Precisely because we have no cure for AIDS, health services must resort to the basic principles of primary health care: more than ever before, health promoters at all levels need to work with communities — jointly planning education and counselling campaigns and developing a community’s capacity to make informed choices about health related behaviour. This is an enormous challenge — a community-based approach is not the usual outcome of conventional health training.

This concern — expressed by a doctor working for an international development organisation — is one shared by all those involved in AIDS prevention and control. Health education about AIDS should not just involve the production of leaflets and posters, radio and television programmes although these materials are obviously important. Persuading people to change their sexual behaviour on a wide scale (central to AIDS prevention and control) is immensely difficult to achieve, challenging our sense of privacy and culture; it takes more than just giving people information. Education must be a two-way process and should enable people to make choices about their lifestyle, based on an awareness of the full implications of AIDS.

Counselling

To achieve this, an element of ‘counselling’ is needed in health education strategies. Counselling involves the sensitive development of a relationship between the ‘counselor’ and the selected individual or group. The term ‘counselling’ does not just refer to the work of trained specialists — many countries do not have the resources for this. In most communities there are individuals whose role in society has already helped them to acquire ‘counselling’ skills, for example, religious leaders and traditional healers. Such individuals should be encouraged to take an active part in HIV counselling. The success of all AIDS education campaigns will rest on a trusting relationship between the health educator and the community. Building such a relationship is closely related to the principles of primary health care: where working closely with selected populations and their leaders is of paramount importance.

Objectives

Health education and counselling will need to focus on different aspects of sexual behaviour and working practices, depending on the selected ‘audience’. Broad-based counselling and health education objectives are summarised below:

- **Health care providers:** to be able to promote awareness of modes of transmission; provide guidelines about ‘safer sex’ (see page 4) and other advice to back up written materials on risk behaviour; recognise clinical symptoms and take sensible precautions when caring for AIDS patients (see AIDS Action issue 1); to follow proper sterilisation procedures when giving injections.

- **Traditional health practitioners:** to use properly sterilised equipment for every injection and any other action which involves piercing the skin.

- **General public:** to increase knowledge about safer sex practices (above all, to avoid having many sexual partners), to demand use of sterile needles, syringes when receiving continued on back page
Reaching schoolchildren

Sex education in the Cameroon

How do adolescent boys and girls learn about sexual matters? Who should give sex education to teenagers? How should this be approached? A recent study in the Cameroon, carried out by Drs Esther Gwan and Jenny Almeida, has successfully identified ways of starting discussions with teenagers about these, and other, questions which may be useful elsewhere as a part of planning AIDS education.

Figure two

Many people don’t talk that easily about sex’ Dr Gwan told AIDS Action. ‘When you meet a group of children, and you say you are going to talk about sex, it’s as if you’d just dropped a bomb. But by the end of the lesson nobody wants to leave the class. It’s a very exciting position to be in. The children are openly talking about very important issues.’

Four key methods were used, which effectively obtained information from 230 schoolchildren (aged 11-16 years) about their sexual behaviour, knowledge of conception, contraception and sexually transmitted diseases (STDs). Slightly more girls were involved in the study than boys, and both sexes were mostly aged 12-15 years. All were GCE O’Level students selected from two bilingual schools in Yaounde. Since Cameroon is a bilingual country (English and French) these schools included the two main cultural groups in the country.

Methods

1. The ‘agony aunt’ letter (in this case ‘Dear Tatta Christine’). This letter expresses a problem relating to a teenager’s sex life, which is open for discussion among children in a class setting. Children were encouraged to take the role of the adviser, Tatta Christine (see figure one) and to write a letter in reply.

2. Children were encouraged to fill in missing information on a line drawing (see figure two) relating to pregnancy, e.g. where the mother carries her baby when pregnant, how the baby grows, and how the mother feeds the baby in the uterus. The sessions were followed by feedback from the children and any specific questions or doubts were discussed and clarified.

Dear Tatta Christine,

I hope you can help me with this terrible problem. Some friends and I from the school have been going out and having some fun with girls of no very good reputation. Do you know what I mean? One of my friends was diagnosed as having a venereal disease. I am really concerned about myself. My family are Christians. I don’t know who I should ask for help. If I had a venereal disease I would feel very embarrassed . . .

Desperate.

Figure one

Children completed a questionnaire asking them to state whether they strongly agree, agree, slightly agree, or disagree with statements made about aspects of sexual behaviour. A second, ‘secret’, questionnaire was handed out to children, who completed it knowing that their responses are ‘secret’, since they do not add their name to it.

Sessions with all age groups resulted in animated discussion and interest in the topics despite some initial shyness (particularly amongst 11-12 year olds).

During the study, 130 parents and 110 teachers of 11-16 year old students were interviewed, as well as 26 health workers involved in clinics for family planning and sexually transmitted diseases.

Results

‘Dear Tatta Christine’:
The letters related to two different topics — premarital sex and fear of sexually transmitted disease. When children were asked what they would do in the same situation they often replied that they would consult their friends, especially those with experience. For most of the children, their peers (friends) were the main source of information.

Outline drawing:
Most of the children knew that a baby depends on its mother to develop and grow. What was not very clear to them,
was the exact nature of this connection — some children connected the baby to the mother’s intestines.

Agree/disagree statements:
Both boys and girls said that ‘love is more important than sex’ but that ‘sex is necessary before marriage to have experience and to know the other one better.’ Religious and moral values were important, but did not seem to greatly affect decisions where personal sexual behaviour was concerned.

Secret questionnaire:
This aroused much interest among the teenagers: ‘it’s a questionnaire and we don’t need to write our names? I like this!’ Obviously, it was still difficult to guarantee that answers were entirely truthful.

Questions covered four areas: patterns of sexual behaviour, knowledge of and attitudes towards sexual behaviour, STDs and AIDS.

The questionnaire revealed that 24 per cent of the teenagers had experienced sexual intercourse. The most common age for starting sexual activity for girls was 13 and for boys 15. Forty-eight per cent of the children had heard about contraceptives (for 45 per cent this meant oral contraceptives). Twenty-seven per cent said that contraceptives were dangerous and could permanently ‘stop people from having babies’.

Many parents thought their children started sexual life at an older age than actually indicated

General indications

Despite the limited amount of accurate knowledge these teenagers had about sexual matters, the study shows that they were able to confront real-life situations concerning adolescent sexuality. Contrary to the views of adults, i.e. that ‘children should not talk about such things . . . they are too young to understand’ the teenagers initiated important discussions about their sexuality.

Interviews with parents revealed that most thought their children started sexual life at an older age than indicated in the teenage study. Dr Gwan noted: ‘both parents and teachers felt very strongly that any method of birth control should not be taught . . . they were worried their children would begin experimenting with sex. However, I feel that withholding information from teenagers makes experimental sex more likely — and more dangerous.

Parents’ role

There has to be some way of overcoming sexual inhibitions between parents and children. I think parents should be given advice on how to approach the subject.’ Parents and children do not communicate about sexual matters. It is only the mother who seems to fulfil any sex education role, and this is usually of a moral, not a practical, nature.’

The study illustrated the vulnerable position teenagers find themselves in: at a time when they need information about sexual matters they are often denied it. Interviews with teachers revealed that schools are not providing enough information about this subject and teachers lacked knowledge about sex education methods. Of the very small amount of sex education that is available in some schools, much of it is not providing the information these teenagers said they wanted. Ninety per cent were interested in knowing about safer sex, and about STDs, both of which are rarely taught.

Health workers revealed that the health services are not reaching the young — services are only available when it is too late, e.g. when unwanted pregnancies or venereal diseases have already occurred.

National campaign

The mass media has influenced a high proportion of young people in Yaounde: the majority of the teenagers interviewed mentioned prostitutes and promiscuous people as high risk groups for AIDS infection. But Dr Gwan commented: ‘from a doctor’s point of view, I don’t think there has been anything very clear about the biological facts about the virus . . . it is useful that people understand that AIDS is terrible, but the context in which AIDS is contracted should be better defined.

‘Everyone has heard about AIDS . . . there has even been a popular record made about AIDS by a famous Cameroonian pop star. But sex education about condoms is viewed with a lot of scepticism. At the moment, the government campaign does not put an emphasis on using condoms. It is a moral dilemma for the government as well.’

Worldwide more than one person in five is a teenager . . . effective AIDS health education for adolescents is crucial

This article is based on an interview with Dr Esther Gwan and on Dr Almeida’s report on their joint study entitled: Methods for Starting Discussions with School-age Cameroon Teenagers, submitted to the Institute of Child Health, University of London (1987).
Guidelines for action

This article provides general advice and guidance for those planning health education and counselling activities on AIDS.

In the absence of a cure or vaccine, changing behaviour through education is the most important way to prevent and control the spread of AIDS. Firstly, however, it is important to be clear about what actions to promote. On the basis of current knowledge, actions for reducing the risk of HIV transmission through sexual behaviour are summarised below:

- Keeping to one sexual partner, or limiting the number of partners to as few as possible;
- Avoiding sexual intercourse with someone who has had many sexual partners;
- Practising 'safer' sex (i.e., avoiding penetration by the penis, of the vagina or anus, avoiding mouth-to-genital contact, avoiding sexual intercourse with many partners, and/or using a condom during penetrative sex);
- Identifying selected groups in the community, for example, adolescents, men and women working away from home, prostitutes.
- Identifying those with influence and are respected within each group. Do this by looking at the political, cultural and social organisations that exist. Or you could organise a health education competition (offer a prize-winning incentive) in order to identify the most talented and highly motivated individuals — who will then make much better educators than outsiders. This is particularly true of children and adolescents, who could design more appropriate teaching materials, and activities, for other youngsters.
- Find out what people feel and think about AIDS, and safer sexual behaviour. Do they think behaviour can be changed? Identify any incorrect beliefs that you will have to try and change. What beneficial beliefs and/or traditional practices could you reinforce and build upon?
- Provide simple training and try to find funds to provide their expenses and, if possible or appropriate, provide a small payment.

Make your advice realistic and acceptable

Consideration of cultural, moral, political and religious attitudes and practices are important in developing health education messages.

- Meet local politicians, parents, religious and other leaders and health workers to discuss the moral issues and agree on acceptable and effective messages.
- Choose messages that are relevant to current social behaviour, so that people take them seriously.
- Do not pass moral judgements on the sexual activities of the communities you work with. Where possible, concentrate on making existing sexual practices safer.

Campaign creatively — use the traditions of drama, story-telling and song.
Use effective communication channels

- Individual and small group counselling is usually the most effective way of changing people's behaviour. You can make the message specific to the needs of a particular audience. Check that they have understood by asking questions. Person-to-person methods are better for explaining information, relieving anxieties and helping people make decisions about their own sexual and other risk behaviour.

- Help to make any talks/discussions more interesting with well chosen visuals, such as large drawings, cartoons, slides or pictures cut out of magazines.

- Use the traditions of drama, storytelling, songs or other oral communication methods. Puppets are a good example; they can be made cheaply and are fun to use. It is also possible to discuss sensitive and potentially embarrassing topics — that would not be acceptable in talks or drama — through the use of puppets (see Puppets for Health manual, listed under Resources, p.7).

- Give local entertainers the basic background on AIDS and let them use their experience to adapt the messages to their own words and music.

- Work with local groups in the production of leaflets which are appropriate to the needs and practices of each group. Leaflets are a useful back-up to counselling sessions. Make the language simple and use pictures. Try out draft versions to make sure that they are understood. Always include an address where people can go for further information.

- Only use posters as part of a broader health education campaign.

- Use the mass media — such as the local radio — for spreading simple messages and always make sure that you tell people where they can get further information and advice.

Campaigning on use of condoms

- Encourage shopkeepers to display condoms where people can easily notice them, and provide educational back-up for them and their customers through radio promotions, posters and leaflets.

- Ensure that people can obtain information on the correct use of condoms, e.g. through free, illustrative leaflets that do not require the user to be able to read.

- Both men and women should be encouraged to insist that their partners use a condom.

In any condom campaign, it is important to make clear that the regular use of condoms can help reduce the risk of HIV transmission; however, they are not fully reliable. They may tear, come off, or they may even have holes (future issues of AIDS Action will deal with the most reliable brands of condoms).

Choose messages carefully

- Avoid using fear. Fear of AIDS, when combined with ignorance, can encourage misunderstandings about who is at risk and why. People will often respond to frightening messages by laughing them off or denying them. Your message should be one of reassurance that the disease can be prevented. If you do use mild fear tactics, always include clear statements about the actions people can take to reduce the risk of getting AIDS, and where they can go for advice.

- Advertise safer sex as something worthwhile, exciting and pleasurable, rather than an inferior version of ordinary sex. Be positive in your advice.

- Make your message as clear as possible. Use local expressions for words meaning sexual intercourse, oral sex, anal intercourse, penis, semen, vagina. For example, in some parts of Africa, condoms are referred to as 'gumboots' or 'raincoats'.

- You do not need to describe the complicated details of the virus that causes AIDS, or of the immune system in order to justify the safer sex message. Build on concepts of disease and family values that the community already understand.

Evaluate and share your experiences with others

- We are still building up experience on how health education can best be carried out in the struggle against AIDS. Sexual behaviours are extremely difficult to change and are influenced by a range of economic, social and cultural factors. Be prepared to share your experiences and to evaluate and modify your programmes.

Dr John Hubley, Senior Lecturer, Health Education Unit, Leeds Polytechnic, Calderley Street, Leeds LS1 3HE, U.K.

*Basing health education campaigns on the use of condoms, for example, will not be acceptable to some communities and their leaders. Do not risk losing their cooperation by initially placing too much emphasis on condom promotion. Concentrate first on building up mutual trust, and provide positive advice on other aspects of safer sex that might be more culturally acceptable and practical. (Editor)

Readers are encouraged to send in their reactions to this, and other, articles on health education in AIDS Action based on their own experiences.
Facing AIDS in Costa Rica

Costa Rica is one of the smallest countries in Latin America, with a population of 2.8 million. Over the last decade, its health services have radically reduced mortality from diarrhoeal and other infectious diseases. But now the country faces the threat of AIDS. Professor Leonardo Mata, President of the National AIDS Commission of Costa Rica, reports.

A total of 16 cases of AIDS per million of population have been recorded in Costa Rica (as of 31 December, 1987). By 31 Jan, 1988, a total of 47 cases of AIDS had been registered. These cases include homosexuals and haemophiliacs. At present, the disease is taking its greatest toll among homosexual men: the first case was diagnosed in 1985, six more in 1986, and a further 19 in 1987. About 55% of cases have been infected with HIV — one of the highest levels recorded worldwide.

Since 1985, only preheated coagulation factors, prepared from blood known to be free from contamination with HIV, have been imported and all donated blood has been screened for HIV using ELISA and confirmation by immunoblot. No AIDS cases have been recorded among injecting drug users (injecting drugs is not a common practice in much of Latin America).

HIV infection

At present, only one case of heterosexually transmitted full-blown AIDS has been recorded — in the sexual partner of an infected haemophiliac. But the country is expecting AIDS to become a problem in the heterosexual population, as is already the case in Honduras and a number of Caribbean countries. Only ten women are known to be HIV antibody positive (two of whom work as prostitutes). 1,500 prostitutes have been tested (ELISA test) and found to be negative.

Magnitude of the epidemic

Estimates of the number of AIDS cases expected to arise between 1988-1992 are: 40 new cases in 1988; 72 in 1989; 118 in 1990; 175 in 1991 and 254 in 1992. These figures are high for a country where the estimated population in 1992 is only 3.1 million. If these estimates are correct (and assuming that, at any one time, half the total number of AIDS cases recorded will have died) deaths from AIDS could exceed mortality due to diarrhoeal and other infectious diseases within five years. During 1987, a total of 80 deaths were recorded due to diarrhoeal diseases in the whole country; no deaths due to polio or diphtheria were recorded.

Health education campaign

A national health education campaign began in April 1985. A pamphlet containing ten easily understood messages was widely distributed throughout the country, and the messages were printed in five major daily newspapers. Television programmes covered basic issues, and AIDS education is being incorporated into the curriculum of secondary and high schools.

Updates and recommendations from the World Health Organisation and US Centers for Disease Control were translated into Spanish for distribution to medical professionals and other health workers. Talks and workshops are being given in health and biological science institutions.

Education about safer sex and the distribution of condoms in gay discos, and other public places began in November 1987. Most of the above activities have been coordinated by the National AIDS Commission and its committees, with significant collaboration with the media, NGOs, volunteers and the general public.

Fear and controversy

AIDS has generated more fear, misunderstanding, conflict and controversy than any other health problem in recent years. Neglect of its importance during 1985-6, resulted in timid actions and lack of funds for prevention and control activities. Lack of understanding by health workers — including doctors and microbiologists — resulted in discrimination against patients in certain hospitals, and a refusal to carry out examination of blood or other body fluids.

AIDS is testing our ability to deal with a social problem of great complexity, which threatens to affect every family. Achieving a balance between the rights of society and those of the individual has been difficult. In the long run, AIDS will test whether or not our society can truly be regarded as humane and civilised.

Professor Leonardo Mata is President of the National AIDS Commission, at the Ministry of Health, Costa Rica, and a member of the editorial advisory board of AIDS Action.

*Haemophiliacs suffer prolonged bleeding after injury because the blood cannot clot; they receive blood products for treatment — coagulation factors — some of which have been infected with HIV from infected blood donors.
The following resource list is the second in a regular series, with a particular focus on health education materials on AIDS, produced in both developed and developing countries. Readers are encouraged to send in additional examples of leaflets and other resources, produced in their own countries.

### TEACHING MATERIALS

- **Learning about AIDS**
  A manual covering participatory health education strategies for health educators with a responsibility for adult education about AIDS. Developed in the U.K. Using group work, case studies and role play, *Learning About AIDS* includes: guidance on how to use participatory approaches to AIDS education; medical information about transmission and current therapies; exercises to help adults learn about AIDS; guidance on how to evaluate the effectiveness of AIDS education and a resource list. Available from: AIDS Virus Education and Research Trust (AVERT), PO Box 91, Harsham RH13 7YR, U.K. Price: £3.95 plus postage (e.g. up to £7.00 for air mail).

- **Teaching AIDS: Educational Materials about AIDS for School Teachers**
  By Dr John Sketchley. Pack of materials including: training component (helps teachers handle AIDS related issues in the classroom); information (for teachers to use as resource on relevant facts); activities (for classroom use in graded age groups). The pack consists of a folder containing seven information and related activity sheets with illustrations for class use. Available from: BLAT Centre for Health and Medical Education, BMA House, Tavistock Square, London WC 1E 7HT, U.K. Price: £3.50 plus postage.

### INFORMATION SOURCES

**Bureau of Hygiene and Tropical Diseases**
LSHTM,
Keppel Street, Gower Street,
London WC1E 7HT, U.K.

**Activities:** An information clearinghouse, covering tropical and communicable diseases worldwide. The Bureau produces *AIDS Newsletter* (see AIDS Action issue 1) and *AIDS and Retroviruses Update* — a monthly bibliography which groups by subject annotations all the papers and articles on AIDS and retroviruses located by the Bureau in the previous month. Contains an author index. All entries form part of the AIDS Database and are searchable electronically (see below). Annual subscription rate: £95.00 (overseas).

From *What is AIDS? A Manual for Health Personnel* CMC, Switzerland.

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### BOOKS/MANUALS

- **Puppets for Better Health: A manual for community workers and teachers**
  By Gill Gordon. Describes, through words and pictures, how puppets can be used for health education in communities: could easily be adapted for education around AIDS prevention. Explains how to create stories that are locally appropriate, how to make puppets and props for shows, preparation of shows and follow-up of health messages used. Available from: MacMillan Distribution Ltd, Houndsmills, Basingstoke, Hampshire RG21 2XS, U.K. Price £7.50 plus postage.

- **What is AIDS? A Manual for Health Personnel**
  A short booklet written to help health workers respond to, and learn about, AIDS. Also available in French and Spanish. Contains information about all the main facts, and clear illustrations. Describes very clearly how the virus is and is not spread, and the need for compassionate and sensitive care of patients. Available from Christian Medical Commission, World Council of Churches, 150 route de Fémey, 1211 Geneva 20, Switzerland. Price: Free of charge.
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The London Summit of Health Ministers met on 26-29 January 1988, to discuss AIDS prevention and control. One hundred and forty-eight countries were represented, with 114 Ministers of Health in attendance, an unprecedented number of ministers attending any meeting on any subject. Ninety-eight ministers or heads of delegations spoke on behalf of their countries’ AIDS prevention and control efforts. The summit proclaimed 1988 Year of Communication and Cooperation to Combat AIDS, and adopted the following declaration:

1 Since AIDS is a global problem that poses a serious threat to humanity, urgent action by all governments and people the world over is needed to implement WHO’s Global AIDS Strategy as defined by the Forty-fifth World Health Assembly and supported by the United Nations General Assembly.

2 We shall do all in our power to ensure that our governments do indeed undertake such urgent action.

3 We undertake to devise national programmes to prevent and contain the spread of human immunodeficiency virus (HIV) infection as part of our countries’ health systems. We shall involve to the fullest extent possible all governmental sectors and relevant nongovernmental organisations in the planning and implementation of such programmes in conformity with the Global AIDS Strategy.

4 We recognise that, particularly in the absence at present of a vaccine or cure for AIDS, the single most important component of national AIDS programmes is information and education because HIV transmission can be prevented through informed and responsible behaviour. In this respect, individuals, governments, the media and other sectors all have major roles to play in preventing the spread of HIV infection.

5 We consider that information and education programmes should be aimed at the general public and should take full account of social and cultural patterns, different lifestyles, and human and spiritual values. The same principles should apply equally to programmes directed towards specific groups, involving these groups as appropriate. These include groups such as: policy makers; health and social service workers at all levels; international travellers; persons whose practices may place them at increased risk of infection; the media; youth and those that work with them, especially teachers; community and religious leaders; potential blood donors and those with HIV infection, their relatives and others concerned with their care, all of whom need appropriate counselling.

6 We emphasise the need in AIDS prevention programmes to protect human rights and human dignity. Discrimination against, and stigmatisation of, HIV-infected people and people with AIDS undermine public health and must be avoided.

7 We urge the media to fulfil their important social responsibility to provide factual and balanced information to the general public on AIDS and on ways of preventing its spread.

8 We shall seek the involvement of all relevant governmental sectors and non-governmental organisations in creating the supportive social environment needed to ensure the effective implementation of AIDS prevention programmes and humane care of affected individuals.

AIDS: a worldwide effort will stop it
9 We shall impress on our governments the importance for national health of ensuring the availability of the human and financial resources, including health and social services with well-trained personnel, needed to carry out our national AIDS programmes, and in order to support informed and responsible behaviour.

10 In the spirit of United Nations General Assembly Resolution A/42/8, we appeal: to all appropriate organisations of the United Nations system, including the specialised agencies; to bilateral and multilateral agencies and to nongovernmental and voluntary organisations, to support the worldwide struggle against AIDS in conformity with WHO's global strategy.

11 We appeal in particular to these bodies to provide well-coordinated support to developing countries in setting up and carrying out national AIDS programmes in the light of their needs. We recognise that these needs vary from country to country in the light of their epidemiological situation.

12 We also appeal to those involved in dealing with drug abuse to intensify their efforts in the spirit of the International Conference on Drug Abuse and Illicit Trafficking (Vienna, June 1987) with a view to contributing to the reduction in the spread of HIV infection.

13 We call on the World Health Organisation, through its Global Programme on AIDS, to continue to: exercise its mandate to direct and coordinate the worldwide effort against AIDS; promote, encourage and support the worldwide collection and dissemination of accurate information on AIDS; develop and issue guidelines on the planning, implementation, monitoring and evaluation of information and education programmes, including the related research and development, and ensure that these guidelines are updated and revised in the light of evolving experiences; support countries in monitoring and evaluating preventive programmes, including information and education activities, and encourage wide dissemination of the findings in order to help countries to learn from the experiences of others.

14 Following from this Summit, 1988 shall be a Year of Communication about AIDS in which we shall:

— open fully the channels of communication in each society so as to inform and educate more widely, broadly and intensively;

— strengthen the exchange of information and experience among all countries; and

— forge, through information and education and social leadership, a spirit of social tolerance.

15 We are convinced that, by promoting responsible behaviour and through international cooperation, we can and will now begin to slow the spread of HIV infection.

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Social aspects of AIDS prevention and control

National AIDS prevention and control programmes throughout the world operate in substantially different epidemiological, social, economic and political environments. However, they have been faced with a similar range of complex social issues, involving screening, employment, housing, access to health care and schooling.

In the light of the experience of national programmes to date, as well as current knowledge about HIV infection and AIDS, WHO/GPA wishes to draw attention to the following social aspects of AIDS prevention and control:

1. AIDS prevention and control strategies can be implemented effectively and efficiently and evaluated in a manner that respects and protects human rights.

2. There is no public health rationale to justify isolation, quarantine, or any discriminatory measures based solely on the fact that a person is suspected or known to be HIV infected. The modes of HIV transmission are limited (sex, blood, mother-to-child). HIV spreads almost entirely through identifiable behaviours and specific actions which are subject to individual control. In most instances, the active participation of two people is required for HIV transmission, such as in sexual intercourse and in sharing contaminated needles or syringes. However, spread of HIV can also be prevented through the health system (e.g. by ensuring the safety of blood, blood products, artificial insemination and organ transplantation, and preventing re-use of needles, syringes and other skin-piercing or invasive equipment without proper sterilisation.

HIV infection is not spread through casual contact, routine social contact in schools, the workplace or public places, nor through water or food, eating utensils, coughing or sneezing, insects, toilets or swimming pools.

Accordingly, an AIDS prevention and control strategy should include:

- providing information and education to the general public, to persons with behaviours that place them at risk of HIV infection (risk behaviour groups), and to HIV infected persons;
- counselling of HIV infected persons;
- ensuring the safety of blood and blood products, skin piercing practices and other invasive procedures.

In accordance with this strategy, persons suspected or known to be HIV infected should remain integrated within society as much as possible and be helped to
The national planning process

The Special Programme on AIDS (SPA) was formally established by WHO on 1 February 1987 (now renamed Global Programme on AIDS/GPA) and assigned the responsibility of urgently mobilising national and international energies and resources for global AIDS prevention and control. The 40th World Health Assembly (May 1987) urged all member states to establish or strengthen AIDS prevention and control programmes in cooperation with GPA, as did the United Nations General Assembly, at its 42nd session in New York (October 1987). To date, over 130 countries have requested collaboration with GPA in developing national plans.

It is intended that all support to national AIDS prevention and control programmes be coordinated and directed under those programmes. It is also intended that the establishment of national plans represents an invitation and opportunity for all institutions active in a country to participate, according to their strengths, in the effort to control the spread of HIV infection and to care for those afflicted with AIDS. An overview of the national planning process is presented below.

Formation of a National AIDS Committee

The formation of a National AIDS Committee (NAC) is the first critical step in the development of an AIDS prevention and control programme. It is the concrete expression of national willingness to confront the complex problems associated with HIV infection. Furthermore, it provides the mechanism for development of all comprehensive activities required to prevent and control AIDS.

The NAC should really act as an advisory body to the Ministry of Health, considering all aspects of programme development and implementation, including legal, ethical, managerial, financial and international issues as well as technical considerations.

The composition of the NAC should be broad enough to ensure representation from all important sectors and organisations of society.

The NAC decides on basic principles and a plan of action to which the programme will adhere, guiding the future development of strategies and activities. Clearly, the approach will differ from country to country.

Nevertheless, there are certain issues which arise in nearly all countries which will need to be considered by the NAC and which may warrant explicit policies. These include:

- surveillance and reporting of AIDS cases and persons infected with HIV in the country;
- counselling of HIV infected persons, AIDS cases, their families and other contacts, including deciding on who will be informed of test results (i.e. the issue of confidentiality);
- distribution of programme responsibilities through intersectoral cooperation, involvement of nongovernmental organisations (NGOs) and the use of the existing health infrastructure and resources.
Short-term plan

An initial epidemiological assessment is required to review and critically analyse existing country data on HIV infection and AIDS cases and, where necessary, to collect and analyse new information.

An initial resources assessment is required to determine the ability of the existing health services to support the epidemiological, educational, laboratory, clinical and preventive components of a national AIDS programme.

Resource assessment considers the availability of resources from the private sector, NGOs, volunteer, government and international organisations. Areas considered include: epidemiological surveillance; laboratory diagnosis, equipment and supply; patient diagnosis, care, treatment and management; education and training of health workers at all levels of the health services; blood banking and transfusion systems; resources for counselling of patients; organisations which can participate in public health communication and education programmes; policies and practices for use and reuse of needles, syringes and other surgical and dental instruments, lancets to diagnose malaria and other skin-piercing instruments wherever used; communication information and education systems, and legislation.

These initial epidemiological and resource assessments typically result in an immediate short-term plan to provide urgently required support.

Medium-term plan

A medium term programme (MTP) serves two important purposes: it acts as a tool for the implementation of the national control programme and identifies what activities will be carried out — where and when, at what cost, and persons to be responsible — and it forms a document which can be used for the mobilisation of external funds.

The medium term is assumed to be three to five years. However, given the uncertainty surrounding the future course of AIDS, it is unlikely that any country will be able to prepare a MTP which will not require revision during this time period.

MTPs typically follow a framework of goal-oriented strategies:

- prevention of sexual transmission, requiring health promotion interventions leading to changes in sexual behaviour;
- prevention of transmission through blood, involving technical (e.g. blood screening) as well as health promotional (e.g. among injecting drug users) programmes;
- prevention of perinatal transmission, involving the training of health care providers and a variety of targeted information, education and counselling programmes.

In addition, planning must provide for the care of AIDS patients and reduction of the impact of HIV infection on individuals, their families and their communities. Since plans for health care workers, training, health promotion and evaluation need more than one strategy, these are sometimes treated in separate sections of the National Plan. A full description of GPA recommendations for planning is available in Guidelines for the Development of a National AIDS Prevention and Control Programme (WHO/GPA).

In support of this planning process, WHO/GPA has assisted in the preparation of 75 short-term plans and 21 medium-term plans. Immediate support has been provided for 71 countries, involving technical services agreement or other form of technical and financial support.

AIDS Surveillance Report

The global total of reported cases of AIDS, as of 10 February, 1988, is 77,984 from 162 countries. AIDS has been reported from every part of the world.

<table>
<thead>
<tr>
<th>Continent</th>
<th>Number of cases</th>
<th>Countries reporting cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>8,752</td>
<td>48</td>
</tr>
<tr>
<td>Americas</td>
<td>59,217</td>
<td>44</td>
</tr>
<tr>
<td>Asia</td>
<td>225</td>
<td>28</td>
</tr>
<tr>
<td>Europe</td>
<td>9,004</td>
<td>28</td>
</tr>
<tr>
<td>Oceania</td>
<td>786</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>77,984</td>
<td>162</td>
</tr>
</tbody>
</table>

Lack of reporting and widespread under-recognition and under-diagnosis of AIDS means that the number of reported cases is a marked underestimate of the true incidence of AIDS. WHO estimates that as of late 1987, approximately 150,000 cases of AIDS have actually occurred worldwide. Even these estimates do not adequately describe the current clinical burden caused by HIV because AIDS cases represent only the end-stage of severe and irreversible damage due to HIV infection.

Any questions about the content of the WHO REPORT should be sent to WHO/GPA/HPR, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

AIDS: a worldwide effort will stop it