ment authority should then be adhered to by all health institutions viz. government, voluntary agencies, charitable and private organisations.

DIAGNOSIS

The dental profession is in a unique position of being able to detect first signs ond symptoms of HIV infection through orol manifestations. This can contribute to its early dignosis. It needs a more thorough examination of the oral cavity than normally done by paying attention to the teeth or the tooth the patient is complaining of. Most of us moy need some training in orol medicine to actuolly detect patients with possible HIV infection. As the loboratory procedures are expensive it may be necessary to put emphasis on clinical identification. Of significance are the periodontal lessions though no criteria have been established to relate to HIV infection. The dental profession can contribute to more accurate identification of AIDS patients.

TREATMENT OF AIDS PATIENTS

This hos raised ethical problems. In developed countries where there are advanced infection control facilities some dentists are refusing treatment to AIDS patients. What about those of us with poor facilities with no constant supply of gloves? These patients are in greater need of treatment than those who are not infected therefore they should be given priority. Every effort should be made to ensure infection control that will give the dentist the ossurance of not being infected.

EDUCATION

The dental worker has an important part to play in the compaign to educate the public in the prevention of AIDS. This will need educating ourselves first and collaborating with other disciplines within the medical professions. It also calls for inclusion in the training of dental personnel to knowledge of AIDS and the known methods of prevention so that they can play their part in their normal activities within the communities they will serve.

Courtesy of National AIDS control programme in Tanzania.

WORLD HEALTH ORGANISATION Global Programme on AIDS (GPA)

REPORT

For our mutual benefit

This article focusses upon the role of non-government organisations (NGOs) in national and international AIDS prevention and control strategies, written from the perspective of the World Heolth Organisation's Global Programme on AIDS (GPA). Cooperation between NGOs, WHO and national AIDS committees is of vital mutual benefit in promoting effective programmes.

Apart from individuals, there are three main forces in confronting AIDS - governments, intergovernment organisations, and non-government organisotions. While it is important to look at what organisations and governments have in common in their approach to AIDS, it is equally useful to look at the differences. It is through differing strengths and weaknesses that governments and NGOs can combine their resources to confront the AIDS crisis successfully; becouse no one sector - government or non-government - can face this problem alone.

What role can NGOs play in AIDS control programmes?

The most importont collective resources that NGOs can bring to any AIDS programme is their experience of working at community level. Such a community focus can help to bridge the gap between a notional policy and local oction. In general, NGOs can respond more immediately than governments to the local needs of those who are ill and their families, and often have access to sectors of the population not always reached by campaigns initiated ot a national level, for example, rural populations and illiterate or marginalised groups. In addition, NGOs with experience in working for community development have expertise in promoting primary health care in developing countries and are able to adapt this for AIDS health education. Collectively, NGOs can contribute a wealth of community bosed experience to any national or international AIDS care and control strategy.

What is the relevance of WHO's Global AIDS Strategy to the work of local NGOs?

WHO's Strategy is founded on three basic objectives - shared both by its member governments and by NGOs:

* prevention of HIV infection and AIDS
* limiting the personal ond sociol impoct
* unifying national and internotional responses.

NGOs share at least the first two of these objectives ond thus hove a common interest in combining resources with WHO. NGO/WHO cooperation is based on one fundamental objective - mutual benefit in a common fight for effective care and prevention strategies.

Endorsed by every country of the world, the Global AIDS Strategy is founded on bosic principles arising from knowledge of HIV and its spread, and on worldwide experience of infectious disease control. This makes the strategy acceptable in all countries and provides an international framework within which governments can set their own policies and programmes. It is broad enough for every organisation wishing to work effectively on AIDS to find a place within it.

NGOs can often respond more immediately than governments to local needs, and have access to sectors of the population not always reached by national campaigns.

At country level, the Strategy includes establishing National AIDS Committes and planning three to five year medium term plans (MTPs). A country's MTP provides a reference framework for all participating organisations, including NGOs. This framework is not intended to control the activities of NGOs-simply to guide and coordinate, thus avoiding wasteful dupliction of work and the production of contradictory health messages, while ensuring that plans are consistent and resources are made available and used to their best advantage.

What are the main elements of cooperation between WHO and NGOs?

* provision by WHO to NGOs of relevant up-to-date information when requested, for example, on scientific developments, epidemiological information or country programme development.

* provision of information from NGOs to WHO based on project experience, for example, evaluation, planning and project implemetation. WHO then tries to ensure that similar organisations have access to this information.

* joint action to strengthen working relationships between NGOs and national AIDS programmes.

* cooperation at an international level, for example, in the planning and implementation of counselling workshops, development of health education materials, human rights, condom quality control, and NGO-NGO liaison.

* pooling international resources and contacts. Working through NGOs with international and national net-works, WHO can more effectively disseminate and receive information and advice from an extensive collection of NGO contacts. Such NGOs include the International Council for Voluntary Associations, The League of Red Cross and Red Crescent Societies, the UN NGO Committee on Narcotics and Substance Abuse, Caritas, the UK NGO AIDS Consortium for the Third World, and the International Federation of Free Teachers Unions.

What sort of NGOs does the GPA work with?

There are three main categories of NGOs that the WHO/Global Programme on AIDS is working with:

* AIDS service organisations - NGOs that predominantly work on AIDS, including responding to the needs of people with HIV infection/AIDS in areas such as housing, counselling, home care, political or legal help, as well as public education and information.

* NGOs working in developing countries who already have a wealth of experience, particularly in the areas of primary health care and community development, on which to base new work on AIDS. Many have integrated AIDS work into existing activities such as mother and child health, clinical care, health education and training. These may be national NGOs or they may have headquarters in other countries.

* NGOs working in developed countries which are increasingly becoming involved with AIDS issues, such as haemophilia societies, ethinic organisations, prostitutes' associations and labour unions.

What kind of activities is WHO/GPA planning with NGOs? WHO/GPA is involved in the following activities at the international level:

* promoting NGO participation at major international meetings

* developing the efficient exchange of information between WHO and NGO umbrella organisations or consortia.

* developing a directory that is accessible and kept up to date, of international and national NGOs active in the prevention of HIV infection/AIDS.

At the national level:

* furthering consultation between NGOs and national AIDS programmes. This can be done individually, or through meetings of NGO groups and the notional programmes. Such cooperation can be initiated either by the authorities or by NGOs. In countries where WHO/GPA field staff are in place, they support both governments and NGOs in the development of coordinated programmes within the medium term plan. For example, in Uganda, over 25 NGO projects have been included in the MTP, in areas including counsellor training and blood donor recruitment. In Kenya, over 11 NGOs are working within the national programme on production of health education materials from magazines to teachers' manuals, and the training of counsellors, clinic staff and youth workers.

* promoting a simplified system for funding of NGO projects in line with the national medium term plans. This has already happened in Zambia, for example. A contract was set up at the end of 1988 through an exchange of letters between the WHO representative and the Church Medical Association of Zambia, who are now carrying out a major health promotion and community care project.

* encouraging national AIDS committees to include representatives of appropriate NGOs among their members, and to include NGOs in review teams for medium term plans.

The balance between cooperation and maintaining independence for NGOs working within medium term plans is an impor-

tant one. While ensuring that their projects fit into the overall framework of national programmes, NGOs still remain autonomous, keeping their financial and political independence; many NGOs are independently funded and their projects have been self-generated, relfecting their own capabilities and assessment of needs.

It is important to remember that the Global AIDS Strategy is about cooperation rather than control: that is, the coordination of efforts to achieve maximum impact. This co-operation is the only mechanism that will be farreaching enough to stop AIDS.

Youth and AIDS

By April 1989, 148 countries had reported a total of more than 145,000 cases of AIDS. WHO estimates that the real total is closer to 450,000 and that worldwide between five and ten million people are infected. By 1991, about one million new cases of AIDS could occur in people already infected with HIV.

Why focus on youth?

At least half of those infected with HIV are under the age of 25, making AIDS a major concern affecting youth today. About 20 per cent of all people who have AIDS are in their twenties. A large proportion of them became infected during adolescence. The high proportion of cases in the 20 to 29-year-old age group indicates that infection probably occurred when they were 15-19 years of age.

The rate of increase of HIV infection among young people in many countries, even in places where the prevalence of AIDS or HIV infection is not yet high, is disturbing. In Bangkok, where many people who use injectable drugs are under the age of 25, the rate of HIV infection among such drug users seeking treatment has increased from zero two years ago to over 40 per cent today.

The risk of HIV transmission amang young people may not be fully recognised, or there may be insufficient programmes providing young people with information, skills or the means they can use to protect themselves. Young people need to be aware of the possible consequences of uprotected sexual intercourse and experiementation with drugs. They may also become infected if they lack the means or ability to act on the knowledge they have.

HIV infection and its consequences are changing the world in which young people find themselves, and rapidly altering the context in which they have to make decisions about behaviour.

Many young people are not yet aware of the effect HIV infection may have on their lives. Throughout the world, sexual intercourse is the most frequent and important mode of transmission in HIV infection. Because of the social taboos and sensitivity associated with sexual behaviour and communication about it, public health officials and educators often face major problems in their prevention and control efforts, especially if they are dealing with young people between the ages of 10 and 24 years.

What are the consequences of HIV infection?

The diagnosis of HIV infection in a young person (who may feel well for years) can be disruptive not only because of fears about future illness and death: life choices about sexuality, marriage or partnership, pregnancy and work take on an added dimension of difficulty, uncertainly and hardship.

There is no reason to fear people who are infected with HIV. However, young people who are infected with HIV have been forbidden to attend school and take part in sports, or have lost their employment or housing. They have been prevented from travelling or living in some areas. HIV infected young people have sometimes been refused Scholarship places at university, or jobs. Although feeling well, they may be irrationally treated as severely ill, and forbidden to participate in normal activities because they are regarded as somehow disabled.

Young people can prevent the spread of the virus that causes AIDS

They can do this by learning the facts about AIDS in order to protect themselves and those they love and teach others how to stop the transmission of HIV.

Young people who do not have sexual intercourse or use injectable drugs or do not share needles greatly reduce the risk of infection. If a young person does have a sexual partner and both are uninfected and faithful, and are not using injectable drugs or sharing needles, they are at little risk of HIV infection in the United States of America and many European countries. In other countries, they may still be at risk from outside sources such as infected blood transfusions. The number ofsexual partners should be kept to a minimum, and for the entire duration of sexual intercourse a condom should be properly used. Sexual intercourse should be avoided with people who have many sexual partners, such as male or female prostitutes, or with persons who may be using injectable drugs.

Why don't more young people protect themselves against HIV infection?

Cultural traditions, beliefs, fears or other inhibitions may prevent young people from learning about sexual transmission of HIV and methods of prevention, or from acting on the knowledge they have.

Parents and community leaders may not favour communication about sexual matters because they do not wish to acknowledge that many young people are sexually active. They may also fear that prevention programmes which include sex education may encourage sexual activity. These barriers often delay communication until well after the time of first intercourse, despite the fact that it is preferable for young people to become aware of sexual choices and their consequences before their first sexual experience.

Young people may understand how to prevent transmission, but those who are sexually active may not have ready access to modes of prevention such as condoms.

What is being done to Prevent HIV infection among young people?

Over 150 countries now have National AIDS Committees to advise on the development of AIDS prevention and control programmes. Of these, over 50 have medium term plans with a large education and health promotion component. Most of