for whom I was told sexual activity often starts at age 11 or 12, needs much improvement. High school graduates asked me if I believed that AIDS existed. The government has avoided taking responsibility. Political and tribal leaders and traditional doctors must play a role through educational radio programs and village visits. More medical staff is needed. The hospitals should make more educational videos about HIV, AIDS and STDs, featuring local residents, and show them on battery-powered televisions in hospitals and villages.

Drugs might start as gifts, such as those used for tuberculosis in Lesotho's mission hospitals. For example, I am sending recently outdated drugs. If only zidovudine were available for HIV-positive pregnant women, even for short periods.[3] Unfortunately, a diagnosis of HIV can mean violence if the woman's husband finds out, and without treatment such a diagnosis yields no benefit.

Considering the drug-related improvement in AIDS mortality in the US[4] and the worsening statistics in most developing nations, which bear over 90% of the world's HIV/AIDS burden (a reflection in part of social inequities[1]), governments, pharmaceutical companies, international agencies and philanthropists will have to give very generously if this pandemic is to be controlled.[1]

M. Henry Gault, MD
Professor Emeritus
Memorial University of Newfoundland
St. John's, Nfld.

References

1. Msamanga GI, Fawzi WW. The double burden of HIV infection and tuberculosis in sub-Saharan Africa [editorial]. *N Engl J Med* 1997;337:849-51.
2. Morris K. HIV epidemic could number 40 million by year 2000 [news]. *Lancet* 1997; 350:1683.
3. Kigotho AW. Trial to reduce vertical transmission of HIV-1 on schedule in Uganda [news]. *Lancet* 1997;350:1683.
4. Steinbrook R. Battling HIV on many fronts [editorial]. *N Engl J Med* 1997;337: 779-80.

Marathon's success

One objective of a small group within Ontario's Ministry of Health in the 1970s was to develop a type of group practice for Northern Ontario communities that would not wither and die after a few years. The underserviced-area program of the time did not venture into a long-term plan for Northern health care, so the article "A Marathon session: A town's MDs develop a philosophy to call their own" (*CMAJ* 1998;158[11]: 1516-7), by Michael OReilly, about the family physicians in Marathon, Ont., cheered me immensely.

Their success has been made possible, in part, by the local hospital. Doctors in another Northern paper town had an opportunity in the 1970s to integrate doctors, hospital and community care in a single organization to provide coordinated service. It was too radical a move for the doctors — the Ontario Medical Association nearly had a seizure!

The use of small-town hospitals as walk-in clinics is not confined to Northern communities, as I noted recently.[1] In places like Marathon the doctors' offices belong in the hospital unless there are specific distances to overcome. The duplication of facilities wastes money and effort, and so does the separation of medical and hospital services. Night phone calls need go only to the duty doctor in the hospital, since all doctors would be familiar with most patients in a small town (aided by computerized records, of course).

Seven doctors may be a little much for the 5500 would-be patients in Marathon, but I agree that a major cause of failure of previous efforts to provide care in the North has been a shortage of doctors. An underserviced, isolated community does not need a doctor: it needs doctors. Any medical group in the North must be able to function effectively with one doctor away consistently.

My praise for Dr. Gordon Hollway and all the family physicians in his group, and to Dr. George Macey and the entire community of Marathon — your creativity and energy are heartening.

John S.W. Aldis, MD
Port Hope, Ont.
Received by email

References

1. Aldis JSW. The disorganized state of primary care [letter]. *CMAJ* 1998[7];158:865.

Understanding Quebec's policy on nursing training

I was surprised by the reaction to Quebec's new proposal to reduce the level of nursing training, as described in the news brief " 'Dumbing down' of Quebec RN education irks nurses, MDs," (*CMAJ* 1998;158 [10]:1262), by Barbara Sibbald. This proposal, which goes against the current worldwide trend to increase the level of nursing training, is perceived as being unsound, a policy that can only lead to an overall reduction in the quality of care offered to Quebecers.

However, the critics forget that this new policy is perfectly consistent with Quebec's current efforts to control health care spending. Few of those who graduate as nurses from junior college programs will find it cost-effective to complete an additional 4 years to earn a degree, to end up with only a modest increase in overall income. What better way to control health care costs than to keep absolute control over a body of minimally trained health care workers who are among the lowest paid in the world but are forever stuck in Quebec because their credentials are not transferable. Similar policies affect Quebec physicians: their training options are restricted, and they receive profes-

sional certification that is not valid outside Quebec.

Benoît Desjardins, MD, PhD
Pittsburgh, Pa.

National incidence study of child abuse and neglect

In her recent editorial "Child abuse: a community problem" (*CMAJ* 1998;158[10]:1301-2), Dr. Harriet L. MacMillan contends that research into the causes and prevention of child maltreatment has been lacking. To strengthen its knowledge in this area, Health Canada is developing the Canadian Incidence Study of Reported Child Abuse and Neglect. Expert consultations with public health authorities, provincial/territorial child-protection officials, native child welfare organizations and others were held in 1997.

The objectives of the study are to develop national estimates on the incidence of child maltreatment and to monitor trends and develop baseline data concerning the reporting of maltreatment. We also want to improve our understanding of the types and severity of child maltreatment and generate strategies for directing resources to at-risk children. Finally, we want to produce information to help develop targeted programs and policies.

A multistage cluster-sampling strategy will be used to address 4 principal types of maltreatment: physical, sexual and emotional abuse and neglect. Data will be collected directly from child welfare workers; the data source will be participating provincial/territorial child welfare agencies selected randomly across Canada.

The study will build on the methodologies used in US and Ontario incidence studies.[1,2] Standard operational definitions of maltreatment will help ensure the consistency, quality and rigour of the data. A standard data-collection instrument will be used to minimize the response burden and ensure data quality. Data collection will end next spring, and data analysis will be completed early in 2000. Information and analysis stemming from the study will be disseminated widely.

Gordon Phaneuf, MSW
Chief
Lil Tonmyr, MSW
Child Maltreatment Division
Health Canada
Ottawa, Ont.
Received by email

References

1. Sedlak AJ, Broadhurst DD. *The Third National Incidence Study of Child Abuse and Neglect (NIS-3)*. Washington: US Department of Health and Human Services; 1996.
2. Trocmé N, McPhee D, Tam KK, Hay T. *Ontario Incidence Study of Reported Child Abuse and Neglect*. Toronto: Institute for the Prevention of Child Abuse; 1994.

Submitting letters

Letters must be submitted by mail, courier or email, not by fax. They must be signed by all authors and limited to 300 words in length.

Letters that refer to articles must be received within 2 months of the publication of the article. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

Note to email users

Email should be addressed to **pubs@cma.ca** and should indicate "Letter to the editor of *CMAJ*" in the subject line. A signed copy must be sent subsequently to *CMAJ* by fax or regular mail. Accepted letters sent by email appear in the Readers' Forum of *CMA Online* (**www.cma.ca**) promptly, as well as being published in a subsequent issue of the journal.

Pour écrire à la rédaction

Prière de faire parvenir vos lettres par la poste, par messager ou par courrier électronique, et non par télécopieur. Chaque lettre doit porter la signature de tous ses auteurs et avoir au maximum 300 mots. Les lettres se rapportant à un article doivent nous parvenir dans les 2 mois de la publication de l'article en question. Le *JAMC* ne correspond qu'avec les auteurs des lettres acceptées pour publication. Les lettres acceptées seront révisées et pourront être raccourcies.

Aux usagers du courrier électronique

Les messages électroniques doivent être envoyés à l'adresse **pubs@cma.ca**. Veuillez écrire «Lettre à la rédaction du *JAMC*» à la ligne «Subject». Il faut envoyer ensuite, par télécopieur ou par la poste, une lettre signée pour confirmer le message électronique. Une fois une lettre reçue par courrier électronique acceptée pour publication, elle paraîtra dans la chronique «Tribune des lecteurs du *JAMC*» d'*AMC En direct* (**www.cma.ca**) tout de suite, ainsi que dans un numéro prochain du journal.