

Universal Precautions to Prevent the Transmission of HIV

Description of the tool:

Universal infection-control precautions are practices that schools, like other organizations, need to follow to prevent a variety of diseases. Precautions should include policies on caring for wounds, cleaning-up blood spills and disposing of medical supplies. This tool describes the **standard precautions** to be taken in schools to prevent HIV transmission, along with a list of the supplies that the school will need in order to apply them.

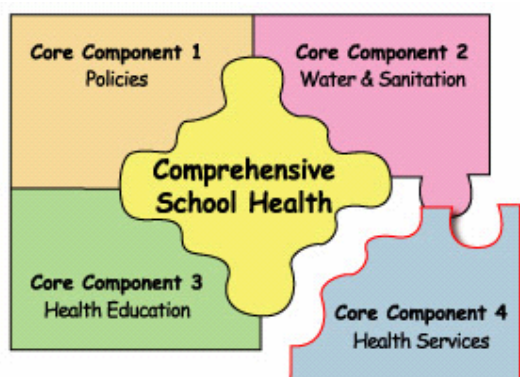
The information in this tool was adapted by UNESCO from the following publications:

Education International, WHO, UNESCO 2001. *Training and Resource Manual on School Health and HIV/STI Prevention*; and
WHO, UNAIDS, UNESCO, 1999. *WHO Information Series on School Health, Document Six: Preventing HIV/AIDS STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools*.

Description of the documents:

The first provides teachers and trade union leaders working in the field of HIV/AIDS prevention with resources and examples of interactive skill-building activities designed to strengthen their teaching and advocacy skills.

The second explains how HIV prevention programmes can be effective in reducing the risk of HIV infection among young people and offers suggestions as to how schools can work with the community to identify and implement appropriate and effective ways to prevent HIV infection among young people.



This information supports Core Component #4 of the FRESH framework for effective school health: **skills-based health education**. It will have a greater impact if it is reinforced by activities in the other three components of the framework.

Universal Precautions to Prevent the Transmission of HIV¹

Normal teaching and learning activities do not place anyone at risk for HIV infection, but accidents and injuries at school can produce situations where students or staff might be exposed to another person's body fluids. Because very often people do not know they are infected with HIV, and as it is not possible to tell someone is infected by the way he or she looks, school personnel should apply "universal precautions" to every person and every body fluid in every situation.

Universal infection-control precautions are practices that schools, like other organizations, need to follow to prevent a variety of diseases. Precautions should include policies on caring for wounds, cleaning-up blood spills and disposing of medical supplies.

While these precautions are valuable in preventing certain diseases, such as flu, chicken pox or ear infections, schools must recognize that HIV is more difficult to transmit. HIV and other sexually transmitted infections are not transmitted by casual contact, such as shaking hands, hugging, using toilet seats or sharing eating utensils. Even kissing or deep kissing does not transmit HIV.

Universal precautions are simply policies and procedures that schools establish and follow as safeguards during emergency situations. To reduce fear and discrimination, schools should inform all staff and students about the infection-control policy and address concerns through open discussion.

Standard precautions include:

1. Do not make direct contact with any person's blood or body fluids. **Wear gloves** when attending to someone who is bleeding or when cleaning up blood, vomit, faeces, pus, urine, non-intact skin or mucous membranes (eyes, nose, mouth). Gloves should be changed after each use. Learners should not touch blood or wounds but should ask for help from a staff member if there is an injury or nosebleed.
2. Stop any bleeding as quickly as possible. Apply pressure directly over the area with the nearest available cloth or towel. Unless the injured person is unconscious or very severely injured, they should be helped to do this themselves. In the case of a nosebleed, show how to apply pressure to the bridge of the nose.
3. Help injured person to wash graze or wound in clean water with antiseptic, if it is available, or household bleach diluted in water (1 part bleach, 9 parts water). Cover wounds with a waterproof dressing or plaster. Keep all wounds, sores, grazes or lesions (where the skin is split) covered at all times.
4. Wash hands or other skin surfaces that become exposed to blood or other body fluids immediately and thoroughly. Hands should be washed immediately after gloves are removed. Cleaning should be done with running water. If this is not available, pour clean water from a container over the area to be cleaned. If antiseptic is available, clean the area with antiseptic. If not, use household bleach diluted in water (1 part bleach, 9 parts water). If blood has splashed on the face, particularly eyes or the mucous membranes of the nose and mouth, these should be flushed with running water for three minutes.

5. Wash contaminated surfaces or floors with bleach and water (1 part bleach, 9 parts water). Seal in a plastic bag and incinerate (burn to ashes) bandages and cloths that become bloody, or send them to an appropriate disposal firm. Any contaminated instruments or equipment should be washed, soaked in bleach for an hour and dried. Ensure that bathrooms and toilets are clean, hygienic and free from blood spills.
6. Every school must ensure that there are arrangements for the disposal of sanitary towels and tampons. All female staff and learners must know of these arrangements so that no other person has contact with these items.

Essential supplies include:

To prevent HIV transmission when accidents happen at school, each school should have the following supplies on hand at all times:

- **Two first aid kits, each containing:**
 - Four pairs of latex gloves (two medium, two large), *to be worn at all times when attending a person who is bleeding from injury or nosebleed.*
 - Four pairs of rubber household gloves (two medium, two large). Anyone who cleans blood from a surface or floor or from cloths should also wear gloves.
 - Materials to cover wounds, cuts or grazes (e.g., lint or gauze), waterproof plasters, disinfectant (e.g., household bleach), scissors, cotton wool, tape for securing dressings and tissues.
 - A mouthpiece, for mouth-to-mouth resuscitation. *Although saliva has not been implicated in HIV transmission, mouthpieces should be available to minimise the need for emergency mouth-to-mouth resuscitation.*
- **A bottle of household bleach**
- **A stock of plastic shopping bags checked for holes**

If there are no gloves available, plastic bags can be put on your hands, so long as they have no holes and care is taken not to get blood or cleaning water on the inside.
- **A container for pouring water**

If your school has no running water, a 25 litre drum of clean water should be kept at all times for use in emergencies.

¹ Adapted from Education International, WHO, UNESCO 2001. *Training and Resource Manual on School Health and HIV/STI Prevention*; and WHO, UNAIDS, UNESCO, 1999. *WHO Information Series on School Health, Document Six: Preventing HIV/AIDS STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools.*

Screening for Abuse among Pregnant Teenagers

Description of the tool:

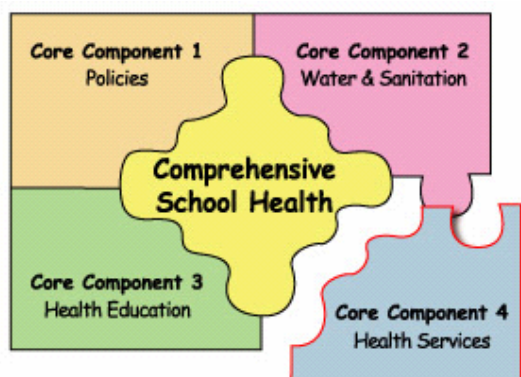
This tool provides basic techniques and a set of questions for school-based counsellors, clinicians, or teachers who work with pregnant teenagers, especially those who have been sexually or physically abused.

The information in this tool was adapted by UNESCO in collaboration with Health and Human Development Programs at Education Development Center, Inc. from the following publication:

Guard, A. (1997). *Violence and teen pregnancy: A resource guide for MCH practitioners*. Newton, MA: Children's Safety Network, Education Development Center, Inc.

Description of the document:

This guide provides information for health professionals and other practitioners working with adolescent girls on issues related to violence and teenage pregnancy. It describes the tools and techniques that have been developed to address the complex problems related to violence and teenage pregnancy.



This activity supports Core Component #4 of the FRESH framework for effective school health: **school health services**. It will have a greater impact if it is reinforced by activities in the other three components of the framework.

Screening for Abuse among Pregnant Teenagers ¹

Violence against pregnant women is a complicated and serious health problem. When abuse is directed against a pregnant teenager, the issue becomes even more complex because the risks of violence exist in conjunction with other adolescent health risks – delayed and sporadic prenatal care, inadequate nutrition, and use of alcohol and other drugs.

Teachers and other school staff members, such as school-based counsellors or clinicians, have a crucial role to play. They have numerous opportunities to communicate key prevention and intervention messages to and about adolescents. This tool provides information for teachers and other school staff members on how to deal with pregnant teenagers, especially those who suffer from violence.

I. What to Look for

There are many potential signs of abuse among pregnant girls. Some of the more frequently observed indications are:

- injuries to the face, breasts, genitals, or abdomen
- injuries to the hands and forearms (from warding off blows)
- old injuries, such as bruises, burns, and fractures
- delays in seeking care for injuries
- injuries inconsistent with the offered explanation
- late or sporadic prenatal care and frequently missed prenatal appointments
- a partner or family member who answers for the teen or refuses to let her be seen alone
- a history of sexually transmitted infections (STIs) and pelvic inflammatory disease
- depression
- evidence of sexual assault

The teenager's injuries and other evidence of abuse should be carefully documented with body maps, photographs, and written notes so that her medical record is complete and can be used as evidence should she decide to pursue the matter in court. It also gives future providers important information for her care.

II. How to Ask and Respond

Many domestic violence protocols suggest using direct questions, such as "Has a partner ever hit, kicked, or otherwise hurt or threatened you?" Others suggest something like this: "Violence is a common event in the lives of many of my clients. Is anyone in your life hurting you?"

Screening and counselling for adolescents need to be open-ended enough to allow for unexpected and multiple answers. Ask specifically whether anyone else, besides the partner, has hurt her. Too much emphasis on a boyfriend may exclude disclosure of abuse by family members or others.

Many teenagers will not feel comfortable disclosing abuse at the first opportunity. One study has suggested that in this situation, you may want to say, "Talking about abuse isn't easy. You may not be ready today. When you are, we're here to listen."

Some nurses report that they prompt more disclosure when they use a structured screening method, whilst others recommend a more open-ended approach. Use of either approach may depend in part on the practitioner's own comfort level and experience with broaching the subject.

Domestic violence lawyers recommend that, when they are counselling, providers should listen and ask questions in a non-judgmental way, acknowledge the young woman's feelings, and remind her that she does not deserve this treatment. Provide her with referrals and information on legal options (calling the police, pressing charges, taking out restraining orders, etc.). Restraining orders should include the teenager's home, school, and workplace in order to provide her with more complete protection.

It is important to express care and concern for the pregnant girl herself, not only for her baby. A research study has suggested, "Views of violence against women often are cast in terms of how it puts *others* at risk (such as, the police officers who intervene to try to stop it, the children who witness it, or the fetuses who are aborted because of it) rather than in terms of the danger to the woman."

III. Issues to Address

- **Ask about past abuse**

Remember, the strongest predictor for future abuse is a history of abuse. If the young person has been beaten before becoming pregnant, she may well be at risk again.

- **Include sexual abuse in your school's definition of abuse**

Sometimes battered women are forced to engage in unwanted sexual activities. Pregnant women are not immune to these assaults. Indeed, sexual assault cannot be completely separated from domestic violence. This connection is starkly shown by a recent study that asked women infected with HIV what happened when they revealed that they had contracted the virus. Some of the partners responded by beating and raping them. Conversely, sexual abuse is often the cause of premature pregnancy among young girls.

- **Ask whether the teenager needs help disclosing her pregnancy**

Caregivers responsible for providing pregnancy test results to teenagers should ask whether the girl needs assistance in sharing this news with her partner or guardian. If

needed, elements of a safety plan should be incorporated into the girl's plan for disclosing the pregnancy.

- **Ask whether the abuse has been escalating**

Are the incidents becoming more frequent? More severe? Are the threats becoming more explicit or more violent? Is the batterer threatening to commit suicide? Use the attached Danger Assessment to assist with these questions.

- **Ask about weapons**

The presence of a firearm adds to the peril in which an abused woman or girl lives. A number of localities have recognised and responded to this hazard by confiscating firearms from defendants who are under restraining orders or orders of protection. It is, therefore, important to restrict a person convicted of domestic violence or abuse from having a firearm.

- **Understand her reasons to stay or leave**

Pregnancy is a time when some women want to stay connected with their partners, despite the abuse, whilst others will be motivated to leave. Shelter workers have noted that residents will often express the desire to reconcile so that the baby will know its father. In addition, financial, social, emotional, or familial interests may give her a strong incentive to stay in the relationship.

However, the risk of abuse during her pregnancy can also motivate a woman to leave in order to protect her unborn child. Counsellors and providers can help the pregnant teen develop a clear understanding of her situation, the risks she confronts, and the options available to her so that she can make an informed decision.

IV. When to Ask

Ask *several times*, in different trimesters, if possible. Many available statistics on rates of violence during pregnancy were derived from studies in which women were only asked once during their pregnancy. In programmes that screened the women more than once, the rates were even higher. By making these questions a routine and regular part of care, both provider and client will become more comfortable with the subject and with each other. An atmosphere of trust helps teens talk about difficult subjects. Finally, multiple screenings allow for a more rapid response to any initiation of abuse.

A fourfold approach is needed:

1. All patients, not simply those presenting injuries, need to be screened at some time for violent victimization. Routine screening has the advantage of alerting all women to the possibility of abuse and of increasing the likelihood that abuse will be detected early on. In addition, it allows time for a relationship of trust to develop between the client and the provider.
2. Pregnant girls and women should be screened *regularly* for abuse as part of their ongoing prenatal care. Used consistently, screening tools and protocols can help providers incorporate violence screening, counselling, and referral into their daily practice.
3. Victims of abuse need to be screened and tested for pregnancy. Too often, the pregnancy goes undetected, leading to delayed prenatal care and inattention to other health risks.

4. A history of abuse should be recognised as a risk factor for current or future abuse.

V. Screening for Pregnancy

Bear in mind that many pregnant teenagers deny or are unaware that they are pregnant. The question, "Are you sexually active?" may be too vague for some girls, as many teenagers – both boys and girls – are psychologically unprepared to acknowledge or deal with the consequences of being sexually active.

Teenagers often delay testing for pregnancy if they suspect they might have a positive result. Psychological barriers, in particular, fear and reluctance to acknowledge the pregnancy, were named in one study as the most important factors for which teens delayed testing. Procrastination leads to delayed decision-making and late entry into prenatal care.

The role of schools to reach teenagers who are reluctant and encourage them to volunteer for screening and testing for both pregnancy and abuse is critical. Schools are the best placed to provide psychosocial and emotional support to teenagers so that they can share their grievances and problems with teachers and counsellors.

Attachment:

Danger Assessment Instrument²

Several risk factors have been associated with increased risk of murder for women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of murder in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please note down the approximate dates during the past year when you were abused by your partner or ex-partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing, no injuries and/or lasting pain
2. Punching, kicking, bruises, cuts, and/or continuing pain
3. "Beating up," severe bruises, burns, broken bones
4. Threats to use a weapon, head injury, internal injury, permanent injury
5. Use of a weapon, wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Date	Type and severity of abuse

Write down “Yes” or “No” for each of the following.

("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

	1.	Has the physical violence increased in severity or frequency over the past year?
	2.	Does he own a gun?
	3.	Have you left him after living together during the past year? (If you have <i>never</i> lived with him, check here ___)
	4.	Is he always looking for money?
	5.	Has he ever used a weapon against you or threatened you with a weapon? (If yes, was the weapon a gun? ____)
	6.	Does he threaten to kill you?
	7.	Has he avoided being arrested for any kind of violence?
	8.	Do you have a child who is not his?
	9.	Has he ever forced you to have sex when you didn't want to?
	10.	Does he ever try to choke you?
	11.	Does he use illegal drugs?
	12.	Is he an alcoholic or problem drinker?
	13.	Does he control or try to control most or all of your daily activities? For instance, does he tell you whom you can be friends with, when you can see your family, and how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ____)

14.	Is he violently and constantly jealous of you? (For instance, does he say, "If I can't have you, no one can.")?
15.	Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ____)
16.	Have you ever threatened or tried to commit suicide?
17.	Has he ever threatened or tried to commit suicide?
18.	Does he threaten to harm your children? (If you don't have children, check here: ____)
19.	Do you believe he is capable of killing you?
20.	Does he follow you or spy on you, leave threatening notes or messages on your answering machine, destroy your property, or call you when you don't want him to?

_____ Total "Yes" Answers

Thank you. Please talk to your teacher or counsellor about what the Danger Assessment means in terms of your situation.

¹ Guard, A. (1997). *Violence and teen pregnancy: A resource guide for MCH practitioners*. Newton, MA: Children's Safety Network, Education Development Center, Inc.

² Adapted from Campbell, J.C. (2003). *Danger Assessment*.
<http://www.son.jhmi.edu/research/CNR/Homicide/DANGER.htm>

Characteristics of Youth-Friendly Services

Description of the tool:

Given the growing recognition that “youth-friendly” services are needed if young people are to be adequately provided with reproductive health care, this tool is designed to help teachers, counsellors, service providers and other staff working in schools and HIV/AIDS or reproductive health clinics to improve their existing services for students at risk and make them “youth-friendly”.

The information in this tool was adapted by UNESCO in collaboration with Health and Human Development Programs at Education Development Center, Inc. from the following publication:

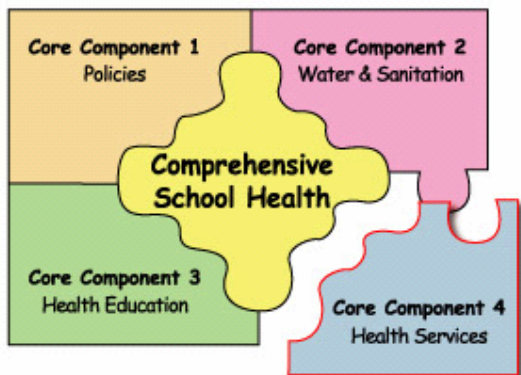
FOCUS on Young Adults 1999. *Making Reproductive Health Services Youth Friendly*. Washington, D.C.: Focus on Young Adults.

The full text of this document is available at the following website address:

http://www.dec.org/pdf_docs/PNACK127.pdf

Description of the document:

The document focuses on providing information to establish and implement “youth-friendly” reproductive health care services, including those for HIV/AIDS. Such services are able to effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining these young clients for continuing care. Whether services are provided in a clinical setting, in a youth centre or at a workplace or through outreach to informal venues, certain youth-friendly characteristics are essential to effective programs, such as specially trained providers, privacy, confidentiality, and accessibility.



This information supports Core Component #4 of the FRESH framework for effective school health: **school health services**. It will have a greater impact if it is reinforced by activities in the other three components of the framework.

Characteristics of Youth-Friendly Services¹

Services can be said to be “youth-friendly” if they have policies and attributes that attract young people to the facility or programme and provide them with a comfortable and appropriate setting. These types of services meet the needs of students and young people and encourage them to follow up their visits.

Some of the adaptations and additions needed to make services “youth-friendly” have been identified by adolescents themselves. Others have been identified by service professionals, including some that have been evaluated as part of an overall effort to provide effective reproductive health and HIV/AIDS services for young people.

School health facilities that hope to attract, serve, and retain young students have to consider a whole array of adjustments and additions that relate to provider, facility, and design characteristics. Whilst some are relatively minor and others more extensive, some potential changes may vary in importance according to the target audience, which would suggest that a needs assessment should be undertaken before any choice is made about changes.

I. Provider Characteristics

- *Specially trained staff*

Having special staff trained to work competently and sensitively with young people is often considered the single most important prerequisite for establishing youth-friendly services. Acquired skills must include familiarity with adolescent physiology and development, as well as appropriate medical options according to age and maturity. Refresher courses must be made available to keep staff members informed and their skills up-to-date.

Equally important are interpersonal skills so that young people can feel at ease and have no qualms about talking of their needs and concerns. This objective is sometimes achieved when providers are close in age to the student or the same sex.

The ability to speak the same language as the young people attending a given clinic is also important. In addition to those providing counselling and medical services to adolescents, other staff members should demonstrate positive attitudes towards these clients and focus on young people's special concerns. Of particular importance is the attitude of the receptionist, who is usually the first point of contact.

- *Respect for young people and students*

Respect can be fostered within a training exercise; however, some providers bring deeply entrenched biases against adolescent sexual activity to their job or find it difficult to relate to adolescents with respect. Staff members responsible for the selection of trainees, staff and supervisors who will work with young people should carefully consider such attitudes.

- *Privacy and confidentiality honoured*

Privacy and confidentiality are extremely important to young people. Counselling sessions and examinations must be private, and young people must feel confident that their concerns will not be spoken of to others. For example, that the nurse will not tell their mothers that they came to the clinic for reproductive health and HIV/AIDS care.

- *Adequate time for client and provider interaction*

Students and young people tend to need more time than adults to open up and reveal personal concerns. They are usually frightened about coming to the clinic with, often worrying about being pregnant, and need reassurance and active encouragement to speak freely.

Time is needed to discuss myths, such as girls cannot get pregnant the first time they have intercourse, and to dispel them. When possible, clinicians and counsellors should schedule more time with young people than with adults.

Providers should be able to handle questions about body image and development, sex, relationships, sex and condom negotiation, as well as to explain contraceptive methods, their side effects and management.

- *Peer counsellors available*

Evidence indicates that many young people prefer talking to their peers about sensitive issues, although they also tend to believe that health care professionals *know more* about technical issues. It is productive, therefore, to have peer counsellors available as alternatives or to supplement some aspects of the counselling activities.

One U.S. study showed that in a clinical setting, trained peer counsellors aged 17 and 18 were able to foster contraceptive compliance among sexually experienced young people more positively than nurses aged 26 to 29.

II. Health Facility Characteristics

- *Separate space and special times set aside*

Offering separate space, special times, or both seem important for some young people, such as first-time clinic users, students who are not sexually active, and marginalized students who are especially suspicious of mainstream healthcare. A separate service also facilitates providers' efficiency in arranging youth-friendly features, but before considering this, a needs assessment amongst a diverse group of probable users should be conducted.

- *Convenient hours*

Opening clinics at times when young people can conveniently attend, i.e. e., late afternoons, evenings, and weekends, is a must for to effective recruitment. Whilst young people needing urgent care may be willing to leave class, those who need prevention services (but may be unaware of how important they are) are more reluctant to take the time off.

- *Adequate space and sufficient privacy*

Adequate space is needed so that counselling and examinations can take place out of sight and sound of other people. This means separate rooms with doors and a non-intrusion policy. A provider-youth client study in Zimbabwe showed that, although counselling took place in a separate room in most clinics (92%), people could overhear 23% of the sessions and could see what was happening during 32% of the sessions. More than one-third (36%) of the sessions were interrupted by other staff members.

- *Comfortable surroundings*

The service environment will vary according to the target audience. In general, young people prefer a comfortable setting with posters or décor that matches their tastes and interests, and is not too sterile. In Chile, when programme planners converted a cluster of homes into a clinic the healthcare providers wore street clothes instead of “medical whites” so as to maintain a “demedicalized” atmosphere.

III. Programme Design Characteristics

- *Youth involvement in design and continuing feedback*

The participation of young people in identifying their needs and preferences for meeting those needs is fundamental in designing youth-friendly services. Characteristics such as privacy, confidentiality, and respectful treatment are nearly always top priorities.

Other features, such as separating the clinic from other services, and the presence of peer counsellors, will vary according to the cultural context or specific norms of the target population. In addition to creating an environment more likely to meet their needs, involving youth in the design of the programme and in continuous feedback will enhance their “ownership” of the programme. A feeling that will motivate young people to recruit their peers and to advise on adjustments.

- *Drop-in clients welcomed, and appointments arranged rapidly*

Because adolescents rarely plan ahead, the possibility of being seen without an appointment can increase adolescent attendance. If an adolescent is turned away and told to return at another time, or must wait several weeks to be seen after making an appointment, the likelihood that he or she will not show up is much greater.

- *No overcrowding and short waiting times*

Young people do not like to wait a long time for attention in a clinic and may even choose not to wait. They may even tell their peers about this, which gives the facility a bad reputation and dissuades future clients.

- *Affordable fees*

Cost can be a significant barrier. Services must be offered free or at low cost, possibly on a sliding scale, including credit and flexible payment options.

- *Publicity and recruitment that inform and reassure students*

Students have to know that clinics and other service programmes exist and where they are located, but they also have to know what services are provided and be assured that they are welcome and will be treated with respect and in confidence.

This information can be posted up in school corridors and other central locations. Announcements should set out the services offered, locations and opening hours of the clinics. Teachers or staff from the clinics could inform students about the availability of programmes and services.

Recruitment is often best handled by young people, both formally (such as distributing printed information or making presentations) and informally (by word of mouth). Satisfied clients offer the best recommendations for use of a particular service.

- *Boys and young men welcomed and served*

Although it is not possible in all societies, welcoming male partners can, where feasible, prove beneficial. When a young woman's boyfriend is willing to go with her to the clinic, then this can be an important element in her decision to seek services.

Furthermore, when young men are present this provides opportunities to encourage shared responsibility for decision-making and contraception, and to satisfy their needs for reproductive health and HIV/AIDS information, counselling, and services.

Designing programmes especially for young males that are sensitive to their values, motivations, feelings, and cultural influences while encouraging equitable male and female relationships would be very beneficial. Other outreach programmes targeting young men, especially those involving condom distribution, STI (Sexually Transmitted Infections) and HIV prevention have proved successful.

- *Wide range of services available*

Students will feel more confident about receiving the care they need the greater the number of their health needs that can be met within the facility or programme. Whenever students have to be sent somewhere else for another service the risk of their not showing up increases.

Whenever possible, there should be an attempt to identify and provide the most needed reproductive health or HIV/AIDS services as "one-stop shopping." Such services should include sexual and reproductive health counselling, contraceptive counselling and emergency contraception, STI and HIV prevention, STI diagnosis and treatment, nutrition services, sexual abuse counselling, prenatal and postpartum care, abortion services and post-abortion care.

- *Necessary referrals available*

Whilst desirable, it is almost never possible to provide a service that meets all the needs of adolescents. For this reason it is important to be able to establish effective working arrangements with other agencies to ensure that young people receive the services they need and to ensure that referral sites provide appropriate, youth-friendly treatment.

III. Other Possible Characteristics

- *Educational material available on site and to take*

Some students prefer to learn about sensitive issues on their own, using written or audiovisual materials, because their level of discomfort can be too great to retain

information during a face-to-face session. Students can read through this sort of material while they are waiting to be seen. Some materials should be available for young people to take home so that they can look at them later, particularly if the topics are complicated.

- *Group discussions available*

Not all students feel comfortable discussing with their peers. However, this type of information exchange can be very productive. Because it helps adolescents to realize that they are not alone in their fears and can provide peer support in obtaining care or seeking solutions to problems.

- *Delay of pelvic examination and blood tests possible*

Some young women are very frightened of pelvic examinations, blood tests, or both and it is this fear that most probably deters many young women from going to a clinic and obtaining contraception.

An experimental programme in the United States called "Smart Start," increased the numbers of young people coming to a clinic by offering the option of delaying the requisite pelvic examination for six months but still being able to obtain oral or other contraceptives. Delaying the pelvic examination can encourage young women to return for family planning services.

IV. Examples of some preferred characteristics for services as identified by young people

- In a Caribbean study, young people described an ideal centre as one that offered many services, was open in the afternoon and evening with empathetic, knowledgeable and trustworthy counsellors, that did not look "like a clinic."
- In a Youth Information Centre, established as a pilot project by the Planned Parenthood Association of South Africa, young people identified the most important factors in clinic choice as staff attitude (95%); environment (location, decor, and atmosphere) (89%); contraceptive methods (85%); and opening hours (81%).
- A study about adolescent access to reproductive health information and services in Nicaragua and Kenya, reported that young people want confidential services (preferably outside their local area); good human treatment (trustworthy, non-punitive providers who specialize in dealing with youth); and counselling services in centres especially for young people.
- After conducting research with adolescents in Africa, Asia, Latin America, and the Caribbean, the International Centre for Research on Women recommends that reproductive health services be private, confidential, affordable, and accessible and staffed with sensitive service providers.
- A U.S. study on why adolescents decide to seek healthcare in general, 14 out of 15 top-ranked items pertained to providers. Six concerned interpersonal factors such as honesty, respect, and confidentiality and four pertained to infection control (showing adolescents' concern over HIV transmission).

- A U.S. adolescent clinic reported that the most important reasons young people gave for their initial attendance were that the clinic was only for them and that the services were free. Other important factors were convenient scheduling and location, friendly staff, a clinic used by their peers, and confidentiality.

To sum up, the characteristics of reproductive health and HIV/AIDS services preferred by young people – including students – can depend on who is the user or what the clinical visit is about. For example, special opening hours or setting aside clinics for adolescents only are variously ranked high and low in importance by young people.

Nevertheless, even where special hours were not high on the list for clinic choices (in one U.S. study) young people who were virgins or had had their first experience of sexual intercourse two months before were more likely to enrol in a clinic with special hours set aside for young people. In Jamaica, a special evening clinic for youth attracted many first-time clients.

One suggestion is that young people, especially by at-risk youth, want this separate service to overcome their resistance to using the traditional healthcare system. Given cultural and other differences amongst young people, it is important to ask members of the intended audience specifically about their preferences for such services.

¹ FOCUS on Young Adults 1999. *Making Reproductive Health Services Youth Friendly*. Washington, D.C.: Focus on Young Adults. http://www.dec.org/pdf_docs/PNACK127.pdf

Making Effective Referrals for Students at Risk of Infection with HIV

Description of the tool:

This tool is designed for school staff and school-based service providers responsible for students' health care needs. It provides guidelines for assessing an individual's risk for HIV and other sexually transmitted infections, for making referrals to needed services, and for assuring the quality and efficacy of referral services.

The information in this tool was adapted by UNESCO in collaboration with Health and Human Development Programs at Education Development Center, Inc. from the following publication:

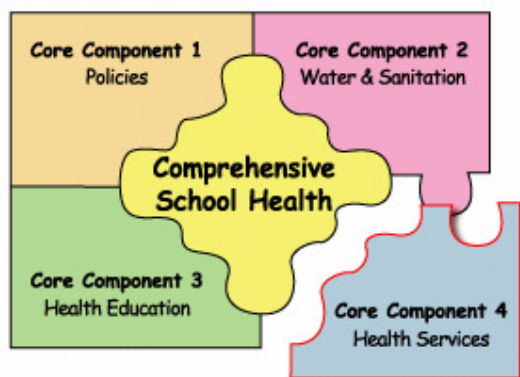
CDC Morbidity and Mortality Weekly Report (MMWR), 1999. Revised *Guidelines for HIV Counseling, Testing, and Referral*. Atlanta. CDC.

The full text of this document is available on CDC's website at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm#top>

Description of the document:

These guidelines have been developed for service providers who offer HIV counseling, testing, and referral (CTR). They are intended to be used to develop CTR policies and services in both traditional clinical settings as well as in schools and communities. As far as possible, the recommendations in this document are based on evidence from available scientific sources. Where scientific evidence is lacking, the 'best practices' recommended by specialists in the field have been used.



This information falls under Core Component #4 of the FRESH framework for effective school health: **school health services**. It will have a greater impact if it is reinforced by activities in the other three components of the framework.

Making Effective Referrals for Students at Risk of Infection with HIV¹

The following guidelines have been drawn up to help school staff or school-based service providers identify individuals' risk for HIV infection and develop effective systems for referring students to necessary services. When dealing with students or other young people, it is especially important to bear in mind that a variety of adolescent-specific factors, both psychological and situational, may inhibit them from going through with referrals and, therefore, from getting the help they need to remain HIV-free or cope with an HIV-positive diagnosis. Most schools will not provide the variety of health services that students at risk for HIV, or those already infected, desperately need. Teachers and other school staff can, however, play a critical role in protecting young people from the ravages of HIV and AIDS if they are properly trained to help students assess the risk related to specific behaviours, and if the school has established policies and procedures for making and following up on referrals to other specialized agencies.

1. Determine students' HIV risk

A student's individual HIV risk can be determined through risk screening based on self-reported behavioural risk and clinical signs or symptoms. Behavioural risks include injection-drug use or unprotected intercourse with a person at increased risk for HIV. Clinical signs and symptoms include the presence of sexually transmitted infections (STIs), which indicate increased risk for HIV infection, or other signs or symptoms (e.g., of acute retroviral or opportunistic infections) that might suggest the presence of HIV infection. Most people with HIV do not have any visible symptoms for many years. Once symptoms do begin to show, some of the more common ones include the following:

- Rapid weight loss
- Profuse night sweats
- Ongoing, unexplained fatigue
- Swollen lymph glands

- Diarrhoea that lasts longer than a week
- White spots or blemished in the mouth or throat
- Pneumonia

Do not assume that a student is infected if he or she has any of these symptoms as each of them can relate to other illnesses. The only way to determine if the student is infected with HIV/AIDS is to have him or her tested.

There is insufficient data to support the efficacy of any one approach to risk screening based on self-reported behavioural risk over others (e.g., face-to-face discussion or interviews, self-administered questionnaires, computer-assisted interviews, or simple open-ended questions asked by the staff member). The following two strategies can be used to elicit self-reported HIV risks:

- Open-ended questions by the staff member, for example:
 - “What are you doing now or what have you done in the past that you think may put you at risk for HIV infection?”
 - “Do you know how to reduce your risk of being infected with HIV?”
 - “Do you talk with your partner(s) about these issues?”
- Screening questions (i.e., a checklist) for use with a self-administered questionnaire, face-to-face or computer-assisted interview, or other instrument, for example:

“Since your last HIV test (if ever), have you . . .

- injected drugs and shared equipment (e.g., needles, syringes, cotton, water) with other people?
- had unprotected intercourse with someone you think might be infected (e.g., a partner who injected drugs, has been diagnosed or treated for a sexually transmitted infection (STI) or hepatitis, has had multiple or anonymous sex partners, or has exchanged sex for drugs or money)?’
- had unprotected vaginal or anal intercourse with more than one partner?’
- been diagnosed or treated for an STI, hepatitis, or tuberculosis?’
- had a fever or illness of unknown cause?’
- been told you have an infection related to a “weak immune system”?’

Anyone who responds affirmatively to any of the above questions should be considered at increased risk of HIV.

2. Implement effective referrals

Once a student’s HIV risk has been determined, he or she should receive help to accede to and receive needed services, and completion of referrals to such services should be verified. Within the context of HIV prevention counselling and testing, the following elements should be considered essential for the implementation of referral services.

- *Assess Student Referral Needs*

The school-based service provider should consult the student to identify essential factors (a) that are likely to influence his or her ability to adopt or sustain behaviours to reduce risk for HIV transmission or acquisition and (b) that promote health and prevent disease progression. Assessment should include examination of the student's willingness and ability to accept and complete a referral. Service referrals that match the student's self-identified priority needs are more likely to be successfully completed than those that do not. Priority should be placed on ensuring that HIV-infected students are assessed for referral needs related to medical care and prevention and support services aimed at reducing the risk for further transmission of HIV.

- *Plan the Referral*

Referral services should respond to students' needs and priorities and be appropriate to their culture, language, sex, sexual orientation, age, and developmental level. In consultation with students, teachers or relevant school staff should assess and address any factors that make completing the referral difficult (e.g., lack of transportation, school schedule, cost). Research indicates that referrals are more likely to be completed if services are easily accessible to students.

- *Help Students Access Referral Services*

Students should be given all information necessary to successfully access the referral service (e.g., contact name, eligibility requirements, location, opening hours, telephone number). Providing students with assistance (e.g., setting up an appointment, introducing the student to the counsellor at the referral agency, sorting out transport) will help in the completion of referrals. The consent of the students must be obtained before sharing identifying information to complete the referral. Teachers and peers can be an important help to students identifying needs and planning successful referrals.

- *Document Referral and Follow-Up*

School-based service providers or teachers should find out and make a note of whether the student accessed the referral services. If not, the school staff or teacher should find out why. If the student did go through with referral, the teacher or school staff should determine his or her degree of satisfaction. If the services were unsatisfactory, the school-based service provider should offer additional or different referrals. Documentation of referrals made, their status and student satisfaction with them should help school staff better meet the needs of students. Information obtained through follow-up of referrals can identify barriers to completing the referral, responsiveness of referral services in addressing student needs, and gaps in the system.

3. Ensure quality referral services

School-based service providers or teachers should know and understand the needs of their students, be aware of available community resources, and be able to provide services in a manner appropriate to the students' culture, language, sex, sexual orientation, age, and developmental level. To ensure quality referrals, staff members or teachers could consider including the following elements in planning for and implementing referral services:

- *Education and Support of Staff Members*

Staff members providing referral services must understand student needs, have the necessary skills and resources to address these needs, have the authority to help the student procure services, and be able to advocate for students.

- Training and Education:

Staff members in schools should receive adequate and appropriate training to implement and manage referrals. If no such training or education system is in place in the school, the school administrator must put the relevant staff member in contact with local departments or resources offering it. Local health departments, agencies responsible for AIDS prevention, and local offices of international agencies such as the Red Cross are helpful in arranging resources for education and training. Training and education should focus on what resources are available and the ways of managing referrals, as well as promote understanding of factors likely to influence the student's ability and willingness to use a referral service (e.g., readiness to accept the service, competing priorities, financial resources, etc.). Referrals are more likely to be completed when a staff member can correctly evaluate a student's readiness to adopt risk-reducing behaviours. Research indicates that cross-training increases knowledge and understanding of school-based and community resources among service providers and can point to gaps in services.

- Authority:

Staff members providing referrals must have the necessary authority to accomplish a referral. Supervisors or school administrators must ensure that staff members understand referral policy and protocol and have the necessary support to provide referrals. This means that one provider must have the authority to refer to another (e.g., through memoranda of agreement) or to obtain student consent for release of medical or other personal information.

- Advocacy:

Staff members who negotiate referrals must possess the knowledge and skills that are needed to advocate for students. This can help students obtain services by negotiating barriers to access to services and promoting an environment in which providers are better informed regarding students' needs and priorities.

- *Coordination and Collaboration*

School-based service providers should develop and maintain strong working relationships with other schools and agencies that might be able to provide needed services. Schools or schools-based service providers who offer HIV prevention counselling and testing but not a full range of medical and psychosocial support services should develop direct, clearly delineated arrangements with other providers who can offer them. Coordination and collaboration promote shared understanding of the specific medical and psychosocial needs of students requiring services, current resources available to address these needs, and gaps in resources.

Memoranda of agreement or other forms of formal agreement are useful in outlining provider/agency relationships and delineating the roles and responsibilities of collaborating schools and health care providers in managing referrals. When confidential

student information is shared between coordinating providers, such formal agreements are essential. These agreements should be reviewed periodically and modified as appropriate.

- *Referral Resources*

Knowledge of available support services is essential for successful referrals. When essential resources are not available on site, schools should identify appropriate resources and link students with them. A resource guide should be developed and maintained to help staff members make appropriate referrals. The resource guide should specify the following:

- Name of the provider or agency
- Range of services provided
- Target population
- Service area(s)
- Contact names and telephone and fax numbers, street addresses, e-mail addresses (if available)
- Opening hours
- Location
- Competence in providing services appropriate to the student's culture, language, sex, sexual orientation, age, and developmental level
- Cost of services and acceptable methods of payment
- Eligibility
- Application materials
- Admission policies and procedures
- Directions, transport information, and accessibility to public transport
- Student satisfaction with services

¹ CDC Morbidity and Mortality Weekly Report (MMWR), 1999. Revised *Guidelines for HIV Counseling, Testing, and Referral*. URL: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm#top>

Special Eating Needs of People Living with HIV/AIDS

Description of the tool:

This tool provides information for service providers and teachers about special eating needs for people, including young people, living with HIV/AIDS. The tool explains how HIV/AIDS affects food intake, food absorption, and body weight and what kind of nutrients and foods are needed for an infected person. Teachers could use it as an informational tool when designing class lessons for students aged 15 to 19 years of age.

The information in this tool was adapted by UNESCO in collaboration with Health and Human Development Programs at Education Development Center, Inc. from the following publication:

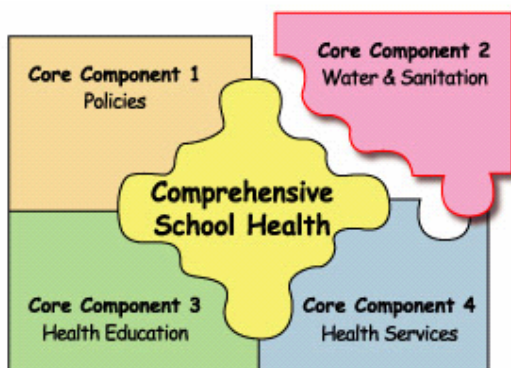
FAO 2002. *Living well with HIV/AIDS: A manual on nutritional care and support for people living with HIV/AIDS*. Rome: FAO.

The full text of the document is available on FAO's website at:

<http://www.fao.org/DOCREP/005/Y4168E/Y4168E00.HTM>

Description of the document:

Meeting immediate food, nutrition and other basic needs is essential if people with HIV/AIDS are to live with dignity and security. Providing for their nutritional care and support is important at all stages of the disease. This manual offers home care agents, local service providers and school staff some practical recommendations for a healthy and well balanced diet for people living with HIV/AIDS. It describes some of the common complications they can experience at different stages of infection and suggests local solutions that emphasize using local food resources and home-based care and support.



This information supports Core Component #2 of the FRESH framework for effective school health: **water, sanitation and the environment**. It will have a greater impact if it is reinforced by activities in the other three components of the framework.

Special Eating Needs of People Living with HIV/AIDS ¹

A person infected with HIV/AIDS who shows no signs of illness does not need a specific “HIV-diet.” However, they should make every effort to adopt a healthy and balanced diet to meet their increased protein and energy requirements and maintain their nutritional status. Once people with HIV/AIDS become ill they will have special needs.

People living with HIV/AIDS have increased nutrient needs

When infected with HIV, the body's defence system – the immune system – works harder to fight infection. This increases energy and nutrient requirements. Further infection and fever also increase the body's demand for food. Once people are infected with HIV they have to eat more to meet these extra energy and nutrient needs, which will increase even further as the HIV/AIDS symptoms progress.

HIV/AIDS reduces food intake

People with HIV/AIDS often do not eat enough because:

- the illness and the medicines taken for it may reduce the appetite, modify the taste of food and prevent the body from absorbing it;
- symptoms such as a sore mouth, nausea and vomiting make it difficult to eat;
- tiredness, isolation and depression reduce appetite and the willingness to make an effort to prepare food and eat regularly;
- there is not enough money to buy food.

HIV/AIDS reduces the absorption of food

Food, once eaten, is broken down by digestion into nutrients. These nutrients pass through the gut (bowel) walls into the bloodstream and are transported to the organs and tissues throughout the body where they are needed. One of the consequences of HIV and other infections is that when the gut wall is damaged, food does not pass through properly and consequently is not absorbed.

Diarrhoea is a common occurrence in people with HIV/AIDS. When a person has diarrhoea the food passes through the gut so quickly that it is not properly digested and fewer nutrients are absorbed.

Reduced food intake and absorption lead to weight loss and malnutrition.

HIV/AIDS affects weight

When someone does not eat enough food, or food is poorly absorbed, the body draws on its reserve stores of energy from body fat and of protein from muscle. As a result, the person loses weight because body weight and muscles are lost. Weight loss may be so gradual that it is not obvious. There are two basic ways to find out whether weight is being lost:

- Weigh the person on the same day once a week and keep a record of the weight and date. For an average adult, serious weight loss is indicated by a 10 percent loss of body weight or 6 kg to 7 kg in one month. If no scales are available at home, make an arrangement with a chemist, clinic or local health unit for a weekly weighing session.
- When clothes become loose and no longer fit properly.
- If someone loses weight they need to do something to increase weight to the normal level.

Gaining weight

Weight is gained by eating more food, either by eating larger portions and/or eating meals more frequently, using a variety of foods. Here are some suggestions for gaining weight:

- Eat more staple foods such as rice, maize, millet, sorghum, wheat, bread, potatoes, sweet potatoes, yams and bananas.
- Increase intake of beans, soy products, lentils, peas, groundnuts, peanut butter and seeds, such as sunflower and sesame.
- Include all forms of meat, poultry, fish and eggs as often as possible. Minced meat, chicken and fish are easier to digest. Offal (such as kidney and liver) can be the least expensive source.
- Eat snacks regularly between meals. Good snacks are nuts, seeds, fruit, yoghurt, carrots, cassava crisps, crab crisps and peanut butter sandwiches.
- Slowly increase the fat content of the food by using more fats and oils, as well as eating fatty foods – oilseeds such as groundnuts, soy and sesame, avocados and fatty meat. If problems with a high fat intake are experienced (especially diarrhoea), reduce the fat intake until the symptoms are over, and then gradually increase it to a level that the body can tolerate.
- Introduce more dairy products such as full-cream milk, sour milk, buttermilk, yoghurt and cheese into the diet.
- Add dry milk powder to foods such as porridge, cereals, sauces and mashed potatoes. However, do not use coffee and tea whiteners, which do not have the same nutritional benefits as milk. Note that some people may find milk difficult to digest. It should be avoided if it causes cramps, a feeling of being full or skin rashes.
- Add sugar, honey, jam, syrup and other sweet products to the food.
- Make meals as attractive as possible.

Increase the number of meals and snacks in a day. If poor appetite persists or the person is ill, it is a good idea to spread the food intake throughout the day. Snacks should be included in the daily meal plan.

- A snack is any readily available nutritious food that can be eaten without much preparation. Good snacks are nuts, seeds, fruit, yoghurt, carrots, cassava chips, crab chips and peanut butter sandwiches. With at least three meals a day and snacks in between, there is less likelihood of malnutrition or weight loss.
- Care-givers should ensure that sick members of the family are given preference, fed more frequently and receive extra servings to maintain their weight and strength. Food should be served in an attractive way.
- If someone needs to stay in bed, food and water should be kept within easy reach.

Exercise improves well-being. Regular exercise makes a person feel more alert, helps to relieve stress and stimulates the appetite. Exercise is the only way to strengthen and build up muscles. The body uses muscles to store energy and protein that the immune system can draw upon when required. Exercise is therefore especially important for maintaining the health of people with HIV/AIDS.

Everyday activities such as cleaning, working in the field and collecting firewood and water may provide enough exercise. If someone's work does not involve much exercise, an enjoyable exercise programme should be found that can be part of his or her daily life. Exercise should not be tiring or stressful. Gentle muscle-building exercise is recommended and walking, running, swimming, or dancing are all suitable. People with HIV/AIDS need to find the exercise that they enjoy and that suits their situation.

Prevent weight loss during and after illness. Infection increases the body's requirements for nutrients. Illness also reduces the appetite, causing weight loss.

Early treatment of infection is important to maintain body weight. If infection persists and cannot be cured by nutritional management within a couple of days, advice and treatment should be sought from a doctor, nutritionist, nurse or local health worker.

Once the infection is over and the person is feeling better, he or she should start eating normally again. It is important to regain the weight lost as soon as possible and to restore the body's nutritional reserves.

Increase vitamin and mineral intake

Vitamins and minerals are essential to keep healthy. They protect against opportunistic infections by ensuring that the skin, lungs and gut remain healthy and that the immune system functions properly. Of special importance are vitamin A, vitamin C, vitamin E, certain B-group vitamins and minerals such as selenium, zinc and iron. A mixed diet should provide enough of these vitamins and minerals.

Vitamin A is important to keep the skin, lungs and gut healthy. Vitamin A deficiency increases the severity of diseases such as diarrhoea. Infection will increase the loss of vitamin A from the body. Good vitamin A sources are dark green, yellow, orange and red vegetables and fruit. These include spinach, pumpkin, cassava leaves, green peppers, squash, carrots, amaranth, yellow peaches, apricots, papaya and mangoes. Vitamin A is also contained in red palm oil, yellow maize, orange and yellow sweet potatoes, egg yolks and liver.

Vitamin C helps to protect the body from infection and helps in recovery. It is found particularly in citrus fruits such as oranges, grapefruit, lemons and mandarins. Guavas, mangoes, tomatoes and potatoes are also good sources of vitamin C.

Vitamin E protects cells and helps resistance to infection. Foods containing vitamin E are green leafy vegetables, vegetable oils, peanuts and egg yolks.

Vitamin B-group is necessary to keep the immune and nervous system healthy. Vitamins, however, may be lost from the body through the use of certain medicines for the treatment of tuberculosis. Good food sources include white beans, potatoes, meat, fish, chicken, watermelon, maize, grains, nuts, avocados, broccoli and green leafy vegetables.

Iron-deficiency anaemia is a widespread problem in many countries, especially among women and children. Good iron sources are green leafy vegetables, seeds, whole-grain

products, dried fruit, sorghum, millet, beans, alfalfa, red meat, chicken, liver, fish, seafood and eggs.

Selenium is an important mineral because it helps to activate the immune system. Good sources include whole grains such as whole-meal bread, maize and millet and dairy products such as milk, yoghurt and cheese. Meat, fish, poultry, eggs and other protein-rich foods are also good sources, as are peanut butter, dried beans and nuts.

Zinc is also important for the immune system. Zinc deficiency reduces the appetite. Sources include meat, fish, poultry, shellfish, whole-grain cereals, maize, beans, peanuts and milk and dairy products.

Further recommendations

The vitamin content of food can be damaged during cooking, so it is better to boil, steam and fry vegetables for a short time only. Boil vegetables in a little water and use the water afterwards for cooking to retain considerable amounts of vitamins and minerals. Vegetables will lose some of their vitamins and minerals if soaked for a long time.

The skins and kernels of grains and legumes contain vitamins, in particular of the B-group. Processed refined grains have lost many of their vitamins, minerals and proteins so whole grains such as brown bread and unrefined cereals are better sources than white bread and refined cereals. Fortified cereals and bread are preferred because of their higher vitamin content. If a person has diarrhoea, however, whole unrefined grains and cereals should be avoided because these insoluble fibres make the diarrhoea worse. Soluble fibre foods such as bananas are recommended. Fibres are contained in many plant foods. Soluble fibres will bind water in the gut and reduce diarrhoea.

Micronutrient supplementation – what, how much and when?

When food intake is low, multivitamin and mineral supplements – often in the form of pills – can help to meet increased requirements. However, these supplements are often not available, and are expensive, leaving less money for food. Therefore, it is better to provide a good mixed diet whenever possible rather than buy supplements.

If supplements are considered necessary, the following guidelines should be adhered to:

- Discuss your intake of vitamin and mineral supplements with your health worker or nutritionist.
- Always take vitamin pills on a full stomach. Be consistent and take them regularly.
- It is probably cheaper to take a combined product with minerals rather than several pills containing different vitamins and minerals. However, iron may be a problem for people with HIV/AIDS because it can increase the activity of some bacteria. Therefore, supplements that do not contain iron are better.
- Take all vitamin or mineral supplementation according to the instructions on the label. More is not better. Taking high doses can cause nausea, vomiting, decreased appetite and liver and kidney problems and can interfere with the immune system. This is particularly true for vitamin A, vitamin E, zinc and iron.
- Micronutrient supplements can be useful but cannot replace eating a balanced and healthy diet.

¹ FAO 2002. *Living well with HIV/AIDS: A manual on nutritional care and support for people living with HIV/AIDS*. Rome. FAO. <http://www.fao.org/DOCREP/005/Y4168E/Y4168E00.HTM>