

workers as well as MSM. We hope that Sonia Gandhi's presence at the AIDS conference in Thailand is a step toward official recognition of the issues inherent to the epidemic.

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#### References

1. Arora P, Cyriac A, Jha P. India's HIV-1 epidemic. *CMAJ* 2004;171(11):1337-8.
2. Dandona L, Dandona R, Radhakrishnan S, Kumar GA, Gutierrez JP, FPP Team-ASCI, et al. Sex behaviour of men who have sex with men and risk of HIV in Andhra Pradesh, India [abstract]. *eJLAS* 2004;1(1):WePeC6082. Available: [www.iasociety.org/ejias/show.asp?abstract\\_id=2171737](http://www.iasociety.org/ejias/show.asp?abstract_id=2171737) (accessed 2005 Apr 26).
3. Dandona R, Dandona L, Radhakrishnan S, Kumar GA, Gutierrez JP, FPP Team-ASCI, et al. Barriers to condom use for anal sex among men who have sex with men in Andhra Pradesh, India [abstract]. *eJLAS* 2004;1(1):WeOrC1332. Available: [www.iasociety.org/ejias/show.asp?abstract\\_id=2171967](http://www.iasociety.org/ejias/show.asp?abstract_id=2171967) (accessed 2005 Apr 26).

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#### [Two of the authors and a colleague respond:]

We thank Edward Mills for pointing out, in response to our article on India's HIV-1 epidemic,<sup>1</sup> that men who have sex with men (MSM) are contributing to the HIV-1 epidemic in India. We think there are similarities between MSM and commercial sex workers, but also important differences.

In Andhra Pradesh state of India, about 40% of both MSM and commercial sex workers reported being currently married.<sup>2</sup> Similarly, 56% of MSM and 47% of commercial sex workers reported inconsistent condom use with male partners and paid clients, respectively.

But the sexual networks of commercial sex workers matter more than those for MSM in the growth of the HIV-1 epidemic. First, male clients or regular partners of commercial sex workers are more likely to spread HIV-1 further than are the wives of MSM. A national behavioural survey of 85 000 adults in 2001<sup>3</sup> found that 12% of males but only 2% of females reported nonregular sex partners in the previous year (for Andhra Pradesh, the comparable percentages were 19% and 7%). Second, the absolute number of commercial sex workers in the country may range from 5 million to 16 million.<sup>4</sup> The absolute number of MSM is not known but is probably lower. Thus, the annual absolute volume of partners is likely greater for commercial sex workers. Third, it is likely that the variation in sexual contacts among commercial sex workers is greater than that for MSM. The absolute volume of partners and its variance are key determinants of HIV-1 growth in mathematical models.<sup>5</sup>

We agree that more research is needed on MSM populations, including estimates of their size. If MSM are married, then the epidemiology of HIV-1 for this group and their partners may differ from that of MSM in Western countries. However, the overwhelming control priority is peer-based education on condom use, sexual and general health, negotiation skills and community collectivization efforts for female sex workers.<sup>6</sup>

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#### References

1. Arora P, Cyriac A, Jha P. India's HIV-1 epidemic. *CMAJ* 2004;171(11):1337-8.
2. Dandona L, Gutierrez JP, McPherson S, editors. *Key Indicators for Frontiers Prevention Project: report on baseline study in Andhra Pradesh, India*. Hyderabad, India: International HIV/AIDS Alliance, Centre for Public Health Research Administrative Staff College of India, National Institute of Public Health; 2004. p. 10, 28, 44, 60.
3. National AIDS Control Organization. *National baseline general population behavioural surveillance survey 2001*. New Delhi, India: Government of India, Ministry of Health and Family Welfare; 2001.
4. Venkataramana CB, Sarada PV. Extent and speed of spread of HIV infection in India through the commercial sex networks: a perspective. *Trop Med Int Health* 2001;6(12):1040-61.
5. Nagelkerke NJ, Jha P, de Vlas SJ, Korenromp EL, Moses S, Blanchard JF, et al. Modelling HIV/AIDS epidemics in Botswana and India: impact of interventions to prevent transmission. *Bull World Health Organ* 2002;80(2):89-96.
6. Jha P, Nagelkerke JD, Ngugi EN, Prasada Rao JV, Willbond B, Moses S, et al. Reducing HIV transmission in developing countries. *Science* 2001;292(5515):224-5.

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#### Correction

In the third instalment of our series about evidence-based medicine,<sup>1</sup> the source of the qualitative classification of kappa shown in Table 1 was incorrectly cited. The correct reference is Sackett DL, Haynes RB, Guyatt GH, Tugwell P. *Clinical epidemiology: a basic science for clinical medicine*. 2nd ed. Boston: Little, Brown and Co; 1991. p. 30.

#### Reference

1. McGinn T, Wyer PC, Newman TB, Keitz S, Leipzig R, Guyatt G, for Evidence-Based Medicine Teaching Tips Working Group. Tips for teachers of evidence-based medicine: 3. Understanding and calculating kappa. *CMAJ* 2004;171(11):Online-1 to Online-9. Available: [www.cmaj.ca/cgi/data/171/11/1369/DC1/1](http://www.cmaj.ca/cgi/data/171/11/1369/DC1/1) (accessed 2005 May 16).

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