Case-cross over studies are used to assess brief exposures (e.g. high-ambient temperature) that may cause a temporary increase in risk of diseases (e.g. death), and have the advantage of controlling for confounding by factors that differ between individuals such as age and co-morbidities. A novel application is reported in this issue in an evaluation of factors determining condom use in female bar and hotel workers in Tanzania. Unsurprisingly condoms were more often used with casual rather than regular sex partners, for hotel sex and when gifts were received—all indicative of a high-risk situation. Condoms were less often used with men >10 years older than the woman; partner alcohol use and knowledge of HIV status were not associated with condom use. The authors focus on the decision-making process—those women reporting that they decided or that it was a mutual decision were 10 times more likely to use condoms—and comment that it is much easier for a woman to negotiate with a stranger than with her regular partner. Interventions attempting to increase use of condoms in long-term relationships, supposedly based on mutual trust, are unlikely to provide a satisfactory solution. So, the authors consider interventions to reduce the number of concurrent partners and promote use of female condoms may be more useful.

Chlamydia infection is one of the commonest sexually transmitted diseases contributing substantially to the 340 million new cases of bacterial or protozoan sexually transmitted infections. World Health Organization, in common with the British health service and the US Preventive Services Task Force, believe that Chlamydia screening is a good thing. So, why do Nicola Low and colleagues conclude ‘there is an absence of evidence supporting opportunistic Chlamydia screening in the general population younger than 25 years?’ The previous reviews of the evidence suggested fair to good evidence to support screening. The main issue appears to be the organizational system in which screening is conducted—if you use a population register to invite women for screening rather than chance encounters with women attending health services for various reasons (‘opportunistic’ screening), some low quality evidence of benefit can be found. These authors were not randomized controlled trial (RCT) obsessed in their definition of evidence—they note that Chlamydia rates were falling in Sweden before the opportunistic screening service became operational. Low and colleagues suggest that clinical equipoise on the balance of benefits and harms of screening remains—but the alacrity with which World Health Organization and other influential groups and health services have adopted Chlamydia screening suggests that there is no equipoise. Indeed, the language of our commentators from CDC Atlanta on the review is interesting: ‘... it is risky to draw conclusions [given the small number of studies reviewed] about which approach to screening works best’. Presumably, it is not possible to countenance a view that screening maybe just does not

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work! Both authors and commentators agree that more research is needed—no surprise there.

Have you ever wondered what your adolescent child is thinking about? According to a study from Goa, India—it is quite likely to be suicide. Sangath, a leading Indian mental health non-governmental organization (NGO) which led the research was recently awarded a prestigious Macarthur Foundation International Award for its work. In this issue, we publish a report of one of the largest studies ever done on suicidal behaviour among young adults. Overall, almost 1 in 20 reported suicidal behaviour in the previous 3 months. This sounds incredibly high but is consistent with findings in other low- and middle-income countries where rates as high as 20% have been reported. But, the really perturbing issue is the difference between girls and boys—completed suicide rates in girls, of 50 and 70 times higher, in high-income vs low-income countries; for boys the rates are only four times higher. Furthermore, verbal autopsy studies have shown that routine statistics on suicide grossly underestimate the true burden. The focus of this study was to examine whether common mental disorders—largely depression—are as important as in high-income countries, and whether relationship problems, physical and sexual abuse played a role. What did they find? Mental disorders—as detected by the GHQ12—were strongly associated with suicidal behaviour in the previous 3 months and had the largest population attributable risk of the risk factors examined. Physical and sexual abuses were both independently associated with suicidal behaviour in both boys and girls. The authors conclude that prevention of suicidal behaviour will require efforts to reduce gender disadvantage in Indian communities and that early detection and treatment of common medical disorders in young people should be given higher priority.

Also on the theme of gender inequality in India, Rocca and colleagues report their findings from a cross-sectional survey of slum dwellers in Bangalore, India in this issue. Over a quarter of the women surveyed had experienced physical domestic violence in the previous 6 months. As this was a convenience sample, it is uncertain whether the prevalence estimates are representative, but the real point of the article is the highlighting of some worrying associations: increased odds of violence among women in ‘love’ marriages (vs arranged marriages), and those who participated in social groups and vocational training. As the authors acknowledge a ‘love’ marriage may not imply an empowered woman making her choices but may be the result of a forced marriage to legitimize a pregnancy. The women empowerment interventions that Pillai and colleagues would like to see used to reduce the gender inequalities in India, clearly have the potential—in some circumstances—to put women at increased risk of violence. Replication of Rocca’s findings using more robust prospective designs is needed. For example, augmenting the evaluation of women’s empowerment projects to include both qualitative and quantitative information about domestic violence (and including husband’s perspectives) would be a valuable addition to our understanding of the relationship between empowerment and domestic relationships.

Finally, where are the cabbages in this editor’s choice? Cabbages and Condoms is the name of a successful restaurant in Bangkok (Sukhumvit Soi 12) that is run by Mechai Viravaidya’s Population and Community Development Association. This NGO won the 2007 Gates Award for Global Health not for the quality of the food (although the chicken certainly is not rubbery) in the restaurant but for its work in family planning and HIV/AIDS prevention. The restaurant is famous for giving out condoms instead of after-dinner mints which is part of a long-running strategy to change social behaviour. Mechai popularized use of condoms in Thailand in the 1960s and 1970s as part of family planning programmes and to this day the popular word for a condom is a ‘Mechai’. Mechai’s approach to health promotion is to make new behaviours—like using a condom—commonplace. In the 1970s, he suggested famously that there were at least 10 uses for a condom (besides the most obvious one—see Box 1 and Figure 1) which meant that carrying condoms at all times was simply a sensible and useful thing to do. Indeed at a village celebration of Thai new year in 1979, I was intrigued to see many young people in various states of inebriation each clinging onto a brown paper bag. In the bag were a strip of ‘yaa maa’ pills (literally horse medicine—amphetamines) and a handful of condoms. Very useful. Take a look in your wallet and if there is not a condom there, put two or three in right now—and remember to learn at least two or three alternative uses for them.

References

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Box 1 Uses for a condom

1. Balloon to amuse children.
2. Transporting water.
3. Lubricant for shaving.
4. Make-shift field shower.
5. Making flower arrangements.
6. Tying the neck of a bag.
7. Waterproof covering for wound dressing.
9. Keeping fingers clean while changing car tyre.
10. Covering leaky ointment, oil, perfume bottles when travel packing.
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