

Highlights from this issue

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Thirty years into the HIV epidemic, we are still asking basic questions about how to measure the effectiveness of condom use. The importance of consistent condom use is strongly emphasised in health promotion literature, yet the evidence base for this is problematic—since reasons for condom use relate to perceived STI risk, and data are mostly retrospective in nature. Crosby *et al*¹ report a prospective study using electronic daily diaries. The authors explored the relationship between both correct and consistent condom use, and STI acquisition, concluding that consistent use alone was not associated with STI rates, but consistent together with correct use was. The paper is interestingly discussed in an editorial by Ingham,² who commends the prospective approach to measuring quality of use. Ingham also sets out a future research agenda for exploring ‘violations’, ‘errors’ and ‘lapses’—based on literature about young drivers and accident probability. Both research paper and editorial are a fascinating read.

Sickle cell disease is an important co-morbidity for many patients with HIV around the world, and is well known to interact with risk for malaria. Nouraie *et al* report a repeated cross-sectional study of sickle cell patients in the USA,³ suggesting that sicklers may have a lower risk both of HIV acquisition and progression. Ubaro in an accompanying commentary emphasises that while these early findings should be treated with caution, further population based studies and mechanistic studies will be fruitful.⁴

What do patients want? Llewellyn⁵ and Miners⁶ report linked studies exploring patient preferences for STI services in the UK, in the context of increased provision of such services in primary care over the past decade. Llewellyn *et al* report that while many participants were willing to test within general practice, perceived lack of expertise was a barrier as was the apparently limited range of tests in general practise. A discrete choice experiment presented by Miners again

emphasised patients’ preference for staff with specialist knowledge, and for the availability of testing for all infections. These are important messages for policymakers.

Patient views are also explored a study by Conway *et al*,⁷ who describe quality of life valuations for HPV associated cancer health states. The authors explored valuations of various genital cancers, as well as oropharyngeal cancer. HPV prevention programmes are likely to become increasingly complex as the wide range of pathologies caused by the many HPV serotypes become better understood. Cervical Pap test screening is gradually becoming replaced by HPV focussed tests—Guan *et al*⁸ describe the potential for self-collection of cervical HPV samples in rural Chinese women. What will HPV vaccination look like in 30 years time, I wonder?

Hepatitis C is an increasing concern among HIV positive—and negative—men who have sex with men (MSM). In a systematic review,⁹ Yaphé *et al* show that HIV positive MSM had rates of acute HCV 4.1 times higher than HIV negative MSM. Given the health and economic costs of HCV, targeted prevention programmes need to be explored.

Other interesting topics this month include the high rate of undiagnosed HIV infection in Spain’s primary care system,¹⁰ the reliability of PCR testing for gonorrhoea,¹¹ optimising HIV counselling and testing,¹² and the lessons from enhanced chlamydia surveillance.¹³

As we go to press, health advocates are looking forward anxiously to the outcome of the American presidential elections, which will have resonance around the world. Sexual health and education are more vulnerable to statements and actions of ‘principle’, uninformed by evidence, than other fields of public life. Whatever the outcome, we will continue to educate policymakers and to empower practitioners through honest scientific enquiry and informed debate.

Competing interests None.

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