Health professionals as health educators and surveillance and monitoring

Some sources of health education material and AIDS information

- Local health education department
- Local sexually transmitted disease clinic
- Special AIDS line 0800 555777
- Healthline telephone service: 01 981 2717, 01 980 7222, 0345 581151
- Health Education Authority, 78 New Oxford Street, London WC1A 1AH 01 631 0930
- The Terrence Higgins Trust, BM/AIDS, London WC1N 3XX
Helpline 01 833 2971 (7 pm-10 pm every day)
- The Haemophilia Society, PO Box 9, 16 Trinity Street, London SE1 1DE 01 407 1010
- SCODA (Standing Conference on Drug Abuse), 1-4 Hatton Place, London EC1N 8ND 01 430 2341
- Welsh AIDS Campaign 0222 464121
- Scottish AIDS Monitor 031 558 1167
- Northern Ireland AIDS Line, Belfast 0232 226117

Many health professionals may be asked to speak to other health and social services workers, to local schools or colleges, and need to be armed with relevant facts. The box gives a short list of useful contacts from which health education materials, including leaflets and videos, can be obtained. Voluntary and pressure groups often offer a fund of information on local resources, as well as providing support for individuals. Health education messages need to be imaginative, comprehensible, and relevant to the group addressed. Advice from local health education officers and local groups is often essential in helping to get the appropriate message across. Prevention cannot be limited to health service settings and will need to include community work in pubs, clubs, and schools. Other strategies in New York and London include employment of "outreach workers" working closely with voluntary groups to contact particularly young drug users outside the health care setting.

The effectiveness of preventive strategies and estimates of the magnitude of the epidemic can be assessed only by continued monitoring of HIV infection rates and occurrence of AIDS cases.

All doctors are invited to participate in confidential reporting of cases of AIDS to the Communicable Disease Surveillance Centre (61 Colindale Avenue, London NW9 5EQ; telephone 01 200 6868). Public health service and other laboratories also report numbers and risk group of seropositive tests to Colindale.

Evaluation of health education strategies also requires population studies of knowledge about AIDS, social studies of sexual and drug using behaviour, and seroprevalence studies in different risk groups.

A continued and coordinated national and international effort through education, surveillance, and research is required if we are to meet the public health challenge of AIDS.

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Letter from . . . Amsterdam

Changing attitudes about lifestyles

ROBIN HULL

Big railway stations are exciting places, full of purposeful bustle. Amsterdam central station is getting a little too exciting. Late at night there has always been the risk of mugging because the insatiable need of the city's population of drug addicts leads to much petty crime. Six times in two years the locks on my car have been forced in search of anything that can be used to pay for drugs. Threat to property has until recently rarely been associated with personal violence, but now the screwdriver is becoming a popular weapon. The kind one uses to fix electrical apparatus makes an unusual weapon. Held in the clenched fist, with the business end protruding from the ulnar border of the hand and delivered with a

firm blow to the chest a screwdriver leaves only a tiny entry wound; the victim is aware of little more than a playful thump on the chest until his tension pneumothorax builds up later. This injury is so small that it can easily be overlooked by victim and doctor. Now there is a new technique for persuading unwary late night travellers to give up money near the central station, where one may be held to ransom by nothing more than a hypodermic needle, used and dirty. In this city where needles slip so often in and out of veins and where the prevalence of human immunodeficiency virus escalates the mere sight of a needle is an effective wallet emptier.

A haven

This picture of Amsterdam is not fair, for crime is only one aspect of this beautiful but sordid city. This is a cosmopolis of intense

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contrast combining total permissiveness with the restrictions of Calvinism and, above all, freedom. The Dutch, particularly the Amsterdammers, regard freedom as paramount, respecting the right of the individual to do his own thing in religion, politics, art, or sexuality. Thus a person must be free to poison or infect himself, and British attitudes, revealed in antismoking and anti-AIDS (acquired immune deficiency syndrome) advertisements, are viewed as appallingly paternalistic. This attitude applies to much preventive medicine. It is an invasion of autonomy to offer screening for hypertension or other disease. If such measures are to be undertaken they must be requested by the patient not suggested by the doctor. There is little wonder that those who feel persecuted by other societies are attracted to a city as free as this. So throughout its history Amsterdam has been a haven for people oppressed by religious or racial persecution. This attracted a huge Jewish community to the city, which lost a tenth of its population during the holocaust, leaving behind an even stronger demand for freedom. Recently Amsterdam has offered its liberality to those who want an alternative lifestyle. With its long tradition of hospitality for the seamen thronging its port, bars and brothels flourish. The tall warehouses along the canals and the decrepit houseboats offer crammed accommodation for squatters who are attracted by the ease of access to drugs or are in flight from war and famine in Africa and Asia.

This complicated urban society offers a culture medium for disease. The thriving gay groups, the promiscuity of the red light district, and the drug transactions on the infamous Pill Bridge provide the links of the chain along which the AIDS virus moves from the homosexual community via intravenous drugs to the girls who must ply their trade the harder to buy more drugs. A general practitioner friend working in the inner city has had seven patients die from AIDS, and there are many more to come. "These people are all my own age and mostly my friends"; no wonder he seems depressed. It is hard not to be gloomy when contemplating such a picture and difficult to see how this, most aptly named, vicious circle might be broken.

There are ways to do this and the municipal health services are working hard but are hampered by attitudes. For example, a well dressed businessman who struck up conversation in a bar roundly accused my wife of Calvinism when she mildly suggested that monogamy might help the problem. There is fear along the canals and in the alleys. It must have been the same when the cobbles rang to the sound of jackboots and the Frank family cowered in their attic. Fear stimulates another characteristic of the Dutch, their

stubbornness, making them even less likely to abandon the lifestyles which have much to do with their fear.

Attitudes

I have been working at a mission a bare 100 m from Pill Bridge surrounded by brothels, sex theatres, and gay bars. Here I meet and talk to human beings with appalling drug problems or living with the knowledge that they have AIDS. They undermine my middle class prejudices. They do things to themselves I would not care to do, and it is easy to condemn, to throw the first stone, until we laugh together and suddenly they are real people suffering the probability of a future almost as bleak as that which faced the Frank family in 1944.

We are faced with an exponential epidemic with no prospect of cure or vaccine for several years. This is everybody's business and there are things that can be done but they require major shifts in attitudes and in priorities in medicine. Ironically it is the often under-regarded caring aspects of medicine that are likely to be most useful. Science, we hope, will one day provide a cure, but until then we must fall back on care. We must strive to alter behaviour, particularly in relation to sex and drugs. But we will not alter the way people behave while we hold critical attitudes to their behaviour. Holier than thou attitudes cut no ice with frightened people who seek solace in the very behaviour we want to change. So the first need is a change in those who would change others and that probably means many in the medical profession.

It is impossible to know the size of the problem that is upon us, but the way in which the disease afflicts the heterosexual population of Africa makes it likely that there will be many deaths in Europe. Africa is far away. So, you may think, is Amsterdam, but what is happening there today may well be mirrored in Birmingham, Bolton, or Bath in the near future. We must start now, particularly in general practice as the counsel of a known and trusted doctor may exert a profound effect on attitudes and behaviour. We must teach about AIDS and urge monogamy in a non-moralistic manner. We must come to terms with forms of anogenital and orogenital sexuality so that we can discuss them openly and non-pejoratively, for when we are seen to understand and not to blame then healthy advice is more likely to be heard. This will require enormous efforts and resources within primary care, and there is most urgent need for redirection of resources to caring not only for those who have the disease but for the enormous numbers who suffer AIDS anxiety.

Will we do it in time?

What can be done to help a patient whose snoring is causing marital problems?

At least 20% of the population aged over 40 have a serious snoring problem.¹ Though this is an often ignored cause of marital disharmony, what has only recently come to light and is more worrying is that between 20% and 50% of these heavy snorers have evidence of obstructive sleep apnoea, and in many a classic history of nocturnal apnoeic periods and daytime hypersomnolence is given by the offended marital partner. In other individuals with socially unacceptable snoring, however, obstructive sleep apnoea is not diagnosed until polysomnography is performed. The importance of obstructive sleep apnoea is in the nocturnal reduction of oxygen saturation, the retention of carbon dioxide, the presence of cardiac arrhythmias, and an increased risk of cardiovascular disease.¹

A sensible clinical grading of snoring² would be: grade 0, no snoring; 1, occasional mild snoring or snoring on the back only and no apnoea or daytime hypersomnolence; 2, habitual snoring in all positions and no apnoea or hypersomnolence; 3, habitual snoring with some episodes of apnoea, disturbed sleep pattern, or daytime hypersomnolence; and 4, obstructive sleep apnoea (proved).

Traditional non-surgical remedies for excessive snoring such as weight loss, alcohol avoidance, bedhead elevation, chin and head straps, and tongue restraining devices are unsuccessful. Electronic under pillow "snoring" alarms are designed to alert the offender to change posture. These are unlikely to be effective in serious snoring (grades 2, 3, and 4) because snoring occurs in all positions. The occasional mild snorers in group 1 are unlikely to

prove a nuisance to marital partners and an alarm such as the "snoozer" will probably be less effective and certainly more costly (at £50) than the more traditional elbow. Nasal surgery, tonsillectomy, and uvulectomy also give poor and unpredictable results. In all of the above treatments the excessive "redundant" pharyngeal and palatal tissue which has been shown by cineradiography to be the likely cause of the obstruction remains unaltered. The application of continuous positive airway pressure is effective but impractical, and tracheostomy is unacceptable. In 1981, however, Fujita described the uvulopalatopharyngoplasty, or UPPP. This procedure, in which redundant soft palate uvula and pillars of fauces and sometimes posterior pharyngeal wall mucosa are removed, cures 90-100% of symptomatic snorers and over 50% of people with proved obstructive sleep apnoea.³ Five to 10% of people have postoperative nasal escape during eating or, rarely, speaking. These side effects almost invariably disappear within a short time. Postoperative discomfort is little worse than that after tonsillectomy. Snoring not cured by this procedure is reported as being due to conservative resection by the surgeon.—W V CARLIN, consultant ear, nose, and throat surgeon, Stoke-on-Trent.

1 Lugaresi E, Cirignotta F, Coleagrin G, Piara C. Some epidemiological data on snoring and cardiocirculatory disturbances. *Sleep* 1980;3:221-4.

2 Gordon ASD, Giles ML, Harding DA, Morton RP. Surgery of snoring. *J Laryngol Otol* 1986;100:1263-7.

3 Simmons FB, Guilleminault C, Miles LE. The palatopharyngoplasty operation for snoring and sleep apnoea: an interim report. *Otolaryngology—Head and Neck Surgery* 1984;92:175-80.