Policies in Solidarity

AIDS action provides an overview of some key points raised at the Second International Conference for Non-government Organisations (NGOs) working on AIDS held in Paris, 1-4 November, 1990.

Beauty Mulenga (not her real name), a Zambian married with four children, was one of the speakers at the opening plenary of the largest meeting ever held of NGOs working on AIDS. She, her husband and five year old son are all HIV positive. Beauty was one of many attending the conference who are HIV positive or have AIDS. Co-founder of a self-help organisation, Positive Action, Mrs Mulenga had this message ‘...we must not wait for others to fight our battles for us. I am HIV positive but AIDS has not beaten me. I will fight this monster and its effect on me, on my family and my community.’

Beauty’s personal experience, which she has turned into an act of community-based solidarity, provided a concrete example of the conference theme ‘Policies in Solidarity’. This four-day conference, which brought together over 850 participants from 81 countries, focused on the essential link between public health, human rights and the importance of building local and international co-operation. These issues were best clarified by Dr Jonathan Mann, former head of the World Health Organisation’s Global Programme on AIDS and now Professor of Epidemiology and International Health at Harvard School of Public Health.

Dr Mann began his speech ‘...who would have thought, ten years ago ... that our collective response to a viral epidemic would [promote] a revolution - a revolution in health.’

This health ‘revolution’ started when people were faced with immediate, practical problems relating to HIV infection and AIDS, such as how to educate and protect people at risk, and how to ensure access to adequate health care. These problems have been faced before, but the difference with AIDS is that ‘many courageous people simply refused to accept the unacceptable ... when the status of health or educational or social systems was simply not good enough.’

What does ‘solidarity’ mean?

Developing a community response to this new disease has raised other issues, such as defending the rights of people infected with HIV. By now, most people realise that discriminating against those infected with HIV drives people away from prevention and care programmes, making these less effective and increasing the danger of HIV to the whole population. It is recognition of the link between human rights and public health which forms the basis of solidarity.

Most participants would agree with Dr Mann’s definition of solidarity as collective action based on ‘a fundamental need...solidarity is not charity’. Charity depends on isolated actions of goodwill. Solidarity works through collective thought and action, based on a practical understanding that we cannot act in isolation. The modern world creates interdependence: ‘just as the price of gasoline depends on events far beyond our national borders ... so the air we breathe and the viruses in our environment are globally linked. Just as there is really no longer any such thing as a purely national economy [unaffected by international economies] there is no longer a national health without reference to the larger world.’

What is this in practice?

The more practical aspects of building international solidarity were dealt with in five main seminar tracks (see box on page 7), as well as some of the open forum sessions. Final recommendations will involve taking collective action on specific issues relating to: gaining better access to drugs and treatment; services and care, as well as gaining access to appropriate information on treatment; defence of the equal rights of people with HIV/AIDS; developing more effective prevention programmes and building stronger community-based organisations.

Specific conference recommendations included: encouraging further direct participation of marginalised groups in prevention programmes, including drug users; decriminalisation of drugs (since this would remove a serious problem in carrying out prevention programmes among users); promotion of research into the use of traditional medicines (see page 7); strengthening essential drugs programmes in underdeveloped countries; campaigning against excessive profit-making of drug companies.

Continued on page 7
How to plan a project and apply for funds

Dr Peter van der Tas, Medical Advisor for AIDS programmes at MEMISA Medicus Mundi, provides practical guidelines.

Before writing a project funding proposal, it is helpful to do the following:

1. Define the problem: e.g. lack of awareness in the community on AIDS/HIV. State what the situation might be if nothing is done.
2. Develop a strategy: think about what you are trying to achieve and summarise a way of doing this. Find out if others think your strategy will work.
3. Plan your implementation: describe in detail how you will put your strategy into practice. When considering staffing, timescale, resources and so on, you may become aware of difficulties and constraints (such as leave of absence for people with other jobs, rainy season, elections). Make a detailed summary of necessary personnel, and other material resources. This will help you to prepare the budget and will alert you to other missing parts in the planning. It will also enable you to determine what is available locally and nationally and what may need to be requested from abroad. Consider all options for local financial contributions to the project.

4. Prepare a draft budget: this is a financial plan which specifies the cost of planned activities and when the money will be spent. Express your costs in an internationally recognised currency if inflation is at a high rate in your country. Costs come in two forms: capital expenditures (e.g. equipment, materials) and recurrent expenditures (e.g. salaries, office costs).

5. Review your plans critically: do this in consultation with colleagues, local authorities and with the help of relevant literature. Try to anticipate likely problems and examine the practicality of implementing your ideas.

6. Find out about donor policy: most donor agencies only fund certain types of projects according to their specific funding policy. Find out by writing a letter clearly describing what your intention is (including a brief summary of strategy and implementation and the total funds you are seeking). State which other agencies you are approaching for help. Address your letter to a named individual at the agency concerned (try to find out who the relevant person is - some kind of previous personal contact greatly helps your proposal). You should then receive a reply which will help you to decide whether and how to continue with your application.

7. Prepare a draft proposal: while waiting for the response to your letter(s), prepare a written project proposal, using the guidelines in the adjacent box. After you have received a reply, adapt your proposal and submit it according to the specific instructions of the agency concerned. If you submit the proposal to more than one agency, inform each of them to whom you have submitted your request. Many agencies prefer to co-fund a project with other donors.

8. Monitoring, evaluation and sustainability: think about how you intend to test your effectiveness in meeting your objectives and keep track of the project as it develops. Be sure that you are able to collect the information outlined in your planned evaluation (e.g. Continued on page 4
Doing it our way

Many organisations working on AIDS were formed quickly in response to a growing crisis. Often staff have taken on a far broader range of responsibilities, for which they have received little training. Cheryl Overs, co-founder of the Prostitutes' Collective of Victoria, Australia, describes how staff identified the training they needed, and set about getting it.

The Prostitutes' Collective of Victoria (PCV) was set up well before the beginning of the AIDS epidemic. We began as a small group of sex workers (prostitutes) and women friends lobbying for the social and legal rights of those who make their living through selling sexual services.

When AIDS appeared in the early 1980s, we knew that sex workers - as opposed to their clients - would be blamed for HIV transmission. We also knew that AIDS information for sex workers would not be handled well by government authorities who were also responsible for enforcing laws discriminating against sex workers.

We rapidly found ourselves acting as health educators - producing pamphlets, counselling, and distributing condoms and lubricants. Within a very short time we were providing outreach services to male, female and trans-sexual sex workers in illegal and legal brothels, on the street and in escort agencies. We opened a drop-in centre which offers counselling and advice on where to get further help and a needle-exchange programme - the only one in the main drug using area (where injecting drug users can exchange their used needles for new ones, so that dirty needles are not shared).

Limitless tasks, limited experience

More and more, we were asked to provide information and advice or to assist in a crisis. In those early days, we had little experience and would often end up discussing how to respond to a situation on the way to the job - some major discussions were carried out in the back seat of my old car!

The objectives of the organisation were broad and we were enthusiastic to meet them. But it seemed there was no limit to the kinds of situations in which our workers could be called on to provide assistance: a suicide, a transsexual sex worker raped by men in the 'AIDS unit' of a prison, overdoes, needlestick injuries, broken condoms, lost children, lost homes... Some workers, not surprisingly, became exhausted and ready to leave.

Looking back, it is clear that our problems stemmed from a lack of training. Training enables better use of resources - especially human resources. We clearly needed help in areas like management and planning: we had to set goals and limitations, as individual workers and as an organisation.

Finding a solution

In July 1990 we organised a one day workshop, attended by all staff, to assess training needs. This strengthened commitment to training among staff and began a process of setting up a training programme. The workshop consisted of three sessions, outlined below.

Session one: What is training?

Training should be a process which enables us to learn appropriate skills, and to develop the confidence to use those skills to their best advantage. A broad range of training experiences were discussed. Many staff members felt, for example, that group workshops are over-used and that more creative approaches to training are needed. We developed a list of the key features of good and bad training. For example, good training should:

- ensure that participants do not feel threatened or criticised
- be responsive to the expressed needs and comments of participants
- be fun and interesting.

Bad training is:

- too formal, where the trainer gives instructions and information without considering the needs and feelings of participants
- too simple or obvious for the level of participants' experience
- based on playing 'silly' games on the instructions of a facilitator who is the only one who thinks it is a good idea

This opening session went well. It created an environment in which workers became training 'consumers', keen to ensure that they obtained the best possible 'product'.

Session two: Identifying needs

We set about identifying a range of subjects which could be covered in a comprehensive training programme. Using a series of subject headings, we all contributed our ideas. We put aside 'real world' considerations about how much this was going to cost, or what was practical, and allowed the session to become a free discussion about what really good training might be. No less than 150 separate topics were identified. The main areas included:

- Understanding our own organisation - in our case, this included looking at the origins of the prostitutes' rights movement in Australia; the roles of sex workers, non-sex workers, people with HIV/AIDS, members and volunteers within the organisation; our policy on HIV testing, prostitution law and drug use.

- Skills development and staff support - this list was endless but included time management, use of office equipment, public speaking, project proposal writing, dealing with difficult situations, supervising others and being supervised, staff recruitment, volunteer training, and coping with stress and grief.

- Information on HIV/AIDS - for example, how do we make medical terminology clear and accessible?

- Defining our work and our values - in any workplace terms and ideas are used which new staff may not fully understand. For example, we often forget to explain what we really mean by 'sex work', 'advocacy', 'racism', 'peer education', 'homophobia', and so on.

Session three: Strategy

This focused on setting a practical and realistic strategy for training which met our needs as far as possible. The group were less optimistic about the tasks of this session, due to the apparent lack of appropriate trainers and finances.

We made a list of problems and tried to suggest practical solutions: for ex-Continued on next page
**Common fungal infections in HIV disease**

Fungi exist everywhere and range from microscopic organisms to large, edible mushrooms; some fungi can produce disease in humans by invading human tissue. Invasive fungal disease may be divided into:

- **superficial**, involving the surface of the skin and mucous membranes
- **subcutaneous**, causing disease beneath the skin surface
- **systemic** (deep) mycoses, affecting internal organs such as the lung, spleen or brain.

Most people develop some form of fungal infection at some time in their lives, varying from mild skin disease to life-threatening meningeal infection. However, those with HIV infection/AIDS are more vulnerable to infection with superficial and systemic mycoses. Management of fungal infections in people with HIV infection is the same as for patients not infected with HIV. However, severer, recurrent forms of fungal infection are more likely in those infected with HIV. Only infections that commonly occur in people with HIV infection (most of which are also common in people not infected with HIV), will be considered here.

### Superficial fungal infections

#### I. Candidiasis

This is the most common of all fungal infections in humans. Superficial candidiasis is a term used to describe a wide range of infections of the skin and mucous membranes caused by various species of *Candida*. Those dealt with here include oral, oesophageal, vaginal and penile thrush. *Candida albicans* is the species most frequently involved. It is a saprophytic yeast often found in the mouth, gastrointestinal tract and vagina of a normal healthy person. However, it can proliferate and cause disease, usually in people who have some other underlying condition, such as diabetes mellitus or immune deficiency as a result of HIV infection or some forms of cancer. Prolonged use of antibiotics can cause oral and vaginal thrush. Thrush is also seen more often in infancy, pregnancy and old age.

#### Clinical features

- **Erythematous**: this is seen as a red area on the dorsum (upper surface) of the tongue where the skin surface looks raw. Some patients will also complain of soreness in the mouth, throat and at the corners of the lips, which may be inflamed.
- **Hypertrophic**: the mucous membrane looks red with white fungal plaques of material. These plaques may be seen on any part of the tongue, as well as on the inside of the cheek, the roof and back of the mouth.
- **Pseudomembranous**: this has the appearance of a white, patchy membrane covering the tonsils and the pharynx.

Patients with oesophageal thrush present with sore throat, painful swallowing and retrosternal chest (pain behind the breast bone). The pain can be so severe that the patient cannot eat solid food and hence loses weight. In persons with HIV infection, oesophageal thrush indicates advanced immunosuppression and the condition is commonly seen in persons with 'slim disease' (HIV associated wasting).
Vaginal thrush is an extremely common manifestation of candidiasis in women who are not HIV infected; however, in those who are, symptoms may be far more troublesome and recurrent. Women experience itchiness and discomfort of the vulva and vagina with some swelling and redness. The vaginal epithelium (skin) is red and inflamed and a thick white vaginal discharge may be seen, often with white flakes, and there may be adherent white plaques on the epithelial surface. The discharge is non-odorous.

In men, infection of the glans penis and foreskin with C. albicans is called candidial balanoposthitis. The condition is not commonly encountered and when diagnosed other underlying factors should be looked for. Until recently, the commonest underlying condition was diabetes mellitus; HIV infection is, however, recognised as increasingly common in men with penile thrush. Candidial balanoposthitis causes itching of the penis and sometimes a discharge under the foreskin; some swelling of the foreskin may result in a relative tightening and splitting of the skin. Occasionally white adherent plaques are seen. In circumcised men there can be redness of the glans penis, but the plaques and discharge are not normally present, although there may be an itchy, bumpy rash on the glans penis.

**Diagnosis**
Clinical diagnosis is often sufficient. Where laboratory equipment is available, C. albicans is confirmed by the microscopic examination of secretions and skin scrapes. A wet preparation of material obtained from the affected area is examined microscopically and the large budding yeast cells and hyphae may be seen even without staining. Gram stained preparations reveal the presence of large gram positive budding yeast cells and hyphae. C. albicans is fairly easily cultured in the laboratory on Sabouraud’s agar.

**Treatment**
Oral and oesophageal thrush may be treated systemically with ketoconazole or fluconazole tablets for 7-10 days. Alternatively, patients may be treated topically (although this is often less effective) with nystatin taken orally in a dose of 100,000 units four-hourly for 14 days. In persons with HIV infection, low dose treatment can be continued to prevent symptoms recurring. Vaginal and penile thrush are quite easily treated with either povidone iodine applications or liberal daily applications of 1 per cent aqueous solution of gentian violet. (See table below).

If infection persists, treatment with the more costly creams and pessaries of either the polyene antibiotics (nystatin or amphotericin B) or the imidazole derivatives (miconazole, econazole or clotrimazole) is required. Patients with more resistant infection may need systemic antifungals such as ketoconazole 200-400mg orally daily for seven days, or fluconazole 50-100mg orally daily for seven days.

### 2. Tinea versicolor
This is a superficial fungal infection found worldwide caused by Malassezia furfur. It is an extremely common condition but in HIV infected individuals may become quite extensive.

**Clinical features**
The rash of tinea versicolor is usually asymptomatic, although occasionally itchy. Scaling confluent macules (spots which overlap and form flaky bits of skin) are found on the back, chest, neck and upper arms. Usually the macules are hypopigmented (pale), but may be hyperpigmented (dark). Widespread, extensive and disseminated lesions can be seen occasionally in persons with HIV infection, which may cover the entire back, chest, neck and upper limbs.

**Diagnosis**
Potassium hydroxide preparations of skin scrapes examined microscopically will reveal the yeasts and hyphae of M. furfur.

**Treatment**
Applications of keratolytics such as Whitfield’s ointment are effective. Alternatively 1 per cent selenium sulphide lotion or 20 per cent sodium thiosulphate lotion may be used. Failing this, topical miconazole, econazole or clotrimazole may be used.

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3. Dermatophyte (ringworm) infections

Ringworm infections are caused by a group of fungi which are capable of invading the keratinised tissue of the skin, nails and hair. **Tinea corporis** (ringworm of the trunk and limbs) occurs more commonly in immunosuppressed hosts and in such subjects the infection may be quite widespread. **Tinea capitis** (scalp ringworm) in adults is usually suggestive of underlying immunosuppression. **Tinea pedis** (foot ringworm) is an extremely common condition and is not found any more commonly in persons with HIV infection. However, the ‘dry type’ infections of the palms and soles caused by *T. rubrum* are more common in persons with HIV infection.

**Clinical features**

Scalp ringworm causes scaling, itching and hair loss in the affected area. The ‘dry type’ infections of the palms and soles cause scaling of the skin, including the sides and upper surface of the feet, and may be associated with nail infection. If the nails are affected, this is known as onychomycosis and occurs more often in persons with HIV infection and immunosuppression. Itching is not a feature of the infection.

Ringworm of the trunk and limbs produces an annular plaque (ring shaped lesion) with a raised edge. In immunosuppressed hosts these lesions may not maintain the annular shape, and can be diffuse and extensive. Occasionally on the limbs the lesions have a nodular (rounded, raised) appearance.

A condition resembling **tinea imbricata** is occasionally seen in patients with HIV infection, who suffer extensive scaling on the trunk.

**Diagnosis**

The diagnosis of dermatophytosis (ringworm infections) can be confirmed by microscopically identifying fungal elements in skin scales and tissue scrapings mounted in 20% potassium hydroxide. Fungi are quite easily cultured in the laboratory.

**Treatment**

Treat circumscribed areas of infection with topical antifungals. Widespread infection and scalp and nail infections need to be treated with oral antifungals. For localised lesions apply Whitfield’s ointment twice daily. This treatment is cheap and effective; however, the newer imidazole derivatives (clotrimazole, econazole, miconazole) and ointments of undecenoic acid, tolnaftate and haloprogin may also be used with success. Systemic treatment with oral griseofulvin 0.5-1.0g daily for 20 days is effective.

**Subcutaneous mycoses**

Subcutaneous infections caused by fungi occur rarely and there does not seem to be an increasing prevalence of such infections among people with HIV infection.

**Systemic mycoses**

The systemic or deep mycoses include some of the more serious fungal infections. Those that occur only in immunosuppressed hosts include cryptococcosis and histoplasmosis.

1. Cryptococcosis

This is caused by **Cryptococcus neoformans**, which commonly leads to meningitis. However, infection of the lungs and other disseminated forms of the infection may also occur. Patients with meningitis usually complain of headache, vomiting, fever and neck stiffness, and may have other symptoms related to AIDS (see also AIDS Action issue 11). The patient may be confused, delirious or even comatose. Hepatosplenomegaly, generalised lymphadenopathy and pulmonary signs may also be present.

**Diagnosis**

This is made upon finding typical cryptococci in sediments of cerebrospinal fluid stained with india ink. The cerebrospinal fluid will show a raised protein and a low glucose level and there are usually few lymphocytes, if any. The cryptococcal antigen test will be strongly positive in the blood and cerebrospinal fluid.

**Treatment**

Amphotericin B 0.3-0.6mg/kg/day intravenously (IV). Alternatively fluconazole may be given orally or IV in a dose of 400mg daily until the cerebrospinal fluid is clear. Maintenance of 200mg daily of fluconazole is also necessary as relapses commonly occur.

2. Histoplasmosis

This is caused by **Histoplasma capsulatum** which is usually inhaled and in the majority of subjects no symptoms or signs develop; however, in patients with HIV infection, histoplasmosis is usually a fatal illness. Patients may present with fever, weight loss, hepatosplenomegaly, thrombocytopenia and generalised lymphadenopathy, and may complain of cough. Chest examination may reveal pneumonitis and chest X-rays may show basal infiltrates of pleural effusion. Some patients present with oral and cutaneous ulcers where such lesions may reveal the diagnosis. Treatment is often unsuccessful, but in some cases intravenous amphotericin B or oral itraconazole is effective.

Professor Ahmed Latif, University of Zimbabwe Medical School, Department of Medicine, PO Box A178, Avondale, Harare, Zimbabwe.

**Explanation of medical terms**

**Cutaneous**: relating to the skin

**Dermatophyte**: fungus which is parasitic upon the skin, nails or hair

**Hepatosplenomegaly**: enlarged spleen and liver

**Keratinised**: tissue which is or has become hard and horny

**Lesion**: well-defined, abnormal area of change in structure of an organ or part of the body due to injury or disease

**Lymphadenopathy**: abnormal enlargement of the lymph nodes

**Meninges**: the membranes which surround the brain and spinal cord

**Mycosis**: disease caused by fungus

**Oesophageal**: involving the oesophagus (a muscular tube linking the throat to the stomach)

**Pneumonitis**: inflammation of the lungs

**Pulmonary**: of, relating to, or affecting the lungs

**Saprophytic yeast**: a fungus which derives its nutrients from absorbing dissolved organic material, especially products of organic breakdown

**Systemic treatment**: generalised, affecting the whole body

**Thrombocytopenia**: decrease in the number of blood platelets associated with haemorrhaging (internal bleeding)

**Topical treatment**: focusing on one part of the body.
AIDS and the traditional healer

Despite the fact that most of the world's AIDS patients are being treated using traditional medicines, there is little research or exchange of information on how and where traditional remedies are being successfully used. More significantly, there is little recognition of the vitally important role played by the traditional healer in the spiritual and social well-being of patients.

Since there is no cure for AIDS, the general aim of traditional medicine is to increase the patient's quality of life. Speaking at the international NGO conference in Paris, Dr Jing-Nuan Wu, Director of the Green Cross Centre for Traditional Medicine, USA, spoke of the different levels of healing used in traditional Chinese medicine: spiritual, nutritional, herbal and acupuncture.

The nutritional level is given particular attention, as Dr Wu stressed that about half of those dying of AIDS are basically dying of malnutrition. The Centre encourages patients to eat well and regularly and is researching herbal formulas which increase the ability of the gut to absorb nutrients.

In a discussion about the scientific evaluation of herbal remedies Dr Sam Kalibala, from Uganda, pointed out that traditional healers will use local herbs whether or not they are tested. The important thing is to recognise that patients 'don't really care what happens to their T-4 cells (part of the immune system), what they want is a better life.' In many cases, it is the traditional healer who may offer this.

The Green Cross Centre would like to hear from others working on AIDS and traditional medicine. Please write to: Green Cross, Centre for Traditional Medicine, 1510 U Street NW, Washington DC 20009, USA. Other useful contacts: Zimbabwe National Traditional Healers’ Association (ZINATHA), PO Box 1116, Harare, Zimbabwe; (for further information) AHRTAG, 1 London Bridge Street, London SE1 9SG, UK.

Continued from page 1

and those producing HIV testing kits; providing care which is responsive to cultural and religious needs as expressed by the patient.

Moving from idea to reality

The uncertain beginnings of the International Council of AIDS Service Organisations (ICASO) - discussions around which dominated much of the conference - is one example of attempts to transform the idea of international solidarity into reality. ICASO was first expressed as an idea to bring together community-based organisations under one umbrella group, in Vienna in 1989. The Paris conference provided an opportunity for NGOs to debate its role and structure. This involved the selection of regional representatives from Africa, Asia-Pacific, the Caribbean, Europe, and the Americas.

The process showed the difficulties of building international co-operation. Many participants did not feel they could speak for others from their region who were unable to attend. For many who had not attended the previous international NGO meetings in Vienna and Montreal (or the ICASO meetings in Kampala, Rio de Janeiro, Sydney and San Francisco), ICASO was a new development which they had little time to consider fully. This made it difficult to agree on every issue, and raised the problem of ensuring that all regions and organisations are fairly represented.

Participants did, however, agree that ICASO should work towards supporting stronger regional links (see page 8) and that the 16-member council of representatives should liaise with the organisers of the 7th International Conference on AIDS (see WHO Report page 4) to ensure NGO needs are met. This may or may not involve the organisation of specific NGO meetings alongside the 7th International.

ICASO's success will depend on its ability to provide its members with practical support and to ensure they are democratically represented. The will is certainly there; the council of representatives has specifically stated its aim to provide a mouth-piece for under-resourced communities.

The fight against this 'monstrous' epidemic is now over ten years old. More than ever, the conference showed that it is important to keep our primary 'enemy' in sight. In doing so, we must ensure that we create and support structures for solidarity which are genuinely responsive to the many varied groups working on AIDS - at international, regional, national and local levels.

Conference details


Attended by over 850 participants from more than 81 countries, with 160 delegates from developing countries sponsored by more than 30 different funding sources, including the governments of Britain, Comité France SIDA, 45 Rue Rébéval, 75019 Paris, France.

Five seminar tracks ran concurrently in addition to plenary sessions, each with a distinct theme and programme:

• Drugs and Treatment
• Education and Prevention
• Advocacy and Human Rights
• Services and Care
• Organisational Development

A full conference report and list of participants with contact addresses is available on request from conference organisers.
International Council of AIDS Service Organisations (ICASO)

This global, umbrella AIDS Council was founded in Paris in November 1990 to help promote the collective interests of AIDS-related organisations worldwide. Strong regional community-based networks are essential to allow ICASO to represent fully the needs of organisations at international forums, e.g. meetings with donors and policy makers. Readers are encouraged to establish links with sister organisations through their regional ICASO contacts:

Anglophone Africa: Mazuwe Banda, Churches Medical Association of Zambia, PO Box 34511, Lusaka, Zambia.
Francophone Africa: As Sy Elhadj, ENDA Tiers Monde, BP 3370, 05 rue Kleber, Dakar, Senegal.

Conference cancelled
The Third International Symposium on AIDS Information and Education, originally planned to be held in the Philippines, February 1991, has been indefinitely postponed by the World Health Organisation. This is due to existing Philippine immigration regulations which discriminate against those wishing to enter the country who are HIV positive or who have AIDS.

Publications

Action for Youth AIDS Training Manual
Produced specifically for youth workers as a practical guide to planning and developing AIDS prevention programmes with youth groups. Can be copied and/or adapted locally. 184 pp loose-page format. Price 20 Swiss francs (cheques made out to LRRCS).
Available in English, French and Spanish from: Health Department, League of Red Cross and Red Crescent Societies, P.O. Box 372, CH-1211 Geneva 19, Switzerland.

Triple jeopardy: women and AIDS
The term 'triple jeopardy' was first used by the Society for Women and AIDS in Africa (SWAA), to describe the three ways in which women's lives are affected by AIDS: as individuals, mothers and care-givers. This useful report covers a wide range of social and psychological issues facing women worldwide. Price £6.95, 104 pp.
Published by Panos, 9 White Lion Street, London N1 9PD, UK.

The report covers the first regional NGO conference held on AIDS, at which all southern African countries were represented, including the newly independent Namibia. Subjects covered in the workshops included human rights, counselling, training, role of traditional healers, testing, treatment and self-help. Price Zim$10.00, 75 pp.
Copies available from SANASO (Southern African Network of AIDS Service Organisations), c/o ACT, PO Box 7225, Harare, Zimbabwe.

Letter

Two condoms safer than one?
Reading through AIDS Action 11, I came across a very peculiar recommendation in the answer to the letter 'Are condoms safe?' In your reply you concluded that 'it is much safer to use two condoms at once - one on top of the other'. According to my knowledge this is regarded as less safe than using one condom. There is a risk that the condoms will slip off sooner because of the lubrication or that increased friction between two condoms will lead to leakage or breakage.

There are not too many condoms around in the Third World, so when you advise people to use two at once, it suggests to me that more unsafe contacts will take place or that people won't bother with them at all.

Maria Paalman, SOA Stichting, Postbus 19061, 3501 DB Utrecht, The Netherlands.

Nick Partridge from the Terrence Higgins Trust, UK, replies:
The idea of using two condoms at once to increase safety has been around for a long time and can only seem logical and sensible if you doubt the safety of condoms in the first place. Unfortunately, there is little or no agreement about what can be said with any certainty about condom safety, including using two at once. There is a clear need for further research.

The real problem with any suggestion of using two condoms is that it undermines basic confidence in using them at all. This cannot help in the vital task of encouraging people to use condoms properly, which is fundamental to ensuring the lowest possible level of condom failure.

Currently, in the UK and elsewhere, the major debate continues to focus on what can be proved about the success of using a single condom in the prevention of HIV transmission.
In this issue, the future priorities and new internal structure of the Global Programme on AIDS (GPA) are summarised, with a special focus on the ways in which collaboration between non-government organisations (NGOs) and National AIDS Programmes is encouraged.

The challenge of partnership

Dr Michael Merson, Director of the Global Programme on AIDS, summarises the key programme priorities which will form the basis of working partnerships between governments, non-government organisations (NGOs) and international bodies.

For anyone who may doubt the need for partnerships in our fight against AIDS, I challenge them to look at how the global epidemic continues to spread rapidly to new areas. If we do not take every opportunity to unite our efforts, the projections of the spread of HIV which we are now facing may indeed turn out to be gross underestimates.

GPA collaboration with NGOs has a policy basis in the resolution 1 adopted last year by the World Health Assembly. As official policy, this resolution is a useful tool and can be used as the basis for developing partnerships between NGOs and governments.

What do partnerships mean for WHO?

This is best illustrated within the context of our current priorities:

1. **Strengthening national AIDS control programmes.** These focus increasingly on effective ways to interrupt sexual transmission of HIV. Programmes will include organisations already working in prevention and treatment of sexually transmitted diseases (STDs) and in condom promotion, such as those running family planning clinics or health centres, and those representing communities with special concerns about STDs.

2. **Rapid response to the social and economic consequences of HIV/AIDS.** In sub-Saharan Africa alone we need to plan how to feed, clothe, shelter and educate the ten million orphans of HIV infected parents expected by the year 2000, and how to cope with the deaths that will occur among teachers, health, agricultural and industrial workers and political leaders.

Summary of a presentation at the Second International Conference of AIDS NGOs, Paris 1-4 November 1990

From the beginning many NGOs rightly said that AIDS is a social issue, not just a medical one; it is now clear that AIDS is a development issue that will place a heavy burden on development agencies, particularly those who have not yet considered how they are going to confront this crisis. AIDS poses a challenge and is a cause for coalition building; the involvement of individual women and women's organisations, for example, should be encouraged as an essential component of every community's response.

GPA is also concerned with discrimination against people with HIV or AIDS, which has varied greatly from country to country, and community to community. The advocacy of NGOs in their communities, along with the action of government and international bodies, is crucial for ensuring that public health is not undermined by discrimination.

3. **Strengthening the technical basis of AIDS prevention and care.** Many of these activities, such as condom use, have been undertaken by NGOs, and have been labour intensive and carried out in small populations. Our urgent task is to determine the key element of these interventions and to adapt and expand them to cover at-risk individuals everywhere. We know, for example, that condoms protect, but we do not yet know enough about how to increase their use substantially. We need high quality, action-oriented research into successful interventions.

4. **Promoting research into new vaccines and drugs.** Some drugs and vaccines are already being tested in individuals, and some could soon be ready for field testing. Testing sites need to be identified now. Because NGOs are responsible for up to half of the health care services in some countries, NGO clinics and hospitals in developing countries are likely to be included in these sites. It is in the areas

Continued on next page
The World Health Organisation's Global Programme on AIDS (GPA) is responsible for providing global leadership and co-ordinating activities for the prevention and control of AIDS, through the development and implementation of the Global AIDS Strategy. This Strategy has three main objectives:

- to prevent HIV infection
- to reduce the personal and social impact of HIV/AIDS
- to unify national and international efforts against AIDS.

How is the programme organised?

In September 1990, GPA adopted a new structure at its Geneva headquarters (figure 1). This structure is designed to help carry out priority areas of work within GPA's general roles and functions. For a summary of the roles of the organisational units, see appendix 1 on page 4.

How should organisations or individuals working on AIDS relate to GPA headquarters?

Those directly involved in planning and implementing programmes at a country level in collaboration with GPA may already have established working relations with headquarters.

For those not directly involved at country programme level or not yet collaborating with GPA country staff,

whether or not to contact GPA will depend on what kind of organisation you work for, what your technical, material or information needs are and whether or not you think GPA can help.

The first point of contact in any enquiry is likely to be at a local or regional level, e.g., contact with national AIDS programme staff, or GPA staff in national or regional WHO offices (see addresses).

If you feel GPA in Geneva could provide you with support not found locally, or should know of your working experience and situation, then you should write to the relevant department or unit, by first identifying (in appendix 1) the section dealing with the appropriate GPA function or role.

For example, if your organisation is involved in biomedical or epidemiological research, letters should be addressed to the Office of Research; enquiries relating to social and behavioural research should be sent to the Office of Co-operation with National Programmes, since the Intervention, Development and Support unit includes responsibility for carrying out intervention-linked studies on the reduction of high-risk behaviour.

If it is not clear which unit you should contact, initial enquiries should be directed to the NGO Liaison Officer in the Office of the Director. This applies, for example, if you are an NGO wanting to know how to obtain funds internationally, or how to get in touch with similar organisations worldwide.

With the exception of the Partnership Programme - see details overleaf - GPA itself is not a funding organisation. It can act as a clearinghouse for information on potential donors. Also, GPA can assist donor agencies willing to support AIDS-related projects with advice on where to best target funds.

What is the Global Commission on AIDS?

The Commission serves as an advisory body to the Director-General of WHO on matters relating to the Global Programme on AIDS, including review and evaluation of GPA activities from a scientific, technical, and operational viewpoint. The commission comprises up to 30 biomedical and social scientists, primary health care specialists, legal and economic experts, technical and aid management specialists, who serve in their personal capacities.

Members are proposed by the Director of GPA and appointed by the Director-General of WHO for a period of three years. Nominations/applications for membership should be sent to Dr Michael Merson, Director of GPA.

What is the GPA Management Committee?

The Management Committee acts as an advisory body to the Director-General of WHO, making recommendations on the programme of activities and budget of GPA, including matters related to policy, strategy, finance, management, monitoring and evaluation.

The Committee represents the interests and responsibilities of WHO's external partners collaborating in the implementation of the Global AIDS Strategy.

The Committee is informed of all policy decisions and recommendations concerning GPA made by the World Health Assembly and the Executive Board, and those recommendations concerning GPA made by the Global Commission on AIDS. Committee membership is made up of:

- the governments of those countries which contributed undesignated funding in support of GPA's general budget in the previous fiscal year;
- two government representatives from each of WHO's six regions - these are selected by the respective regional committees from among Member States collaborating with GPA, appointed for three-year terms by the respective Regional Committees;
- six major intergovernmental organisations contributing to the implementation of WHO's Global AIDS Strategy, namely UNDP, UNICEF, UNFPA, UNESCO, World Bank and the CEC (Commission of the European Communities);
- the Chairman of the Global Commission on AIDS.
How do NGOs currently participate in the GPA Management Committee?

Representatives of non-government organisations involved in AIDS prevention and care may, on request, be granted observer status, as may representatives of governments and intergovernmental organisations not already included on the Committee. Observers attending the Management Committee may contribute to discussion on all agenda items except during the formulation of recommendations.

NGOs applying for observer status should:

- send in a written request (for each meeting) to GPA at least six weeks before the meeting, preferably longer, giving information about the structure and goals of their organisation if applying for the first time;

- provide an update of their work on AIDS/HIV.

Applications are then assessed and NGOs informed about two weeks prior to the meeting as to whether they can attend. Travel and accommodation expenses are not provided.

The Management Committee has also suggested that an NGO representative should join the 36 government and inter-governmental representatives as a collective member. If they wish to take this up, NGOs worldwide would need to establish a mechanism through which they can select such a representative.

When does the Management Committee meet?

Twice a year. The first meeting in 1991 will be 23-24 April 1991. For further information, please write to: The Deputy Director, GPA.

Addresses of the six regional WHO offices

**WHO Regional Office for Africa**
PO Box 6
Brazzaville
Congo
Tel: 242 833860
Fax: 242 831879

**WHO Regional Office for the Americas (AMRO)/Pan American Health Organisation (PAHO)**
525 23rd Street N.W.
Washington DC 20037
Tel: 1 202 8613200
Fax: 1 202 2235971

**WHO Regional Office for the Eastern Mediterranean**
PO Box 1517
Alexandria 21511
Egypt
Tel: 203 4820223/4 or 203 4830090/6/7
Fax: 203 4839816

**WHO Regional Office for Europe**
8 Schriftigvjej D.K.
2100 Copenhagen 0
Denmark
Tel: 45 31290111
Fax: 45 31181120

**WHO Regional Office for South East Asia**
World Health House
Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110002
India
Tel: 91 113317804 or 91 113317823
Fax: 91 11338607

**WHO Regional Office for Western Pacific**
PO Box 2932
1099 Manila
Philippines
Tel: 632 5218421
Fax: 632 521036

Regional NGO Liaison: In addition to the NGO liaison officer post based at the Geneva headquarters, there are currently two regionally appointed NGO liaison officers: Dr Pamela Hartigan, based at AMRO/PAHO, Washington DC and Mr Henning Mikkelson at the European office, Copenhagen. NGOs are encouraged to collaborate with their respective regional WHO offices to examine the possibilities of creating similar NGO liaison officer posts.
The partnership programme: leading by example

GPA’s pilot NGO funding scheme, known as the Partnership Programme was established in 1990, with a view to encouraging national AIDS programmes to follow GPA’s lead and give consideration to NGO activities in their budgets.

In 1990, the Partnership Programme distributed about US$1 million: as such, the Programme was not expected to provide substantial and long-term funding for AIDS projects worldwide - and this was not its intention. However, the programme will enable selected NGOs to carry out genuinely innovative projects in the fields of prevention, care or advocacy at the community level. 1990 grants were normally less than US$ 50,000.

GPA expects to announce details of the scheme for 1991 shortly.

For information on how to apply for funds, write to: Bob Grose, NGO Liaison Officer, Global Programme on AIDS, WHO, 1211 Geneva 27, Switzerland.

Publications

The following are available from WHO/GPA, 1211 Geneva 27, Switzerland.


WHO AIDS Series:


Prevention of sexual transmission of HIV. No. 6, 1990.


Forthcoming conference: ‘Science challenging AIDS’

The Seventh International Conference on AIDS will be held in Florence, Italy on 16-21 June, 1991. The programme will integrate four major tracks of research: Basic Science (track A); Clinical Science (track B); Epidemiology and Prevention (track C); and Social and Behavioural Science (track D).

Registration fee of Italian lire 625,000 and full hotel registration details and payment to be received by 1 April 1991.

For further information and registration form contact: Cristina d’Addazio, Laboratory of Virology, Istituto Superiore di Sanita, Viale Regina Elena 299, 00161 Rome, Italy. Tel (396) 4457888 or 4462331. Fax: (396) 4453369/0. Telex: 610071.

APPENDIX 1

GPA: Broad areas of responsibility

Office of Director: The Director is responsible for planning and managing the Programme’s activities, in accordance with its policies and priorities, and is assisted by an advisor on policy and scientific affairs. The Deputy Director’s specific responsibilities include guiding the Programme in its role as advocate for protecting human rights and avoiding discrimination against HIV infected people and people with AIDS; developing effective working relations with non-government organisations; organising meetings of the GPA Management Committee; and co-ordinating GPA’s involvement in international conferences on AIDS.

Policy Co-ordination: elaborating and maintaining consistency of GPA policies, preparing and providing information to the public and documents for the governing bodies of WHO and of the United Nations system; co-ordinating relations with and provision of technical advice to organisations and bodies of the United Nations system; organising meetings of the Global Commission on AIDS.

Programme Planning and Management: developing and monitoring programme targets and indicators; monitoring, through a global information system, the status of the HIV/AIDS pandemic and the response to it at national, regional and global levels; formulating recommendations for the effective and efficient use of resources for AIDS prevention and control internationally, including assessment of the economic aspects of the epidemic in the health sector.

Administrative Support Services: co-ordinating administrative support to GPA meetings, particularly for major international conferences; document production and distribution; developing and maintaining an electronic data processing system.

Office of Co-operation with National Programmes: overseeing and co-ordinating technical and managerial support for planning, implementation and monitoring of national AIDS programmes; developing effective programme interventions for prevention and care; developing and supporting the application of methods of evaluation of national AIDS programmes.

This Office comprises two main units as indicated in figure 1 i.e. Intervention Development and Support, and Operational Support and Monitoring. Note that Intervention Development and Support is responsible for: carrying out intervention linked studies in collaboration with national AIDS control programmes to determine the most effective approaches for implementing strategies for HIV prevention and care; developing guidelines and materials for national programmes on the implementation of programme interventions; developing methods for the evaluation of national programmes; carrying out social and behavioural research e.g. Knowledge, Attitude, Practice and Belief (KAPB) surveys.

Office of Research: promoting, co-ordinating and supporting biomedical and epidemiological research for improved HIV/AIDS prevention and control; monitoring the latest research developments and ensuring rapid exchange of information among researchers and public health administrators; collecting and disseminating information on the course of the HIV/AIDS pandemic and forecasting future trends.

This office comprises five units as indicated in figure 1.

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