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Keys to Success

What makes an HIV prevention project successful? Clearly, different approaches and activities are appropriate for different groups, but successful projects have elements in common. For example, they start with the interests and concerns of the groups that they are trying to reach, and involve those groups in the design and implementation of the project.

This issue of *AIDS Action* summarises the principles of successful projects and looks at some projects that have put these principles into practice.

Once your project has begun, how do you keep it going? This issue also contains tips on how to sustain a successful project, including activities for identifying the factors that enable a project to continue.

The experiences of different countries are documented in this issue. One article takes a comprehensive look at the interface between government and civil society organisations in four countries, namely Malaysia, Thailand, Philippines and India. The dynamics of such an interface are also discussed.

In northern Thailand, communities have developed more positive attitudes to people affected by HIV, by identifying sources of support within their own community.

Aside from the strategies described in this issue, there are others which may prove to be equally successful, depending on where and how these strategies are carried out. On the other hand, what works in one community may not be as successful in another community for a variety of reasons. In adapting strategies that you can implement in your own project, keep in mind the people you will be working with and those who will benefit from the project. To achieve genuine success, being sensitive to the culture of the community is crucial. The examples in this issue show that it is possible for people to act together to reduce the risk of HIV.

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WHAT WORKS BEST?

After more than 15 years of HIV prevention activities, we have a clearer idea of what is likely to work well.

The best HIV prevention programmes use a combination of 'persuasion' and 'enablement'. Persuasion means giving people accurate information and motivating them to protect their health. This includes encouraging people who are at low risk from HIV not to change their behaviour.

Enablement means making it easier for people to put knowledge about protecting their health into practice. It includes making condoms easily available and making health services accessible and supportive. It means changing laws and policies, so that people at risk, such as young people, sex workers and injecting drug users, can be easier to reach.

Successful strategies

A review of HIV prevention programmes worldwide shows that the most successful programmes:

- involve the community
- build partnership and trust between people
- involve people with HIV in all stages
- develop the skills and knowledge of the community
- create an open and accepting environment
- involve other sectors as well as health (multisectoral)
- win support from people in power
- are carefully planned and evaluated
- recognise that even well planned approaches sometimes fail.

Successful programmes have several components, which together make up a good prevention package:

(1) **information** about HIV transmission
(2) **activities** to encourage people to assess risky behaviours
(3) **training** in communicating about sex and drug-related issues
(4) **access** to resources such as condoms and appropriate health services.

People's concerns

HIV prevention is rarely a person's only concern. It is important to:

- begin with people's own interests and needs
- involve people in the design and implementation of the project
- recognise the realities that people face in their daily lives
- focus on the sexual health of men as well as women
- examine the positive aspects of sexual health, including pleasure and enjoyment, as well as problems such as unwanted pregnancy and sexually transmitted infections
- link sexual health to people's broader concerns.

Young people are often targeted with HIV prevention messages by adults. It is especially important to begin with their interests, encourage their participation, and link HIV issues into broader concerns, such as relationships, families and plans for the future.

Injecting drug users are at risk of HIV from both sex and sharing injecting equipment. HIV prevention strategies also include:

- stopping injecting drugs, which may mean switching to non-injected drugs (this is the safest option)
- using sterile needles and syringes, and not sharing them (safe if done every time)
- cleaning equipment between use (safe but difficult to do properly).

There is evidence that drug injectors can and will change their behaviour to reduce HIV-related risks.

Sex workers and men who have sex with other men Sex work and sex between men are highly stigmatised and illegal in some countries. For these reasons, these groups can be difficult to reach. The best way may be through community-based outreach workers or peer educators.

Essential evaluation

Evaluation is essential to the success of HIV prevention programmes. Evaluation can provide useful feedback for developing the project. Many projects are not evaluated because of pressure on time and resources. However, evaluation need not be expensive or time consuming if the aims and activities of the project are properly thought out and written down before the project begins.

New opportunities

New technologies are continually becoming available. Vaginal microbicides, which kill HIV and other sexually transmitted infections, are being developed. In some countries, the female condom is becoming more available and affordable, providing more choice, especially for women whose partners are reluctant to take responsibility for sexual and reproductive health.

Sources:
HIV prevention works. In: Highlights from an official satellite symposium of the XI International Conference on AIDS, Vancouver. Ottawa: Canadian Public Health Association.
Sexual behaviour and HIV/AIDS: a review of the effectiveness of health education and health promotion. Aggleton, P. Utrecht: Landelijk Centrum GVO for the International Union for Health Promotion and Health Education and the Commission of the European Communities, 1994.
Success in HIV prevention - some strategies and approaches (see page 8).

Peter Aggleton, Director, Thomas Coram Research Unit, Institute of Education, 27/28 Woburn Square, London WC1H 0AA, UK.

Community SUPPORT

Village communities in northern Thailand have identified resources that they can use to support people affected by HIV.

Nearly half the people affected by HIV in Thailand live in the north. Poverty is high and communities have little understanding of how to support families affected by HIV.

In 1993, CARE International in Thailand started a project to improve people's understanding of HIV issues, and support families affected by HIV. Improving the care of people with HIV can also help to make HIV prevention more effective.

The Living with AIDS project covers over 140 villages. It is based on two concepts - 'comprehensive care' and the 'continuum of care'. Comprehensive care means setting up systems to provide families with medical, psychological and economic support. Continuum of care means ensuring continued care, by strengthening links within families affected by HIV, and between family members, health services and others within and outside the local community.

Identifying Resources

When the project began, most people did not know how to use local resources that could support families affected by HIV. They did not regard the community itself as a resource, but often looked to outside programmes.

CARE uses a participatory process of 'resource mapping' to identify local resources that are available but not being used. CARE staff and village volunteers - about four people in each village who have been selected and trained by local health centre staff - organise a session with local leaders and others who are interested in helping families affected by HIV. These may include affected families themselves, although they are not identified as such.

The session starts with a discussion about the health situation in the village. The discussion inevitably leads to HIV and how the community is coping. Members of the group then draw a map of the village. They discuss people and organisations from whom medical, psychological and economic support may be sought for HIV-affected families. They draw these on the map. Resources may include:

MEDICAL SUPPORT (including home-based care) - district hospital, village primary health care centre, traditional healer, places to obtain herbal medicines, village volunteers, local drug store, Buddhist monks, family members

PSYCHOLOGICAL SUPPORT - religious institutions, teachers, local groups of people with HIV, respected people in the village, health centre staff, district doctor, family, neighbours

ECONOMIC SUPPORT - existing groups such as sewing groups or farmers, village heads, local employers, village revolving funds, provincial public welfare office, relatives, schools, projects that provide assistance for children or occupational support (such as grants or revolving funds, technical advice or marketing support).

The groups are asked three questions about each resource:

- *Is it being used?*
- *If not, what is preventing it from being used?*
- *If it is, how can it be made more useful?*

Making Plans

The discussions may take several sessions to complete, depending how interested the group is and how detailed the discussions are. In villages with a group of people with HIV, separate discussions are held with this group.

By the last session, the group is more aware of the needs of affected families and the potential role of the community in helping to meet those needs. The discussions lead to action plans to make better use of the resources.

Results of the discussions are entered onto the map or listed on newsprint paper kept in the village. The maps and lists are reviewed from time to time to see whether use of local resources has improved.

After the mapping exercise, the community's awareness of sources of support, and ways in which the community itself can help affected families, has grown significantly, particularly among families with HIV-positive members. Greater awareness has also led to positive attitudes to families affected by HIV.

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Governance and HIV:

The Challenge and Myths of Decentralisation and NGO-State Interface

by Lester Coutinho

Over the last decade there has been a recognition of the need to create structures that allow for decentralisation and an effective interface between state and civil society organisations (CSOs) in order to achieve the objectives of various development programmes. The HIV/AIDS epidemic, perhaps more than any other global situation, has brought home this message most forcefully while also underlining the urgency of the matter, especially in developing countries where the epidemic is growing faster than anywhere in the world. The convergence of "Governance and HIV" has assumed significance in view of the threat that the epidemic poses to the development achievements in developing countries.

In the recent past several governments and CSOs engaged in HIV/AIDS programmes, supported by organisations like the UNDP, have explored strategies to see how this interface may be actualised and sustained in diverse contexts. The experiences focused on herein were discussed at the UNDP Satellite Symposium on "Governance and HIV" held in October 1997 during the 4th International Conference on HIV/AIDS in Asia-Pacific at Manila.

Understanding Governance

Though political theorists and development professionals have not arrived at any consensus on what constitutes governance, the term must not be misunderstood to mean only that which concerns "government", but must be understood in the wider sense of the manner in which a society governs itself. Governance is defined by the UNDP as the "complex mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences." The three key processes that are crucial to good governance are: participation, accountability and transparency, and the three actors are *the State, the Private Sector and Civil Society Organisations* (CSOs). Good governance is not a goal in itself, but is aimed at enhancing appropriate and effective responses to challenges of development, especially in crisis situations like the HIV epidemic. Governance, thus, has wider implications for any process of development.

Governance is not about a single formula for all, but it is about an appropriate and effective response that is evolved in particular contexts. Two important aspects of governance are decentralisation and the interface between government and civil society organisations.

Decentralisation primarily entails reducing the size of large bureaucratic structures and moving away from a centralised approach of policy making, planning and implementation of various programs for the delivery of civic services. The interface between State and Civil Society is the political space (and social space) in which people are given more opportunity to take part in the decision making processes.

The case studies discussed below afford an opportunity to examine some concrete issues that were encountered in the process of evolving a response to the epidemic as experienced in these contexts.

Decentralisation in Thailand

The shift towards initiating processes of decentralisation here was enabled by several factors; some internal, like the high prevalence of HIV/AIDS, recommendations emerging from the National Economic and Social Development Plan (1997-2001), and pressure from within the government; and other external factors, like pressure from agencies working in the Northern region and the international community.

The main strategies for decentralisation included; establishment of the Northern Thailand HIV/AIDS Coordination Committee, allocation of block grants, streamlining of procedures for granting NGOs funds, and promotion of NGOs and community-based organisations. As opposed to other regions of the country, the Northern region experienced a shift of authority for planning, prioritising and budgeting decision-making from provincial to sub-provincial levels.

In order to ensure a decentralised functioning of the program for Northern Thailand a committee of governmental and non-governmental representatives carried out several interventions. These efforts of decentralisation led to several immediate and long-term outcomes. Firstly, the central government allocated funds (for the first time in the country's history) for HIV/AIDS prevention programmes in the northern region independent of any ministry of the government.

Secondly, through an allocation process carried out by a task force that comprised both governmental and non-governmental representatives, government funds were made available to NGOs. This process was streamlined in 1995 so that funds were allocated by regional screening committees, where decisions were made by persons in close contact with the local situation.

Finally, the initiatives towards decentralisation resulted in greater involvement of non-governmental and community-based organisations not only in allocation of funds, but also in policy formulation and planning. The decentralised process also led to organisations being enabled to play a more effective role at the community level.

The Northern AIDS Programme guided by more decentralised plans and processes made specific interventions for the younger generation, people at risk and for those living with HIV/AIDS and their families. After the introduction of more decentralised functioning of the programme, the following was observed: flexibility in funding, agencies at central and provincial level recognised as partners, and shift of specific responsibilities from central to provincial levels.

Government-NGO Interface in the Philippines

The legal provisions of the Constitution, the Local Government Code of 1991, the presence of a dynamic NGO community, friendly government officials and support from international agencies were the main factors that allowed for the emergence of an interface between government and civil society in the Philippines. Here the dynamics of government and civil society could be described as a "critical collaboration" wherein there was cooperation, and also a respect for each other's differences and an acceptance of "critical constructive comments". The representation of PLWHA in these initiatives was also significant.

At the national level the interface between government and civil society organisations was actualised through the Philippine National AIDS Council (PNAC) whose primary responsibility has been to advise the President on policy development for the prevention and control of HIV/AIDS, and to coordinate and collaborate with other organisations in the implementation of the National AIDS Prevention Strategy - a policy document which itself was much influenced by experienced and credible members of the NGO sector.

The interface between state and CSOs in the case of the Olongapo City AIDS Foundation Inc. (OCAFI) and inter-agency HIV/AIDS Network (IHAIN) was primarily born out of the need of various sectors to collaborate and intensify their efforts in

addressing the HIV/AIDS situation. These CSOs supported by state agencies as well as the local media, religious groups and other social institutions have been able to launch several awareness and advocacy programmes at the local level.

The Malaysian Experience

The Malaysian AIDS Council (MAC) was set up primarily to coordinate the response of NGOs, as well as to have a single channel of funding. During the early stages the MAC was primarily concerned with ensuring that the work of the NGOs did not overlap with that of the government. The government was also appreciative of the NGO efforts of working with marginalised groups and also the condom promotion programme since this was considered a sensitive activity for the government. The responsibilities of the MAC gradually expanded to include capacity building. It later went on to set up a resource centre, a communication unit and also a hospice service. Fund raising, especially from the private sector, was an added responsibility.

Advocacy also became an important issue on the Council's agenda. It engaged in advocacy for better prevention and education programmes and for the rights of PLWHA. A collaborative venture, which included the government, led to the formulation of the AIDS Charter which states the rights and responsibilities of all Malaysian with regards to HIV and AIDS. However even though the government participated in the discussions and praised the effort, it did not endorse this document due to difference of perceptions.

But the interface with the government was not always smooth. As the MAC grew more experienced and professional, the relationship with the government suffered some strains. On the one hand NGOs felt that their better experience with various social issues gave them the right to voice their concerns for better governance of HIV in Malaysia. The government-NGO interface was affected by political instability and changes, as well as dissension over issues like condom use, mandatory testing of Muslim couples and school students testing positive for drugs, and the state's isolationist attitude towards sex workers.

In 1997 the relationship between NGOs and the government improved following a change of leadership in the Health Ministry. The recognition of the importance and credibility of the MAC was also due to its high domestic profile and its international networks.

The Emerging Indian Scenario

In India the voluntary sector has on the one hand been disenchanted with government policies on development, but on the other has been dependent on the state for financial support. With specific reference to the HIV/AIDS epidemic, a study carried out in Tamil Nadu with high level NGO activity, and Bihar with low level NGO activity, has pointed out to the fractious relationship between the government and NGOs.

Even though the State has ostensibly recognised the significance of a multisectoral approach, in practice there remains much to be desired. Very early in the epidemic the National AIDS Control Program (NACP) recognised the NGOs' experience in community level work, and drew up parameters for NGO involvement at various levels. But these guidelines were concerned more with administrative and organisational matters, than with programmatic issues. The success of the NACP, especially with regard to involvement of NGOs, has been varied across the states. While some states have put into place structures that allow for greater involvement of NGOs, in other states the entire programme has hardly taken-off.

While the NACP, with its medium term and strategic plans has been able to set up structures of policy advising and execution or programmes at the central and state levels; the National AIDS Control Organisation (NACO) has provided the lead in preparing policy recommendations and implementing programmes in collaboration with NGOs. In policy the government has emphasised decentralisation to the states and partnership with NGOs at lower levels. However, for a host of reasons ranging from political and administrative instability, insufficient staff and infrastructure, inadequate utilisation of funds and the absense of a conducive environment for NGO participation, the NACP has not been able to attain its major objectives. The requirement that each state appoint an NGO nodal agency has only been implemented in Tamil Nadu and Maharashtra, while other states are yet to respond.

NGOs have been reduced to implementing partners (service delivery), and their involvement in policy making has been minimal, though a few NGO representatives have been included in the National AIDS Committee. NGO representatives were also included in the former Technical Advisory Committee, and more recently in the Technical Resource Groups (TRG), but the functioning of these continues to leave much to be desired. From time to time NACO has organised consultative workshops with NGOs, but these seem to have been reduced to token gestures. NGOs continue to be perceived suspiciously by the state. Bureaucratic norms that govern the process from NGO selection to funding, monitoring and evaluation, coupled with the larger culture of malpractice (within State and NGOs) has produced a mutual suspicion so that NGOs are unwilling to work with the government. On the other hand NGOs without adequate resources (training, skill and experience) have mushroomed and joined the HIV/AIDS bandwagon of merely implementing (at times not even so much) donor-driven agendas.

Emerging Concerns

The four experiences offer insights into the processes of the interface between government and civil society, and decentralisation. True to our Asian sensibilities (which are heightened further before the "outsider") we seem to have readily distanced ourselves from the unpleasant or problematic aspects of our experiences. The case studies in the Philippines and Thailand seem to tell a happy story of government-NGO interface. While this may largely be true, it is necessary that some of the tensions and differences be examined more openly so that these may become learning experiences for others. There are also other concerns in both these countries: in Thailand, the primary concern is with regard to sustainability as there is still lack of institutional base and legislative support for what has been initiated. The decentralised policy and funding mechanisms have not been systematised in legislation. The present economic and political scenario in the region may also have its own fallout in relation to these efforts. In the Philippines, the concerns have largely to do with the need for streamlining the organisational arrangements, and to create the scope for further localising of responses, formalising the tie-ups with local government for effective policy advocacy, and involving other key actors like media, business groups and the Church.

Finally in recommending effective governance as the key to achieving the goals of sustainable human development, and hence also the control of the HIV/AIDS epidemic, we run the risk of creating new hierarchies based on not only the nature of the epidemic, but also on the nature of the governance. As pointed out by Marina Mahathir of Malaysia the discourse of governance may inherently possess a colonising tendency. The lack or absence of what is constituted as good governance in relation to modern liberal democratic societies could result in a new political geography wherein nations are mapped by their levels of effective governance. The diverse experiences if nothing else underscore the importance of recognising plurality - the nature of interface between state and NGOs will be determined as much by the nature of the epidemic, as by the nature of state, NGOs and the wider cultural, political and economic contexts. The potrayal of a fairy-tale happy co-existense of state and NGO may not only be unrealistic, but also deeply flawed as an expectation because the relationship between these two actors is inherently ridden with tensions and conflicting visions.

ACTIVITY

What does a project need?

In a group, brainstorm the elements that enable a project to keep going.

Ask people to write three elements on three pieces of paper. They might include:

- *community participation in planning the project*
- *recognition by the community that there is a need for the project*
- *range of funding sources*
- *competent staff*
- *budget that the community can raise*
- *gradual growth of the project*
- *well planned activities with enough time to carry them out*
- *collaboration with other agencies.*

Pin up all the pieces of paper. Ask the group to put them into three categories:

- *project sustainability*
- *financial sustainability*
- *managerial sustainability.*

Divide the group into three smaller groups. Ask each group to consider one category. Ask them to spend half an hour thinking about what your organisation needs to do in this category to enable it to develop.

ACTIVITY

Who should you work with?

Thinking about who is affected by your project can lead to useful local partnerships.

Put a large sheet of paper on the wall. Write your group's name in the middle and draw a circle round it. Draw two wider circles around the circle, labelled 'community' and 'external audiences'.

Ask the group to brainstorm which groups they should be working with (such as mothers, local shopkeepers, national AIDS programme staff, donors and religious organisations). Write them in the appropriate circles. You could also rank how important these partners are.

Building on SUCCESS

AIDS Action looks at how small projects can grow bigger.

Most groups involved in HIV prevention start small. Expanding can be difficult. Here are some practical tips:

WORK WITH THE PEOPLE IN MOST NEED WITHOUT STIGMATISING THEM Groups that are clear about what makes people vulnerable to HIV, and who the most vulnerable people are, are most likely to succeed.

IDENTIFY THE PROBLEM CLEARLY Many groups believe that, if they can change people's views, people will change their behaviour. However, people's behaviour depends on other factors too. For example, people may sell sex because they need the money, even though they know it can be risky.

USE PARTICIPATORY METHODOLOGIES Find out the views and needs of the people you are working with, and draw up plans with them. A non-governmental organisation (NGO) in Bangladesh started a treatment centre for drug users. After a while they asked drug users whether the centre met their needs. They found that no women used the centre, although some drug users were women. The women were unwilling to go to a centre that was for drug users. So the NGO changed the centre to a health centre serving the whole community.

GAIN SUPPORT FROM THE COMMUNITY People who feel that a project will benefit them will be more willing to support it. After some time, the NGO's support for the health centre became unnecessary. The centre is now supported by the local community through fundraising activities such as musical events and donations of daily newspapers made available in the centre.

BUILD ON WHAT YOU DO BEST A Bangladeshi NGO which ran a successful HIV prevention project with truck drivers was tempted to spread the work across a wider area. They first reviewed the project and identified several weaknesses - they were not reaching women, nor were they reaching the truckers' friends, families or other contacts, such as hotel staff. The NGO is now looking to involve more of these people, rather than spread to other areas.

ESTABLISH YOUR GROUP Established groups are in a better position to expand. Try to obtain legal status as a registered charity or recognised group. Keep records of meetings and activities. Have a system of financial control, even if this is simply keeping money in a safe box and recording payments in and out.

FORM LOCAL PARTNERSHIPS Develop partnerships with other NGOs, local government departments and community groups. An organisation in the Philippines invited a range of local community groups to its annual meeting. Some HIV prevention groups were worried about attending. However, by attending they formed some useful partnerships. During World AIDS Day, for example, the Rotary Clubs participated in HIV prevention activities which previously the HIV groups had been running on their own.

With thanks to Mrs Kabita Begum, HASAB, Bangladesh and Arturo Cristobal, PHANSuP, Philippines.

HIV-related diarrhoea

Diarrhoea is the passage of loose stools three or more times a day. Persistent diarrhoea (lasting more than two weeks) is more common in people who have advanced HIV disease than in those who do not. For many it is a major problem.

The main dangers of diarrhoea are dehydration and malnutrition. People with HIV-related diarrhoea can become malnourished and lose weight quickly, mainly because they do not eat well because of poor appetite. Also, because weight loss ('slim') is associated with HIV, a person with diarrhoea may be assumed to have HIV, and be stigmatised.

Preventing diarrhoea

Good hygiene and nutrition are the best ways to prevent diarrhoea. Drinking boiled water is best, but is often not practical. Washing hands frequently with soap is more practical. Other strategies are to: store food under a cover; wash eating and cooking utensils; wash raw fruit and vegetables; dispose of waste properly; keep anything dirty, such as soiled bedding, out of reach of children.

To prevent and treat diarrhoea, people with HIV need nutritious food that is easy to digest (see box: 'Eating well').

Diarrhoea is a common problem for people with HIV. AIDS Action outlines ways to prevent and treat it.

Treating diarrhoea

Common causes of persistent diarrhoea in developing countries include protozoas (microscopic organisms) such as cryptosporidia, isospora and microsporidia. Other causes include bacteria such as shigella, and probably viruses. The HIV virus might cause diarrhoea, although there is no conclusive evidence.

The cause of HIV-related diarrhoea varies from one area to another, and is often quite localised. It is useful to identify common causes in an area, and draw up treatment guidelines for the area. Ideally, these should cover the major causes, so that people need not be investigated individually.

Adults with diarrhoea should:

- Drink more fluids than usual.
- Continue to eat (see: 'Eating well').
- Take vitamin supplements such as folic acid and vitamins C and A, if available.
- Treat dehydration with oral rehydration salts (ORS).
- Relieve symptoms with codeine phosphate, loperamide or diphen- oxylate. These drugs reduce the pain, volume and frequency of diarrhoea, although possible side-effects include dryness of the mouth, sleepiness, loss of coordination, blurred vision and distended abdomen.
- Treat the cause of the diarrhoea with treatments such as TMP/SMX (isospora); metronidazole (giardia); albendazole (microsporidia, crypto-sporidia). However, resistance can develop. For example, salmonella and virtually all shigella in Zambia are resistant to these drugs, so people with HIV in Zambia who have bloody diarrhoea should take nalidixic acid and metronidazole. Also consider TB as the cause. Some traditional herbal remedies control diarrhoea.

People who do not respond to these treatments are seriously ill. The main aim should be to relieve their distress, using codeine phosphate or loperamide, and offer fluid - oral rehydration or intravenous fluids in hospital. For someone with fever, try systemic antibiotics such as intravenous or intramuscular cephalosporins.

It is important to keep the area around someone with diarrhoea clean, to prevent infecting other people.

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EATING WELL

People with diarrhoea need plenty to drink and plenty of easily digestible, bulky foods containing a lot of nutrients and calories. Make foods easier to digest by cooking them well or mashing them. Encourage people with low appetites to eat small amounts often.

Take plenty of:

water, soups and diluted juices

✔ *cereal (such as rice) with beans, meat or fish; oil can be added to increase energy*

✔ *yoghurt, eggs, bananas*

✔ *other bulky or juicy foods such as potatoes, water melon, barley, paw-paw, rice water, millet or sorghum porridge, steamed fruit.*

Avoid:

✗ *high-fibre foods such as whole-grain cereals, or fruit and vegetable peel*

✗ *sugary foods or drinks, such as commercial soft drinks, which can worsen diarrhoea (and provoke thrush)*

✗ *raw foods, cold foods, acidic fruit such as oranges*

✗ *irritating foods such as pepper.*

Sources: AIDS home care handbook, Global Programme on AIDS, WHO, Geneva, 1993; Food for those with HIV/AIDS. L. Epstein, Cape Town, Hope Productions, 1995.

CHILDREN

Do not give anti-diarrhoeal drugs to children under five years of age.

Give children plenty to eat and drink (see 'Eating well'), plus vitamin and mineral tablets if available. Children will continue to need extra food after the diarrhoea has gone, to enable them to regain any lost weight.

For further information see 'Caring with confidence'. Details on page 8.

***Success in HIV prevention* - some strategies and approaches**
Provides an overview of research into HIV prevention with different groups (gay men, young people, etc.) and gives sources of further information. £6.95 from AVERT, 11-13 Denne Parade, Horsham RH12 1JD, UK.

UNAIDS Best Practice Collection -
Following is a list of this collection. To obtain copies of materials, contact HAIN or UNAIDS at unaids@unaids.org or UNAIDS Information Centre, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

Women and AIDS
Discusses women's biological, social and economic vulnerability to HIV infection and points out that the only way to protect women is through empowerment.

AIDS and Men Who Have Sex with Men
Sex between men occurs in most societies. For cultural reasons, it is often stigmatised by society. The public visibility of male-to-male sex, therefore, varies considerably from one country to another. Sex between men frequently involves anal intercourse, which carries a very high risk of HIV transmission for the receptive partner, and a significant risk, though a lesser one, for the insertive partner. HIV prevention programmes addressing men who have sex with men (MSM) are therefore vitally important. However, they are often seriously neglected - because of the relative invisibility of MSM, stigmatisation of male-to-male sex, or ignorance of lack of information.

Tuberculosis and AIDS
The growing epidemic of HIV has breathed new life into an old enemy -tuberculosis. The HIV epidemic spurs the spread of TB and increases the tuberculosis risk for the whole population. For those who are HIV-positive, the TB risk is especially great and the outcome often fatal.

Blood Safety and AIDS
Discusses benefits of transfusions and the risks attached to it.

Community Mobilisation and AIDS
Community-level action - much of it initiated persons infected or affected by HIV - has always played a major role in the global response to AIDS. In many countries, community response came before the official national response - most notably awareness, prevention, policy and legal changes, impact alleviation, advocacy, and family or community care and support.

Relationships of HIV and STD declines in Thailand to behavioural change : a Synthesis of Existing Studies
This paper summarises existing epidemiological and behavioural data, documenting changes over time on both national and regional levels; examines the relationships between behaviour and HIV/STD infection; determines the feasibility of linking behavioural and epidemiological aspects of the epidemic; examines the correlation of behavioural change with epidemiological change; and determines the practical implications of these findings for continuing Thai national programme and policy needs.

Caring with confidence: practical information for health workers who prevent and treat HIV infection in young children covers HIV transmission and prevention, diagnosis, caring for children with HIV, treatment of common illnesses, and supporting families caring for children with HIV. It is intended for health workers, educators, NGOs and those working with community organisations, who are involved with HIV prevention and with the management and care of young children with HIV and AIDS. Limited copies are available from HAIN. Free to developing countries (£10/US$20 elsewhere)

Update on Contraceptives:
Beyond Acceptability: Users' Perspectives on Contraception ed. By TK Sundari Ravindran, M Berer, & J Cottingham
A collection of papers inspired by a recent international workshop on this theme, whose aim was to move beyond the concept of acceptability towards a greater understanding of the perspectives of the people who use contraception themselves. It brings together the experience of researchers, contraceptive service providers and women's health advocates. The papers include original research carried out in Chile, India, Ivory Coast, South Africa and Britain and in two cross-country studies; reviews and analysis of the existing literature and proposals for future directions.
Contact Reproductive Health Matters, 29-35 Farringdon Road, Farringdon Point, London EC1M 3JB, UK.
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The international newsletter on HIV/AIDS prevention and care
AIDS action

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