

AIDS briefs

Younger women in Africa are using condoms

Prevention efforts are working better than many think, according to a recent article in the *Lancet*, as there has been a significant increase in the number of young women in Africa reporting both increased condom use and sexual abstinence. The authors found that a motivation for increased use of condoms was often contraception and argue that 'programmes promoting family planning and HIV prevention have common interests'.

Investigators from the London School of Hygiene and Tropical Medicine and the World Health Organization looked at almost 133 000 single women aged between 15 and 24 years in 18 sub-Saharan African countries, using national demographic and health surveys to determine changes in levels of abstinence or condom use between 1990 and 2004.

The investigators focused on changing levels of primary abstinence (virginity); secondary abstinence (no sex within the previous 3 months); and use of contraception, including condoms, in the previous 3 months.

Overall, there was no real shift in the number of young women reporting themselves virgins – the increased levels of virginity found in 7 countries being offset by a reduction in reported virginity in 6 other countries. Only in Cameroon and Ghana were there 10% or greater increases in the proportion of self-reported virgins.

The level of secondary abstinence did increase from a median of 44% to 49%. The increase in secondary abstinence was statistically significant in 7 countries, and exceeded 10% in 5. In 7 countries, however, abstinence trends were erratic, and in Burkina Faso the proportion of women reporting secondary abstinence actually fell significantly.

Of the women reporting any sex within the previous 3 months, the proportion saying that they used any contraception increased from 33% to 37%. Use of less effective methods of contraception, such as periodic abstinence, fell significantly, but the proportion of women saying that they used highly effective methods of birth control, such as oral contraceptives, remained stable.

The investigators then looked at condom use. They found that condom use increased from a median of 5% to 19%. This rise in

condom use was statistically significant in 13 countries and over 10% in 9 countries. Interestingly, increased levels of condom use did not appear to be linked to the severity of the local HIV epidemic, with countries in west Africa recording the largest increase in condom use, with use in the harder-hit eastern and southern African countries remaining lower.

When the investigators looked at self-reported condom use for most recent intercourse, they found that this increased from 20% to 28%, with significant increases seen in 7 countries – 6 seeing an increase of above 10%. The authors point out that, across the study period, this amounts to an annualised increase of around 1 - 4% a year, squarely in line with the uptake of all forms of contraception in the industrialised world between 1965 and 1998.

A median of 59% of women said that their primary motivation for using condoms was pregnancy prevention.

'Fewer than 10% of sexually active single women stated that they would like to have a child in the next 12 months [in the DHS surveys];' the authors note, highlighting the fact that abortion is illegal in many African countries and that unsafe abortion is more frequent in Africa than in any other part of the world. It appears that the fear of unwanted pregnancy might be as great as the fear of AIDS for many young women in West and Central Africa.

The investigators emphasise that levels of abstinence changed less than condom use, but there was an increase in secondary abstinence that they attribute to more cautious partner selection, reduced frequency of sex, or a combination of both.

'Our central conclusion is that the sense of failure pervading HIV prevention efforts in Africa is unjustified and that investment in condom promotion and marketing have had an appreciable effect, at least for young single women.'

Cleland J, et al. *Lancet* 2006; 368: 1788 - 1793.

Revised guidelines for diagnosis of smear-negative and extrapulmonary TB

The World Health Organization (WHO) have released revised guidelines for the diagnosis of smear-negative and extrapulmonary TB in areas of high HIV

prevalence. The new guidelines revise previously used algorithms in an effort to speed up the diagnosis of smear-negative pulmonary and extrapulmonary TB in resource-limited settings wherever HIV is prevalent.

The diagnosis of TB in someone who is HIV-positive can be problematic, particularly as the usual methods of smear culture and chest X-ray often don't work. Smears may be negative and chest X-rays may not be typical of pulmonary TB. Extrapulmonary TB is also more common in co-infection with HIV.

The new guidelines suggest only two sputum specimens for smear microscopy from someone who is HIV-infected or when there is strong clinical evidence of HIV infection. This will reduce the time, and the number of visits the patient has to make to the clinic, required to make a diagnosis. If one of the specimens is positive, a diagnosis of pulmonary TB can be made.

If both the specimens are smear negative, but a chest X-ray suggests TB, the suggestion is to treat for TB, monitor, and make the diagnosis on a positive response to treatment. In addition, a diagnosis of smear-negative TB can be reached once a specimen sent for culture comes back positive for *Mycobacterium tuberculosis*.

Any patient with a temperature higher than 39°C, a pulse rate of over 120 per minute and a respiratory rate of over 30 per minute should be treated with a broad-spectrum intravenous antibiotic and, depending on the CD4 count or the clinical setting, treatment for *Pneumocystis pneumonia* (PCP, also known as *Pneumocystis jirovecii pneumonia*) should be considered as well. The patient should, if possible, be transferred to a high-level centre for further treatment. The recommendation is not to wait for diagnostic evidence of TB or HIV.

The revised definition of extrapulmonary TB requires obtaining a positive result, by smear microscopy or culture, on at least one biological specimen from the site of infection. Or, a diagnosis may be made if there is histological or strong clinical evidence consistent with extrapulmonary TB in a person with (or strongly suspected of having) HIV, and a decision to treat with a full course of anti-TB treatment.

The full guidelines can be seen online: http://www.who.int/entity/tb/publications/2006/tbhiv_recommendations.pdf

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