Surviving the streets

El Gato is a fifteen year old who has lived on the streets of a large Latin American city since the age of eight. He has been imprisoned five times, hospitalised twice, and forced to live in institutions for abandoned or 'delinquent' children. He visits his mother every three or four months and occasionally stays with her during public holidays. For the past three years he has regularly sold sexual favours to adults to survive. Living on the streets has exposed him to scabies, lice, fleas, conjunctivitis, impetigo, amoebic dysentery, giardiasis, ascariasis and gonorrhoea. More recently, he was infected with HIV (the virus that causes AIDS).

Millions of children and adolescents work and live on the streets of the world's cities; begging at crowded intersections, shining shoes, working as parking boys, selling newspapers, or stealing from market stalls. At night they sleep on the pavement or under park benches. These children are often seen as a threat to society or an embarrassment to governments. Denied affection, education and help, they are often abused by others, imprisoned and even – as in Brazil – murdered by squads hired to rid the streets of 'pests,' believed to be a threat to the tourist industry. They survive through experience and gather together in gangs to create a family and support structure. They see adults as their enemy and most fear and hate the police.

'Survival sex,' international sex tourism and sexual abuse affect the lives of millions of children living in poverty worldwide. Children often become victims of adult sexual exploitation and are sexually active amongst themselves. Since street children are therefore at increasing risk from HIV, they may suffer even more discrimination. A doctor attending children in one of Brazil's largest state reformatories admitted: 'When a child tests HIV positive, I tell them, "Prepare to die. You are going to die, you have AIDS." We expel them. We cannot keep them here.' Not only is it cruel and misleading to tell a child with HIV that s/he is going to die (the child may remain healthy for many years), throwing them back on the street with a 'death sentence,' and without ongoing support, is totally inhumane.

But as more street children become infected with HIV, they may suffer even more discrimination. Behavioural change can only come from promoting self-worth and creating an environment where children can make informed choices. Children, on and off the streets, need to feel good about themselves, earn money, have fun, and have the opportunity to study and work in dignified employment.

In this issue.

- Practical guidelines working with street children
- Country reports Colombia and Southern Africa
- HIV and the nervous system diagnosis and treatment
- WHO Report evaluation guidelines; using videos

The international newsletter for information exchange on AIDS prevention and control
continued from page 1

For those who have never worked with street children, the guidelines on pages 2-3 give some practical ideas about where to start. But the children themselves are the experts: they know what their concerns are and how they see their own future. Unless these concerns are listened to and addressed, no street child will listen to warnings about AIDS.

Beyond meeting immediate health needs, the broader issue of why children are living on the streets in the first place needs to be addressed. The threat of AIDS and other sexually transmitted diseases, or the increase in drug addiction, cannot be separated from lack of choice and opportunity.

By the end of this century, many former street children will be living in slums and shanty towns, prison cells and working class neighbourhoods. Many of today’s street children, including El Gato, may be living with AIDS. We must try to ensure that he, and others like him, do not die without humane care and support; that others protect themselves from becoming infected with HIV in the first place. And with a broader vision, we can work to reduce the numbers of those forced to live on the streets through poverty, homelessness or war.

Mark Connolly, consultant for Street Kids International.

News

First International Conference on AIDS and Homeless Youth: an agenda for the future
Held June 25 1990, San Francisco, USA.

"I am pleased you are all here talking about AIDS and street children and thinking of ways to educate us. But there is a problem. We often do not listen to what most adults tell us."

These were the words of Byron Gómez, a 16 year old living on the streets of Guatemala City who spoke during one of the final working sessions at the above conference. It was a timely reminder to participants that the aim should be to take action with children, not just for them. Youths themselves need the opportunity to lead in the development of creative programmes for their peers. This first international conference on AIDS and homeless youth brought together participants from 27 countries, including clinicians, policy makers, researchers and youth workers, to discuss ways of working together on a broad set of issues.

For conference papers: G. Cajetan Luna, Mount Zion Hospital and Medical Centre, 1600 Divisadero Street, San Francisco, CA 94120, USA.

Knowing where to start

Dr Judith Ennew from Streetwise International provides some practical advice for AIDS educators and others planning to work with street children

There are three basic principles to remember when planning educational programmes with children who survive on the streets:

- the main obstacle to successful programmes is our own attitudes;
- the main resource in any programme is the children themselves;
- AIDS education can only succeed in the context of overall personal development: you cannot expect children to protect themselves if they have no sense of their own worth.

Start with yourself

- Examine your own, and your society’s, attitudes and prejudices towards street children, their sexual and other behaviour and AIDS. What do your colleagues believe and say about these children?
- Find out what the children think and believe about themselves! Don’t be afraid of approaching the children: it’s OK to say ‘hello.’
- Recognise that sexual intercourse takes place between children, as well as in the sexual exploitation of children by adults. Be aware that sexual abuse takes place in families, orphanages and prisons. Do not deny the children’s sexuality or sexual experience, or lower their self-image, by making them feel ‘bad’ because they earn money by prostitution or engage in homosexual relationships.
- Beware of creating special groups. For example, many projects make the mistake of separating girls out from the boys, giving food, shelter and clothing only to the girls. This encourages female dependency. If you make differences between groups of children you must have good reasons for doing so. Discuss these with the children.
- Remember that street children should not be seen as passive recipients of care. They are survivors in their own right and must be respected as such.
- Beware of creating dependency. Most projects start with the idea of providing food or shelter. You do not have to give food unless children are hungry, and they may have no need for special buildings. As one project
Finally, examine your motivation for working with street children, as well as that of other volunteers. Avoid allowing the vulnerability of these children to satisfy the emotional needs of the adults concerned.

Use local resources

- Remember that the children themselves are the main resource. Programme staff must get to know and understand them.
- Use the children themselves as educators. Identify the 'gang' leaders, or street educators who have often spent years on the streets themselves. Don’t assume that you must start with videos and comics because children enjoy these. Personal contact is the best way for messages to be passed on and remembered. People of all ages who are not accustomed to learning with posters, books and videos often have a different perception of two-dimensional media. If you want to use video, or slides, why not make your own with the children?
- You do not need vast amounts of money or large, purpose-built premises to start up a local programme. Use existing local resources (a church-run day centre?) and involve families and communities. Some organisations may be willing to provide resources or funding e.g. medical associations, business community or the national Red Cross.
- Share resources and experiences with other projects. Children have a range of problems and require a range of services. Many of these services already exist. The problem may be one of access. Sometimes street children are chased away from hospitals and clinics because of their bad reputation. Avoid providing parallel services, but try to ease access to, and delivery of, existing services. This will often involve adapting existing services and working to change the attitudes of staff.
- Pass on your own experience of working with street children to other health professionals and educators.

Discussing health and sex

- Work towards improving the general health and self image of the children. Like most children living in poverty, their health will already be poor. Giving them the knowledge and the facilities to improve this will increase their self respect, as well as help resistance to infection and/or the development of AIDS.
- Discuss safer sex in the context of the children’s other concerns, such as broader health issues, personal safety, economic survival, job skills, legal and other rights, housing, drug taking and so on.
- When you encourage condom use in sexual relationships, emphasise that this applies to sexual contact with friends as well as with adults/clients/strangers.
- Help the children gain access to condoms and teach them how to use them. Showing a picture of a penis gives very little idea to a child who may not identify with body parts drawn in outline, especially if the rest of the body is not drawn. Discussion and practical demonstration, using a banana or piece of wood carved to look like a penis, works much better. Allow the children to play with condoms and become familiar with them. They might blow them up as balloons! Turn their play into education.
- Be prepared to discuss anal intercourse with all the children, not just the boys. There is widespread evidence that girls practice anal intercourse to avoid pregnancy. Bring topics like this into the general discussion of sex and reproduction.
- Don’t emphasise death as the worst thing about AIDS. Although death is a very real threat to street children (they live violent and dangerous lives), they are more concerned with day-to-day survival. Ana Filgueiras, a project worker in Brazil, suggests: ‘If you tell them AIDS makes you very weak, that's something they're afraid of. They know that when they're weak, they can't survive on the street.’
- Above all, don’t over-publicise the issue of street children being a ‘risk group’ for HIV infection/AIDS. This will only increase discrimination against them.

Further information: Streetwise International, The Old Maltings, Green Lane, Linton, Cambridge CB1 6JT, UK.
**Action magazine on AIDS**

The environmental health magazine, *Action*, is distributed to 11,500 primary and secondary schools in Botswana, Zambia and Zimbabwe. It has 16 pages of information and ideas, cartoons, stories and competitions, on subjects ranging from water and health to population, wildlife, and tree-planting. Published with a teacher’s insert, it reaches an estimated one million children aged between ten and fourteen years. Last year the *Action* team, based in Zimbabwe, decided to produce an issue on AIDS. Steve Murray describes planning this issue.

In early 1989 government policy meant that it was difficult to get accurate information on the number of AIDS deaths or estimated levels of HIV infection in Zimbabwe. So we approached planning an *Action* issue on AIDS with some caution. We also knew that to reach more children, we had to encourage more teachers to take up the issue. We tried to do this through a special 16-page pull out section for teachers, giving background information on AIDS and practical ideas for approaching AIDS education.

**Where did we start?**

As with all *Action* issues, we started by holding discussions with a range of local groups already involved in the subject concerned, in this case AIDS. These included the AIDS Counselling Trust (Harare), the Department of Community Medicine at the University of Zimbabwe, the National AIDS Control Programme and curriculum developers in the ministries of health and education in the countries concerned. An editorial advisory team was formed with representatives from ministries and non-government organisations working in AIDS management, education and counselling. To plan the issue, we also used information gained from earlier AIDS awareness workshops, and knowledge, attitude and practice surveys carried out amongst pupils and teachers.

**Planning the message**

The team identified areas of public misconception about AIDS/HIV and tried to ensure that the magazine clarified these. They included:

- confusion between AIDS and HIV and how HIV infection leads to AIDS;
- the belief that only certain groups of people e.g. prostitutes, get AIDS;
- widespread denial that AIDS was a new or serious problem;
- lack of accurate knowledge about AIDS/HIV among teachers.

The magazine tried to combat the fear, stigma and panic associated with AIDS, emphasising the supporting role which the extended family and the community can play in the care of people with AIDS/HIV.

**Making the message fun**

The magazine had to provide accurate information in an entertaining way, to help teachers and pupils think positively about how they could stop themselves becoming infected with HIV. Lots of comic strips (some in colour) and humorous illustrations were used. The section titled ‘You can’t get AIDS by touching’ uses cartoons to expose false beliefs, such as ‘AIDS is a disease caused by a spell put on an unfaithful woman by her jealous partner’. ‘A family crisis’ is a short, comic strip story set in a township family home, involving a young couple whose first baby, George, dies from AIDS. The story deals with reactions of the extended family, while its sequel ‘Let Love Continue’ (see figures 1 and 2) looks at the wider community response. The stories relating to the death of baby George reflect the fact that in southern and central Africa, infant mortality from AIDS is rising; around 20 per cent of AIDS cases are in the 0-4 years age group.

**Pull out teachers’ pages**

The following is a summary of contents:

- Ways of approaching AIDS education, including basic facts and figures about AIDS.
- Activities for pupils based on the magazine including summary of the main teaching points.
- Instructions for playing educational games e.g. board game played with dice. Players complete one circuit of the board, and may land on ‘discussion’ or ‘question’ squares. Two packs of discussion/question cards include subjects like: As long as you stay away from people in the city, you won’t catch AIDS/What is the most common way people get infected with HIV in our country? There are fifteen printed cut-out discussion cards and nine question cards (with answers) ready to use.

*Action*, Environmental Health Magazine, 282 Herbert Chitepo Avenue, P O Box 4696, Harare, Zimbabwe. Tel: Harare 724401.
Home from home

Helping children on the streets of Bogotá

Every Tuesday and Friday night, from 8.00pm until 6.00am, a doctor and three volunteers from the Colombian Red Cross drive around the streets of Bogotá in a van installed with a solar heated shower room and small clinic. The van stops in areas where groups of street children live. Rosa Gaviria talked to the staff and children involved.

The project’s medical doctor, Dr Castro, explains: ‘The children get to know the van’s regular timetable. Because it is an area of the city which doesn’t involve the police or the authorities, little by little the children come to trust us. Some just come for a shower, others because they need treatment for illness or injury; or some just want to chat about their problems.’

Forty per cent of the population of Colombia live in absolute poverty. This is the underlying cause of the dreadful problems faced by children living on the streets; problems which include violence, drug addiction and sexual exploitation. Some children sleep in the appalling conditions of the sewers which run under the wealthy hotel and banking district to escape the worst of the violence, such as bombs and ‘social clean-ups’. These clean-ups are carried out by private death squads who murder street children, beggars, drug addicts, prostitutes and homosexuals in selected areas. Such killings accounted for over 400 deaths in 1989.

Drug use

The children commonly take drugs to suppress feelings of fear, hunger and cold. Fourteen year old Elena, who lived on the streets for seven years, explains: ‘We used drugs a lot to stop thinking about the hunger, especially at night. It’s difficult to live on the streets and not take them. You’re in the park alone and miserable, you see some kids smoking and sniffing and they invite you over – they’re nice to you. At least at the start.’

Youngsters often begin with sniffing glue, or ‘boxer’ as it is known, and then start adding aspirin and banana peel to strengthen its effects. They siphon off petrol from cars and inhale that. These habits create respiratory, kidney and eye problems. Elena added: ‘After we had been sniffing glue for five or six years, we got really bad chests and blood started coming out of our noses.’

STDs and child-size condoms

When living in such conditions, sex among friends provides a source of comfort to the children, or a source of cash from adult clients. Adult exploitation is commonplace. Dr Castro explains: ‘Some adults specialise in developing links with the children in order to rent them out for sex. They take children off the street, wash them, give them smart clothes for the night and then deliver them to a client. The child gets paid only a tiny proportion of the fee and is then returned to the streets.’

Not surprisingly, sexually transmitted diseases (STDs) among the children are very common. HIV/AIDS has also been identified as a problem, but it is almost impossible to find out the rate of HIV infection as children resist having blood tests of any kind. Attempts at enforced testing by state health authorities have caused an outcry. All Red Cross programmes which involve blood tests are strictly based on the principle of voluntary consent.

In addition to providing free medical treatment from the van, Red Cross staff carry out preventative health education including the promotion of safer sexual behaviour. But, as Dr Castro points out: ‘One of the main problems in trying to prevent the spread of STDs is that child-size condoms are not available. No child is going to use a condom if it’s always slipping off.’

Leaving the streets

During their night’s work, the project staff try to refer some of the children to other organisations which can provide a home or more permanent care. ‘The children have started advising the staff which of them may want to try leaving the streets. But normally it is only the most recent arrivals who can be referred, as they have not become so “addicted” to street life.’

One such organisation is the Foundation for the Children of the Andes, set up and run by a Colombian businessman. The Foundation runs three houses providing basic education, practical training, recreational activities and medical care. One of the main objectives is to try and show children what family life can be like. Elena, who now lives at the Foundation explains: ‘On the streets nobody cares and you get abused. But here they look after you like they were your own parents.’ A fundamental principle of the house is freedom; the children can leave whenever they want. ‘Not surprisingly, few of them do – at least, not until they have better life choices in front of them.’

Names in this article have been changed.

Further information: Colombian Red Cross, Apartado AERO 11-10, Bogotá, Colombia
HIV and the nervous system

Dr Chris Conlon summarises current knowledge on common HIV-related neurological disorders, which will be of use primarily to health personnel working in referral centres.

Scientific terms in italics are explained in the box below.

Neurological problems associated with HIV are common. In western studies, roughly ten per cent of patients present with neurological symptoms and signs, and up to three-quarters of AIDS patients have nervous system (NS) abnormalities detected at autopsy. In the parts of Africa where HIV is endemic, the prevalence of HIV-associated neurological disorders is largely unknown, but is a recognised problem. Neurological diseases related to HIV can be broadly grouped into two categories: (1) direct effects of HIV itself on the nervous system, and (2) indirect effects of HIV, where immunosuppression leads to opportunistic infections and tumours.

Direct effect of HIV

Some of the effects of HIV occur early in the course of the disease. Many people (perhaps the majority) have asymptomatic NS infections, the only signs being in the cerebrospinal fluid (CSF). The abnormalities include a raised CSF protein and a moderate increase in lymphocytes. A few people develop acute neurological symptoms and signs at the time of sero-conversion. This may take the form of acute confusional states (delirium), seizure, acute aseptic meningitis, encephalitis or encephalomyelitis. There may also be associated abnormalities in the peripheral nervous system. Usually patients recover over the course of a few weeks with no obvious clinical after effects.

At a later stage, some patients may develop neurological problems before they develop AIDS (the final stage in HIV disease). These may consist of peripheral neuropathies (sometimes painful) and isolated peripheral nerve palsies. Occasionally patients develop an ascending paralysis, like Guillain-Barré syndrome, with weakness initially in the lower limbs that subsequently develops in the upper limbs. Paralysis of the respiratory muscles is life-threatening. Sometimes a transverse myelitis occurs, with paralysis of the lower limbs as well as marked sensory losses. This can mimic spinal cord compression.

AIDS Dementia Complex Perhaps the commonest NS problem, known as the AIDS Dementia Complex (ADC), occurs in the later stages of HIV infection, usually after the patient has been diagnosed with AIDS. The disorder is characterised by cognitive, motor and behavioural abnormalities. Patients may show slowness of thinking and have difficulties with concentration and memory and may eventually become quite apathetic. The appearance of acute confusional states (delirium) is also possible. Early motor problems include poor balance and coordination; the patient may note that s/he is becoming clumsy. More rarely, patients develop an acute psychosis and can become manic. However, as ADC advances, patients are listless and apparently indifferent to their illness. They become completely dependent on the humane care and support of others.

Explanation of scientific terms

**ataxia:** an inability to co-ordinate voluntary muscular movement, symptomatic of nervous disorder.
**encephalitis:** inflammation of the brain, causing confusion, limb weakening, or even coma.
**encephalomyelitis:** concurrent inflammation of the brain and spinal cord, causing malfunction of thought, consciousness and use of limbs.
**focal neurological signs:** e.g. localised disturbances such as a stroke or hemiplegia resulting from damage to specific areas in the brain.
**hemiplegia:** paralysis of one side of the body, or part of it, resulting from injury to the motor centres of the brain.
**meningitis:** inflammation of the membranes surrounding the brain and spinal cord (aseptic; not associated with bacterial infection).
**myelitis:** inflammation of the spinal cord or bone marrow (transverse myelitis: inflammation across one section, rather than lengthwise).
**nerve palsies:** damage to specific peripheral nerves leading to specific muscle weakness.
**neuropathies:** abnormal and usually degenerative state of the nervous system or nerves.
**peripheral nervous system:** the part of the nervous system outside the central and autonomic nervous system e.g. the femoral nerve.
**psychosis:** serious mental illness, characterised by lost contact with reality, often with hallucinations or delusions.
**retnitis:** inflammation of the retina which may lead to blindness.
these chronically ill patients is often best in the home with the support of the family rather than in hospital.

**Opportunistic infections**

The nervous system is prone to a variety of opportunistic infections as the individual’s immune system declines. The most important and the most common infections are cryptococcal meningitis and toxoplasma encephalitis.

**Cryptococcal meningitis** This usually presents with a headache and fever and may therefore mimic malaria. Usually there are subtle neurological signs, such as mild neck stiffness, ataxia and occasional cranial nerve palsies. Diagnosis is by examination of the cerebrospinal fluid; while there may be only a few white blood cells and the biochemistry may be normal, India ink staining will reveal the cryptococci. Treatment involves the use of systemic antifungal drugs, such as amphotericin B (0.3mg/kg/day, I.V.) fluconazole (400mg/day) or itraconazole (200mg/day). Therapy should be continued for at least six weeks.

**Toxoplasmosis** This usually presents with focal neurological signs, often mild hemiplegia, due to a cerebral abscess. Diagnosis is difficult, even with sophisticated X-ray facilities, and as the only sure way of making the diagnosis is by a brain biopsy, most clinicians use a therapeutic trial of antitoxoplasmosis treatment if they suspect the diagnosis. Initial treatment is with a combination of pyrimethamine (50-75mg/day) and sulphadiazine (4-6 grams/day) in divided doses, usually for at least three weeks. Other combinations that can be used are pyrimethamine (same dose) and dapsone (100mg/day), and pyrimethamine and clindamycin (300mg four times per day). Cryptococcosis and toxoplasmosis, like other opportunistic infections in AIDS, need to be suppressed by some form of maintenance therapy that is continued indefinitely after the initial treatment of the acute illness. This usually involves the administration of the same drugs used for acute treatment, but at lower doses.

Other opportunistic infections can also cause NS problems. Tuberculosis, candida and herpes simplex can all lead to focal cerebral disease. Cytomegalovirus and herpes zoster may lead to peripheral neuropathies or to a transverse myelitis. It should also be remembered that cytomegalovirus causes retinitis.

**Tumours and progressive multifocal leukoencephalopathy (PML)** Focal neurological problems, usually hemiplegias, may result from tumours of the brain, the commonest being a lymphoma. Very rarely, Kaposi’s sarcoma occurs in the brain. These tumours can only be reliably diagnosed by brain biopsy. They respond poorly to treatment and carry a bad prognosis.

Another condition seen occasionally is progressive multifocal leukoencephalopathy (PML). This is a slowly progressive and fatal disease, probably caused by a papovavirus, that presents with focal neurological signs, e.g. hemiplegias, or a stroke.

**Summary**

The spectrum of NS disease associated with HIV is quite broad. The acute symptoms may improve spontaneously, but many of the manifestations associated with later stages of HIV infection have no treatment and a poor outlook. However, prompt diagnosis of some of the opportunistic infections, especially cryptococcal meningitis and toxoplasmosis, is important, as these usually respond well to specific therapy.

Dr Chris Conlon, John Radcliffe Hospital, Oxford, UK. Dr Conlon has worked for a number of years in Zambia, managing AIDS patients at the University Teaching Hospital, Lusaka.

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**Letters**

**Are condoms safe?**

In my country, efforts are made to reduce the spread of HIV/AIDS by counselling. People are encouraged to use condoms as a safe way of avoiding infection.

After ejaculation the penis goes limp, and there is back pressure within the condom itself. This will make the semen flow out. If the man is HIV positive, will he not infect the woman with whom he has a sexual relationship? We must find safer ways rather than condoms!

Nuru Percival Kaoza, Ludewa District Hospital, PO Box 3, Ludewa, Iringa, Tanzania.

Ed. Condoms, when PROPERLY used, are relatively safe method of protection against sexually transmitted diseases (including HIV). Proper use of condoms includes: putting on the condom as soon as the penis is hard and before it touches the other person’s genitals; withdrawing the penis immediately after ejaculation while it is still hard, holding the condom in place; only using water-based lubricants (if used at all) as some lubricants, such as Vaseline, weaken the rubber and may cause the condom to break; and disposing of the condom safely. Since all condoms may break or split, people should realise that they are still taking a risk if they have penetrative sex; it is much safer to use two condoms at once - one on top of the other.

**Routes of transmission of HIV**

I would like to ask two questions on HIV transmission:

1. If food is contaminated with the blood of an HIV infected person, would the person who ate the food be infected with HIV?
2. You said in AIDS Action issue 1 that infected mothers can pass the virus on to their unborn children, either during pregnancy (through the placenta) or during birth. Then you said the spread of HIV can be prevented from mother to child. Could you tell me how it is prevented?

S Bangura, Njala University College, Freetown, Sierra Leone.

Ed. The answer to the first question is no. Unless the food is obviously covered in fresh blood (in which case you wouldn’t eat it) the chances are that there would not be any active virus on the food. HIV is a fragile virus and needs to be inside a living cell to survive for any length of time. Obviously, cooking will destroy the virus, as it is sensitive to heat.

The risk of an HIV positive mother transmitting the virus to her unborn child varies between 20-40 per cent in different parts of the world (see AIDS action, issue 9). The only way of preventing transmission from mother to child is by preventing initial infection in the mother, through education and safe blood supplies.
Resources on street children

Publications

General


Street Youth and AIDS, published by the Federal Centre for AIDS, Health Protection Branch, Health and Welfare Canada, 301 Elgin St, Ottawa, Canada, K1A 0L2. An excellent study, based on good research.

An experience with street children, by Fabio Dallape, available from the Undugu Society of Kenya, PO Box 40417, Nairobi, Kenya.

An international directory of projects working with street children. Price: £30.23 approx.

Child Workers in Asia, quarterly publication available from 4/68 Mooban Tawanna, Soi Puak Chit, Vipwadi Rangsit, Bangkok 10900, Thailand. Carries regular articles on street workers and child prostitutes (US$12.00 per year).

Prostitution

An international directory of projects for child victims of prostitution will be published in French, English and Spanish, early 1991 by the International Catholic Child Bureau, 65 rue de Lausanne, Geneva, Switzerland. It will contain details of health and sex education activities.

Human rights

AIDS and street children are human rights issues. Details of children's human rights issues can be obtained from: Defence for Children International (DCI), Case Postale 85, CH 1211 Geneva 20, Switzerland. DCI publishes Children's Rights Monitor, a quarterly publication in French, English and Spanish. There is likely to be a local DCI organisation in your country. DCI Geneva can supply details.

AIDS education

Help with changing health workers' attitudes towards AIDS and sex education is found in Working with Uncertainty by Hilary Dixon and Peter Gordon, available from: Cambridge Health Promotion and AIDS Service Training Department, Addenbrooke's Hospital, Hills Road, Cambridge CB2 2QQ, UK (price around £13.00. 2nd edition). Another useful booklet on this area is Talking AIDS: a guide for community work by Tony Klouda and Gill Gordon, available from TALC, PO Box 49, St Albans, Herts, AL1 4AX, UK. (price £1.25).

Sources of information

You can find out more about the work of many other researchers and street workers, including details of organisations run by children themselves, by contacting the international database on street children at: Streetwise International, The Old Maltings, Green Lane, Linton, Cambridge CB1 6JT, UK.

Another organisation to contact is Street Kids International (SKI), 56 The Esplanade, Suite 202, Toronto M5E 1A7, Canada. Based in Canada, SKI started its activities with street children in Khartoum. See educational materials below.

Educational materials

Street Kids International (see above) has produced an animated cartoon video on AIDS called Survivors, for use with street children. It features a Karate street hero and tells the story of two boys living on the street, one of whom becomes infected with HIV and dies of AIDS. SKI have also produced an educator's manual to accompany this video, entitled The Karate Kids. Both video and manual are available from Street Kids International. Other language editions are available.

The Child-to-child Programme at the Institute of Child Health, 30 Guilford St, London WC1, UK, have produced activity worksheets to help children make their own health decisions such as Smoking: Think for Yourself and Deadly Habits (on drug use, smoking and STDs). Available from: TALC, PO Box 49, St Albans, Herts, AL1 4AX, UK.

Free factsheets on Street children and AIDS/HIV and Streetgirls available from: Childhope USA, 333 East 38th St, New York, NY 10015, USA.

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Using audio-visuals in health education

Simone Chaze, consultant to the Global Programme on AIDS, provides some practical hints on how to get the best out of using film and video in health education.

Before using film or video for health education, consider the following:

- Is the intended audience used to watching films? Does the community have more traditional, and possibly more effective, ways of communicating e.g. through dance, theatre or puppets?

Do not assume that video film is always the best way of educating people.

Are you showing the right film?

Always watch the film yourself before you show it to a group of others. Make sure it is relevant for the audience and for their culture. Cultural differences can mean that people do not understand the message properly. Do not forget that the impact of the film comes primarily from the visual style, rather than the content of the verbal message. The tone of the film (whether it is terrifying, aggressive or intellectual) will also affect the film’s impact.

You need to bear in mind that those watching a film receive its messages, impressions and information at several different levels:

- **content of the script** is the vocabulary appropriate and understandable? Do the tone, music and spoken messages used go well together or are they disjointed?
- **visual images** are they acceptable and understandable to the audience? If you are in any doubt, try a test viewing with a few people.

The length of the film is an important consideration. About 10-15 minutes is the maximum attention span. Beyond 30 minutes, it is difficult to keep the interest and attention of the audience.

Do you have the right equipment?

- Are the specifications of the video-cassette and the video recorder compatible? For example, you cannot use a Betamax cassette with a VHS machine.
- Is the video recorder available for use on the required day at the required time?
- Can the room used for video showing be easily darkened?
- Is the cable long enough to position the video equipment so that everyone can see and hear clearly?
- Check the local availability of electricity.

One TV screen is sufficient for a small audience up to about 30 people; several TV screens can be synchronised for a simultaneous showing in a large room. But for most large audiences (more than 50 people) consider using a cine-film. If you do not have a portable film screen, use a blank wall.

Presenting the film

Be brief. Talk about the film’s length, its origins, theme and subject matter. Say why you are showing it, and how it is linked to the objectives of the meeting or the training course. Where appropriate, mention the aspects of the film you want particularly to be noted. Run through some of the film’s important points. An audience not used to audio-visual technology could be distracted by the technology itself.

The intention of showing a film is not only to get a message across; you are also trying to provoke verbal and emotional reactions which will open discussion. The film projection must therefore be arranged to allow time for discussion. Never stifle discussion by showing the film and then immediately closing the meeting/session.

There are different ways to use

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One small TV screen is not sufficient for large audiences.
Presenting information

You can use videos to complement or illustrate a discussion, by showing a film that gives information on a specific topic, such as the AIDS virus, and how it works. This may include the testimony of someone infected with AIDS, for example. After showing the film give the audience time to express their emotions and give spontaneous reactions. Respect their silence. Then get the discussion going with an open question, such as: 'Now that you’ve seen the film, how easy do you think it is to become infected with HIV?' Make sure the audience has understood the film's message, and see if you need to clarify or give more information. Then the discussion can be broadened to cover aspects which directly affect the audience.

As a teaching aid

The video film is an excellent teaching aid. You can flick forwards and backwards, stop the film for discussion, analyse the script and the visual images.

The course leader should make a guide for him/herself to steer the group through the analysis; cutting the film into sections, stopping the film when it seems necessary. The leader must know the film well and guide the participants without losing sight of the training objectives.

Training teachers

Video film can be used for practical exercises and to experiment with the effectiveness of teaching methods. For example, you could ask the trainee teacher to work alone on a section of the film; put together a guide for discussion; list the elements which s/he wants to highlight and give reasons; and show how s/he would lead the discussion. You could invite a trainee to adapt use of the film for different target audiences, and to identify sections to be cut or added. A film can be used to organise other teaching sessions by adapting it into a sketch, cartoon or play.

Evaluating AIDS health promotion

Nina Ferencic, from the Health Promotion Unit of the Global Programme on AIDS, gives some practical guidelines on approaching the evaluation of health promotion programmes.

It has been stated many times: health promotion is the key to preventing the further spread of HIV. And it can lessen the emotional, social and economic impact of the epidemic. But how can we be sure of this? The answer lies in effective evaluation. Evaluation must be an integral part of health promotion programmes, in order to assess their efficiency and effectiveness.

What is health promotion?

Health promotion aims to change the behaviour of individuals and society with the aim of improving health. Effective AIDS health promotion combines what is known about AIDS with communication, information and education strategies designed to change behaviour, create a supportive environment for that behaviour change, help stir public policies and secure the social services and resources necessary for positive change. Health promotion relies on many different channels of information and education to achieve a sustained impact on public health.

What is evaluation?

Evaluation is a valuable tool for programme planning and decision making. In order to be effective, AIDS health promotion programmes should be based on a set of informed decisions, resulting from ongoing evaluation. This implies two things. One, that programmes should be flexible enough to adapt to new insights and recommendations arising from evaluation research; and two, that evaluation must provide timely feedback to programme decision-making in a straightforward and appropriate manner.

One of the main purposes of evaluation is to answer practical questions about programme functioning and effectiveness, which can help to reorganise the programme if necessary. Evaluation should not only reveal whether the programme is achieving the desired results, but might also question the programme aims.

Evaluation should also be applicable to day-to-day decision making, to help bring about changes that are necessary. There is no point knowing about the impact of a programme once it is over, when the information cannot be used to improve it. Although most programmes would benefit from evaluation, there are often limited financial and personnel resources available to carry it out.

Approaching evaluation

The decision to evaluate is usually a joint one made by a programme and its participants, together with a ministry, department, organisation or funding agency.

The objectives and expectations of the evaluation need to be clearly agreed by all those concerned. Before evaluation begins it is also necessary to come to an agreement about what the current programme objectives are, and which objectives are to be evaluated.

Avoiding suspicion

An evaluation process can be resented or viewed as threatening by programme staff, who may feel that the results will be used to criticise their work. To avoid misunderstanding and suspicion, evaluators must understand the details, aims and limitations of the programme itself, and the difficulties involved in its current functioning. Evaluators must also clearly explain the purpose and methods of the evaluation to programme staff, and how the information gained will be used. Remember, it is usually the programme which is to be evaluated, not the programme staff!

Information gathering

Most programmes require some basic information about their aims, such as: who are the health messages aimed
Evaluation reports should be kept short and simple, containing practical recommendations of use to day-to-day programme decision-making.

Assessing comprehension of the message

Although people may have seen or heard health messages, they do not necessarily understand them. An evaluation must find out whether people in the target audience understand the message and see it as relevant to them individually. For example, do they understand that they have to use a new condom every time they have sexual intercourse? Do they understand where they can obtain condoms? Do they understand what condoms are?

Changes in knowledge and attitude may show that an information campaign has had immediate effect; changes in practice, however, may be impeded by factors beyond the control of the programme - such as poor health services, inadequate supplies of condoms, or other factors. It is therefore essential that evaluation results are interpreted, keeping in mind the broader social, cultural and economic context.

Carrying out the evaluation

In addition to deciding what to evaluate, it is necessary to decide how to carry out the evaluation. A number of designs and methods can be used, such as carrying out epidemiological surveys, face-to-face interviews, focus group discussions; taping and analysing workshops; analysis of existing programme information (records, reports, diaries); measuring frequency and scope of publicised health messages; asking verbal or written questions. A decision has to be made about what level or complexity of evaluation is required:

- How complex is the research method to be?
- How will the results be analysed? e.g. are computers available?
- How big a sample should be taken?
- How detailed should a questionnaire be?

More ambitious and large-scale evaluation activities are more expensive, since they involve more time (and often more material resources) to carry out. The choice of evaluation technique will depend on the time, expertise, personnel and financial resources available. However, the most sophisticated procedures are not necessarily the best. It is more important to have an appropriate quality of evaluation, adjusted to the purpose of the evaluation and the level of confidence that the evaluators need to have in the results. In addition, evaluators should be cautious in the use of their results: such as avoiding the assumption that changes in behaviour are caused only by the existence of the programme, or that a small-scale evaluation applies to a wider programme or group of people.

In general, evaluation of health promotion programmes should be kept simple and to the point, with the primary objective of improving the health promotion activities concerned.

Further reading


Partners in Evaluation: evaluating development and community programmes with participants, by Marie-Thérèse Feuerstein. Available from: Teaching Aids at Low Cost (TALC), PO Box 49, St Albans, Herts AL1 4AX, UK. Price: £3.00 inc p&p.
Educating youth

The following is a brief guide to research and educational activities with youngsters in and out of school, co-ordinated by the Global Programme on AIDS:

In school

- In co-operation with UNESCO, pilot health promotion and educational projects have started in Sierra Leone, Ethiopia, Jamaica, Tanzania, Mauritius and the Western Pacific. The overall objective is to develop and evaluate strategies for effective health promotion in schools, and to encourage collaborative work among ministries, non-government organisations (NGOs), youth and teacher organisations. A WHO/UNESCO Guide for School Health Education to Prevent AIDS and Sexually Transmitted Diseases will be available shortly from WHO/GPA (address below).

- A series of international and regional meetings have been held, including: regional seminar in Bangkok, February 1990, for Asia and the Pacific, co-organised with UNESCO, which provided the first occasion for top officials from ministries of health and education to meet and plan regional and national strategies; World Consultation of Teachers on AIDS education in Schools held in Paris, April 1990, co-organised with the International Labour Organisation; regional meeting in Ethiopia in May, to outline the development of a school curriculum and teacher-training programme for Africa.

Out of school

The emphasis at present is on promoting systematic, research-based approaches to health promotion.

- WHO/GPA is collecting and reviewing information about the experiences of existing youth and adolescent programmes around the world. A guide for setting up health promotion programmes will be developed by the end of 1991, as well as a series of programme modules. Prototype training materials will be developed and field-tested for use in institutional and non-institutional settings.

- Research and evaluation activities will be carried out, with the aim of assisting health educators to make the best use of their own research into developing effective health promotion messages, and using more effective channels of communication. As part of these planned activities, a Technical Working Group on reaching and communicating with youth met in August 1990 in Geneva.

- A number of other activities have also taken place, for example, international training workshops for youth leaders organised jointly by WHO with the World Assembly of Youth in Cameroon and Barbados, and knowledge, attitudes and practice (KAP) surveys among young people conducted in Nigeria, Cyprus, United Kingdom and elsewhere.

Papers from meetings and reports of KAP surveys available on request from WHO/GPA.

World AIDS Day 1990 focus on women

Women and AIDS is to be the theme for World AIDS Day 1990. Dr Nakajima (Director General of WHO) said this focus will reflect the increasing impact of AIDS on women, as well as the crucial role that women play in preventing infection with the human immunodeficiency virus (HIV), and caring for people infected with HIV or who have AIDS. This event will be undertaken within the broader framework of women, health and development, particularly at the country level.

World AIDS Day aims to:

- heighten awareness about the risk of HIV infection and AIDS, especially in women;
- highlight the impact of HIV/AIDS on women around the world including medical, social and psychological aspects;
- strengthen AIDS prevention activities and programmes at all levels of society, especially as they concern women;
- promote respect and care for all HIV infected people and people with AIDS;
- contribute to a lasting dialogue, sustained activity and long term commitment among all people in countries around the world.

This annual event will also highlight the link between women's status within society and opportunities open to them for behavioural changes, and draw attention to the special concerns related to HIV and pregnancy, childbirth and raising children.

WHO estimates that at least eight to ten million people worldwide are now infected with HIV, and that approximately one third are women. Increases in the rate of HIV infection reflect the growing incidence of heterosexual transmission around the world. As a result, there will be an increasing rate of HIV infection, AIDS cases and deaths among women and children in the 1990s. During the 1980s, the HIV/AIDS pandemic caused an estimated 500,000 cases of AIDS in women and children, most of which have been unrecognised. During the 1990s, WHO estimates that the pandemic will kill an additional three million or more women and children. In addition, more than ten million uninfected children will be orphaned, because their HIV infected mothers and fathers will have died from AIDS.

Millions of people around the world participated in the second annual World AIDS Day on 1 December 1989 which focused on young people and AIDS. With events held in over 160 countries and at WHO offices around the world, it was the largest global day of information and activities against HIV/AIDS ever held.

WHO will provide the following materials for World AIDS Day 1990:

- World AIDS Day newsletters (containing ideas and guidelines for planning events)
- Special World AIDS Day poster and Action Kit
- Special issue of World Health Magazine on Women and AIDS
- Media materials on Women and AIDS
- Advice on working with the media.

If you are not already on the WHO World AIDS Day mailing list, contact: World Health Organization, GPA/PIO, 1211 Geneva 27, Switzerland.


- Top left photograph, showing a close-up of a European patient with AIDS, depicts skin lesions caused by molluscum contagiosum and not (as indicated) shingles.
- Photograph used to illustrate persistent generalised lymphadenopathy (PGL); a second arrow should have indicated symmetrical enlargement of the lymph glands on both sides of the patient's neck (in the photograph, the right side is less pronounced). Lumps associated with PGL are usually symmetrical, and the glands are firm, discrete and not tender. They are not usually very large and may be difficult to see. A lymphoma should be suspected where the lymph node enlargement is very pronounced, painful and asymmetrical.