"Albertine to see the Police Surgeon," by Christian Krohg

prostitutes watched over by a police officer. Two magnificent "ladies of the night" dominate the painting.

Would AIDS have been tackled differently had it presented as a disease of women spread by women?

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1 Danziger R. An epidemic like any other? Rights and responsibilities in HIV prevention. *BMJ* 1996;312:1083-4. (27 April.)

HIV negative people should be responsible for protecting themselves

EDITOR,—Renée Danziger reports on moves to change the emphasis of policy on HIV prevention on the grounds, apparently, that AIDS has become "normalised," but the evidence that she presents to justify this assertion is unconvincing.¹ She points out that in the West the epidemic has not spread as rapidly as predicted; she is right, but how can this be said to show normalisation? If anything, it tends to prove the effectiveness of those elective preventive measures that she seeks to challenge.

Danziger argues that, because of the development of new treatments, the benefits of knowing whether one is HIV positive outweigh the possible harm. Unfortunately, the position is still not that clear cut. People with HIV infection have a longer life expectancy now than in the early years of the epidemic, but this is due as much to successful management of opportunistic infections as to treatment of the HIV infection. Combination treatment looks hopeful, but then so did early intervention with zidovudine once upon a time. The decision whether to have an HIV test still demands a careful weighing of pros and cons.

Danziger's version of normalisation may reflect the viewpoint of epidemiologists or clinicians, but what of the perception of people with HIV infection, of groups at risk, or of the general public? I am due to attend a funeral in a remote corner of England, where the family and friends of the person who has died will pretend

that death was not due to an HIV related condition. Has AIDS really been normalised?

Apparently the obvious needs to be restated: policies for prevention should take into account both the peculiarities of the medical condition in question and the social and cultural make up of the target population. What works with gay men in London may or may not work with working class women in Brazil.

There are, of course, some worrying examples of irresponsible behaviour,² but most people with HIV infection do not need lessons in behaviour from the rest of us. The lengths to which my HIV positive friends have gone to protect their sexual partners have always moved me. As a gay man who is HIV negative, however, I believe that the responsibility for protecting my body lies not with them or with Michelangelo Signorile¹ but with me.

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2 Catchpole MA, Mercey DE, Nicol A, Rogers PA, Simms I, Newham J, *et al* on behalf of the Collaborative Group. Continuing transmission of sexually transmitted diseases among patients infected with HIV-1 attending genitourinary medicine clinics in England and Wales. *BMJ* 1996;312:539-42. (2 March.)

Maternal mortality in India

Maternal mortality is falling in India but at slower rate than in Britain

EDITOR,—James Owen Drife's patronising article on India's maternal mortality, despite its feeble justification, angered me.¹ Articles in this genre—clever Western doctor on holiday in India shows how bad the local doctors are—usually are ill researched, perpetuate ignorance, and expose the author's naivety and supercilious attitude.

Drife says that Indian doctors attending a conference in Delhi, where a session on in vitro fertilisation was the main attraction, were blasé about their country's maternal mortality. The Europeans attending the conference were upset

about it, though "these were not our patients but how could we ignore them?" The speaker who talked about his job training primary care workers—the right answer to the problem—was formerly a consultant in England. The only people who left the hall when this doctor spoke were female Indian doctors wearing expensive dresses.

Drife forgets that doctors who attend expensive conferences in Delhi often work in tertiary care. They usually pay to listen to topics of interest to them, and why not? A large number of doctors working in primary care are not former consultants from Britain. They are unlikely to attend conferences of this type. Perhaps Drife expects doctors to wear clothes that reflect their country's maternal mortality.

By referring to the death during childbirth of the queen in whose memory the Taj was built, Drife creates the impression that maternal health care has not changed in India since then. He adds that maternal mortalities in Britain and India were the same in 1935 but that the rate subsequently fell in Britain because people got angry about it. India's maternal mortality has also fallen since 1935 but more slowly. This difference in the rate of fall is unsurprising given Britain's relative prosperity. A rich country is likely to improve the health of its mothers faster than a poor country. Drife should realise that you need more than anger to solve socioeconomic problems such as illiteracy. This "more" usually means money; without it, anger is a frustrating emotion. Drife mentions a recent study of 140 moribund women, of whom 97 arrived at hospital by bus, 12 by ambulance, and some by bullock cart. Does he wonder what these figures might have been in 1935?

Drife is welcome to write about India's health and compare it with Britain's without forgetting India's comparatively minuscule resources. But, hopefully, he will stick to British tourists, the Taj, and Princess Di's bench.

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1 Drife JO. We know why they die. *BMJ* 1996;312:1044. (20 April.)

Preventable ill health occurs in Britain too

EDITOR,—James Owen Drife rightly bemoans the lack of action on preventable disease in India.¹ The images—of a lack of anger, of affluent doctors walking away, of greater interest in in vitro fertilisation—are compelling. "Any nation without the will to get angry is a pitiful place," he says. Just so.

There is an uncanny echo in the same issue when Graham Watt talks about preventable ill health on our doorstep in Britain.² The difference is only of dimension. How many who read Drife's article will read Watt's too and discern similar detachment, this time among affluent doctors in Britain. Why is this? With finite money, is there a fear that if more was spent on social issues or prevention then less would be available for technological techniques, such as in vitro fertilisation, that we too prefer? Is this another reason for looking at values in medicine itself—that others follow where we lead?

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2 Watt GCM. All together now: why social deprivation matters to everyone. *BMJ* 1996;312:1026-9. (20 April.)