

# Letters to the Editor

## *Candida Albicans* for Georgia

I am a graduate student in Population Genetics at the University of Georgia's Department of Genetics, I am conducting a study of global genetic diversity in *Candida albicans*. (My advisor is Jonathan Arnold, [arnold@bscr.uga.edu](mailto:arnold@bscr.uga.edu)). *C. albicans* overgrowth is often one of the first signs of human immunodeficiency virus (HIV) infection and our goal is to travel the evolutionary history of *C. albicans* strains from different ethnic groups, especially non-Europeans. We do not have strains from any Pacific country and would greatly appreciate your sending us about five to ten samples of *Candida albicans* obtained from each ethnic group possible. We would especially value samples from those communities that have had little contact with Europeans, if possible.

If you are concerned the strains would not survive, one technique that has worked well is to place a small square of sterile filter paper (like Whatman) on the colonies and lightly press for a few seconds. Then remove the filter paper and wrap in sterile aluminum foil. The strain number may be written directly on the foil packet with a marker. The colonies arrive as a dry mat attached to the paper and grow well when placed on a YPD plate. An alternate method is to pour about 1 ml of media into sterile microcentrifuge tubes, stab with the strain of interest and let grow for 1 - 2 days prior to shipment. In either case, the strains must be double-sealed for shipment and we will pay for the cost of shipping, if desired. If possible, we would like to know approximately when the strain was collected, the body site of collection and whether the host was HIV positive or not.

If you do not have any samples but know of someone who may, please feel free to show them this letter. Thank you very much.

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Please contact Ms Fundyga if you are interested. **Ed.**

## Tb training in Micronesia

In November 1997, the Francis J. Curry National Tuberculosis Center (CNTC) conducted two training sessions on tuberculosis in Micronesia. The Centers for Disease Control and Prevention (CDC) funds the CNTC, a joint project between the San Francisco Department of Public Health and the University of California, San Francisco. Co-sponsors for the Micronesia courses included the American Thoracic Society; the Asian Pacific Nurse Leadership Council; the College of Nursing, University of Guam; the Department of Public Health Services, Commonwealth of the Northern Mariana Islands; the Hawaii Lung Association; the Ministry of Health and Environmental Sciences, Republic of the Marshall Islands; the Office of Pacific Health and Human Services, U.S. Department of Health and Human Services; and the Pacific Basin Medical Association.

Most lectures for the course were given by Gisela Schechter, and Charles Daley. Typical of the Center's standard Tuberculosis Intensive courses, presentations included transmission, diagnosis, treatment, screening, environmental control, preventive therapy, multi-drug resistant tuberculosis, pediatric tuberculosis and HIV-related tuberculosis.

The courses were tailored as much as possible to local needs. In Saipan, the CDC recommendations were used as a basis for diagnosis and treatment protocols covered in the course, with the CDC's Core Curriculum on Tuberculosis, (Tb) as the CDC/American Thoracic Society's "Treatment of Tb and Tb Infection in Adults and Children," distributed to course participants. In Majuro, the World Health Organization's (WHO) guidelines were emphasized in lectures and lecture outlines; the WHO's recently published DOTS booklet was also distributed. Locally based physicians in each location presented lectures on region-specific epidemiology of TB and strategies of TB control. In Saipan, Artin Mahmoudi, and Jon Bruss, served as local faculty; in Majuro, Kennar Briand, and Alan Talens, presented the region-specific lectures.

The first training was held in Saipan, the Commonwealth of the Northern Mariana Islands (CNMI), on November 5th - 7th. The second training session was at Majuro. The overall average course rating was 9.75. Training locations were chosen according to centrality of location and need, according to increasing rates of TB disease. In both the CNMI and in Majuro, as in most of the world, there was a dramatic rise in TB cases in the late 1980s. Many participants at both locations stressed the importance of getting CME credit for courses, as both location and delays in receiving course information make attendance at most CME courses difficult.

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This has been edited for space considerations. **Ed.**

## The Healthy Islands Paper – 1

This paper (see p. 180 *this issue*) summarises the development of the 'Healthy Islands' concept based on WHO Healthy Cities, Health Promoting Schools initiatives around the world utilising Niue as an example of how the concept is working in practice in the Pacific.

The authors demonstrated clear enthusiasm for the concept but like many zealots who promote WHO designated 'health-institutions', it is difficult to take them seriously. WHO initiatives are notorious for being ideological rather than practical and its regional offices tend to accept concepts developed in other parts of the world without due consideration to local relevance. Pacific countries are more likely to accept WHO and other foreign aid initiatives because of the attached money and the fear of missing out. These initiatives may not be local priorities and often divert energies and resources away from the real priorities.

Healthy Islands has the same risks. On the surface, it is difficult to argue against health promotion initiatives which aims to keep people well and the settings approach has merit. However, the project appears to be imposed on Pacific Countries and funded by foreign aid. It is being driven by foreign 'experts' even though there is an abundance of skilled Pacific nationals who could manage the project effectively and efficiently. The long term sustainability of the project is questionable because of continuing foreign funding and marginal local ownership. If Pacific Countries are serious about 'Healthy Islands' as the key strategy for health promotion in the region, local funding must be found and foreign involvement limited to specific areas of expertise not available locally.

The Niue example is not likely to provide useful lessons for other PC because of its unique position. The authors of this paper would be well advised to 'evaluate' the project with local or regional spectacles.

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## The Healthy Islands Paper - 2

The authors of this paper (see p. 180 *this issue*) characterise the current situation well. Health care has to a large extent been funded by outside donors, who identify what they see to be the major health problems, and devise what they consider to be the best solutions. The resultant programs usually involve little recipient-country input or investment, and die a slow death when the donor money gives out. The authors recommend that this fragmented approach to health be replaced by an integrated approach which emphasizes staying healthy to being with, mainly by fostering a healthy

setting. The community, involved from the beginning, will identify how best to stay healthy within their own island communities, and integrate the various resources available to attain this goal. (In so doing, it might be added, communities may call upon, indeed rediscover, the ways their ancestors stayed health, and self-reliance may actually be enhanced along with better health). It all sounds pretty logical. It even sounds like it might work.

So how to implement it? Well, we are given the example of Niue, a small island with a small population. The steps on the way to establishing the Healthy Islands approach in Niue are outlined. First of all, outside support was (enthusiastically) requested, from Australia. Consultants, also from Australia, got involved. A dedicated Country Coordinator was appointed. And a Project Committee. A workshop was conducted, of course. Policies were reformulated, relevant initiatives were undertaken, framework statements were issued. And the Committee have indicated that by the year 2000, the project will have developed its own funding base. Apart from being a bit pessimistic about the funding prospect, I wonder what funding base the project needs at all: since one of the purposes of the project is presumably to unite all the current fragmented funding bases alluded to in the introduction, one would suspect that more than enough funding for the project would thus be freed up from existing resources.

Beyond this, I'd like to have heard a bit more about those little baskets - did the community construct these themselves, or were they provided from donor funds? I'd like to hear about more than the oral health policy itself - has anything concrete come of it, is water fluoridated, do people brush more often, are children's teeth being protected with sealants? I'd like to know what those health-promoting schools are actually doing, what they've done - are there gardens at the schools are actually doing, what they've done - are there gardens at the schools, are the children apprenticed to traditional farmers and fisherman, thereby learning the important of diet and activity to health? And while the Committee contributes its input to making the planned new hospital a health-promoting one, has it looked at making the old one health-promoting in the interim, thus demonstrating that it's not the building, but rather the activities and services, that truly promote health? And what will happen when the next donor comes along with its pockets full of tempting cash for a disease-oriented program: will the tiny island nation, newly committed to the Healthy Islands concept, demand that the donor conform as well or take its cash elsewhere?

It's a bit premature yet to maintain that concept has engendered practice, if by practice we mean more than policy formulation and committee statements.

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