# Letters to the Editor

*Chairman, P.O. Box 1440, Auckland, New Zealand*
*Telephone: (09) 520 2398 Fax: (09) 522 0759*

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## Asia Pacific Academy of Ophthalmology

The purpose of this letter is to introduce your readers to our oganisation whose primary purpose is to provide basic ophthalmic training for doctors working in the Pacific region. Our organisation is funded by a charitable trust which operates in New Zealand and works in close co-operation with the Asia Pacific Academy based in Singapore.

Essentially our organisation invites candidates to apply to fellowships through our secretariat based at the Auckland School of Medicine. Normally applications have come from or been supported by government health authorities. The successful candidates are flown to Auckland at the expense of our trust (our major sponsor is Air New Zealand) and accommodation in Auckland is also paid for by our trust. The training in ophthalmology is provided by the staff at Auckland Hospital and the Auckland School of Medicine which allows candidates to experience hands on practical clinical training from health professionals ranging from our senior ophthalmic surgeons to registrars and ward staff.

The level of tuition for each candidate will vary considerably depending on each case and the special needs of the community the doctor is serving. In the case of many Pacific island doctors the essential needs are treatment of traucoma and cataract extractions. The duration of each fellowship in Auckland is determined between our organisation and the candidate's employer during the selection process.

Our organisation is anxious to ensure we are eliciting a wide demand for our fellowships in every corner of the Pacific and to meet the needs of all Pacific communities. For the first time in a long time we do not have a candidate for fellowship in 1995, although there is a likely prospect in 1996 from Lautoka, Fiji from where Dr Than Tun Oo may return to Auckland for a second fellowship.

My trustees and I are hopeful that as a result of this letter you will assist us in identifying future candidates and help us to promulgate the work of our trust. In particular, we would be interested to know of a possible candidate from the Pacific in the next 12 months.

*Rob Fenwick*

## STD and AIDS among children in Australia

There is concern among health professionals in Australia about the frequency with which young people may become infected with HIV and various STD. These are mirrored by anxieties in the community and have led to a number of health education programs which have stressed the risk of AIDS but have paid little attention to the other consequences of unprotected sexual activity. These programs have a risk of in fact creating a sense of false security among teenagers.

**Traditional STD:** There are three STD that are frequent in the Australian community - chlamydia, gonorrhea and syphilis. These are rarely reported prior to the age of 14 years. In the age group 15 to 20 the annual notification rate for chlamydia in boys is about 50 per 100000 population and for girls almost 300 per 100000. These rates rise further in the age group 21 to 24 and then falls away. Chlamydial infection in women remains a major cause of long term infertility.

Similarly gonorrhoea is very uncommon under the age of 15 years. The infection rate for males 15 to 19 is about 45 per 100000. The peak incidence is among the 20 to 25 years old with the rate of 70 per 100000. There is probably substantial under reporting of gonorrhoea. The total number of notifications for these diseases for all age groups in 1994 is given in Table 1.

**HIV infection:** A total of 123 children under the age of 13 years have been diagnosed since the introduction of HIV testing in 1985 to 1994. Thirty-six were regarded as having

Table 1. Notification of new STD infections in Australia during 1994 for all age groups*

| STD | Number of cases |
|---|---|
| Chlamydia | 6474 |
| Gonorrhoea | 2714 |
| Syphilis | 2295 |
| HIV | 1059 |

* *Probably under reported.*

acquired the infection by vertical transmission from their mothers and 66 from blood transfusion. In 1994, 19 new cases of infection in children aged 13 years or less were reported, all acquired by vertical transmission from an infected mother. Reports of sexually acquired HIV in the 15 to19 age group have been extremely few. Peak ages for reporting of new HIV infections are from 30 to 40 years. Australia has been particularly fortunate in limiting the number of vertical HIV infections. This has been attributed to the success of the needle exchange programs for intravenous drug users.

Besides intravenous drug use, the other major risk factor in Australia is anal intercourse. Transmission of HIV as a result of vaginal intercourse seems to be low in Australia compared to Asia and Africa. The lack of reported infections in the 15 to 19 year olds may reflect the relative infrequency of anal intercourse in this group or alternatively the reluctance to report such sexual practices. It has been the impression in Australia that males under 20 years old are rarely willing to acknowledge their homosexual lifestyle.

**Sexual activity of children:** There is a fairly widespread belief in Australia that most adolescents are sexually promiscuous and this has been reinforced by a number of surveys. A study of randomly selected secondary school children in Melbourne indicated that at the age of 12 to 13 years, 8% of boys had had sexual intercourse and 1.8% of girls. By 15 years the rates had risen to 20% and 10%, respectively. By 17 years, 38% for boys and 36% for girls. For those who by the age of 17 had had sexual intercourse, 67% of the boys and 50% of the girls had it on very few occasions. Most have only one sexual partner and 70% of the sexually active boys and 60% of the girls have always used a condom. Only 10% of both genders never used a condom.

There are no reliable data on the level of sexual activity of young people beyond the age of 17 or once they have left school but again anecdotal impression is that it increases quite markedly. This of course is the age when STD becomes more frequent.

**Sexual health education program:** Most sexual health education programs in Australia targeted at young people have stressed the risk of acquiring HIV infection from unprotected heterosexual activity. In fact the data suggest that the risk of acquiring HIV infection from unprotected vaginal intercourse in Australia is extremely low. The major risks from unprotected heterosexual activity are the acquisition of chlamydia, gonorrhoea, syphilis and unwanted pregnancy. These have received little attention in the publicity aimed at young people. There is concern that as youths realise that the risk of acquiring HIV is relatively small they will not take appropriate action to avoid the major outcomes listed.

**Pacific children in Australia:** Data on STD and HIV by ethnic groups in Australia is hard to come by. Therefore it is not possible to provide any reliable information on the incidence of STD among Pacific children. Discussions with colleagues in major paediatric institutions suggest that STD is not a significant health problem for Pacific children. Regrettably the major hospitals in Australia have not provided adequate care for children with STD and the majority have to attend clinics that provide services for all age groups.

While chlamydia, gonorrhoea and syphilis are significant health problems among older adolescents in Australia, HIV infection is very uncommon. The impression is that pattern is no different for Pacific teenagers living in Australia. The relatively low level of sexually active people aged less than 17 years and the relatively high rate of condom usage are the probable explanations for this pattern of infection. In the development of educational programs on STD and AIDS for young Australians from the Pacific islands, the current patterns of infection and sexual activity must be determined so that the health prevention programs can be appropriately designed.

*Professor Peter D Phelan*
*Department of Paediatrics, Royal Children's Hospital, Parkville, Victoria 3052, Australia*

## SPC information exchange for the prevention of AIDS and STD

The Pacific Islands AIDS and STD Prevention Project (PIASSP), set up 4 years ago at the South Pacific Commission (SPC), New Caledonia, includes an information exchange component. It was originally set up as part of a worldwide network of World Health Organization (WHO)-funded information exchange centres on STD and AIDS. WHO support for these centres was subsequently reduced or dropped off altogether. In the case of the SPC centre, WHO funding was halved in 1992 and has not been forthcoming since 1993. The SPC centre nevertheless maintains a good relationship with WHO Geneva and Manila, and receives one copy of all WHO AIDS/STD publications free and good discounts on bulk purchases of publications.

It is difficult to separate out the information exchange from the other functions of the PIASSP and SPC Community Health Services as they operate as an integrated unit. Briefly, the exchange collects and disseminates information and materials on AIDS and STD with an emphasis on education, and on materials relevant to the Pacific. The exchange has a large collection of books, journals, videos, reports, audio tapes, journal articles, stickers, pamphlets, condom packages, and even t-shirts, which can be copied or photographed on request, or used for displays.

These materials are catalogued onto SPC's library database (over 1500 entries so far) and a catalogue, *AIDS/STD Information*, is issued twice yearly, listing the latest additions, with a summary and evaluation for each entry and details on where to order them. From time to time, special information packages for particular target groups are compiled and distributed. These have included materials for school curriculum development, prisons, seafarers, and dentists.

Appropriate materials, including books and videos are purchased in bulk and distributed to National AIDS Committees (and, stocks permitting, even to Provincial committees in Papua New Guinea) as well as at least one other 'resource centre' in each country (mainly libraries or NGO offices). The intention is that the materials be made available for use by the community. Initially, National AIDS Committees in each Pacific Island country were asked to nominate suitable resource centres but most either did not reply or nominated their own offices, where we felt that the materials would not be available to the public. The network of resource centres for distribution of materials was established using the Pacific Island Information Centre (University of the South Pacific) libraries, the offices of NGOs active in AIDS prevention, and in the Micronesian countries thanks to the assistance of the Pacific Island Association of Libraries and Archives. Material which could be useful for curriculum development or classroom use is also sent to Departments of Education throughout the Pacific. AIDS/STD prevention materials produced at the national level in the Pacific and suitable for adaptation is shared with National AIDS Committees in SPC's 22 island member countries, the latest being a video produced by high school students in the Cook Islands.

Problems with the exchange include not knowing how the materials are used in all cases, or whether they are being used as we have not yet done a survey, and there have been few in-country visits by the documentalist. However the feedback we have had has been very positive and we know that some recipients are using the materials including *AIDS/STD Information* extensively. We also know that some of the materials distributed have been adapted. One recent success story was when some Canadian publications for primary schoolchildren which we supplied to the Northern Province of New Caledonia later formed the basis of an AIDS education programme in its primary schools.

We have shared our mailing lists with several overseas networks, eg. AHRTAG in London, HAIN in the Philippines, Family Health International in the USA so that those in our resource centre network will receive the regular publications of these organisations, such as *AIDS Action* and *AIDScaptions*. We also purchase WHO's *World AIDS Day Newsletter* in bulk and distribute it to our network.

Everything produced by PIASSP including 2 videos (*Charlotte's Story* and *Like Any Other Lovers*), posters and other publications (often in bulk), *Pacific AIDS Alert* and *AIDS/STD Information* is distributed to National AIDS Committees and national resource centres. The quarterly *Pacific AIDS Alert*, which includes news from the Pacific and stories about successful approaches to AIDS/STD prevention is mailed to over 5000 addresses, mainly in the Pacific. The documentalist who runs the information exchange also edits the French version of *Pacific AIDS Alert (Alerte au SIDA)*.

Over 30 requests per month for information or SPC materials are received. These requests are mainly from the Pacific, but with an increasing number from around the world as SPC AIDS prevention materials have recently featured in AIDS newsletters, or catalogues of appropriate low-cost materials, eg. *AIDS Action* and *Resource Pack on Sexual Health and AIDS Prevention* (AHRTAG, London). In the Pacific, requests come from a wide range of people and organisations including churches, youth and women's groups, prisons, schools, trade unions, health educators, and individuals in remote villages. Organisations in Australia, New Zealand and the USA have also received materials from PIASSP.

Advice and assistance can be given with the setting up of AIDS/STD resource collections for NGO. Subject searches of computer databases can be made on request, using SPC's library database, CD-ROM, or overseas online services such as MEDLINE. The project as a whole offers training, and small grants to non-government organisations for AIDS/STD prevention. Activities conducted through the small grants have included the production of brochures, posters, drama and videos, workshops, TV and radio spots, community outreach, and condom distribution.

For further information, or to be included on our mailing list, please contact: Pacific Islands AIDS and STD Prevention Project, South Pacific Commission, B.P. D5, Noumea 98848, New Caledonia. Tel. (687) 26 20 00, fax (687) 26 38 18.

*Patricia Sheehan*
*Health Documentalist, South Pacific Commission, Noumea, New Caledonia.*

## If there are innocent victims of AIDS - is anyone guilty?

We have all heard or read about the "innocent victims" of AIDS - babies born to infected mothers or recipients of infected blood products. Universally our responses is full of sympathy, concern, feelings of how tragic that someone innocent has gotten such a deadly disease.

Recently Greg Louganis in the USA announced he has AIDS. Greg is one of the greatest divers the world has ever known, and yet when the story broke did the coverage by the media talk at all about how tragic this is, was there any

showing of sympathy and concern for Greg? No... he wasn't an innocent victim like Arthur Ashe or Ryan White. No, Greg is gay and he got infected through sexual intercourse with another man. So if he's not an innocent victim, I guess that means he is a guilty victim right? And because of his behaviour, he deserved to get the disease. People who deserve something don't get public or media sympathy and support.

The media were not completely devoid of concern however. The first stories focused almost exclusively on the diving accident Greg had at the last Olympics when he hit his head on the board. The media made much of the fact that he bled into the pool, and that the doctor who stitched Greg up between dives didn't use any gloves. Lots of concern was shown regarding the possibility, however remote, that Greg through his accident might have infected someone else - an innocent victim. But any concern for Greg himself? None that I read or heard about.

Without question it's tragic that babies get HIV infection from their infected mothers or that people have gotten infected through contaminated blood products. These babies and people deserve all the concern and support we can muster, just like for people who have any other life-threatening, or debilitating illness or condition. What I don't understand is why we have deemed people who get infected through sexual intercourse or through the sharing of needles, by implication, as guilty, and also by implication, either consciously or unconsciously, as deserving it.

There is also no question that in fact people who do get infected through sexual intercourse or through the sharing of needles did behave in such a way that allowed them to get infected. Whether knowingly or unknowingly, such people did consciously do something that resulted in infection. So in the strictest sense one could say that therefore, as a result of their behaviour, they deserved the consequence. So Greg doesn't deserve our collective sympathy because he got what he deserved. Right?

But wait a minute. Why do we selectively apply this logic to AIDS and not to other diseases or events? Regardless of what the tobacco companies still maintain, there isn't anyone in America or the Pacific who doesn't know, or at least hasn't heard, that smoking or using tobacco products is bad for one's health. Lung and oral cancer, heart disease... we all know that these deadly and debilitating illnesses can and do result from using tobacco. When someone we know develops lung cancer as a result of smoking, are we any less sympathetic because this person is a guilty victim of cancer rather than an innocent victim who led the healthiest of lifestyle and got cancer regardless? Do we make moral judgements, consciously or unconsciously, about the smoker with lung cancer because his or her behaviour had a direct bearing on the development of the disease and withhold our human caring, concern and sympathy as a result? Fortunately we do not. We visit the person in the hospital, we rally behind and support the person and his/her family. We think it is a tragedy regardless of innocence or guilt.

How about the person who drinks too much alcohol one night and runs off the road into a tree. Do we withhold our concern and caring because clearly the person's behaviour had a direct bearing on the accident happening? No, we may not condone the behaviour, but we don't believe the person deserved to get hurt as a result. Or do the newspapers feature articles stating that so and so had a car accident as a result of having too much to drink and as a result is dying in the hospital, but focus almost exclusively on pointing out how that person could have killed any number of other people on the road because of this behaviour? I haven't read any such articles.

Why have we made AIDS different? Because people get infected with HIV through behaviours that many people believe are wrong, or at least make us uncomfortable-sex outside of marriage, sex between individuals of the same sex, anal sex (!) or the use of illicit drugs-we have decided people with HIV infection who didn't get infected innocently are less deserving of our understanding, compassion and care.

The real tragedy is not that there are innocent victims of AIDS. The real tragedy is that more and more people, innocent or guilty, continue to become infected with HIV. In our moral posturing, based in part on this notion of innocence and guilt, we justify the withholding of information and means that could help more people from becoming infected. It's now fourteen years since AIDS was first identified in the USA, and we are still debating whether making condoms available promotes sexual activity, or whether needle exchange programs promote injecting drug use.

And the overwhelming tragedy is that we have allowed ourselves to base our sympathy and concern for someone with HIV infection or AIDS, whether that someone be as talented and gifted as Greg Louganis, or just anyone else, on how the person got the disease. Fourteen years into this disease and we still reject and condemn people with AIDS. That, it seems to me, is a critical area where we are in arrears in our moral behaviour.

*Clifford Chang*
*Executive Director, Big Island AIDS Project, PO Box 11510, Hilo, Hawaii 96721-6510*

## Kanak constructs of AIDS in New Caledonia

In New Caledonia, no studies have been carried out that are likely to improve AIDS prevention among the Melanesian population while taking into account its particular cultural characteristics. Little is known about sexual behaviours in New Caledonia. The sensitivity of the issues requires a study using an ethnographic approach. Therefore we have submitted to the National Agency for Research on AIDS (ANRS, France) a proposal to study conceptualisations of sexuality and AIDS among young Kanak women, who are sexually active and living in rural areas and Noumea. The objectives of the study:

- to understand how the word "AIDS" and the information that circulates in relation to this subject, are interpreted in terms of the categorisations Kanak women use in relations to the opposite sex, sickness and contagion;

- to study - through Kanak women's life histories, perception of the risk of AIDS and constraints bearing on them - the models of thought (traditional or modern) they refer to in order to confront such a risk; and

- to determine the social meanings attached to AIDS and to the practises thereby developed in the general context of social and political change, and particularly the changes undergone by gender relations within Kanak societies.

**Present situation:** New Caledonia is one of the three Pacific islands (with Guam and French Polynesia) reporting the highest rates of HIV. Moreover, it is the country where the increase in cases now appears to be most rapid. In February 1, 1995 the number of notified AIDS cases was 37 and HIV was 115. In 8 June 1995 there were 43 and 123 respectively for a population of only 183000 persons. New Caledonia Melanesians - the Kanak - represent 47% of the population. The Kanak population of New Caledonia is characterised by extreme youthfulness (50% of individuals are under 20 years old, 80% under 40). In Kanak societies, which are patrilinear and virilocal, gender relations are characterised by: the subordination of women; a social expectation that women should become mothers; women being unable to refuse sexual advances by the partner without risking physical violence; and a high frequency of collective rapes of young girls.

The first cases of HIV infection were recorded in 1986. Although the ethnic distribution has not been communicated by local medical authorities. Statistics reveal an increasing local transmission of the disease. The progressive reduction in the proportion of infections among males (3.92 infected males per infected female at 8/6/1995) equally illustrates the growth in heterosexual transmission of the disease, a pattern similar to that in Fiji and PNG. Although the epidemic is still in its early stages in Melanesia, the rapid increase in the number of cases, the high incidence of STD, an increasingly balanced gender ratio of infection and a high rate of maternal-foetal transmission, together with the inequality of the sexes and the violence exercised against women, all predicate a socio-cultural vulnerability to AIDS, particularly among young women.

**Issues:** Preliminary information show that the interprestation of sicknesses in Kanak societies does not derive from a static system of representations, but to a continuing process of reflection concerning the vents and uncertainties of existence. It seems to be based on concepts among which the search for historical and social origins of illness constitutes a paradigm.

What appears so far about local constructs around AIDS - a term both biomedical and foreign - it is either seen as a white people's disease (like other epidemics since the contact with the West) related to the heavy French military presence in the country, or as an indigenous sickness, belonging to STD. The latter category was known before the colonisation. It is divided into wet STD involving discharges and dry STD with more general signs. It is understandable that some Kanak people class AIDS among the native category of dry STD. The element retained is contamination by blood, the notion of blood being essential not only in the local conception of body fluids into which sperm and mother's milk are classed, but also health in general. This approach towards AIDS, as with other indigenous sicknesses of this category, stresses the possibility of transmission from mothers to children and extrapolates from this aspect to an explanation in which it is women who would seem to be the source of the disease.

Our working hypothesis is that ideas on AIDS are functions not only of gender, educational background and generation of their proponents, but also derive from the various political and social issues at stake. Among these issues, which are especially complex in New Caledonia where the political future is uncertain and where Kanak societies are in a period of abrupt transition, the claim for Kanak cultural identity and women's questioning of traditional gender relations appear to be particularly important.

The results expected from the research should contribute to AIDS prevention by providing a way of understanding the breadth of changes that Kanak women are undergoing and by allowing better adaptation of messages and activities that have up to now tended to be based on French approaches. We should be interested to hear of similar studies in the Pacific other than the excellent work of Carol Jerkins which we are all ready familiar with.

*Christine Salomon-Nékiriai*
*B.P. 7087, Ducos, Noumea, New Caledonia*

# Approaches to HIV/AIDS control in the Pacific - past imperfect, future uncertain?

The impact and costs of current strategies and their implications for the future of HIV control merit careful consideration. This edition of PHD brings together important work on a key public health problem. This is very timely. Encouraging though this is, there are a number of fundamental questions to be addressed which underpin the viability of work in the HIV/AIDS area. This letter will attempt to highlight some of them, and in so doing, stimulate dialogue, in the spirit of this journal.

Available data documenting HIV positivity and AIDS cases in the Pacific show trends consistent with patterns observed elsewhere[1]. The epidemic is still in it's relative infancy, usable predictions as to the future extent or shape of the problem are relatively few and can face methodological difficulties[2]. Published local information on key areas e.g. seroprevalence studies to guide intervention strategies is scarce, even scarcer however, is information about the impact of current Information, Education and Communication (IEC) strategies.

Knowledge growth, one of the key elements of the strategies, has occurred, but behaviour change has been slow to follow, even in groups with high risk behaviour. The exploration of this interface locally has been limited, knowledge of the cultural and socioeconomic underpinnnings of sexual behaviour is little described, although there are a few useful discussions of the issue[3,4]. It should be mentioned that we are not alone as it would appear that our understanding of the effectiveness of differing interventions remains weak globally[5]. Other factors (e.g. the absence of condoms in many countries when and where they are needed most) do not help this situation. Dissemination of information through public media has been fairly extensive, with the local press in many countries around the region responding well. There has been the complementary growth of locally innovative strategies in the region e.g. drama/theatre groups. Encouraging though this is, without demonstrable impact, pressures will grow on funds e.g a number of parties see the coverage on AIDS as disproportionate to the scale of the problem, especially when viewed against other major public health problems (mortality from AIDS in Fiji in 1993 was approximately 1% of that attributable to smoking).

Pressures on resources are always with us and are increasing, donors especially, need to demonstrate to their electorates that funds are delivering value for money. Similarly, the *Evidence Based Medicine* approach is gaining impetus rapidly and will bring added discipline to the resource allocation debate. To date, HIV funding with its significant donor input has been relatively protected, but the donor winds can change direction if alternatives for their dollar seem more pressing or worthwhile. The World Bank in it's 1994 report on the health care systems of it's Pacific member states highlighted that gains in key health indicators in the region had not been of the same magnitude as those achieved by other developing countries for a similar level of investment; they also highlighted the very heavy dependency on donor funds of public health programmes across the board: they viewed this is an unsustainable situation[6].

Akin to the rest of the world[5,7], we need therefore to examine the (cost) effectiveness of our current strategies and the information base for our activities, especially at the current stage of the epidemic in the Pacific. In so doing there is a need to share information and experiences and make this easily available to all; information needs to move rapidly and widely in a usable form beyond the confines of relatively exclusive international meetings.

Where to start? The answers are not simple but the publication of the articles in this journal go some way - useful information on the impact of differing strategies are urgently needed; local mechanisms for working must be user friendly, open and functioning; open and constructive dialogue is needed at several levels. All sooner rather than later.

*Dr David Phillips*
*Department of Community Health, Fiji School of Medicine, Private Mail Bag, Suva, Fiji*

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