

AHRF Update

Books, Reports and Papers published in 2005



Compiled by the African HIV Research Forum



Introduction

This document provides an extensive listing of research published in the 2005 useful to those working with African people living with HIV in the UK. Divided into three sections, books, reports and papers, it lists all the research previously published in AHRF News, as well as some of those which could not be included in the quarterly publication.

Books

Handbook of Health Research Methods: Investigation, Measurement and Analysis. Bowling, A and Ebrahim, S. 2005. Oxford University Press.

This book of edited chapters helps researchers from clinical and non-clinical disciplines plan, carry out, and analyse research, and evaluate the quality of research studies.

The Hope Factor: Engaging the Church in the HIV/AIDS Crisis.

Authentic Media, 2005.

This groundbreaking volume brings together today's foremost Christian thinkers and practitioners who are fighting the HIV/AIDS pandemic around the world. The authors outline the extent of this global crisis; provide case studies detailing noteworthy interventions, and offer biblical reflections on HIV/AIDS

Alshami, B. **UK AIDS Directory.** 2005. NAM Publications.

This directory offers the most comprehensive listing of HIV-related services in the UK. It covers both local and national organisations from the voluntary and statutory sectors, providing details for a huge range of services including testing and treatment centres, support groups, and services for specific communities. "The UK AIDS Directory" gives a unique picture of the UK's HIV sector, and is an invaluable tool for anyone whose work involves making referrals, promoting services and events, researching information or networking with other HIV professionals. Full service and contact details for over 1740 organisations are listed, including: named contacts;

service profiles and opening hours; mailing addresses; phone and fax numbers; email addresses; and website addresses. A simple indexing system makes it possible to search by area, service type, organisation name or contact name.

Gadd, C. **HIV and AIDS Treatments Directory.** NAM Publications.

This resource covers all medical aspects of HIV & AIDS, from in-depth background information on HIV, to the latest information on current treatments. It contains comprehensive reviews of the scientific data on when to start treatment and what to start with, and important updates on: a to z of drugs options during pregnancy treatment for children vaccines. Plus A-Z sections on treatments, illnesses and symptoms.

Pattman R. **Oxford handbook of genitourinary medicine, HIV, and AIDS.** Oxford University Press, 2005.

Genitourinary medicine (GUM) is an expanding specialty which is primarily related to the treatment and prevention of sexually transmitted infections (STIs). A number of GUM departments also offer other sexual health services such as contraception, sexual dysfunction and health promotion. Services are provided by multidisciplinary teams which include doctors, nurses, health advisers (who carry out partner notification and counselling), receptionists, laboratory staff and secretarial support. The "Oxford Handbook of Genitourinary Medicine HIV and AIDS" provides practical, evidence-based information on the specialty, covering medico-legal, ethical, and procedural issues.

Igo, R. **Listening with Love: Pastoral Counselling, A Christian Response to People Living with HIV/AIDS.**

2005. World Council of Churches.

HIV/AIDS has touched the lives of millions of people around the world. For those infected with the disease, and their families, friends and neighbours, living with AIDS is often especially difficult because of the ignorance, fear and prejudice they encounter. Those who live with HIV/AIDS can feel isolated and ashamed, unable to talk to others, unable to express their feelings, unable to voice their fears for themselves and their loved ones. The care and counselling of those living with HIV/AIDS can seem an immensely difficult task.

"Listening with Love" is designed for all those Christians who are called to help people cope with HIV/AIDS. Step by step, it introduces us to the basic medical facts, and guides us through practical, loving approaches that enable us to empathise and communicate with those whose lives have been transformed by the disease. Using everyday language and case studies that reveal the kinds of issues and problems that counsellors typically face, this Bible-based manual helps us discover within ourselves and those to whom we talk the confidence, respect and hope that can help people living with HIV/AIDS overcome their fears.

Reports

TUC Conference on HIV and AIDS: beating the pandemic. Report of the TUC Conference on the workplace response to the global challenge of HIV and AIDS - Saturday 4 December 2004 organised in co-operation with the Bill Morris

Testimonial Campaign on HIV/AIDS. 2005. London, TUC.

On December 4, 2004, the TUC, supported by the Bill Morris Testimonial Fund for HIV and AIDS, convened a conference, which brought together a variety of organisations working to combat the effects of HIV and AIDS, including union members and organisers. The clear consensus was for the formation of a broad coalition involving every worker in every workplace; we need to move from seeing HIV and AIDS not only as an issue for trade union policies, but an issue for workplace practice.

HIV and the Criminal Law. 2005.

Terrence Higgins Trust.

As of Autumn 2005, there have only been five successful prosecutions in England and Wales, and two in Scotland (under a slightly different law). Because the law is currently confused and there is, as yet, no guidance from the Crown Prosecution Service (CPS) on what should be prosecuted, we have to base our advice on the decisions made in those cases and this advice may change in the light of future appeals and other cases. This paper written to help people who give advice in person or on phone lines think through possible responses to questions which are becoming more frequent about prosecution for transmission of HIV in the UK.

HIV and AIDS in African Communities: A framework for better prevention and care. 2005.

London, Department of Health.

HIV and AIDS have disproportionately affected African communities in England. After gay men they are the largest group affected by HIV and since 1999 new diagnoses in Africans have overtaken new diagnoses in other groups. In

line with the Sexual Health and HIV Strategy the framework sets out actions to improve effectiveness of HIV prevention and health promotion, and treatment and care services for African communities affected by or at risk of HIV.

Conway, M. **HIV in Schools: Good Practice Guide to Supporting Children Infected or Affected by HIV.** 2005. London, National Children's Bureau.

This guide provides schools and local education authorities with practical information and suggestions on ways of supporting children and young people living with HIV. It addresses schools' concerns about HIV and sets out some simple ways in which a school can provide a supportive environment for infected and affected children.

Doyal, L, Anderson, J, and Apenteng, P. **"I want to survive, I want to win, I want tomorrow" An exploratory study of African men living with HIV in London.** 2005. Homerton University Hospital, Queen Mary University of London, African HIV Policy Network, Terrence Higgins Trust.

This report examines the lives of a group of African men living with HIV in London. The men have responded to HIV infection in a variety of different ways and many still feel optimistic about the future. But the main theme in these accounts is one of loss. Many do not have the jobs or the money they had planned to acquire. Others are not able to enjoy the sexual experiences which they see as a mark of manhood. Some do not have the relationships with wives or children that would give their lives meaning and connect them with past and future generations. Serious anxieties are expressed by many about their future in the UK, and ongoing access to the anti-retroviral drugs vital for survival. Religion has proved to be a great solace for many while others have gained support from their involvement in voluntary organisations. Most face significant challenges to their sense of themselves as African men.

Hinchcliffe, D. **New Developments in Sexual Health and HIV/AIDS Policy, Third Report of Session: House of Commons Papers 2004-05, 252-1.**

Vol. 1 Report, Together with Formal Minutes. 2005. Stationery Office.

Following on from the Committee's earlier inquiry (HCP 69-1, session 2002-03, ISBN 021501104X) published in June 2003, this report examines progress made to address sexual health issues, including services access and funding, screening policies for chlamydia, sex education, primary care services, and the public health implications of the introduction of charges for overseas visitors for NHS treatment for HIV/AIDS. Findings include that rates of sexually transmitted infections have continued to rise since 2003, despite the introduction of a maximum waiting time of 48 hours for access to sexual health clinics, with problems identified in ensuring increased funding is targeted effectively on the clinics in order to increase their capacity to meet rising demand. The Government should review the GP contract in order to prioritise sexual health needs, with a dedicated training programme established for GPs and practice nurses. The Committee also recommends that by 2007, personal, social and health education (PSHE) lessons in schools should be taught by specialist accredited teachers rather than unqualified form tutors, and established as a statutory assessed part of the National Curriculum.

MAYISHA II Collaborative Group. Assessing the feasibility and acceptability of community based prevalence surveys of HIV among black Africans in England. 2005.

London, Health Protection Agency Centre for Infections.

This report presents the findings of a community-based survey conducted among 1359 Africans in London, Luton and West Midlands with follow-up in-depth interviews among 44 purposively selected survey respondents during 2004-05. Findings from Mayisha II confirm that the impact of discrimination and stigma is widespread within the lives of Africans in the UK and contributes to decisions to HIV test. Outreach work is having an impact on the acceptability of VCT in the

community, but more action is needed to reduce HIV-related stigma and discrimination

Paterson, G. **AIDS Related Stigma. Thinking outside the box: The Theological Challenge.** 2005. Geneva, Ecumenical Advocacy Alliance and the World Council of Churches.

In November 2001, the World Council of Churches convened a meeting of African church leaders, in Nairobi, to draw up an ecumenical plan of action for responding to the AIDS epidemic. It was unanimously agreed that, for churches, the eradication of HIV and AIDS-related stigma must be a priority: a resolution that has since been endorsed, regionally and internationally, by individual denominations. The plan of action itself gave birth to a range of international initiatives. This report is a reflection on some of the challenges encountered, by churches and individual Christians who are grappling with the theological implications of their concern to eradicate stigma.

The UK Collaborative Group for HIV and STI Surveillance. **Mapping the Issues. HIV and other Sexually Transmitted Infections in the United Kingdom: 2005.** 2005. London, Health Protection Agency Centre for Infections.

This 2005 annual surveillance report for the United Kingdom (UK) describes a worrying situation with undiminished and high levels of transmission of HIV and other sexually transmitted infections (STIs) among men who have sex with men (MSM), a steady increase in the number of HIV-infected black Africans in the UK, limited but compelling evidence that heterosexual transmission of HIV within the UK is slowly rising, and continuing high transmission of other STIs, especially chlamydia among young people. The report summarises current surveillance information on HIV and STIs, as well as some of the behaviours underlying transmission, and shows the distribution of the problem across different areas of the country.

UNAIDS. **AIDS epidemic update:**

December 2005. 2005. Geneva, Switzerland, UNAIDS.

The UNAIDS/WHO annual AIDS Epidemic Update for 2005 was launched on Monday 21 November in 19 countries around the world. The annual Update reports on the latest developments in the global AIDS epidemic. With maps and regional summaries, the 2005 edition features a special section on HIV prevention.

UNAIDS. **AIDS in Africa: Three scenarios to 2025 (2005).** 2005.

Geneva, Switzerland, UNAIDS.

This project uses stories rather than projections to explore the future of AIDS in Africa over the next 20 years. This project uses stories rather than projections to explore the future of AIDS in Africa over the next 20 years. Statistics may give a succinct and tragic snapshot of recent events, but they say little of the AIDS epidemic's wider context, or its complex interconnections with other major issues, such as economic development, human security, peace, and violence. Statistics can only hint at the future. Indeed, by 2025, no one under the age of 50 in Africa will be able to remember a world without AIDS.

UNAIDS. **A Report of a Theological Workshop Focusing on HIV- and AIDS-related Stigma** 2005. Geneva, World Health Organization.

Churches and other faith-based organizations continue to play an important part in responding to the AIDS epidemic. This report of a workshop held in Windhoek, Namibia, explores some issues in thinking theologically about AIDS and stigma. The participants were from different Christian traditions and countries; future workshops will cover Muslim, Hindu and Buddhist perspectives.

Papers

Adler M. **Sex is dangerous.** Clinical Medicine. 2005;5:62-8.

Infectious diseases with high mortality, disability and creating public anxiety are not new, but despite this our initial responses to HIV/AIDS have been primitive and slow. Since the start of the epidemic over 60 million people throughout the world have been infected, with the main focus of the epidemic currently in Sub-Saharan Africa. However, there is every indication that the epidemic will move more towards South-East Asia, with increasing numbers in India and China. Infection with HIV has a profound effect on individuals and their families, and can also lead to destabilisation of societies through its effects on the economy, institutions and security. Considerable emphasis has been placed recently on the widespread use of anti-retroviral therapy. This is a worthwhile initiative but is only part of a balanced array of approaches, which requires building a political consensus, social economic interventions and modifying the biology. Strong political leadership is still required, with an approach that recognises that the socioeconomic drivers of this epidemic..

Beck A, Majumdar A, Estcourt C, Petrak J. **"We don't really have cause to discuss these things, they don't affect us": a collaborative model for developing culturally appropriate sexual health services with the Bangladeshi community of Tower Hamlets.** Sexually Transmitted Infections. 2005;81:158-62.

The aim of this study was to identify barriers to accessing sexual health care among the Bangladeshi community of east London and to develop a model of community participation in service development. Qualitative study using one to one interviews with sexual health service users plus focus groups in community settings. Fifty-eight people participated in the study, 12 in individual interviews and the remainder in six focus groups. All were of Bangladeshi origin. Four main themes were reported as impacting on access to services; confidentiality concerns, relevance of services to the community, problems with discussing

sexual issues, and problems with previous experiences of health promotion. Community values regarding sex outside of marriage were an important underlying factor in participants' responses. Existing sexual health services were seen as culturally insensitive by patients and community groups. Community based health initiatives among hard to reach ethnic minority groups should use existing networks of statutory and non-statutory groups to benefit from local expertise and relationships. Steering groups composed of members of the local communities served by the clinic can usefully inform service development.

Boyd AE, Murad S, O'Shea S, *et al* **Ethnic differences in stage of presentation of adults newly diagnosed with HIV-1 infection in south London.** HIV Medicine. 2005;6: 59-65.

This study aimed to establish whether there were ethnic differences in demographic characteristics, the stage at HIV diagnosis and reasons for and location of HIV testing between 1998 and 2000 in a large ethnically diverse HIV-1-infected clinic population in south London in the era of highly active antiretroviral therapy. A retrospective review was carried out of all persons >18 years old attending King's College Hospital with a first positive HIV-1 test between 1 January 1998 and 31 October 2000, and of a random sample of patients attending St Thomas' hospital with a first positive HIV-1 test in the same period. Demographic data, details of reasons for and site of HIV test, clinical stage, CD4 lymphocyte count and HIV-1 viral load at HIV diagnosis were abstracted from the local database and medical records. Comparisons were made according to ethnic group (white, black African and black Caribbean) and over time (1998, 1999 and 2000). Of the 494 patients with new HIV-1 diagnoses between January 1998 and December 2000, 179 (36.2%) were white, 270 (54.7%) were black African and 45 (9.1%) were black Caribbean. There were significant differences across the ethnic groups in HIV risk group, reasons for and site of HIV testing, and clinical and CD4 stage at diagnosis. Among whites, 72.6% were men who had sex with men,

3.4% injecting drug users and 21.2% heterosexuals, compared to 2.2%, 0.4% and 93.3% among black Africans, and 28.9%, 0% and 68.9% among black Caribbeans ($P < 0.001$). Black Africans were more likely to present with an AIDS diagnosis (21.3%) and a lower CD4 cell count [223 cells/microL; interquartile range (IQR) 88-348] compared to both whites (9.9%; 358 cells/microL; IQR 151-508) and black Caribbeans (17.9%; 294 cells/microL; IQR 113-380), who were intermediate between whites and black Africans in their stage of presentation. There was a statistically nonsignificant trend with time, between 1998 and 2000, towards earlier diagnosis based on the CD4 cell count in whites (323 and 403 cells/microL) and black Caribbeans (232 and 333 cells/microL), but a later diagnosis in black Africans (233 and 175 cells/microL). The majority of black Africans were HIV-tested as a result of suggestive symptoms or antenatal screening (58.4%) rather than because of perceived risk (40.5%), in contrast to the situation in whites (24.1% vs. 71.7%, respectively) or black Caribbeans (34.5% vs. 65.5%, respectively) ($P < 0.001$). We found no significant differences across ethnic groups in age, HIV-1 viral load or year of HIV diagnosis. Black Africans continue to present with more advanced HIV disease than whites or black Caribbeans, with no evidence of any trend towards earlier diagnosis. Future educational campaigns designed to promote the uptake of HIV testing among black Africans and black Caribbeans will need to address the multiple barriers to testing, including misperception of risk, stigma and ready access to testing. .

Campbell C, Foulis CA, Maimane S, Sibiya Z. **"I have an evil child at my house": stigma and HIV/AIDS management in a South African community.** American Journal of Public Health 2005;95:808-15. We examined the social roots of stigma by means of a case study of HIV/AIDS management among young people in a South African community (drawing from interviews, focus groups, and fieldworker diaries). We highlight the web of representations that sustain stigma, the economic and political contexts within which these representations are constructed, and

the way in which they flourish in the institutional contexts of HIV/AIDS interventions. Stigma serves as an effective form of "social psychological policing" by punishing those who have breached unequal power relations of gender, generation, and ethnicity. We outline an agenda for participatory programs that promote critical thinking about stigma's social roots to stand alongside education and, where possible, legislation as an integral part of antistigma efforts.

Chadborn TR, Baster K, Delpech VC, *et al*. **No time to wait: how many HIV-infected homosexual men are diagnosed late and consequently die? (England and Wales, 1993-2002).** AIDS 2005;19:513-20.

The authors aimed to present national trends of the estimated number and proportion of late HIV diagnoses and short-term mortality following diagnosis among men who have had sex with men (MSM). To determine separately risk factors for late diagnosis and short-term mortality. Analysis of national HIV/AIDS case reports of new diagnoses linked to CD4 cell counts from the CD4 Surveillance Scheme. Inverse probability weighting adjusted for individuals with no CD4 cell count at diagnosis. Outcomes were late diagnosis (CD4 cell count $< 200 \times 10^6$ cells/l at diagnosis) and short-term mortality (death within 1 year of diagnosis). Of 14,158 new diagnoses, 31% were estimated as late diagnoses. Despite a decreasing trend (P trend < 0.01) an estimated 430 (25%) MSM were still diagnosed late in 2001. Late diagnosis disproportionately affected individuals diagnosed outside London, of non-white ethnicity, and of older age. There were 710 (5.0% of 14 158) deaths within a year of HIV diagnosis. Estimated short-term mortality was 14% for MSM diagnosed late and 1% for other MSM (adjusted odds ratio, 10.8; 95% confidence interval, 7.7-15.9). Short-term mortality declined concurrently with availability of highly active antiretroviral therapy and was independently associated with age and diagnosis outside London but not ethnicity. The continued late diagnosis of one in four MSM means these individuals lose the option to start therapy early, miss opportunities to prevent further transmission and are

approximately 10 times more likely to die within a year of diagnosis. Early diagnosis of all MSM in 2001 could have reduced short-term mortality by 84% and all mortality in that year by 22%.

Chakraborty R. **HIV-1 infection in children: a clinical and immunologic overview.** Current HIV Research. 2005;3:31-41.

Globally, HIV-1 is most often transmitted heterosexually so that nearly half of all infected adults are women of child-bearing age. Infants may acquire infection from vertical transmission. Without treatment most HIV-1 infected children in Africa die before their third birthday; as a result child mortality has increased overall by 35-50%, and by greater than 100% in areas of high seroprevalence. HIV-1 infection has a heterogeneous spectrum of clinical course. Compared to HIV-1-infected adults, survival times are considerably shorter for children who acquire the virus perinatally or during infancy. Factors contributing to accelerated disease progression in infants and children are poorly understood but may include relative immunological immaturity, thymic HIV-1-mediated destruction at a time of active thymopoiesis, and HLA class I sharing between mother and infant. This review will initially discuss clinical and biological determinants of mother-to-child transmission and disease progression in HIV-infected infants and children. Our current knowledge of the mechanisms of T cell depletion is summarised and the host immune response to HIV-1 (innate and adaptive) described in the context of Pediatric HIV-1 infection.

Chen F, Day SL, Metcalfe RA, *et al.* **Characteristics of autoimmune thyroid disease occurring as a late complication of immune reconstitution in patients with advanced human immunodeficiency virus (HIV) disease.** Medicine (Baltimore) 2005;84:98-106.

In this study of the "late" manifestation of autoimmune thyroid disease (AITD) in a cohort of HIV-positive patients following highly active antiretroviral therapy (HAART), the authors discuss how

immune dysregulation and factors associated with the immunopathology of HIV infection fit the current understanding of autoimmunity and provide a plausible basis for clinical observations. New diagnoses of thyroid disease were identified between 1996 and 2002 in 7 HIV treatment centers (5/7 centers completed the study). Patients were diagnosed as clinical case entities and not discovered through thyroid function test screening. Paired plasma specimens were used to demonstrate sequential rise in thyroid antibodies. Seventeen patients were diagnosed with AITD (median age, 38 yr; 65% were of black African or black Caribbean ethnicity; and 82% were female). The median duration of immune reconstitution was 17 months. Graves disease (GD) was diagnosed in 15 of 17 patients. One patient developed hashithyrototoxicosis with atypically raised C-reactive protein, and another developed hypothyroidism. One GD patient had associated secondary hypoadrenalism. The estimated combined prevalence of GD for 4 treatment centers for female patients was 7/234 and for males was 2/1289. The denominator numbers were matched controls, from 4 centers able to provide data, who commenced HAART during the same time (January 1996 to July 2002) and who did not develop clinical AITD. The mean baseline pre-HAART CD4 count was 67 cells/mL, and the mean increase from nadir to AITD presentation was 355 cells/mL. AITD patients were more likely than controls (95% confidence interval, chi-square test) to be severely compromised at baseline (as defined by a CD4 count < 200 cells/mL or the presence of an acquired immunodeficiency syndrome [AIDS]-defining diagnosis), and to experience greater CD4 increments following HAART. AITD may be a late manifestation of immune reconstitution in HIV-positive patients taking HAART, and immune dysregulation may be an important factor.

Conaty SJ, Cassell JA, Harrison U, *et al.* **Women who decline antenatal screening for HIV infection in the era of universal testing: results of an audit of uptake in three London hospitals.** Journal of Public Health

(Oxf) 2005;27:114-7.

Universal screening for HIV in early pregnancy is strongly promoted policy in the United Kingdom with a target of 90 per cent uptake. We identified characteristics of women declining screening by conducting an audit at three hospitals in inner north London. In early 2002 midwives were asked to complete an audit form following first antenatal appointment. Of 2,710 women attending 401 (15 per cent) declined an HIV test. Of women who declined 38 per cent reported they had been tested for HIV in the past; 65 per cent accepted every other antenatal test. In multivariable analysis parity (OR: 1.19; 95 per cent CI 1.10-1.29 per additional child), declining other tests (OR: 3.10; 95 per cent CI 2.44-3.93 per test declined) and previous HIV testing (OR: 1.70; 95 per cent CI 1.30-2.23) were predictors of declining an HIV test. Women declining screening were not obviously from high-risk demographic groups: women from sub-Saharan Africa were not at greater risk of declining an HIV test than women from other regions.

Cooke FJ, Geretti AM, Zuckerman M. **Human T-cell lymphotropic virus antibody prevalence in HIV-1-infected individuals attending a sexual health clinic in South-East London.** Journal Medical Virology. 2005;76:143-5.

HIV and human T-cell lymphotropic virus (HTLV) are both retroviruses with similar routes of transmission. A number of reports suggest variable clinical outcomes in HIV and HTLV co-infected individuals. There is no published information regarding the prevalence of HIV and HTLV co-infection in the UK. We therefore carried out an unlinked anonymised retrospective study to investigate the prevalence of HTLV co-infection in HIV infected patients attending a sexual health clinic in South-East London. We identified sera from 777 HIV-1 positive adults (504 male, 273 female) who had attended our sexual health clinic between January 2000 and March 2001. Serum samples stored at -20 degrees C were initially tested by HTLV-1 and HTLV-2 antibody enzyme-linked immunoassay (EIA). An immunoblot assay was carried out on reactive samples to discriminate between viral subtypes. Samples with indeterminate results were also analyzed by

Western blot. The prevalence of HTLV antibody was 0.8% (five patients with HTLV-1 and one with HTLV-2). Four of the HTLV-1 co-infected patients were females born abroad, of Black African or Caribbean origin. The other HTLV-1-infected patient was a male in the Black Other ethnic group born in the UK, demonstrating that transmission may occur outside recognized areas of high endemicity. The HTLV-2 co-infected individual was a White male born in Italy, and was likely to have been infected through intravenous drug use. The results suggest HTLV antibody screening should be considered in the local HIV infected population of south London.

Dougan S, Patel B, Tosswill JH, *et al* **Diagnoses of HIV-1 and HIV-2 in England, Wales, and Northern Ireland associated with west Africa.** Sex Transm.Infect. 2005;81:338-41. Reports of new HIV diagnoses received at the Communicable Disease Surveillance Centre were analysed. Individuals probably infected in west Africa and those infected through heterosexual intercourse within the United Kingdom by a heterosexual partner infected in west Africa were included. Between 1985 and 2003 inclusive, 1324 individuals diagnosed and reported with HIV had probably been infected in west Africa, with 222 diagnoses made in 2003. 917 (69%) were HIV-1 infected and 52 (6%) HIV-2 or HIV-1/HIV-2 co-infected. For 355 (27%) the HIV type was not reported. The proportion of HIV-2 and HIV-1/HIV-2 infections varied by country of infection ($p < 0.001$): ranging from the Gambia (11.7%-15.2%) to Nigeria (0.7%-1.0%). A further 130 individuals were probably infected through heterosexual intercourse within the United Kingdom by a heterosexual partner infected in west Africa. 89 (68%) were HIV-1 infected and three (2%) HIV-2 infected or HIV-1/HIV-2 co-infected. For 38 (29%) HIV type was not reported. The number of people infected with HIV in west Africa and diagnosed in E,W&NI has increased in recent years, and there is evidence of heterosexual transmission within the United Kingdom from people infected in west Africa. While numbers of HIV-2 diagnoses remain relatively low, an appreciable proportion of people infected in some

west African countries and diagnosed in the United Kingdom may be HIV-2 positive, with implications for prognosis and treatment.

Dougan S, Elford J, Rice B, *et al*. **Epidemiology of HIV among black and minority ethnic men who have sex with men in England and Wales.** Sex Transm.Infect. 2005;81:345-50. Ethnicity data from two national HIV/AIDS surveillance systems were reviewed (1997-2002 inclusive), providing information on new HIV diagnoses and those accessing NHS HIV treatment and care services. In addition, undiagnosed HIV prevalence among MSM attending 14 genitourinary medicine (GUM) clinics participating in the Unlinked Anonymous Prevalence Monitoring Programme and having routine syphilis serology was examined by world region of birth. Between 1997 and 2002, 1040 BME MSM were newly diagnosed with HIV in E&W, representing 12% of all new diagnoses reported among MSM. Of the 1040 BME MSM, 27% were black Caribbean, 12% black African, 10% black other, 8% Indian/Pakistani/Bangladeshi, and 44% other/mixed. Where reported ($n = 395$), 58% of BME MSM were probably infected in the United Kingdom. An estimated 7.4% (approximate 95% CI: 4.4% to 12.5%) of BME MSM aged 16-44 in E&W were living with diagnosed HIV in 2002 compared with 3.2% (approximate 95% CI: 2.6% to 3.9%) of white MSM ($p < 0.001$). Of Caribbean born MSM attending GUM clinics between 1997 and 2002, the proportion with undiagnosed HIV infection was 15.8% (95% CI: 11.7% to 20.8%), while among MSM born in other regions it remained below 6.0%. Between 1997-2002, BME MSM accounted for just over one in 10 new HIV diagnoses among MSM in E & W; more than half probably acquired their infection in the United Kingdom. In 2002, the proportion of BME MSM living with diagnosed HIV in E&W was significantly higher than white MSM. Undiagnosed HIV prevalence in Caribbean born MSM was high. These data confirm the need to remain alert to the sexual health needs and evolving epidemiology of HIV among BME MSM in E&W.

Doyal L, Anderson J. **'My fear is to fall in love again...' How HIV-positive African women survive in London.** Social science & Medicine 2005;60:1729-38.

Many studies are now documenting the circumstances of people living with HIV/AIDS in different parts of the world. We know an increasing amount about the experiences of women who make up the majority of those infected in countries in sub-Saharan Africa. However, very few researchers have examined the lives of female migrants from the region living with HIV. This article begins to fill that gap by exploring the situation of 62 women from different parts of Africa receiving treatment from the National Health Service in London. It is based on a qualitative study carried out between 2001 and 2002 using semi-structured interviews. The analysis explores the ways in which the women's lives are shaped in complex ways by their sex and gender, by their status as migrants and by their seropositivity. It examines the nature of their survival strategies, focusing mainly on the management of information, the use of health services and the importance of spirituality in their lives. The article concludes by highlighting the paradox whereby these women have access to treatment that would be unavailable in their own countries but their survival depends on them remaining in a country which few regard as 'home'.

Epprecht M. **Black skin, 'cowboy' masculinity: A genealogy of homophobia in the African nationalist movement in Zimbabwe to 1983.** Culture Health & Sexuality 2005;7:253-66.

This paper examines the intellectual and social origins of racialist homophobia in contemporary Zimbabwean political discourse, exemplified by President Robert Mugabe's anti-homosexual speeches since the mid-1990s. It challenges the notions that such homophobia is either essential to African patriarchy or simple political opportunism. Tracing overt expressions of intolerance towards male-male sexuality back to the colonial period, it focuses on ways in which notions of appropriate, respectable, exclusive heterosexuality within the 'cowboy'

culture of White Southern Rhodesia trickled into, or were interpreted in, the African nationalist movement. It concludes that understanding this history could improve efforts to address concerns around sexual health in Zimbabwe and elsewhere in the region, particularly silences around same-sex sexuality in HIV/AIDS education and prevention

Evans EM, Nye F, Beeching NJ, Gill GV. **'Disappearing diabetes'-resolution of apparent Type 1 diabetes in a patient with AIDS and cytomegalovirus (CMV) infection.** *Diabetes Medicine.* 2005;22:218-20. A 30-year-old African female with established acquired immunodeficiency syndrome (AIDS) and no history of diabetes, presented in severe diabetic ketoacidosis (DKA). Blood pH was 6.96, serum bicarbonate 5 mmol/l, plasma glucose (PG) 33.0 mmol/l, and urine heavily positive for ketones. She responded to standard treatment and was established on twice-daily subcutaneous insulin. Four months later her insulin was stopped because of hypoglycaemic attacks on small doses. A glucose tolerance test (GTT) at 6 months postdiagnosis was normal (fasting PG 4.4 mmol/l and 2 h PG 7.5 mmol/l), and at 12 months random PG was 4.1 mmol/l and HbA1c 4.3%. The onset of her apparent Type 1 diabetes coincided with an HIV-associated cytomegalovirus (CMV) infection, and a reversible 'CMV insulinitis' may be an explanation. Alternatively, the patient may have had what has recently been described as 'atypical diabetes' in African or Afro-Caribbean diabetic patients. Here resolution of diabetes may occur after presentation, though complete return to normoglycaemia after true DKA is very unusual.

Fenton KA, Mercer CH, McManus S, *et al.* **Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections: a probability survey.** *Lancet* 2005;365: 1246-55. Ethnic variations in the rate of diagnosed sexually transmitted infections (STIs) have been reported in many developed countries. The authors used data from the second British National Survey of Sexual

Attitudes and Lifestyles (Natsal 2000) to investigate the frequency of high-risk sexual behaviours and, adverse sexual health outcomes in five ethnic groups in Great Britain. Striking variations in number of sexual partnerships by ethnic group and between men and women were noted. Reported numbers of sexual partnerships in a lifetime were highest in black Caribbean (median 9 [IQR 4-20]) and black African (9 [3-20]) men, and in white (5 [2-9]) and black Caribbean (4 [2-7]) women. Indian and Pakistani men and women reported fewer sexual partnerships, later first intercourse, and substantially lower prevalence of diagnosed STIs than did other groups. There was a significant association between ethnic origin and reported STIs in the past 5 years with increased risk in sexually active black Caribbean (OR 2.74 [95% CI 1.22-6.15]) and black African (2.95 [1.45-5.99]) men compared with white men, and black Caribbean (2.41 [1.35-4.28]) women compared with white women. Odds ratios changed little after controlling for age, number of sexual partnerships, homosexual and overseas partnerships, and condom use at last sexual intercourse. Interpretation Individual sexual behaviour is a key determinant of STI transmission risk, but alone does not explain the varying risk across ethnic groups. Our findings suggest a need for targeted and culturally competent prevention interventions

Lohse N, Hansen ABE, Jensen-Fangel S, *et al.* **Demographics of HIV-1 infection in Denmark: Results from the Danish HIV cohort study.** *Scandinavian Journal of Infectious Diseases* 2005;37 :338-43. A population-based cohort study design was used to describe the demographic characteristics of the HIV-infected population in Denmark and their variation over time. HIV treatment in Denmark is restricted to 9 centres, and all 3941 HIV-1 infected patients more than 15 y old seen at these centres in 1995 - 2003 were included. The study found an estimated HIV prevalence of 70 per 100,000, and a mean annual incidence rate of 5.1 per 100,000 persons. The number of newly infected individuals was stable with a median of 231 per y (period 1995 - 2002), whereas the

number of deaths decreased from 166 in 1995 to 50 in 2000 ($p = 0.000$) and remained stable thereafter. Of the enrolled patients, 75 % were males, 80 % were Caucasian, 13 % were black African, and the primary risk behaviour was male-to-male sexual contact (44 %), heterosexual contact (36 %), and injection drug use (11 %). During the y 1995 - 2003 the authors found an increase in age at diagnosis ($p = 0.000$), and no major changes in gender, race, mode of infection, or baseline CD4+ cell count and viral load, neither overall nor within subgroups of patients. In this period 14.5 % had AIDS at the time of HIV diagnosis. The data do not confirm concerns about unmonitored evolution in the HIV epidemic in Denmark.

McGarrigle CA, Mercer CH, Fenton KA, *et al.* **Investigating the relationship between HIV testing and risk behaviour in Britain: National Survey of Sexual Attitudes and Lifestyles 2000.** *AIDS* 2005;19: 77-84.

A large, stratified probability sample survey of sexual attitudes and lifestyles was used to estimate the prevalence of, and identify factors associated with, HIV testing in Britain. A total of 12,110 16-44 year olds completed a computer-assisted face-to-face interview and self-interview. Self-reports of HIV testing, i.e. the timing, reasons for and location of testing, were included. A total of 32.4% of men and 31.7% of women reported ever having had an HIV test, the majority of whom were tested through blood donation. When screening for blood donation and pregnancy were excluded, 9.0% of men and 4.6% of women had had a voluntary confidential HIV test (VCT) in the past 5 years. However, one third of injecting drug users and men who have sex with men had a VCT in the past 5 years. VCT in the past 5 years was significantly associated with age, residence, ethnicity, self-perceived HIV risk, reporting greater numbers of sexual partners, new sexual partners from abroad, previous sexually transmitted infection diagnosis, and injecting non-prescribed drugs for men and women, and same-sex partners (men only). Whereas sexually transmitted disease clinics were important sites

for VCT, general practice accounted for almost a quarter of VCT. HIV testing is relatively common in Britain; however, it remains largely associated with population-based blood donation and antenatal screening programmes. In contrast, VCT remains highly associated with high-risk (sexual or drug-injecting) behaviours or population sub-groups at high risk. Strategies to reduce undiagnosed prevalent HIV infection will require further normalization and wider uptake of HIV testing.

Miller M, Sermer M, Wagner M. **Sexual diversity among black men who have sex with men in an inner-city community.** *Journal of Urban Health-Bulletin of the New York Academy of Medicine* 2005;82:I26-I34. Abstract: Dramatic increases in HIV-incidence rates have been documented for Black men who have sex with men (MSM). Moreover, MSM has become a more visible HIV-transmission route in the Black community, in part due to public interest in the "down low" (i.e., "straight" men who also have sex with men). Interviews were conducted with 21 Black MSM in central Brooklyn, New York City, in efforts to understand the diversity of MSM experience in a low income, high HIV-prevalence community. Two thirds of the men identified as either heterosexual (43%) or bisexual (24%) and 71% of MSM reported recent sex with women. Conformity to masculine social role expectations made it difficult to identify sex partners in the community; therefore, men relied on private sex clubs and the Internet. The findings suggest that stigma surrounding both HIV and homosexuality may effectively insure that nonheterosexual preferences and practices remain bidden in the Black community. A focus on sexual orientation and bisexuality has obscured the issue of race in the HIV/AIDS epidemic among Black MSM. In the long term, public health promotion and HIV prevention will require greater tolerance and acceptance of sexual diversity in the Black community.

Miller RF, Lindley AR, Malin AS, *et al.* **Isolates of *Pneumocystis jirovecii* from Harare show high genotypic similarity to isolates from London at the superoxide dismutase locus.** *Transactions of the Royal Society of Tropical Medicine and Hygiene* 2005;99:202-6.

Pneumocystis jirovecii is the cause of *Pneumocystis pneumonia* (PCP) in humans. Isolates of *P. jirovecii* obtained from patients in Harare, Zimbabwe were genotyped at the superoxide dismutase locus. High genotypic similarity to isolates of *P. jirovecii* obtained from patients in London, UK was observed. These data provide additional support for the hypothesis that *P. jirovecii* is genetically indistinguishable in isolates from geographically diverse locations.

Mohsen AH, Murad S, Easterbrook PJ. **Prevalence of hepatitis C in an ethnically diverse HIV-1-infected cohort in south London.** *HIV Med.* 2005;6:206-15.

There is limited information on the prevalence of and risk factors for hepatitis C virus (HCV) infection among HIV-1-infected patients in the UK. The objective was to determine the prevalence of HCV infection among an ethnically diverse cohort of HIV-infected patients in south London, and to extrapolate from these data the number of co-infected patients in the UK. A total of 1017 HIV-1-infected patients who had attended King's College Hospital HIV clinic between September 2000 and August 2002 were screened for HCV antibody using a commercial enzyme-linked immunosorbent assay (ELISA). Positive results were confirmed by polymerase chain reaction (PCR) or recombinant immunoblot assay. Demographic, clinical and laboratory data were obtained from the local computerized database and medical records. The authors applied HCV prevalence rates in the different HIV transmission groups to the estimated number of HIV-infected persons in these groups in the UK, to obtain a national estimate of the level of HIV-HCV co-infection. Of the 1017 HIV-1-infected patients, 407 (40%) were white men, 158 (15.5%) were black African men, 268 (26.3%) were black African women, and 61 (6%) and 26 (2.6%) were black Caribbean

men and women, respectively. Heterosexual exposure was the most common route of HIV acquisition (53.5%), followed by men having sex with men (36.9%), and current or previous injecting drug use (IDU) (7.2%). The overall prevalence of HCV co-infection was 90/1017 (8.9%), but this varied substantially according to route of transmission, from 82.2% among those with a history of IDU (which accounted for 67% of all HCV infections), to 31.8% in those who had received blood products, to 3.5% and 1.8% in those with homosexually and heterosexually acquired infection, respectively. Multivariate logistic regression analysis identified several independent risk factors for HCV infection: a history of IDU [odds ratio (OR) = 107.2; 95% confidence interval (CI) = 38.5-298.4], having received blood products (OR = 16.5; 95% CI = 5.1-53.7), and either being from a white ethnic group (OR = 4.3; 95% CI = 1.5-12.0) or being born in Southern Europe (OR = 6.7; 95% CI = 1.5-30.7). Based on the 35,473 known HIV-1-infected persons in the UK and the 10 997 estimated to be unaware of their status, we projected that there are at least 4136 HIV-HCV co-infected individuals in the UK and 979 who are unaware of their status. The study highlights an urgent need to increase the uptake of HCV and HIV testing, particularly among injecting drug users, to reduce the risk of onward transmission.

Monteiro EF, Lacey CJ, Merrick D. **The interrelation of demographic and geospatial risk factors between four common sexually transmitted diseases.** *Sex Transm.Infect.* 2005;81: 41-6.

This study analysed age, sex, ethnicity, socioeconomic status, and area of residence for Leeds residents aged 15-54 with *Neisseria gonorrhoeae*, genital *Chlamydia trachomatis*, first episode genital herpes, and first episode genital warts during 1994-5. The 1991 UK census provided denominator population information. Regression analysis showed that young age (15-24 years), ethnicity (with a gradient of risk black >white >Asian), and residence in inner city areas of deprivation were independent risk factors for all STDs. There were highly significant correlations in the

geospatial distribution of incidence rates between the four infections. However, there was variation in the degree of central urban clustering, with gonorrhoea having the most restricted, and genital warts and chlamydia the widest distribution. 31% of all disease occurred in the four inner city census wards, representing 15% of the population. These results are in keeping with core group theory applying in a unified manner to the four most common UK sexually transmitted diseases in this urban area. Population based studies are needed to clarify whether ethnicity is associated with differing sexual behavioural or mixing patterns. Our data suggest that chlamydia screening in women <25 years of age could detect 70% of cases in the community, that such programmes should give particular emphasis to implementation in core group areas, and that they could function as unifying strategies for the control of most common STDs within urban areas.

Muula AS. What should HIV/AIDS be called in Malawi? *Nursing Ethics* 2005;12:187-92.

Abstract: HIV/AIDS is the leading cause of morbidity and mortality in the southern African country of Malawi. At the largest referral health facility in Blantyre, the Queen Elizabeth Central Hospital, the majority of patients hospitalized in medical wards and up to a third of those in the maternity unit are infected with HIV. Many patients in the surgical wards also have HIV/AIDS. Health professionals in Blantyre, however, often choose not to write down the diagnosis of HIV or AIDS; rather, they prefer to use 'SGOT', 'ELISA' and 'spot test' to represent the HIV test, while 'immunosuppression', 'down arrow CD4 disease' and 'ARC' are preferred instead of 'AIDS'. It is possible that health professionals' belief that mentioning HIV and/or AIDS will harm patients is encouraging them to use these euphemisms. The use of less than exact terms to label HIV and AIDS may not be without cost. For instance, future attempts to conduct retrospective case study research may be hampered by this practice, which is not in accordance with

the international classification of diseases. It is suggested that, although stigmatization and discrimination could be important driving factors in the use of cryptic language, it may be more worthy to fight discrimination and stigmatization head-on, rather than create avenues where these reactions may be perpetuated.

Ramaswamy M, McDonald C, Sabin C, et al. The epidemiology of genital infection with herpes simplex virus types 1 and 2 in genitourinary medicine attendees in inner London.

Sex Transm. Infect. 2005;81:306-8. The aim of this study was to characterise the epidemiological and clinical features of genital herpes and the diagnostic role of HSV-2 specific serology in an ethnically diverse cohort of genitourinary medicine (GUM) attendees in inner London. Genital swabs (n = 186) were tested by real time polymerase chain reaction (PCR) and serum samples (n = 70) by HSV-2 specific enzyme linked immunoassay (ELISA). Among 186 patients (median age 29 years), 104/186 (56%) were male and 176/186 (95%) heterosexual; ethnicity was predominantly black Caribbean (76/186, 41%), white (65/186, 35%), or black-African (41/186, 22%). The most common lesion sites were penis (85/104 men, 82%) and vulva (63/82 women, 77%); 114/186 (61%) patients were diagnosed clinically with first episode disease. Women were more likely to present <5 days of onset (p = 0.008). Black Caribbean patients were more likely to present > or = 5 days (p = 0.04) and decline HIV testing (p = 0.03). By PCR, 108/186 (58%) swabs tested positive for HSV-1 (7/108, 6.5%) or HSV-2 (101/108, 93.5%). Independent predictors of a positive PCR were heterosexual group, <5 days of onset, and visible genital ulceration on examination. HSV-2 was associated with black Caribbean and black African ethnicity; HSV-1 with white ethnicity (p = 0.006). By HSV-2 specific serology, 16/42 (38%) first episodes caused by HSV-2 were recurrent infections, and 7/19 (37%) patients with recurrent genital disease but negative PCR had genital herpes. Epidemiological trends in genital HSV-1 and HSV-2 infection appear to vary between ethnic groups in the United Kingdom.

Rapatski BL, Suppe F, Yorke JA. HIV epidemics driven by late disease stage transmission. *Journal of Acquired Immune Deficiency Syndromes* 2005;38:241-53.

How infectious a person is when infected with HIV depends on what stage of the disease the person is in. We use 3 stages, which we call primary, asymptomatic, and symptomatic. It is important to have a systematic method for computing all 3 infectivities so that the measurements are comparable. Using robust modeling, we provide high-resolution estimates of semen infectivity by HIV disease stage. We find that the infectivity of the symptomatic stage is far higher, hence more potent, than the values that prior studies have used when modeling HIV transmission dynamics. The stage infectivity rates for semen are 0.024, 0.002, and 0.299 for the primary, asymptomatic, and symptomatic stages, respectively. Implications of our infectivity estimates and modeling for understanding heterosexual epidemics such as that in sub-Saharan African are explored.

Reidpath DD, Chan KY. A method for the quantitative analysis of the layering of HIV-related stigma. *AIDS Care* 2005;17:425-32.

HIV-related stigma is regarded as one of the major barriers in the development of effective prevention and care programs; but the stigma associated with HIV stigma is not a singular entity. The stigma of the infection is layered with other stigmas, such as those associated with the routes of transmission (e.g., sex work and injecting drug use) and personal characteristics (e.g., race, religion, ethnicity and gender). In developing programs and policies to overcome HIV-related stigma, cognisance needs to be taken of all the sources of stigma, and how they may interact. A novel method is described for examining the layers of HIV/AIDS-related stigma, and secondary data are adapted to illustrate this. The importance of understanding the layering of stigma for the development of effective interventions is also discussed.

Rice BD, Payne LJ, Sinka K, *et al.* **The changing epidemiology of prevalent diagnosed HIV infections in England, Wales, and Northern Ireland, 1997 to 2003.** *Sex Transm.Infect.* 2005;81:223-9.

In 2003, 34 251 adults (15 years of age or over) were seen for HIV related care in England, Wales, & Northern Ireland, (E, W, & NI) representing a 17% increase in the prevalence of diagnosed HIV infections compared with 2002 and a 132% increase compared with 1997. Between 1997 and 2003, as a proportion of total prevalent cases, adults who acquired their infection through heterosexual sex increased from 26% to 49%; black African adults increased from 15% to 35% and diagnosed adults resident in London fell from 62% to 55% of the total. The male to female ratio declined from 5:1 to 2:1. The proportion of adults receiving combination antiretroviral therapy increased from 53% in 1998 to 64% in 2003. There has been a large increase in the number of adults with diagnosed HIV infection seen for care in E, W, & NI since 1997. Changes in the epidemiology of prevalent diagnosed HIV were seen by sex, route of infection, ethnicity, level of antiretroviral therapy, and areas of residence and treatment. In 2003, for the first time, prevalent diagnosed infections acquired through heterosexual sex over-took those acquired through sex between men. These increases have serious implications for the planning and financing of HIV services in the United Kingdom.

Scott BE, Weiss HA, Viljoen JI. **The acceptability of male circumcision as an HIV intervention among a rural Zulu population, Kwazulu-Natal, South Africa.** *AIDS Care* 2005;17:304-13.

Epidemiological and biological studies provide compelling evidence for the protective effect of male circumcision against the acquisition of HIV. Three randomized controlled trials are currently underway to assess the impact of male circumcision as an HIV intervention in traditionally non-circumcising areas with high levels of heterosexually-transmitted infection. This study explores the acceptability of male circumcision among the rural Zulu around Hlabisa and

Mtubatuba, KwaZulu-Natal, South Africa. A cross-sectional convenience sample of 100 men and 44 women was surveyed, and two male focus groups held, to ascertain circumcision preferences within the population. Four in-depth interviews with service providers assessed the feasibility of promoting male circumcision. Fifty-one per cent of uncircumcised men and 68% of women favoured male circumcision of themselves or their partners; while 50% of men and 73% of women would circumcise their sons. For men, the main predictors of circumcision preference pertained to beliefs surrounding sexual pain and pleasure; for women, knowledge about the relationship between male circumcision status and STI acquisition was the key indicator for circumcision preference. Among both sexes the main barrier to circumcision was fear of pain and death. The greatest logistical barrier was that circumcision can presently only be carried out by trained hospital doctors.

Siegfried N, Clarke M, Volmink J. **Randomised controlled trials in Africa of HIV and AIDS: descriptive study and spatial distribution.** *BMJ* 2005;331:742.

The aim of this study was to identify and describe randomised controlled trials on HIV and AIDS conducted in Africa and to map their spatial distribution using exact geographic coordinates. A comprehensive search yielded 284 distinct records that were potentially eligible for inclusion in the database. Of these, 150 articles reported on 77 eligible trials published or reported from 1987 to 2003. Seven trials were identified exclusively from the CENTRAL database. Trials were conducted in 18 of 48 countries in sub-Saharan Africa. None were conducted in north Africa. Only 19 had a principal investigator located in an African country. Forty two trials assessed prevention and 35 assessed treatment. Most studies were funded by government agencies outside Africa (n = 43), with the pharmaceutical industry providing partial support to 16 of these. The pharmaceutical industry provided full or partial support to a further 18 trials. Only 43 trials reported conducting a power calculation for determining sample size. There was no mention of

ethical approval or informed consent in 19 and 17 trials, respectively.

CONCLUSION: The relatively small number of HIV/AIDS trials conducted in Africa is not commensurate with the burden of disease. Geographical mapping as an adjunct to prospective trial registration is a useful tool for researchers and decision makers to track existing and future trials.

Siegfried N, Muller M, Deeks J, *et al.* **HIV and male circumcision--a systematic review with assessment of the quality of studies.** *Lancet Infect.Dis.* 2005;5:165-73.

Abstract: This Cochrane systematic review assesses the evidence for an interventional effect of male circumcision in preventing acquisition of HIV-1 and HIV-2 by men through heterosexual intercourse. The review includes a comprehensive assessment of the quality of all 37 included observational studies. Studies in high-risk populations consisted of four cohort studies, 12 cross-sectional studies, and three case-control studies; general population studies consisted of one cohort study, 16 cross-sectional studies, and one case-control study. There is evidence of methodological heterogeneity between studies, and statistical heterogeneity was highly significant for both general population cross-sectional studies ($\chi^2=132.34$; degrees of freedom [df]=15; $p<0.00001$) and high-risk cross-sectional studies ($\chi^2=29.70$; $df=10$; $p=0.001$). Study quality was very variable and no studies measured the same set of potential confounding variables. Therefore, conducting a meta-analysis was inappropriate. Detailed quality assessment of observational studies can provide a useful visual aid to interpreting findings. Although most studies show an association between male circumcision and prevention of HIV, these results may be limited by confounding, which is unlikely to be adjusted for.

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