Concise summaries and distinct diagnostic algorithms can be completed within a few hours. These give clear advice for more junior doctors and are applicable to all healthcare systems in the developed world. Unfortunately we know that there are many guidelines out there, and more often than not they are being ignored. Let us hope that these guidelines make the difference.

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Preventing HIV

Time to get serious about changing behaviour

It is not easy to write about preventing HIV when we are failing at it. For two decades we have known how to prevent every single route of transmission—sexual intercourse, infected blood products, intravenous drug use, accidental inoculation, perinatal transmission, and breast feeding.[1] Yet the number of people infected with HIV worldwide is estimated at 42 million, with some 5 million new infections each year.[2] How can this be?

Some argue that there is not enough money; others that it is too difficult to change the behaviours that contribute to the spread of HIV. But if behaviour cannot be changed then no amount of money is going to make a big difference in prevention because every successful form of prevention requires change in behaviour.

Governments must change the way they view HIV and AIDS by rearranging priorities for spending. Overall more people are killed by HIV than invading troops. Ministries of health and national public health agencies must supply the resources to test all blood donors and enforce regulations against use of untested blood products, avoiding the continued unnecessary infection of hundreds of thousands of individuals.[3] Communities and their leaders must change cultural practices that contribute to high rates of sexual transmission. All individuals should be tested for HIV regardless of perceived risk factors, to break down the barrier that HIV only affects "them" and not "me." Individuals who are not infected need to be responsible for protecting themselves against infection and infected individuals need to be accountable for not transmitting this ultimately lethal infection. Public health agencies need to devise methods for partner notification that will not result in discrimination or stigmatisation of sexual partners.

Economic, protective, and legal resources should be provided to underage girls to prevent them from being infected by older men and prevent hundreds of thousands of children from becoming victims of sex trafficking.[4]

The inertia that surrounds implementation of prevention strategies must be overcome. Four years after single dose nevirapine was shown to reduce perinatal HIV infection by 50%, less than 4% of pregnant women with HIV infection receive treatment.[5] The efficacy of exchange programmes for needles and syringes have been debated much too long. All that is required to establish an HIV epidemic in a country is a few cases of HIV infection in intravenous drug users, a few cases of HIV infected blood donors, and sexual spread. As China learnt, ignoring these factors provides the foothold for a major epidemic in less than a decade.[6] Breast feeding substitutes that require clean water to be safely administered could prevent hundreds of thousands of infant HIV infections each year.[7] Providing clean water is a fundamental health need and would cost less than providing lifelong treatment for HIV infection.

Being serious about HIV prevention also means changing the behaviour of those who overtly or subtly undermine known methods of prevention. Advocates of abstinence who say that condoms don't work and advocates of condoms who say that abstinence does not work are both wrong. Data from developed and developing countries show that programmes that incorporate abstinence, mutual monogamy, delayed sexual intercourse, and condoms work together to reduce the number of new HIV infections.[8] Programmes and messages that truncate known public health measures are dishonest and cost human lives.

See also *Education and debate* pp 1382-92

BMJ 2003;326:1342–3

Education about HIV and prevention training should be an international priority that produces thousands more trained healthcare workers, teachers, and community leaders—spread throughout all areas of society. A notable impact on prevention cannot occur if large portions of the population are left uneducated. There is not enough time to wait for "trickle down" or "from the centre out" approaches to building education and training infrastructure. One need only travel two hours from major urban areas in developing countries to observe that HIV, but not HIV education, has reached them. Although numbers are not precise, it is likely that 50% or more of the HIV epidemic occurs in rural areas that have limited access to HIV information.

Many of the current educational tools focus on individuals with moderate to high levels of literacy. Information about HIV and AIDS is often not available to healthcare workers, teachers, and students, or for that matter, to community, village, and religious leaders. Currently available information must be translated and adapted to diverse conditions, especially those that exist in rural areas. Because of the low priority given to funding education and training it is not surprising that so many individuals lack basic knowledge on how to prevent HIV infection. Without education at all levels in the community major reservoirs of HV infection and transmission will continue unabated.

Behaviour change does result in a decrease in new HIV infections whether in rich countries such as the US and Europe or in poor ones such as Uganda and Zambia.[2 8] However, without more extensive progress we are deluding ourselves into thinking that the epidemic can be controlled. Behaviour change must encompass all levels—governments, non-governmental organisations, schools, religions, community leaders, and individuals. A good place to start would be with accepting that voluntary counselling and testing should be universally incorporated into health care. Only when these are universally available and accepted by all will individuals know how to protect themselves from becoming infected, how to prevent themselves from transmitting infection, and when to be treated. The amount of HIV testing and the numbers of people infected and uninfected should be the measurement by which we determine the success of prevention programmes.

At this time in the epidemic we don't have the luxury of debating the relative merits of prevention versus treatment. Both are underused and underfunded, and one leads to the other. But being serious about prevention calls for change in behaviour on everyone's part.

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Electroconvulsive therapy

Recent recommendations are likely to improve standards and uniformity of use

Papers p 1363

Electroconvulsive therapy is one of the most controversial treatments in medicine. Opinions are often polarised; some consider electroconvulsive therapy to be effective and potentially lifesaving whereas others regard it as unhelpful and harmful and campaign energetically for it to be banned. In response to comments on a mental health white paper, "Reforming the Mental Health Act," the UK Department of Health commissioned two systematic reviews of electroconvulsive therapy in 2001. One assessed its efficacy and safety in the treatment of depression,[1] mania, and schizophrenia and the other reviewed surveys of patients' experiences and is published in this issue of the *BMJ* (p 1363).[2]

So what is the current status of our knowledge about electroconvulsive therapy? Both reviews reveal the limitations of the primary studies and the need for genuinely collaborative high quality research—rather than research done by consumers for consumers and by clinicians for clinicians resulting in research with limited general credibility. Nonetheless both reviews produced some useful results. The systematic review of patients' experiences found that approximately a third describe persistent loss of memory following electroconvulsive therapy.[2] Rose et al report that there were substantial variations between studies in the perception of benefit from electroconvulsive therapy. The finding that surveys conducted by clinicians tend to report higher rates of perceived benefit whereas those performed by consumers' organisations tend to find lower rates is of particular interest. Of course this may be explained by differences in the selection of the populations sampled or, as the authors suggest, by differences in the focus of the questions and the way they were asked. The review of randomised trials found a reasonable body of evidence on the effects of electroconvulsive therapy in depressive disorder, but less on mania and schizophrenia.[1 4] Electroconvulsive therapy produces more improvement on scales of depressive symptoms than simulated electroconvulsive

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