HIV transmission among men who have sex with men through oral sex

While the risk of transmission through oral sex for men who have sex with men (MSM) is low, discrepancies remain between study findings and there is uncertainty about the exact degree of risk.1

Between July 2001 and September 2003, a total of 4150 MSM were newly diagnosed with HIV infection in England, Wales, and Northern Ireland and reported to the Communicable Disease Surveillance Centre in London. Reports for 1359 cases received during this time included the question “Does the patient believe himself to have been infected through oral sex?” The remaining 2791 cases had only laboratory reports or earlier clinician report forms where this question was not asked.

The oral sex question was answered for 688 (50.6%) of the 1359 cases, of which for 625 (90.8%) the response was no, and yes for 63 (9.2%) cases. For 671 cases this information was not recorded even though the question was included on the form.

All 63 cases where the patient believed himself to have been infected with HIV through oral sex were further investigated by a discussion with the clinician or health-care provider. From these further discussions during the follow up, 27 (42.8%) cases were believed to have been infected from unprotected anal intercourse. Of the remaining 36 cases, 16 (23.3%) claimed to have had only oral sex as their risk for acquiring HIV, with 20 (29.2%) cases always reporting protected anal sex but unprotected oral sex. Previous negative testing history and HIV status of partners was taken into account when discussing possible HIV risk with clinicians or health-care providers.

It is difficult to quantify oral sex risks and this could be an obstacle to accuracy3; none of these individuals were re-interviewed for this study and risk was assessed by clinician and note review only. There may be recall difficulties surrounding condom use, including whether they were used, or if used, coming off or splitting, or brief anal-rectal contact that was not considered relevant or remembered. In addition, there was limited information about whether ejaculation had occurred or about breaks in the oral mucosa. However, 16 cases reported no anal sex and 20 cases reported only protected anal sex and unprotected oral sex. In total this represents 5.2% of those MSM reports where the question was answered. We are aware that, for half, the question was not answered, and if we classified those reports as not infected through oral sex, then 2.6% (36 of 1359) were probably infected through this route. The indication given by these UK surveillance data is that oral sex carries a small but real risk.

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References

The correct approach to modelling and evaluating chlamydia screening

A recent systematic review of economic evaluations suggests that screening for genital chlamydia infection is “cost effective.”1 We are concerned about how the authors reached this conclusion. As the reviewers did not take into account the fact that Chlamydia trachomatis is infectious. The methodological problems arising from this fundamental flaw raise questions about the validity of the conclusion.

The correct model to use in the evaluation of an infectious disease must be capable of encompassing all its effects, including the potential for transmission. Bernoulli first reported such transmission dynamic models in the 18th century.2 The wide misuse of static, as opposed to transmission dynamic, models has been noted in the economics literature on vaccination programmes,3 but the message has been slow to transcend to the economics literature on sexually transmitted infections, with a few notable exceptions.4 In the case of screening for genital chlamydia, someone who is successfully treated might be re-infected; the benefits of treatment in preventing long term sequelae will be lost, and the person could continue to infect others. If they are successfully treated without re-infection, however, they will not transmit infection. Since the two possibilities have opposing effects on the number of cases, the direction of change in the cost effectiveness ratio is uncertain; it could overestimate or underestimate the true cost effectiveness. Economic evaluations that do not incorporate these effects are, therefore, very unlikely to model the outcomes of a chlamydia screening programme accurately.

Although the use of objective criteria to assess the quality of identified papers was praised in a recent STI editorial,5 the checklist used by Honey et al6 is outdated and was not applied appropriately for an infectious disease. This led the authors to include papers whose results might be unreliable. The use of more recent and widely used guidelines, which ask questions about the choice of model type and the justification for the key parameters on which the model is based,7 may have drawn attention to the problems of static models. Furthermore, the review included studies that used “cost per case detected,” which is an inadequate outcome for screening programmes because it does not take into account resource implications associated with the course of action taken by individuals after case detection.

We have recently concluded our own systematic review of economic analyses of screening programmes for genital chlamydia infection, as part of the ongoing Chlamydia Screening Studies project (ClaSS). While the majority of studies we identified had used an incorrect modelling approach, we did identify a full economic evaluation that had used a dynamic model to evaluate chlamydia screening. This was identified by Honey et al but excluded because they thought that it did not fulfill their inclusion criteria.8

We propose that all future economic evaluations of chlamydia screening should use a dynamic modelling approach. A consensus panel to develop guidelines for the conduct of economic evaluations of interventions for sexually transmitted infections could take this recommendation into account.9

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Conflict of interest: The authors are all members of the Chlamydia trachomatis Screening Studies (ClaSS) Working Group. Part of the remit of this group is to conduct a systematic review of economic studies of Chlamydia trachomatis screening and to construct a model with which to evaluate the cost effectiveness of chlamydia screening.

References
2 Bernoulli D. Mathematical and physical memoirs, taken from the registers of the Royal Academy of
In Haryana, India, with a geographical area of 27,632 square miles, an HIV sentinel surveillance was carried out, on a regular basis (1998–2002), on consecutive serum samples of 400 antenatal clinic (ANC) attendees (three sites), and 2,938 usually transmigrant STD clinic attendees (four sites). This was done for each 12 week period per year as an aliquot anonymous testing with one of the ELISA/rapid/simple tests. A sample that was positive with two tests of different assays was considered HIV positive. The other STDs were diagnosed clinically and using appropriate laboratory tests.\(^7\)

Of the 7,933 men and women who participated in the HIV sentinel surveillance from 1998–2002, 15 (0.3%) of 5,200 ANC attendees and 48 (1.8%) of 2,731 STD clinic attendees had HIV. Though HIV prevalence is still below 1% among the ANC attendees, a gradual increase over these 5 years has been observed although statistically it was not found to be significant (table 1). With increasing HIV infection among antenatal women, paediatric AIDS is poised to become an important public health problem.\(^5\) The odds ratio (OR) of HIV infection for men compared to women decreased by age; men aged 20–29 years were nearly thrice as likely as women the same ages to be HIV-infected (OR 2.68 (95% CI 1.1 to 6.7)). When we combined the literacy status for both men and women, the HIV prevalence was statistically significant among the literate of more than fifth grade (p value = 0.0416) but was not found to be significant when combined for ANC attendees. School or college education, therefore, does not have any impact on this epidemic. Emphasis has to be given to educate the general public about AIDS.

Among the STD clinic attendees presenting with genital ulcer, HIV reactivity (3.9%, 7/181) and VDRL reactivity (11.6%, 21/181) were found to be statistically significant (p < 0.05, \(\chi^2\) test used). Therefore, in India, where the overall level of HIV is still low, a high level of STDs in certain states makes for a continuing potential for the epidemic to become generalised among all sexually active adults. Differences across the states may just be a matter of time.\(^4\)

As per the sentinel surveillance data in the year 1998, there were seven moderate prevalence states (prevalence among ANC attendees <1%) but prevalence among the STD clinic attendees >5%) and 19 states were of low prevalence compared to two states only with moderate prevalence rates and 24 states

### Table 1: HIV prevalence rates for the attendees tested in sentinel surveillance programme, 1998–2002

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Antenatal clinic attendees</th>
<th>STD clinic attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV reactive</td>
<td>% (No)*</td>
</tr>
<tr>
<td>Age groups (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–19</td>
<td>0.3 (383)</td>
<td>1.8 (113)</td>
</tr>
<tr>
<td>20–29</td>
<td>0.3 (4171)</td>
<td>2.5 (756)</td>
</tr>
<tr>
<td>30–44</td>
<td>0.3 (630)</td>
<td>2.8 (432)</td>
</tr>
<tr>
<td>&gt;45</td>
<td>0.1 (16)</td>
<td>1.5 (122)</td>
</tr>
<tr>
<td>Sentinel year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb-Mar 1998</td>
<td>0 (400)</td>
<td>3.3 (211)</td>
</tr>
<tr>
<td>Aug-Oct 1998</td>
<td>0 (400)</td>
<td>0.7 (123)</td>
</tr>
<tr>
<td>Aug-Oct 1999</td>
<td>0 (400)</td>
<td>2.2 (274)</td>
</tr>
<tr>
<td>Aug-Oct 2000</td>
<td>0.2 (1200)</td>
<td>1.5 (410)</td>
</tr>
<tr>
<td>Aug-Oct 2001</td>
<td>0.4 (1200)</td>
<td>2.2 (415)</td>
</tr>
<tr>
<td>Aug-Oct 2002</td>
<td>0.6 (1600)</td>
<td>2.2 (415)</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>0.4 (1573)</td>
<td>1.0 (543)</td>
</tr>
<tr>
<td>Rural</td>
<td>0.7 (1227)</td>
<td>2.5 (515)</td>
</tr>
<tr>
<td>Population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrant</td>
<td>0.9 (224)</td>
<td>0.7 (23)</td>
</tr>
<tr>
<td>Non-migrant</td>
<td>0.5 (2576)</td>
<td>3.2 (392)</td>
</tr>
<tr>
<td>Literacy status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literate</td>
<td>0.5 (859)</td>
<td>0.7 (88)</td>
</tr>
<tr>
<td>Literate till 5th grade</td>
<td>0.3 (524)</td>
<td>3.1 (65)</td>
</tr>
<tr>
<td>Literate till 12th grade</td>
<td>0.5 (1173)</td>
<td>2.1 (193)</td>
</tr>
<tr>
<td>Graduation not done</td>
<td>0.4 (244)</td>
<td>4.3 (69)</td>
</tr>
<tr>
<td>Occupation of spouses*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business</td>
<td>0.4 (435)</td>
<td>1.8 (56)</td>
</tr>
<tr>
<td>Industrial and factory</td>
<td>0.3 (325)</td>
<td>3.0 (33)</td>
</tr>
<tr>
<td>Service</td>
<td>0.2 (539)</td>
<td>1.1 (94)</td>
</tr>
<tr>
<td>Agriculture and unskilled workers</td>
<td>0.7 (1241)</td>
<td>1.3 (153)</td>
</tr>
<tr>
<td>Truck/auto/taxi driver</td>
<td>0.3 (160)</td>
<td>16.7 (18)</td>
</tr>
<tr>
<td>Hotel staff</td>
<td>0 (60)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>0 (60)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Students</td>
<td>0 (34)</td>
<td>2.2 (45)</td>
</tr>
<tr>
<td>Syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital ulcer</td>
<td>2.5 (403)</td>
<td>2.7 (118)</td>
</tr>
<tr>
<td>Urethral/cervical discharge</td>
<td>1.0 (511)</td>
<td>0.9 (1043)</td>
</tr>
<tr>
<td>Genital ulcer and discharge</td>
<td>3.4 (59)</td>
<td>1.5 (66)</td>
</tr>
<tr>
<td>Genital warts</td>
<td>2.4 (85)</td>
<td>0 (32)</td>
</tr>
</tbody>
</table>

*Number of attendees.

†Among the antenatal clinic attendees, the majority of the occupations stated are those of the spouses with only occasional women having in that occupation.

p Value = 0.05 (ns = not significant) in all the characteristics (\(\chi^2\) test used).

††Men/women ratio (95% CI) couldn’t be calculated.

\(\chi^2\) test used.

As per the sentinel surveillance data in the year 1998, there were seven moderate prevalence states (prevalence among ANC attendees <1%) but prevalence among the STD clinic attendees >5%) and 19 states were of low prevalence compared to two states only with moderate prevalence rates and 24 states.
with low HIV prevalence rates (prevalence among the STD clinic attendees <3%) in the year 2001 while six states stayed as high prevalence states (prevalence among ANC attendees >1%). Haryana is still maintaining itself in a low level epidemic category. It is speculated that the effect of STD control and screening of ANC attendees for HIV transmission may increase with the maturation of the HIV epidemic as experienced in trials in Tanzania and Uganda. Therefore, we should increase intervention programmes in all high risk groups as well as in the general population of this city while it is still in the early epidemic phase to ensure that this cost effective opportunity is not missed.

Acknowledgements
The authors wish to thank the senior technician in charge, Shri Satpal Singh, for his assistance in the fieldwork and laboratory procedures throughout this study. The statistical help provided by Shri R C Goel, PGIMER, Chandigarh, is duly acknowledged. We also thank Professor Narottam Sharma from the Regional Institute of English Chandigarh, UT for proof reading of the manuscript. We also acknowledge National AIDS Control Organisation (NACO) for its continuing guidance and the supply of free kits for HIV testing.

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DRA, BA, protocol development for field implementation, final approval of manuscript; VG, PG, field implementation of clinical and laboratory procedures, writing: DRA, BA, VG, VGU, analysis and interpretation, critical reviewing of manuscript.

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References

Increased numbers of acute hepatitis C infections in HIV positive homosexual men: is sexual transmission feeding the increase?

Although the principal mode of hepatitis C (HCV) transmission in the United Kingdom is injecting drug use (IDU), the risk for a third of infections is unknown. The contribution of sexual transmission between men who have sex with men (MSM) to the spread of hepatitis C is unclear, however evidence is accumulating that both co-infection with HIV and the presence of other sexually transmitted infections (STIs) facilitate sexual transmission of HCV. With the reported increases in unsafe sex and STIs in HIV positive MSM we questioned whether these circumstances may lead to an increase in the number of HCV infections.

This study was undertaken to determine whether within our clinics, changes in the number of individuals being diagnosed with acute HCV infection were occurring and to ascertain risk factors for acquisition in these individuals.

A case note review of all patients within the HIV and sexual health clinics of St Stephen’s Centre with diagnosed acute HCV infection between January 1997 and December 2002 was performed. Patients newly diagnosed with HCV were identified from departmental computer records. Cases were defined as individuals with a newly positive and a previous negative HCV antibody test. Where negative tests had been performed more than a year earlier, testing of stored samples was undertaken to determine more precise timing of HCV seroconversion. Testing was done using the Monolisa anti-HCV version 2 enzyme immunoassay.

Twenty six male (all MSM) and one female case were identified; median age was 34 years. Twenty five individuals were HIV positive. The median time between negative and positive HCV antibody tests was 5 months (interquartile range 3–10 months). There was a significant increase in HCV seroconversions over the study period (see fig 1).

The indications for HCV testing were the development of abnormal alanine transaminase (ALT) (21), recent IDU (two), sexual contact with HCV positive partner (one), asymptomatic hepatitis (three). Of those tested because of newly abnormal liver function tests (LFTs), 18 were asymptomatic. LFTs were performed as part of routine HIV follow up. There was no increase in HCV tests performed in HIV positive individuals with ALT levels more than 100 IU/l over the study period; however, the percentage of positive HCV tests increased from 0.6 to 9.3 (p value using x2 test for trend <0.001).

Risks for acquisition of HCV were recent unprotected anal or vaginal sex (21) and IDU (two), while in four there were no documented risk factors. Nine individuals were diagnosed with infectious syphilis either concurrently (three) or in the year before HCV seroconversion. Of the HIV positive patients 15 were on antiretroviral therapy (ART) and 11 had a viral load of less than 50 copies/ml. The median CD4 count was 399 x 10^6 /l.

Having multiple sexual partners, a history of STIs, and certain sexual practices have been associated with HCV infection. Reported increases in HCV seroconversion among HIV positive MSM in association with high risk sexual behaviour (unprotected anal sex, fisting, and rimming) suggests an interaction between HIV and sexual practice. As HCV plasma viraemia is higher in co-infected patients and correlates with levels of both saliva and semen, this may facilitate sexual transmission of HCV. Furthermore, there is evidence that ARV treatment may be associated with increases in HCV RNA levels.

While retrospective assessment of factors may be problematic, features of this study make us more confident of attributing risk to sexual activity. Data were collected in both general HIV and specialist hepatitis clinics, and also most patients were under long term follow up allowing cumulative recording of risks particularly those relating to IDU.

Although it is possible that increased numbers result from changing HCV testing thresholds there was no evidence of this when we examined HCV tests performed to investigate those with abnormal LFTs, the commonest scenario leading to diagnosis. As the ALT trigger was present in the HIV positive group and not in the sexual health clinic attendees, the numbers from this source may be under-represented.

Determining the associated factors for transmission of HCV is critically important in order to introduce targeted screening and prevention interventions. As 85% of infected patients become chronic carriers and treatment of acute hepatitis C leads to high clearance rates, these strategies may be crucial in reducing the carrier pool of HCV, further transmissions and the risk of cirrhosis and hepatoma.

The study numbers are small and may represent a pocket of infection not indicative of increased risks in larger populations. However, the manner in which these infections parallel recent increases in STIs gives cause for the concern that risks may be more generalised. Further studies are needed to clarify this trend.

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www.stijournal.com
Transmission of Neisseria gonorrhoeae from a toilet seat

In August 2003 a prepubertal 8 year old girl presented with a sudden onset history of a non-irritating, odourless heavy green vaginal discharge which had developed overnight. She had arrived back in Sydney approxi-
mately 24 hours earlier by an international air flight following an overseas holiday with her mother and two adolescent siblings. The family had spent 72 hours in transit flying from Rome to Sydney via Moscow.

The child was taken initially to her family doctor and a heavy growth of Neisseria gonorrhoeae was isolated. The organism was resistant to both penicillin and ciprofloxacin. On direct inoculation of the sample and a Gram stain showing an initial colony of the bacteria, the child was referred to the author for assessment of possible sexual abuse and ongoing management of the N gonorrhoeae infection.

Before boarding a flight to Moscow the family had spent 3 days in a hotel, sightsee-
ing and the previous 2 days with relatives. During the 8 days before arriving in Sydney, the mother had unusually close contact with the child, had shared a bedroom with her, and had accompanied her almost continually.

The child’s behaviour and demeanour had shown no change and both the child and the siblings were asymptomatic. When ques-
tioned by her mother, the child strongly denied any history of genital contact.

The flights to and from Moscow were noted to be full with no spare seats. Both the mother and the child stated that they were the only users of the toilets during both flights and that by the end of the flights the “toilets were very dirty.”

The mother stated that when the child used the toilet the child always wiped the seat with toilet paper before using it. The child confirmed this. She said her fingers occasionally became dirty while wiping the seat.

A genital examination of the child revealed no significant redness of the introitus or physical abnormality. She had an intact anular hymen; however, the absence of genital injury has no relevance in making a diagnosis that excludes sexual abuse.1

As part of the routine investigation, the matter was reported to the New South Wales Department of Community Services and all family members were tested for N gonorrhoeae and were negative.

It is important that all cases of N gonorrhoeae in children be fully investigated for sexual abuse, and reported to the relevant child protection authorities. There is no doubt that almost all gonococcal vaginal infections in prepubertal children are sexually trans-
mittted,2 and this may include those pre-
viously reported as non-sexual.3 However it is also accepted that cases of non-sexual trans-
mittion of N gonorrhoeae in children do occur,4 but proof beyond all doubt can be very difficult to document scientifically.

On the basis of the demeanour of the child, reports of increasing rates of gonorrhoea in the former Soviet Block countries,5 the incubation period for symptomatic N gonorrhoeae, the history taken and her unusually close supervision of the child, as well as the child’s known behaviour in public toilets, it is the belief of the author that the child most probably contracted the infection via autoinoculation while using a mixed toilet in a crowded aeroplane.

References


urethral swabs or first void urine) among men with symptomatic urethritis was 15.7% and 9.4%, respectively. This should be viewed with concern particularly in developing countries like India where screening for C. trachomatis is not done on a routine basis and, hence, extensive screening should be conducted for detection of genital C. trachomatis infection in men using sensitive and specific molecular assays like PCR.

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References

22nd International Papillomavirus Conference and Clinical Workshop
This will be held 29 April to 6 May 2005 in Vancouver, British Columbia, Canada. Topics will include animal papillomaviruses, diagnosis, epidemiology, HPV associated neoplasia in the developing world, immunology, molecular pathogenesis, natural history, screening, transcription, and treatment.

For more information please contact: 22nd IPC Secretariat, C/o Venue West Conference Services Ltd, #645-375 Water Street, Vancouver, BC V6B 5C6, Canada; tel: +1 604 681 5226; fax: +1 604 681 2503; email: congress@venuewest.com; website: www.hpv2005.org.

16th Biennial Meeting of the ISSTDR
The 16th Biennial Meeting of the International Society for Sexually Transmitted Diseases Research (ISSTDR) will be held 10–13 July 2005 in Amsterdam, The Netherlands. The meeting will be organised jointly by Dutch and Belgian STD researchers. For more information please visit www.isstdr.org.

Answers to MCQs on p 320
(1) a
(2) c
(3) b
(4) c
(5) c
(6) d
(7) d
(8) a
(9) d
(10) b

BOOK REVIEW
Letting Them Die—Why HIV/AIDS prevention programmes fail

What is going on with HIV in South Africa? The epidemic escalates with no sign of slowing down, making the country the worst affected in the world. The government continues to try and find excuses not to deliver either treatment or prevention programmes. The sense of stigma is so palpable that ignorance of serostatus carried to the grave seems to be the usual way of living with the virus.

This book tells the story of an HIV intervention project in Carlestone, a mining area near Johannesburg, where mineworkers and female sex workers eke out a day to day existence in which overindulgence in alcohol and unprotected sex appear to be the norm. It tells a salutary tale of a project conceived optimistically that gets dragged down through petty arguments, jealousy, and mistrust but still emerges to provide fresh insights into how to tackle the epidemic.

Working in HIV in South Africa has always been full of challenges and, based on the story told here, those challenges would appear to be increasing. The author (a social scientist and member of the project research team) reports not only the successes, but also, more bravely, the failings of the project. She sets out her stall to tackle HIV through a project focusing at the community level. The plan was to have a project directed by stakeholders who would work together as a group and develop guiding principles that local HIV affected communities could use to support both individuals and promote HIV prevention programmes among female sex workers, miners, and youth. Unfortunately, the nine groups didn’t cooperate and other individuals saw themselves as just that, individuals rather than members of a cohesive, homogeneous community. Peer education, a major component of the project, faced many difficulties. With the benefit of hindsight, it seems as though many of the important stakeholders did not perceive adequate ownership of the project and became disillusioned early on leaving most of the day to day running to those employed by the project directly.

The book is well written and clear and is recommended reading for anyone contemplating a large scale HIV prevention project, whether as a planner, implementer, or evaluator. The book explains social science terminology succinctly for those with limited knowledge of the discipline. It also demonstrates and describes very well that what works in one part of Africa will not necessarily work elsewhere, and that initial local assessment at the design stage of a large scale project is paramount.

As HIV continues to spread outside the high risk groups, the need to educate at the community level also increases but the former group should not be forgotten. A combination of both strategies is probably the best approach. The reality is that, although the HIV epidemic in South and southern Africa has come a long way, there is still some distance to go. Hopefully, those involved in HIV project management will pick up the lessons set out in this excellent little book.

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do: 10.1136/sti.2003.006957corr1
The reference list of the paper by V J Johnston, H Britt, Y Pan, and A Mindel, entitled “The management of sexually transmitted infections by Australian general practitioners” (Sex Transm Infect 2004;80:212–5), was published incorrectly. The correct reference list can be found as a data supplement to the article online at http://www.stijournal.com/cgi/content/full/80/3/212/DC1.
The correct approach to modelling and evaluating chlamydia screening

T Roberts, S Robinson, P Barton, S Bryan, A McCarthy, J Macleod, M Egger and N Low

*Sex Transm Infect* 2004 80: 324-325
doi: 10.1136/sti.2003.008458

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