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## Television coverage of AIDS and transmission of the AIDS virus

The introduction of the government framework "The national strategy for sexual health and HIV"[1] is necessary for attempts to prevent sexual causes of premature death and ill health, at a time when transmission of HIV is at a record level and heterosexual intercourse is the most commonly reported mode of transmission. However, policy formation alone will not be effective in the fight against AIDS in the United Kingdom. Commentators have noted television coverage of AIDS has declined as the progression of the AIDS epidemic has fallen from media interest.[2] While television coverage raises AIDS awareness and encourages safer sex, it is unclear if it has an impact on infection rates. I have studied the association between television coverage and HIV transmission.

Television programmes with an AIDS specific content broadcast in the United Kingdom between 1981 and 2000 were identified. Criteria for inclusion were UK-wide terrestrial television programmes promoting AIDS awareness and encouraging the practice of safer sex; documenting the life of a person with AIDS; or a dramatisation featuring an AIDS storyline. Televised public education campaigns were excluded from the search, having been reported elsewhere.[3] Television listings data were collected from a Scottish national newspaper (*Daily Record*) providing UK-wide television listings. Hand searching was conducted on the 1st, 15th, and 28th days of the months of February, May, August, and November; from 1981–2000: a 3.3% sample of available coverage. The sample was augmented by additional sources. A search for programmes shown as part of a one-off media campaign (as reported in the literature); between 27 February and 6 March 1987 to promote AIDS awareness and encourage safer sex was conducted. Supplementary programmes were obtained ad hoc from reviewing *The Guardian* CD Rom (from 1989–2000) and *The End of Innocence: Britain in the time of AIDS*.[4]

Thirty seven UK terrestrial programmes covering HIV/AIDS were identified, the earliest in 1983, most recent in 2000, and a peak of programmes in the late 1980s. Between 1996 and 1999 no programmes covering HIV/AIDS were found. Twelve programmes about AIDS were shown during the media campaign of 1987. The decline in television coverage of AIDS contrasts with the steady increase in transmission of HIV (see fig 1 and table on *STI* website).

The findings of my study are tentative, but hint that television coverage of AIDS has declined as transmission of HIV continues. This complements Nicoll and colleagues' argument that AIDS campaigns (often televised) are likely to have reduced HIV transmission in the 1980s.[3] Television is a rich source of information about AIDS, offering a powerful while unevaluated medium for promoting AIDS awareness and safer sex to the general public. Given the current low level of media interest and the ceaseless increase of HIV transmission, it may be beneficial to formally evaluate a national media campaign on this important public health issue using quasi-experimental methods.

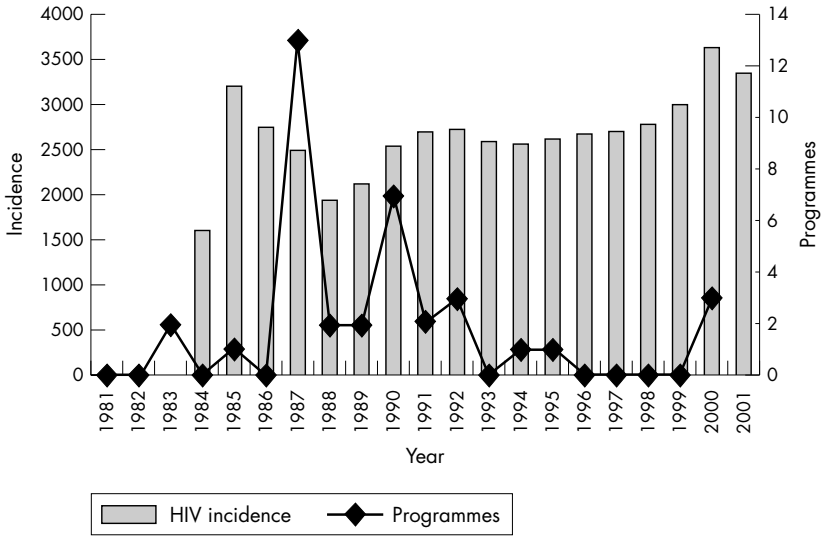


**Figure 1** Television coverage of HIV/AIDS and incidence of HIV transmission in the UK, 1981–2001.

**D J Nicolson**
Centre for Health Services Research, School of Health Sciences, University of Newcastle, 21 Claremont Place, Newcastle upon Tyne NE2 4AA, UK

Correspondence to: d.j.nicolson@ncl.ac.uk

A table of television coverage of AIDS 1981–2000 is on the *STI* website www.stijournal.com/supplemental

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## High frequency of antibodies to syphilis and HIV in hepatitis C virus positive blood donors may reflect its sexual transmission in this region

Hepatitis C virus (HCV) infection is a great cause of concern because of the risk of chronicity and other sequelae. Studies on the prevalence behaviour pattern and sexual transmission of HCV infection among the population are required for formulating strategies to control spread of HCV.[1] The aim of this study was to evaluate the occurrence of HCV in voluntary blood donors as they are known to be a high risk population[2 3] for transmission of these infectious agents. Comparison was made between the presence of syphilis, HBV, and HIV infection in HCV negative and positive blood donors to confirm these as markers or predictors of HIV infection in a high risk population which may reflect the transmission of HCV by a sexual route.

Voluntary blood donors (n = 3905) from New Delhi, India, were randomly recruited between August 2001 to March 2002 and were unpaid. These donors were screened for antibodies to VDRL, hepatitis B surface antigen (HBsAg), hepatitis C virus (HCV), and HIV using previously validated second generation ELISA kits. Data were analysed using the $\chi^2$ test. Odds ratio (OR) was used to measure strength of an association.

**Table 1** Percentage positivity of HBsAg, VDRL, and HIV in HCV positive and negative blood donors

| | HCV +ve (n=61) | HCV –ve (n=3844) | Total |
|---|---|---|---|
| HBsAg (%) | 3 (4.91) | 106 (2.75) | 109 (OR=1.82) |
| VDRL (%) | 3 (4.91) | 129 (3.35) | 132 (OR=1.48) |
| HIV (%) | 9 (14.75) | 31 (0.80) | 40 (OR=21.2) |

$\chi^2$=122.8; p<0.001.
OR = odds ratio, HCV positive versus HCV negative negative blood donors.

The antibodies to HCV were detected in 61 (1.56%), HBsAg in 109 (2.79%), VDRL in 132 (3.38%), and HIV in 40 (1.02%) donors. In HCV negative blood donors, VDRL was detected in 129 (3.35%), HBsAg in 106 (2.75%) and HIV in 31 (0.8%) donors, while in HCV positive blood donors HIV positivity increased significantly to nine (14.75%) OR (21.2) and VDRL and HBsAg reactivity increased to three (4.91%) (OR 1.82 and 1.48 respectively). Thus HIV, VDRL, and HBsAg reactivity was found 21.2, 1.48, and 1.82 times more often respectively in HCV positive blood donors (table 1).

In conclusion, the high frequency of antibodies to syphilis and HIV in HCV positive blood donors may confirm this as a marker or predictor of HIV infection in a high risk population and may also reflect the risk of transmission of HCV by the sexual route, which seems to vary with the population studied.

**A Mittal**
Institute of Pathology (ICMR), Post Box No 4909, Safdarjung Hospital Campus, New Delhi -110029, India; amittal_iop @ yahoo.com

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## Self obtained samples for genitourinary infections

We assessed the concept of self sampling, as part of screening for sexually transmitted diseases, first in the early 1990s in a pilot study.[1] The aim was to assess the validity and acceptability of the procedure as an alternative for the sex industry workers (or as a supplementary method between attendances), for those who are reluctant or unable to attend GUM clinics frequently. Microbiological techniques then were not as developed or as sensitive as today's (PCR) tests.[2] Since then, other studies reported on the feasibility and acceptability of self obtained samples.[3 4]

We read with interest, the article published in *STI*[5] regarding the diagnosis of chlamydia, gonorrhoea and trichomonas infections by self obtained low vaginal swabs. The techniques employed in the Australian study (patients obtaining swabs while sitting or standing) would allow less access to the genital tract than our originally proposed squatting positions. In our study, the patient was advised first by a female nurse on the squatting position and locating the cervix. She was readvised on repeating the procedure and the attempt to take the swabs from the cervical surface. In our study, 86.7% of patients reported their ability to access the cervix (and, therefore, obtain high vaginal/cervical samples). The squatting position has the advantage of providing patients with the freedom to use both hands (one of which may be used to open the vulval lips). The technique is similar to that employed by women for self examination before the insertion of a cervical cap or for the presence of the intrauterine contraceptive device threads.

The new methods of information technology, with their declining cost, can provide extra support to the concept of self obtained samples with easier patient access to their results. The result of the tests may then be obtained by the patient by telephone (possibly via an automated service or a text message, using an identification code number). The procedure is already in use by the banking services for accessing personal and confidential information. It is possible to provide the sampling materials in a "test pack" that may be returned to a central laboratory, by post. The pack may include information and explanatory notes and a coded identification number. This would help to identify the patient's samples, with confidentiality.

The recent escalation in the incidence of sexually transmitted infections, coupled with the increasing workload for GUM clinics is representing a challenge for adopting new ways in combatting the spread of sexually transmitted infections. The exploitation of new ideas, methods, and technologies could be of benefit, especially in areas out of access to advanced laboratory investigations (remote and rural areas). It could also be used as a supplementary method to current medical care (between visits) in special patient groups (for example, adolescents[3] and sex industry workers[6]).

**A R Markos**
Staffordshire General Hospital, Weston Road, Stafford ST16 3SA, UK; stephanie.thorpe@msgh-tr.wmids.nhs.uk

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## A survey of STI policies and programmes in Europe

The survey by Dehne *et al* was carried out in 1998–9 and inevitably does not necessarily represent the current situation.[1] The authors report that the United Kingdom has no national STI programme and management guidelines. The first ever national strategy for sexual health and HIV for England was published in 2001.[2] It contains the two key objectives of ensuring that everyone has better access to information on sexual health and to make services more available and accessible to all those who require them at all ages. The strategy also has specific aims of reducing acquisition, transmission and the prevalence of undiagnosed HIV and STIs. Specific targets to increase the uptake of HIV testing in hepatitis B vaccination have also been set.

The issue of case management guidelines was not detailed in the strategy since this has been specifically tackled by the specialty of genitourinary medicine. A clinical effectiveness group was set up between the Association of Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases in 1997, with the specific remit of producing evidence based national guidelines and standards for those working in the specialty of genitourinary medicine. These were published in *STI* in 1999[3] and updated in 2002.[4]

I hope these observations will help to update the survey with particular reference to England.

**M W Adler**
Department of Sexually Transmitted Diseases, Royal Free and University College Medical School, The Mortimer Market Centre, Off Capper Street, London WC1E 6AU, UK; madler@gum.ucl.ac.uk

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## Polymorphic immune restoration syndrome after effective HAART

HAART is able to suppress HIV replication and restore specific immune responses. We and others[1 2] have demonstrated that previously