home care may be cost-effective under specific conditions. In our report, we recognized that the research in these areas is not extensive and recommended that more be done.

Byrne argues that because of the lack of evidence that home care is cost-effective, the status quo should prevail. This seems a case of misplaced burden of proof. The logic of home care as a substitute for non-acute hospital care is compelling, despite the scarcity of substantiating studies. Should we not be at least as sceptical about the lack of evidence of the cost-effectiveness of much more expensive non-acute care in hospitals?

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Reference

1. *The cost-effectiveness of home care — a rigorous review of the literature* [background paper]. Saskatoon: Health Services Utilization and Research Commission; 1996.

Confidentiality in medical publishing

The International Committee of Medical Journal Editors, of which *CMAJ* is a member, states that a patient's identifying information should be published only when it is "essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication."[1] The guidelines for Experience articles in "Writing for *CMAJ*" state that "The writing should be candid without compromising patient confidentiality."[2] Would we all agree that these principles should apply to photos as well? How, then, did the photograph and references to individual patients by their first names manage to appear in the article "AIDS in Africa: a personal experience" (*CMAJ* 1998;158 [8]:1051-3), by Dr. Meb Rashid? Did the parent or guardian of the boy appearing in the photograph provide written informed consent to the publication of the photo or the egregious violation of confidentiality in the caption? How was this violation essential for scientific purposes? Do the appropriately stringent confidentiality requirements of the international committee apply only to certain sections of *CMAJ* or only to certain patients?

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References

1. International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *CMAJ* 1997;156(2):270-6.
2. Writing for *CMAJ*. *CMAJ* 1998;159(1): 77-8.

Editor's note: Please see the editorial addressing this topic, on page 503.

Facing reality

The lack of appreciation of the sub-Saharan HIV/AIDS pandemic was emphasized by Dr. Meb Rashid in his article "AIDS in Africa: a personal experience" (*CMAJ* 1998;158[8]:1051-3). When I volunteered in 1995 for 5 months in the mission built and supported by Tebellong Hospital in Lesotho, southern Africa, I had no idea that, according to the World Health Organization (WHO), this region was home to 20 million people with AIDS (two-thirds of all cases worldwide). Nor was I aware that the Minister of Health of South Africa had estimated that 20% of that country's population (i.e., 40 million people) was HIV positive, with men and women equally affected but blacks much more affected than whites. Lesotho, a country completely surrounded by South Africa, appeared to have similar statistics.

When my wife and I arrived in Lesotho, medicine at the isolated 46-bed hospital was primitive: no telephone, no blood transfusions, no assays for hemoglobin or glucose. A retired Canadian family physician was the only doctor. Two-thirds of the $1 million for annual hospital operation came from the Africa Inland Mission. Transport of patients to the referral hospital in the capital city of Maseru, of staff and of any medical supplies was provided by the Mission Aviation Foundation. Pilots flew a 4-seat Cesna over mountains 3350 m high and landed on a short dirt airstrip. Conditions for air travel are treacherous, and our pilot later died in a crash.

About half of the adult patients were being treated for tuberculosis, and a third (probably 50% by now[1]) were HIV positive. This combination is a serious double burden in sub-Saharan Africa and has led to a secondary tuberculosis epidemic.[2] I pricked my finger after taking blood from a patient with tuberculosis. It took a month for his HIV test result to come back: positive. And no drugs for treatment were available.

Relatively few patients had symptomatic AIDS in 1995, but this has changed. A recent letter from the able public health nurse stated that her friends, relatives and neighbours are starting to die from AIDS. Home care has been started, and village health workers and family members are being taught to care for the terminally ill. The increasing number of untreated cases will probably reduce farm output and education and lead to increases in crime and serious government problems.

What can be done? The aim is to prevent transmission by reducing the number of sex partners, promoting condom use and controlling STDs. School education for the children,[2]