal relationships in care-giving and care-receiving practices. By calling for a contextual understanding of the ‘orphan burden’, the paper concludes that interventions for orphans may consider care as a continuum in the light of four profiles of extended families, namely rupturing, transient, adaptive, and capable families. Editors’ note: This thoughtful article suggests that the first step in planning programmes to support orphan care requires an understanding of natural coping mechanisms which will differ by geography and culture, as well as over time.

2. Basic Science


Drug toxicity and viral resistance limit the long-term efficacy of antiviral drug treatment for human immunodeficiency virus (HIV) infection. Thus, alternative therapies need to be explored. Lunzen and colleagues tested the infusion of T lymphocytes transduced with a retroviral vector (M87o) that expresses an HIV entry-inhibitory peptide (mac46). Gene-modified autologous T cells were infused into ten HIV-infected patients with advanced disease and multidrug-resistant virus during antiretroviral combination therapy. T-cell infusions were tolerated well, with no severe side effects. A significant increase of CD4 counts was observed after infusion. At the end of the 1-year follow-up, the CD4 counts of all patients were still around or above baseline. Gene-modified cells could be detected in peripheral blood, lymph nodes, and bone marrow throughout the 1-year follow-up, and marking levels correlated with the cell dose. No significant changes of viral load were observed during the first 4 months. Four of the seven patients who changed their antiviral drug regimen thereafter responded with a significant decline in plasma viral load. In conclusion,
the transfer of gene-modified cells was safe, led to sustained levels of gene marking, and may improve immune competence in HIV-infected patients with advanced disease and multidrug-resistant virus. Editors’ note: Gene therapy is a new frontier in HIV treatment just as it is in the treatment of cancer and inherited genetic disorders. In this case, infusing patients’ T-cells which have been modified to inhibit HIV entry was found to be safe in ten people so it is likely that a larger study will now be conducted to look more closely at the extent and significance of the immunological effects.


An estimated 25 million lives have been lost to acquired immune-deficiency syndrome (AIDS) since the immunodeficiency syndrome was first described in 1981. The progress made in the field of treatment in the form of antiretroviral therapy (ART) for HIV disease/AIDS has prolonged as well as improved the quality of life of HIV-infected individuals. However, access to such treatment remains a major concern in most parts of the world, especially in the developing countries. Hence, there is a constant need to find low-cost interventions to complement the role of ART in prevention of HIV infection and slowing clinical disease progression. Nutritional interventions, particularly vitamin supplementation, have the potential to be a low-cost method for being such an intervention by virtue of their modulation of the immune system. Among all the vitamins, the role of vitamin A has been studied most extensively: most observational studies have found that low vitamin A levels are associated with increased risk of transmission of HIV from mother to child. This finding has not been supported by large randomized trials of vitamin A supplementation; on the contrary, these trials have found that vitamin A supplementation increases the risk of mother-to-child transmission (MTCT). There are a number of potential mechanisms that might explain these contradictory findings. One is the issue of reverse causality in observational studies—for instance, advanced HIV disease may suppress release of vitamin A from the liver. This would lead to low levels of vitamin A in the plasma despite the body having enough vitamin A liver stores. Further, advanced HIV disease is likely to increase the risk of MTCT, and hence it would appear that low serum vitamin A levels are associated with increased MTCT. The HIV genome also has a retinoic acid receptor element: Hence, vitamin A may increase HIV replication via interacting with this element, thus increasing risk of MTCT. Finally, vitamin A is known to increase lymphoid cell differentiation, which leads to an increase in CCR5 receptors. These receptors are essential for attachment of HIV to the lymphocytes and therefore, an increase in their number is likely to increase HIV replication. Vitamin A supplementation in HIV-infected children, on the other hand, has been associated with protective effects against mortality and morbidity, similar to that seen in HIV-negative children. The risk for lower respiratory tract infection and severe watery diarrhoea has been shown to be lower in HIV-infected children supplemented with vitamin A. All-cause mortality and AIDS-related deaths have also been found to be lower in vitamin A-supplemented HIV-infected children. The benefits of multivitamin supplementation, particularly vitamins B, C, and E, have been more consistent across studies. Multivitamin supplementation in HIV-infected pregnant mothers has been shown to reduce the incidence of adverse pregnancy outcomes such as foetal loss and low birth weight. It also has been shown to decrease rates of MTCT among women who have poor nutritional or immunologic status. Further, multivitamin supplementation reduces the rate of HIV disease progression among patients in early stage of disease, thus delaying the need for ART by prolonging the
pre-ART stage. In brief, there is no evidence to recommend vitamin A supplementation of HIV-infected pregnant women; however, periodic vitamin A supplementation of HIV-infected infants and children is beneficial in reducing all-cause mortality and morbidity and is recommended. Similarly, multivitamin supplementation of people infected with HIV, particularly pregnant women, is strongly suggested. Editors' note: It has taken quite some time to tease out the role of vitamin A deficiency and whether supplementation is useful and if so, for whom. Although vitamin A deficiency does not appear to increase the risk of HIV transmission, it should be treated and prevented in people living with HIV of all ages on general health grounds.

3. Epidemiology


Baeten and colleagues investigated the effect of human immunodeficiency virus type 1 (HIV-1) subtype on disease progression among 145 Kenyan women followed from the time of HIV-1 acquisition. Compared with those infected with subtype A, women infected with subtype D had higher mortality (hazard ratio, 2.3 [95% confidence interval, 1.0-5.6]) and a faster rate of CD4 cell count decline (P=.003). The mortality risk persisted after adjustment for plasma HIV-1 load. There were no differences in plasma viral load by HIV-1 subtype during follow-up. HIV-1 subtype D infection is associated with a >2-fold higher risk of death than subtype A infection, in spite of similar plasma HIV-1 loads. Editors' note: More is being learned now about differential disease progression and mortality by HIV subtype. For example, survival with subtype E may be less than with other subtypes. This small study examining disease progression with subtype D requires confirmation in larger populations, ideally in comparison with that observed with other subtypes circulating in similar biosocial environments.

4. Gender


The causes of large variation in the sizes of HIV epidemics among countries in sub-Saharan Africa are not well understood. Here Bongaart assesses the potential roles of late age at marriage and a long period of premarital sexual activity as population risk factors, using ecological data from 33 sub-Saharan African countries and with individual-level data from Demographic and Health Surveys (DHS) in Kenya and Ghana in 2003. The ecological analysis finds a significant positive correlation between HIV prevalence and median age at first marriage, and between HIV prevalence and interval between first sexual intercourse and first marriage. The individual-level analysis shows that HIV infection per year of exposure is higher before than after first marriage. These findings support the hypothesis of a link between a high average age at marriage and a long period of premarital intercourse during which partner changes are relatively common and facilitate the spread of HIV. Editors' note: This ecological association makes common sense overall, particularly for young men and increasingly for young women. However, in societies in which adolescent marriage - a human rights concern - is common, HIV prevalence can be higher among married adolescent girls than among unmarried sexually active girls of the same age. This can be
the result of the broader age gap between spouses versus between girlfriend-boyfriends, with implications for pre-marital HIV risk in the husband, and difficulties in negotiating condom use within marriage. Marriage cannot automatically be assumed to be either risky or protective - it is the behaviours that make the difference when HIV is looking for opportunities.


In 2003, Brazil’s Ministry of Health launched a national campaign aimed at promoting the use of condoms by adolescent women. The Carnival Campaign was broadcast on television and radio between February 16 and March 3 and targeted young women, between 13 and 19 years of age, a social group that previously had registered a growth in the number of cases of AIDS and other sexually transmitted diseases (STDs). The Ministry hired Kelly Key, a Brazilian pop singer, to deliver the campaign messages. One of the objectives was to empower the girls and encourage them not to be ashamed to buy condoms and to demand that their partners use them. The article presents the results of a national survey conducted with 1,006 adolescent women, which was sponsored by the Ministry of Health. The results show that campaign materials reached the main target public and that they were very positively received. Moreover, the survey data show that the Carnival Campaign had important effects, generating discussions in the adolescents’ social environments and reinforcing a social norm that favours the participation of women in the purchase and use of condoms. Editors’ note: Social change communication to create and reinforce new social norms for HIV prevention can use strategies like this one which open up space for discussion, negotiation and safer behaviour. Although a well known woman artist influenced and empowered adolescent girls, the fact that the campaign messages were carried on television and radio meant that it was likely that considerable numbers of men and boys would also have seen and heard the messages, enhancing the probability that they will react favourably. The next step is to change social norms about what it means to be a real man so that men and boys will act favourably from the start.


In South Africa, a gender power imbalance exists which may prevent women from negotiating safe sexual encounters. In this study Boer and colleagues tested which constructs from Protection Motivation Theory (PMT) and the Theory of Planned Behaviour (TPB) and their circumstances were most related to condom use intention. The authors hypothesized that in a situation of gender power imbalance, self-efficacy would be a more salient correlate of intended condom use for females, while for males’ attitude to condoms and subjective norm would be more important. This study employed a cross-sectional questionnaire design. Male participants (N=94) and female participants (N=101) from Venda, South Africa completed standard, multi-item, reliable measures of Theory of Planned Behaviour constructs (condom-related attitude, subjective norm, perceived behavioural control, intention) and Protection Motivation Theory constructs (vulnerability, severity, fear, response-efficacy, self-efficacy) and reported their past condom use behaviour. Regression analysis indicated that among males, attitude to condoms and subjective norm were significantly related to intended condom use. Among females, attitude to condoms and self-efficacy were significantly related.
to intended condom use. The findings indicate that in a situation of gender power imbalance, psychosocial correlates of intended condom use differ for males and females. Gender-specific analysis of determinants of condom use may be more appropriate in a situation of gender power imbalance. Editors’ note: The authors’ hypothesis was confirmed: perceived norm is most important for men while for women their level of confidence to propose or insist on condom use is most related to intentions to use condoms. Now if we can increase women’s confidence and create the social norms such that men expect that condoms will be used, we may get high condom use levels yet!

5. Stigma

Chan KY, Stoove MA, Sringernyuang L, Reidpath DD. Stigmatization of AIDS Patients: Disentangling Thai Nursing Students’ Attitudes Towards HIV/AIDS, Drug Use, and Commercial Sex. AIDS Behav 2007 Mar 16; [Epub ahead of print]

This paper analyzes the interrelationships between HIV stigma and the co-stigmas of commercial sex (CS) and injecting drug use (IDU). Students of a Bangkok nursing college (N = 144) were presented with vignettes describing a person varying in the disease diagnoses (AIDS, leukaemia, no disease) and co-characteristics (IDU, CS, blood transfusion, no co-characteristic). For each vignette, participants completed a social distance measure assessing their attitudes towards the hypothetical person portrayed. Multivariate analyses showed strong interactions between the stigmas of AIDS and IDU but not between AIDS and CS. Although AIDS was shown to be stigmatizing in and of itself, it was significantly less stigmatizing than IDU. The findings highlight the need to consider the non-disease-related stigmas associated with HIV as well as the actual stigma of HIV in treatment and care settings. Methodological strengths and limitations were evaluated and implications for future research discussed. Editors’ note: These attitudes likely reflect those of the society in which these nursing students live, which in the past has enacted repressive measures against people who use drugs while generally tolerating people who sell sex. The results of studies like this can help health professionals better understand the attitude shifts and behaviour changes they need to make to better serve their patients.

6. Mother-to-child transmission


Schulte and colleagues’ goal was to determine trends in low birth weight and preterm birth among US infants born to HIV-infected women. The authors used data from the longitudinal Pediatric Spectrum of HIV Disease, a large HIV cohort, to assess trends in low birth weight and preterm birth from 1989 to 2004 among 11,321 study infants. Among women with prenatal care, the authors also assessed risk factors, including maternal antiretroviral therapy during pregnancy, that were predictive of low birth weight and preterm birth using univariate and multivariate logistic regression models. Overall, 11,231 of 14,464 infants who were enrolled in Pediatric Spectrum of HIV Disease were tested during the neonatal period. From 1989 to 2004, testing increased from 32% to 97%. The proportion of HIV-exposed infants who had low birth weight decreased from 35% to 21% and occurred in all racial/ethnic groups. Prevalence of preterm birth decreased from 35% to 22% and occurred in all groups. Any maternal antiretroviral therapy use increased from 2% to 84%. Among
8793 women who had prenatal care, low birth weight was associated with a history of illicit maternal drug use, unknown maternal HIV status before delivery, symptomatic maternal HIV disease, black race, Hispanic ethnicity, and infant HIV infection. Antiretroviral therapy or lack of it was not associated with low birth weight. Among women with prenatal care, preterm birth was associated with a history of illicit maternal drug use, symptomatic maternal HIV disease, no antiretroviral therapy, receipt of a 3-drug highly active antiretroviral therapy regimen with protease inhibitors, black race, and infant HIV infection. The authors conclude that the proportion of infants who had low birth weight or were born preterm declined during an era of increased maternal antiretroviral therapies. These Pediatric Spectrum of HIV Disease trends differ from the overall increases in both outcomes among the US population. Editors' note: It is quite striking that preterm births and low birth weight are on the rise in the USA overall and yet pregnancy outcomes for women living with HIV in all racial/ethnic groups improved from 1999 to 2004. Since antiretroviral therapy or lack of it was not associated with low birth weight, perhaps it was antenatal care itself that turned the tide for infants born to HIV-infected mothers in the US.


The prevalence of HIV infection in the Caribbean is reported to be second only to sub Saharan Africa. HIV in pregnancy has become an increasingly important focus of attention in HIV research because of its role in contributing to spread of the infection. This study sought to establish the prevalence and risk factors associated with HIV infection among antenatal women in the northwest region of Trinidad. Using a cross-sectional survey design, interviews were conducted with each new pregnant attendee to the antenatal clinics in the county of St George West over a six-month period after informed consent was obtained. These women were all offered routine HIV testing in their antenatal assessment. Their HIV results were confirmed through the island’s HIV monitoring facility. The interviews included questions on demographics, known risk factors for HIV infection, mental health history and related information on their partners. Women who had refused testing were also asked to give reasons for this. There were a total of 541 women attending the clinic for the first time during the six-month period seven of them refused testing. Of the remaining 534 women, 37 were HIV positive (6.8%). Fourteen of the HIV positive women (37.8%) admitted to knowing of their status prior to becoming pregnant. Risk factors significantly associated with positive HIV status were early age of first sexual intercourse, a history of sexually transmitted disease, mental health problems and homelessness. Regression analysis established a history of sexually transmitted disease as the only independent predictor of HIV infection in this sample. These findings reveal a high rate of HIV infection among pregnant women in northwest Trinidad and suggest that having a history of sexually transmitted disease is a key determinant of this. Prevention efforts must therefore be targeted at identifying the factors which influence this and these include early sexual activity and the experience of childhood sexual abuse. Editors' note: Although a history of sexually transmitted disease was the only independent predictor of HIV infection among pregnant women in north-west Trinidad, sexually transmitted infections are themselves associated with broader problems which must be addressed on the grounds of human rights (child sexual abuse) and psychosocial health (homelessness and mental health problems). Delaying onset of
sexual debut would go a long way to reducing risk for Trinidadian adolescents and young women.

7. Men who have sex with men


Little research exists regarding men who have sex with men and sexual risk in Nigeria. Prior to the implementation of a targeted HIV/STI prevalence study, structured focus groups incorporating anonymous questionnaires were conducted with members of this population in secure locations in Nigeria. A purposive sample of men was recruited by word-of-mouth. Five focus groups were conducted with a total of 58 men. Mean age was 27 years (range 16-58); 60% had post-secondary education; 56% were employed full or part-time; 83% were Christian; 16% were Muslim; 66% self-identified as bisexual; 31% as homosexual. Participants' experiences were diverse, with ethnic, religious and class distinctions strongly structuring sexual expression. Same-sex community networks were hidden, with social activities taking place in non-commercial, private venues. Socially ostracized by culture, religion, and political will, the risks embodied within same-sex activity are high. For Nigeria—a nation culturally rich and religiously devout—the implications for public health policy are complex. However, these research findings suggest that immediate action is vital to mitigate the impacts of HIV and other STIs. Editors' note: Men who have sex with men are often a hidden population in many countries in sub-Saharan Africa but when service providers work with them to design confidential sexual health services that reach out to them as is the case in a clinic in Dakar, Senegal, these men do come forward for treatment and counselling. Creative and respectful approaches are required to overcome intense stigma and engage communities of men who have sex with men in these settings.

8. Traditional medicine


It has been estimated that more than 80% of people in Africa use traditional medicine. With the HIV epidemic claiming many lives in Africa, the majority of people affected rely on traditional medicine mainly because it is relatively affordable and available to the poor populations who cannot afford orthodox medicine. Whereas orthodox medicine is practiced under stringent regulations and ethical guidelines emanating from The Nuremburg Code, African traditional medicine seems to be exempt from such scrutiny. Although recently there have been calls for traditional medicine to be incorporated into the health care system, less emphasis has been placed on ethical and regulatory issues. In this paper, an overview of the use of African traditional medicine in general, and for HIV in particular, is given, followed by a look at: (i) the relative laxity in the application of ethical standards and regulatory requirements with regards to traditional medicine; (ii) the importance of research on traditional medicine in order to improve and demystify its therapeutic qualities; (iii) the need to tailor-make intellectual property laws to protect traditional knowledge and biodiversity. A framework of partnerships involving traditional healers' associations, scientists, policy makers, patients, community leaders, members of the communities, and funding organizations is suggested as a possible method to tackle these issues. It is hoped that this paper will stimulate objective and constructive debate that could enhance the
protection of patients’ welfare. Editors’ note: The pragmatic approach suggested here fits with the perspectives of the UNAIDS’ best practice publication from November 2006: Collaborating with Traditional Healers for HIV Prevention and Care in sub-Saharan Africa: suggestions for Programme Managers and Field Workers which will shortly be available in the new 16 page Highlights version.

9. Sex work


The Sonagachi Project of Kolkata, India has been recognized as a model community development and human immunodeficiency virus/sexually transmitted infection (HIV/STI) prevention intervention among female sex workers. Limited research has been conducted regarding its applicability outside the South Asian context. This study sought to document the process and effectiveness of integrating community development activities based on the Sonagachi model into an ongoing HIV/STI peer education program with female sex workers in Rio de Janeiro, Brazil. Structured cross-sectional surveys examining HIV/STI-related behaviors and community development measures were conducted among approximately 500 sex workers at pre-and post-intervention. Kerrigan and colleagues found that several community development components including social cohesion and mutual aid were significantly associated with consistent condom use among sex workers and their paying clients at pre-intervention. However, only a minority of women actively engaged in community-building activities over the 18-month study period. In turn, limited changes in community development components and no significant increases in the HIV/STI-related protective behaviors assessed were documented. Findings indicate that internalized stigma and socioeconomic pressures may have constrained the scope and pace of community mobilization in this setting during the study observation period. Editors’ note: Results may not be reproducible when successful approaches are transposed from one project to another if the scope, scale and intensity are not replicated. In this case, the conditions were ripe in terms of solidarity but neither internalized stigma nor socio-economic pressures could be overcome to achieve results similar to Sonagachi.

10. Women and girls


Diiorioi and colleagues examined how African-American mothers’ discussions with their adolescents about sex moderated the relationship between adolescents’ sex-based discussions with their friends and adolescents’ involvement in sexual behaviors. The 425 African-American adolescents were 12 through 15 years of age and had participated in an HIV prevention research project with their mothers. Linear and logistic regression analyses showed that, for girls, age, discussions with friends, and the interaction between mother and friend’s sex-based discussions were statistically significant predictors of sexual behaviors. These findings suggest that the level of discussion with mothers had a moderating effect on the relationship between friends’ discussions about sex and a girl’s involvement in sexual behaviors. Although these results were not apparent for boys, there was a strong
relationship between discussions with friends about sex and sexual behaviors among boys.

Editors’ notes: The results of this study among girls replicates in part what has been seen in other cultural settings: parent-adolescent communication on a variety of topics, including sex, tends to delay sexual debut. If you are a parent, take note!

11. Partnerships


This synopsis seeks to highlight and promote the enormous potential that exists between these two initiatives that seek to address closely related issues and targeting the same populations at risk within a fairly well defined geographical setting. It also attempts to argue that malaria control, just like HIV control, be given high priority in the New Partnership for Africa’s Development (NEPAD) health agenda, as current statistics indicate that malaria is again on the rise. While much attention and billions of dollars have rightly been given to HIV research, treatment and prevention, malaria, and not HIV, is the region’s leading cause of morbidity and mortality for children under the age of five years. This is the bad news. The good news is that unlike HIV, malaria treatment and prevention are relatively cheap. In addition, there is a payback to fighting malaria: support aimed directly at improving health, rather than poverty reduction, may be a more effective way of helping Africa to thrive. Robust and sustained growth may come to Africa through a mosquito net, Artemisinin-based Combination Therapies (ACTs) or a malaria vaccine, rather that a donor’s cheque for economic development initiatives. Editors’ note: We need to get out of our silos, strengthen health systems and look holistically at how we can best address malaria, tuberculosis, and HIV to improve Africa’s development prospects.

12. Harm reduction

Ball AL. HIV, injecting drug use and harm reduction: a public health response. Addiction 2007 Mar 9; [Epub ahead of print]

Injecting drug use is driving HIV epidemics in many countries around the world. There is evidence that such epidemics can be averted, halted and reversed if comprehensive HIV programmes targeting drug users are put into place. The term ‘harm reduction’ is used widely to describe the goals, policies and interventions of such programmes. However, despite its rapidly expanding use, the term has no universally accepted definition. This paper aims to describe the evolution and branding of the term ‘harm reduction’ and the adoption of the concept across a wide range of countries. It highlights a range of issues that remain controversial in the harm reduction discourse related to HIV and injecting drug use, including: the definition of ‘harm reduction’ and related terms; the scope of harm reduction; the promotion of a public health versus drug control dichotomy; the feasibility and appropriateness of harm reduction in low-and middle-income countries; and the strength of evidence on harm reduction interventions. The paper argues that harm reduction should be a core element of a public health response to HIV where injecting drug use exists. The effectiveness of policies and programmes targeting drug users should be measured against public health outcomes. This requires the alignment of drug control measures with public health goals. A ‘model package’ for harm reduction is proposed, which provides guidance to countries on the selection of evidence-based policies and interventions, including: interventions for reducing HIV transmission; treatment of HIV and associated co-
morbidities; appropriate models of service delivery; creation of supportive policy, legal and social environments; and strengthening of strategic information systems to better guide responses. Editors’ note: Ensuring that people who inject drugs have timely access to sterile injecting equipment in adequate quantities is a pillar of harm reduction but it must be contextualized within a comprehensive programme for prevention, treatment, care and support to achieve reductions in HIV incidence and prevalence in this population. Although the UN has defined harm reduction as being needle exchange, substitution therapy and peer outreach, the broader framework presented here by WHO reflects what is really needed to make these components effective.

That was *HIV This Week*, signing off.

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**Editors’ notes on journal access**

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

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


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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.

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