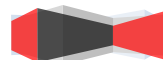


# **NATIONAL POLICY FOR THE MANAGEMENT OF HIV AND AIDS IN SCHOOLS**

**4th Draft March, 2010**

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## MESSAGES

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## GLOSSARY OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
ATRFMU	Advanced Training and Research in Fertility Management Unit
CARICOM	Caribbean Community
CBO	Community Based Organization
CCDC	Caribbean Child Development Centre
CDA	Child Development Agency
CXC	Caribbean Examinations Council
ESSJ	Economic and Social Survey of Jamaica
EU	European Union
FLE	Family Life Education
GOJ	Government of Jamaica
HEART/NTA	Human Empowerment and Resource Training/National Training Agency
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development
ILO	International Labour Organization
JTA	Jamaica Teachers Association
JBTE	Joint Board of Teacher Education
MOEY	Ministry of Education and Youth
MOH	Ministry of Health
NCYD	National Centre for Youth Development
NGO	Non-Governmental Organization
NSSC	National Secondary Students Council
OVC	Orphans and Vulnerable Children
PAHO	Pan-American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PATH	Programme for Advancement through Health and Education
PIOJ	Planning Institute of Jamaica
PTA	Parent Teachers Association
SDC	Social Development Commission
SESP	Social and Economic Support Programme
STATIN	Statistical Institute of Jamaica
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDCP	United Nations Drug Control Programme
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNIFEM	United Nations Development Fund for Women
UNFPA	United Nations Population Fund
UNODCA/UNDP	United Nations Office on Drugs and Crime/United Nations Development Programme
UWI HARP	University of the West Indies HIV/AIDS Response Programme
VCT	Voluntary Counselling and Testing
WHO	World Health Organization





## GLOSSARY OF TERMS

<b>Adolescence:</b>	The period from 10-19 years characterized by physical, biological and psychological development.
<b>Adult:</b>	A person aged 18 years and older.
<b>Advocacy:</b>	To solicit public support for a particular cause; trying to convince other people because you are convinced yourself.
<b>Affected persons:</b>	Persons whose lives are changed in any way by HIV/AIDS due to the broader impact of this epidemic.
<b>Age of Consent:</b>	The age at which a girl can legally consent to have sexual intercourse (currently age 16 as set out in the Offences Against the Person Act) The offence of carnal abuse is committed if the girl is under 16., It is a felony if she is under 12, and a misdemeanor if she is above 12 and under 16.
<b>Age of Criminal Responsibility:</b>	The minimum, age at which a child can be charged with a crime is 12 years.
<b>AIDS:</b>	the Acquired Immuno-Deficiency Syndrome, a cluster of medical conditions, often referred to as opportunistic infections and cancers and for which, to date, there is no cure.
<b>Behaviour Change:</b>	The process of improving or influencing a positive change in attitude and life style.
<b>Child:</b>	A person under the age of 18 years.
<b>Children's Home</b>	Dwelling house, institution or other place where 4 or more children are boarded and maintained by a person who is not their parent or guardian voluntarily or for a fee.
<b>Community of Persons with Disabilities:</b>	This term is used in this code in accordance with the definition given in the Vocational Rehabilitation and employment (Disabled persons) Convention, 1983 (No.159), namely individuals whose



prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment

<b>Discrimination:</b>	This term is used in this code in accordance with the definition given in the Discrimination (Employment and Occupation) Convention, 1958 (No. 111) to include HIV Status. It also includes discrimination on the basis of a worker's perceived HIV status, including discrimination on the ground of sexual orientation.
<b>Employee:</b>	An administrator, teacher or non-teaching support staff employed in an education institution or services
<b>Employer :</b>	a person or organization employing workers under a written or verbal contract of employment which establishes the rights and duties of both parties, in accordance with national law and practice. Governments, public authorities, private enterprises and individuals may be employers
<b>Employment:</b>	Engagement in any undertaking, trade or occupation, carried on for profit or gain, irrespective of whether the employment is free or for reward.
<b>Empowerment:</b>	The process of increasing the capacity to influence behaviour, emotions and lifestyle; it is the process of magnifying ability by whatever means are available.
<b>Felony</b>	An offence which is deemed to be very serious usually attracting a penalty such as a long custodial sentence or a large fine, e.g. sexual intercourse with a girl below 12 years, punishable by maximum life imprisonment.
<b>Gender</b>	All attributes associated with women and men, boys and girls, which are socially and culturally ascribed and which vary from one society to another and over time.
<b>Health Advisory Committee:</b>	
<b>HIV:</b>	The Human Immunodeficiency Virus, a virus that weakens the body's immune system, ultimately causing AIDS.
<b>Incarcerated:</b>	Youth in prison or remand centres whose freedom of movement is circumscribed by law.
<b>Institutionalised:</b>	Youth in places of safety and children's homes; this group includes youth who are wards of the state.



<b>Occupational Health Services:</b>	(OHS) is used in this code in accordance with the description in the Occupational Health Services Convention, 1985 (No.161), namely health services which have an essentially preventive function and which are responsible for advising the employer, as well as workers and their representatives, on the requirement for establishing and maintaining a safe and healthy working environment and work methods to facilitate optimal physical and mental health in relation to work. The OHS also provides advice on the adaptation of work to the capabilities of workers in the light of their physical and mental health.
<b>Parent:</b>	The biological and adoptive parents or custodians, or legal guardians of children
<b>Reasonable Accommodation</b>	Any modification or adjustment to a job or to the workplace that is reasonably practicable and will enable a person living with HIV or AIDS to have access to or participate or advance in employment.
<b>Screening:</b>	Measures to assess HIV status, whether direct (HIV testing) or indirect (assessment of risk-taking behaviour), asking questions about health or about medication used in this policy in the context of exclusion from employment or education
<b>Sex and Gender:</b>	There are both biological and social differences between males and females. The term 'sex' refers to biologically determined differences, while the term 'gender' refers to differences in social roles and relations between males and females. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are affected by age, class, race, ethnicity and religion, and by the geographical, economic and political environment.
<b>Sexual Abuse:</b>	Abuse of a person targeting their sexual organs e. g rape, touching their private parts or inserting objects into their private parts.
<b>Special Needs</b>	The label of "special needs" applies to mental or physical disabilities or circumstances that create an exceptional situation requiring individualized educational programs, physical accessibility or primary care requirements
<b>Street Children:</b>	Children 0-18 years who live or make their home on the streets where they carry out activities such as bathing, sleeping and eating.
<b>Stigma:</b>	A dynamic process of devaluation that significantly discredits an individual in the viewpoints of others



<b>Universal Precautions:</b>	A simple standard of infection control practice to be used to minimize the risk of blood-borne pathogens.
<b>Workplace:</b>	Occupational settings, stations and places where workers spend time for gainful employment.
<b>Window period:</b>	The period of up to three months before HIV antibodies appear in the blood following HIV infection. During this period HIV tests cannot determine whether a person is infected with HIV or not.
<b>Youth:</b>	Someone between the ages 15-24 who has passed through the dependent stage of childhood, in the semi-independence of adolescence or who will soon acquire the maturity of adulthood.

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## EXECUTIVE SUMMARY

### Introduction

HIV and AIDS has become a generalized epidemic in Jamaica that affects the health and well being of large numbers of people from all social classes and occupational groups throughout the country. However, HIV and AIDS is not only a health problem it is a developmental issue that affects the social, cultural, political, and economic fabric of the nation.

In an effort to meet the challenges associated with HIV and AIDS in the Education sector and its possible erosion of the Education system, the focus is on developing stronger links between education and other sectors, especially health, in order to make more resources for HIV and AIDS available to the education sector and to mainstream HIV and AIDS activities in the programmes and services.

The Dakar Framework for Action for “Education for All” (EFA), adopted by the international education community during the World Education Forum (Dakar, Senegal – April 2000), draws attention to the urgent need to combat HIV and AIDS if the EFA goals are to be achieved. Gains made by Governments in terms of access, quality and retention are seriously threatened by the HIV and AIDS epidemic and its impact on the demand for, and supply of education. EFA goals and the Millennium Development Goal for Education cannot be achieved without urgent attention given to HIV and AIDS.

The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment on HIV and AIDS (July 2002) calls for vastly expanded access to information and education, especially youth-specific HIV and AIDS education, necessary to develop the life skills required to reduce risk and vulnerability to HIV infection.



The Ministry of Education has taken the decision to position HIV prevention within the context of a holistic programme of Health and Family Life Education (HFLE) and sees the education sector as having a vital role to play in the country's response to the epidemic. The priority placed on the education sector's response, is based on evidence that education contributes towards the knowledge and personal skills essential for the prevention of HIV, and protects individuals, families, communities, institutions and nations from the impact of AIDS. Education helps to overcome the conditions that facilitate the spread of HIV and can create the understanding and tolerance that contribute to reduced stigma and discrimination against vulnerable and marginalised communities and people living with HIV (UNESCO, 2007). Children of school-age have the lowest HIV infection rates of any population sector. For them, there is a "window of hope", a chance to live a life free from AIDS, if they can acquire knowledge, skills, and values that will help to protect them as they grow up. Providing young people with the 'social vaccine' of education, offers them a real chance at a productive life (World Bank, 2002). Young people who fail to complete a basic education, are more than twice likely to become infected with HIV, and the Global Campaign for Education has estimated that some 7 million cases of HIV&AIDS could be avoided by the achievement of Education for All (GCE, 2004).

The Ministry of Education acknowledges the seriousness of the HIV and AIDS epidemic, and international and local evidence suggests that there is a great deal that can be done to influence the course of the epidemic by creating and enabling a supportive environment. The Ministry is, therefore, committed to minimizing the social, economic and developmental consequences of HIV and AIDS on the education system, on all learners, students and teachers and provide leadership to implement an HIV and AIDS Policy for Schools.

### **Background and Purpose**

This policy document represents a revision of the National Policy for the Management of HIV in Schools which was approved by Cabinet in 2004. The policy has been revised as part of the education sectors proactivity in stemming the impact of the HIV and AIDS epidemic on the education system. The decision to make Health and Family Life Education the main vehicle for age appropriate HIV and AIDS education for children and youth has also led to the revision of the National Health Family Life Education (HFLE) Policy.



At present there is no cure or vaccine for HIV and AIDS and the only way to stop its spread is through attitudinal and behavioural changes as well as management that can be secured effectively through education.

The purpose of this policy is to promote and ensure a clear understanding of:

- A comprehensive approach to HIV and AIDS in the education sector which comprises effective prevention, treatment care and support and impact mitigation at the level of the workplace and in the management of the epidemic;
- the rights and responsibilities of all stakeholders in the sector;
- expected standards of ethical and social behavior;
- commitments by the Ministry of Education and other institutions in terms of human and financial resources.

The policy is derived from and is consistent with all national legislation and regulations on HIV and AIDS, as well as Education priorities and strategies. It is also backed by a National Strategic Plan on HIV and AIDS and a Strategic Plan on HIV and AIDS for the Education Sector developed by a number of education stakeholders in May 2007.

The policy applies to all students including those with special needs, teachers, non-teaching staff, managers, employers, and other providers of education and training in all public formal and non-formal educational institutions that enroll students in one or more grades and at all levels of the education system in Jamaica.





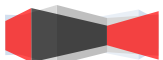
## SITUATIONAL ANALYSIS

### Epidemiology

Assuming a prevalence rate of 1.5% among Jamaicans between ages 15 and 49, it is estimated that there may already be 16,500 people living with HIV and AIDS in the national workforce. In common with other countries in the Caribbean region, the main mode of HIV transmission is heterosexual sex. The epidemic in Jamaica is generalised with an estimated adult HIV prevalence of 1.2% in the 15-49 age group with a range of 0.6% to 2.2% (low to high estimates). (cite source)

Adolescent females aged 10-14 and 15-19 had twice and three times respectively the risk of HIV infection as boys of the same age groups. This is ascribed to social factors whereby adolescent girls are having sex with HIV-infected older men. While young Jamaicans have high rates of early and unplanned pregnancy and sexually transmitted infections (STIs), those at greatest risk of HIV infection are male youth who have sex with men and all youth who engage in transactional sex. The situation in Jamaica shows that the age of first sex for girls aged 15-24 is 15.8 years and for boys in the same age group 13.5 years

Young people, particularly females, constitute a vulnerable group to HIV and at the same time are disproportionately affected by the impact of AIDS on the family. AIDS is the second leading cause of death in children aged 1-4 and there are an estimated 5,125 children under the age of 15 that have lost a mother or both parents to AIDS. The number of children orphaned is set to rise to 5% of all children by 2010.



*Factors  
Influencing the  
HIV and AIDS  
Epidemic in  
Jamaica*

### **Behavioural**

- Adolescent females in the age group 10-19 year have nearly three times higher risk of infection than their male counterparts.
- High risk behaviour includes multiple sexual partners ,early sexual initiation, forced sex and inconsistent to no condom use.
- Women have little or no opportunity to negotiate condom use as men are the sexual decision makers.

### **Socio-Economic**

- Slow economic growth, high levels of unemployment, migration, the growing economic importance of drugs and prostitution or transactional sex increase vulnerability to HIV.
- Access to care and support due to discrimination and stigmatization restrict access to services such as condoms for adolescents and other vulnerable groups.
- Gender roles and inequalities; female subservience results in loss of sexual autonomy, pressures on boys to *perform*; Jamaica’s culture of sexuality “sugar daddy phenomenon”; demands on manhood;
- Discrimination and stigmatisation around HIV/AIDS, especially homosexuality, drives those at risk underground





## VISION STATEMENTS

### *A Vision for Jamaica in 2015*

A prosperous and dynamic Jamaica which upholds the fulfillment of human rights and dignity for all persons, and builds continued social progress based on shared values and principles of partnership. Minds are transformed and extraordinary results are produced in this the most caring and secure country in the Americas, where individuals fulfill their potential, are in control of their destiny, take responsibility for their lives and work always for the larger good.

### *Vision Statement National HIV and AIDS Policy*

To support the vision of the National Policy by protecting the rights of all pupils, students, educators and staff, including those infected and affected by HIV or AIDS; to foster an enabling environment of services, administrative and management structures which are free of stigma and discrimination in each learning institution and to provide access to prevention knowledge and skills, treatment, care, support and other services.





## POLICY GOAL AND OBJECTIVES

### POLICY GOAL

The goal of this policy is to promote effective prevention and care within the context of the educational system, by ensuring that children, youth and resource personnel have access to age appropriate information education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.

### POLICY OBJECTIVES

The objectives of the policy are to:

- i. Highlight the existence of the HIV and AIDS epidemic in Jamaica and in particular in the education system;
- ii. provide guidelines for the delivery of age appropriate life skills Education in schools;
- iii. provide guidelines for institutions on the treatment of students and school personnel living with HIV/AIDS;
- iv. reduce the spread of HIV infection by increasing access to prevention strategies and interventions which promote abstinence and /or consistent condom use;
- v. instill non-discriminatory attitudes towards persons living with and affected by HIV;



- vi. ensure the provision of systematic and consistent information and educational material on HIV and AIDS to students and school personnel throughout the system;
- vii. promote the use of universal precautions in all potentially infectious situations;
- viii. reduce the vulnerability of children at risk-gender stereotypes and abused and street children.

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## GUIDING PRINCIPLES

The principles of the National Policy for HIV and AIDS Management in Schools support the UNGASS Declaration of Commitment on HIV and AIDS, the Millennium Development Goals, the Dakar Framework for Action for “Education for All”, the ICPD Programme of Action, the Vienna Declaration of Human Rights and other international conventions to which Jamaica is a signatory partner. It also supports the principles of the Jamaica National HIV and AIDS Policy adopted by Cabinet.

- **Access to Education**

Every child has the right to education. No student shall be denied access to education on the basis of his or her actual or perceived HIV status.

- **Access to Information**

All Ministry of Education staff and students have the right to relevant and factual HIV and AIDS information and behaviour change communication that is appropriate to their age, developmental level, gender, culture, language and context.

- **Participation**

The meaningful involvement of people living with and affected by HIV and AIDS and most vulnerable groups, including youth, in the design, implementation, monitoring and evaluation of the response to achieve stated outcomes.

- **Equity**

All responses to HIV and AIDS should ensure that no student or staff will be denied access to prevention, knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, gender, age, disability, religious or other beliefs, socio-economic status, geographical location, level of literacy, capacity to understand the



nature of HIV/AIDS and how it is prevented and treated or vulnerability to exposure. This includes orphans, wards of the state, street and working children, out of school youth and children living with disabilities.

- **Promotion and Protection of Human Rights**

An important aspect of the response to the epidemic requires that the rights to equality before the law and freedom from discrimination are respected, protected and fulfilled. Discriminatory practices create and sustain conditions leading to vulnerability to HIV infection and to inadequate treatment, care and support as well as access to preventive services. Promotion and protection of human rights ensures that there is no discrimination based on race, class, gender, sex, sexual orientation, religious or cultural beliefs.

- **Political Leadership and Commitment**

Strong political leadership and commitment at all levels of Education is essential for a sustained and effective response to HIV and AIDS.

- **Good Governance, Transparency and Accountability**

An effective national response to the epidemic requires leadership to mobilize and manage human, financial and organizational resources in the Education sector in an effective, transparent and accountable manner

- **Multi-Sectoral Approach and Partnerships**

The active involvement of all sectors of society is necessary to ensure an effective response including effective partnerships, consultation and coordination with all stakeholders in the design, implementation, monitoring and evaluation of the response.





## LEGISLATIVE FRAMEWORK

Currently, there is no Legislation addressing a number of HIV and AIDS related issues. Policy development has benefited from draft sector workplace policies, a National HIV and AIDS Workplace Policy and other guidelines and plans of action that have included HIV issues.

Local Laws also provide relevant guidelines in the strategic planning process. These include but are not limited to:

- ❖ The Education Act Sections 31 (1,2,3) also raises questions on the treatment of children infected or affected by HIV in the school system and their management in regard to the Public Health Act ( Section 5).
- ❖ Offences Against the Person Act
- ❖ Status of Children Act
- ❖ Council of Legal Education Act
- ❖ The National Council on Education Act
- ❖ Child Care and Protection Act
- ❖ The Public Health Act



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## LINKAGES TO OTHER POLICIES AND INTERNATIONAL AND REGIONAL DECLARATIONS

1. **The United Nations Millennium Development Goals** signed on September 2000 has several points relevant to the development of the MOEY HIV and AIDS Policy for Schools and the HFLE Policy viz:
  - ❖ Achievement of universal primary education by all
  - ❖ Eliminate gender disparity in primary and secondary education, preferably by 2005 and to all levels of education by 2015;
  - ❖ Promote gender equality and empower women
  - ❖ Policy document on the Reproductive Health of Children signed by the Ministry of Health which, allows for the provision of contraceptive advice counseling and treatment to persons under 16 years by Health Professionals at a Health Facility,
2. The **Declaration of Commitment of the United Nations General Assembly Special Session (UNGASS)** on HIV and AIDS sets specific targets for reducing HIV infection in young people and increasing their access to information and service.
3. **Universal Declaration of Human Rights:** the declaration of rights by the United Nations General Assembly. Its relevant articles speak to; human dignity and rights [Article 1], cruel, degrading and inhumane treatment [Article 5], equality before the law [Article 7], the right to privacy [Article 12], the right to social security [Article 22] the right to work and fair remuneration [Article 25], education [Article 26] and participation in the cultural and social life of the community of which he or she is a part [Article 27].
4. **International Labour Organization (ILO) Guidelines:** the ILO Code of Practice on HIV and the World of Work, which focuses on HIV and AIDS as a workplace issue ,(See Appendix 1) and addresses the role workers should play in the limiting of the spread of the epidemic, in the reduction of discrimination and stigmatization of workers on the basis of real or perceived HIV status.



5. **Convention of the Rights of the Child:** due to the fact that children and youth will be a major thrust in the Strategic Plan this document becomes important if the outputs and outcomes will be of a world standard. It emphasizes:
- ❖ Provision of the proper means and tools for any child to have normal material and spiritual development
  - ❖ Ensuring that the child is protected from; backwardness, delinquency, hunger and being a waif.
  - ❖ Provision of relief to a child in times of distress
  - ❖ Empowering the child to ensure protection from exploitation and giving him or her the tools to earn a future livelihood
  - ❖ Ensuring that his or her talents will be used to improving the lot of their fellow men
6. Jamaica is a signatory to the Programme of Action of the 1994 **International Conference on Population and Development** which addresses the rights of young people to reproductive health information and services
7. The **Convention on the Elimination of all forms of Discrimination against Women (CEDAW)** mandates the equal treatment of girls and young women in areas such as education and employment and contains general recommendations on violence

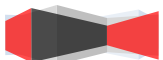




## IMPLEMENTATION MECHANISMS

### 1. Non-Discrimination and Equality

- ❖ No student or staff member (including those with special needs) infected with or affected by HIV or AIDS should be discriminated against directly or indirectly. Speculation or gossip concerning any person suspected of having HIV or AIDS must be discouraged
- ❖ Students and school personnel (including those with special needs) infected with or affected by HIV or AIDS should be treated in a just, humane and life-affirming way.
- ❖ Any special measure in respect of a student or staff member living with HIV should be fair and justifiable in light of medical facts; established legal procedures and principles; ethical guidelines; the best interest of persons with HIV and AIDS; institutional conditions; and the best interest of other students and school personnel.
- ❖ To prevent discrimination, all students, school personnel and key stakeholders such as parents and PTAs, should be educated about fundamental human rights as contained in the Constitution of Jamaica and the UN Convention on the Rights of the Child to which Jamaica is a signatory and the ILO Code of Practice on HIV and AIDS and the world of work.
- ❖ All school personnel (including those with special needs) have the right to continue in their positions as long as they are able to and be provided with necessary leave as accorded to any other chronic illness.
- ❖ All school personnel (including those with special needs) have a right to continue in their positions as long as they are able to, without fear of job security.
- ❖ Persons infected with **and** affected by HIV or AIDS should be involved in all aspects of policy development and planning.



## 2. HIV/AIDS Testing, Admission and Appointment

- ❖ No student (including those with special needs) may be denied admission to or continued attendance at an institution on account of his or her HIV status or perceived HIV status.
- ❖ No staff member (including those with special needs) may be denied the right to be appointed in a post, or to be promoted on account of his or her HIV status or perceived HIV status. Nor shall HIV status be a reason for dismissal, nor for refusing to renew any staff member's employment contract.
- ❖ All school personnel who suspect that they have been denied their rights to appointment or employment because of his or her HIV status, or perceived HIV status, should be facilitated through arbitration.
- ❖ All students and other school personnel with special needs who suspect they have been denied their rights on account of his or her status or perceived HIV status should have access to arbitration.
- ❖ **There is no medical justification for routine testing of students or educators for proof of HIV infection.** The testing of students for HIV as a prerequisite for admission to, or continued attendance at an educational institution, is prohibited. The testing of staff members for HIV as a prerequisite for appointment or continued service is also prohibited.

## 3. Attendance At Institutions By Students With HIV And AIDS

- ❖ Students with HIV and AIDS have the right as any other to attend educational institutions.



- ❖ Students with HIV are expected to attend classes in accordance with statutory requirements for as long as they are able to do so.
- ❖ Students with HIV and AIDS are expected to participate in school activities and should not be excluded from such, as long as they are able to do so.
- ❖ School personnel and administrators living with HIV and AIDS should lead as full a professional life as possible with the same rights and opportunities as other educators and with no unfair discrimination being practiced against them, and should not be excluded from participating in any school activities as long as they are able to do so.

#### **4. Disclosure and Confidentiality**

- ❖ Compulsory disclosure of a learner's, student's or educator's HIV or AIDS status to the school or institution authorities is prohibited.
- ❖ In case of disclosure the Ministry of Education should be prepared to handle such disclosures and give support to Principals on how to handle confidentiality issues.
- ❖ No student (or parent on behalf of a student), or educator, (including those with special needs) is compelled to disclose his or her HIV and AIDS status to the institution or employer.
- ❖ Voluntary disclosure of a student's, educator's or other school personnel's HIV and AIDS status to the appropriate authority should be welcomed, and an enabling environment should be fostered in order to facilitate this disclosure. Confidentiality of such information must be ensured and any form of discrimination is prohibited.
- ❖ Any person to whom information about the medical condition of a student, educator or other employee with HIV and AIDS has been divulged, (including those with special needs) is required to keep this information confidential.



- ❖ Unauthorised disclosure of HIV and AIDS-related information could give rise to legal liability.
- ❖ Confidentiality must be maintained and disclosure of sexually active students made only to the Guidance Counsellor, School Nurse or other designated school personnel.

## 5. Prevention Education on HIV and AIDS

- ❖ A continuing Health and Family Life (HFLE) and HIV and AIDS education programme must be implemented at all schools and institutions for all students and school personnel and school board of management.
- ❖ Age-appropriate and gender sensitive HIV and AIDS education must be delivered via a student-centred, life-skills based Health and Family Life Education (HFLE) for pre-primary, primary and secondary school students.
- ❖ A holistic programme for Health and Family Life Education and HIV and AIDS education should encourage disclosure. This should include the following:
  - providing information on HIV and AIDS and developing the life skills necessary for the prevention of HIV transmission;
  - emphasizing information and skills on appropriate prevention and avoidance measures, including among others, abstinence from sexual intercourse, the use of condoms, faithfulness to one's partner, obtaining prompt treatment for sexually transmitted infections and the application of universal precautions;
  - the association of drug abuse, sexual violence, and sexually transmitted infections (STIs) in the transmission of HIV, and empowering students to deal with these issues;
  - encouraging students to make use of age-appropriate counselling and support services including reproductive health care services ;



- providing mandatory counselling through which access to prevention services is provided.
  - Providing access to prevention services and referrals to the Health Centre as stated in Appendix 2;
  - mandatory counselling should be given to sexually active students by the Guidance Counsellor or School Nurse who should refer the student to the Health centre or youth friendly health service;
  - facilitating and enabling further access to prevention services and client-friendly health services;
  - facilitating the development of accepted attitudes and behaviours towards persons infected with and affected by HIV and AIDS ;and
  - fostering an enabling environment and culture of non-discrimination of persons infected with and affected by HIV and AIDS
- ❖ Teacher training colleges should offer appropriate course content in the pre-service and in-service training of educators to cope with HIV and AIDS in schools.
  - ❖ Teachers colleges should equip trainees and staff with appropriate knowledge and skills in relating to HIV and AIDS issues which includes among others, prevention, stigma and discrimination, universal precautions and the implementation of the National Policy for the Management of HIV and AIDS in Schools.
  - ❖ Participatory methods of learning are more effective including games, role-play and drama. Children should be encouraged to ask questions and to expect reasonable, comprehensible and appropriate answers.
  - ❖ The teacher should be sufficiently prepared and feel at ease with the content and should be a role model with whom students can easily identify.



- ❖ Teacher training should include Health and Family Life Education and should form part of the wider sexual and reproductive health curriculum framework;
- ❖ Educators should also be informed by the principal and Teachers Associations of courses for educators to improve their knowledge of, and skills to deal with, HIV and AIDS, HIV Education For Teachers and Confidentiality.

## 6. A Safe Institutional Environment

The risk of HIV transmission as a result of contact play and contact sport is generally insignificant. The risk increases where open wounds, sores, breaks in the skin, grazes, open skin lesions or mucous membranes of students, educators and other staff are exposed to infected blood. Application of universal precautions will be practiced to contain the risk of HIV transmission during contact play and contact sport.

Students and teachers with open wounds, sores, lesions, grazes of the skin will not be allowed to participate in contact sports.

If bleeding occurs during contact play or contact sport, the injured player must be removed from the playground or sports field immediately and treated appropriately. Only then may the player resume playing and only for as long as any open wound, sore, break in the skin, graze or open skin lesion remains completely and securely covered.

Staff members acting as sports administrators, managers and coaches have special opportunities for meaningful education for sports participants with respect to HIV/AIDS including education re safe sex, and should encourage participants to seek medical and other counselling where appropriate.

The Ministry of Education will ensure that:

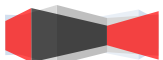
- ❖ Provisions are in place for all institutions to implement universal precautions to eliminate the low risk of transmission of all blood-borne pathogens, including HIV, in educational institutions. (Details of universal precautions are included in Appendix II).



- ❖ All schools and institutions will provide training in first aid for students, teachers, volunteers, and all other school personnel, and are required to make available and maintain at least two first-aid kits.
- ❖ Where the first aid kit is not readily accessible the teaching area will be equipped with a pair of latex or household rubber gloves.
- ❖ Serviceable Latex or household rubber gloves will be available at every sports event and should also be carried by the activity supervisor.
- ❖ First-aid kits and appropriate cleaning equipment will be stored in one or more selected rooms in the school or institution and should be accessible at all times.
- ❖ The contents of the first-aid kits will be checked monthly against a contents list by a designated member of personnel of the school or institution.
- ❖ A fully equipped first-aid kit will be available at all institution events and should be kept on vehicles used for the transport of students to events.
- ❖ All students, educators and other school personnel, including sports coaches, will be given appropriate information and training on HIV transmission, the handling and use of first-aid kits, the application of universal precautions and the importance of adherence to universal precautions.

## **7. Refusal To Study With Or Teach A Student With HIV/AIDS Or To Work With Or Be Taught By An Educator With HIV/AIDS**

Refusal to study with a student, or to work with or be taught by school personnel with, or perceived to have HIV and AIDS, should be pre-empted by providing accurate and understandable information on HIV and AIDS, including information on stigma and discrimination, to all staff members, students and their parents.



Where the incidence of refusal arises, the situation should be resolved by the principal, in accordance with the principles contained in this policy, the Education Act, and other relevant legislation and policies.

## 8. Gender Sensitivity in HIV Prevention

Ensure age and gender-appropriate sexual and reproductive health programmes to achieve HIV prevention in schools including:

- ❖ Educational and Outreach efforts must *be* focused on motivating behaviour change, which will be primarily achieved through HFLE and include responding to the socio-cultural factors, myths, expectations and double-standards that apply differently to girls and boys which inhibit self- protection from HIV and AIDS. Participatory methodologies appropriate for each group should be used to encourage self-reflection, discussion and critical analysis about the different pressures and barriers in adopting preventive behaviours. Sexuality, reproductive health and rights, relationship and violence issues should be discussed in relation to STIs/HIV and AIDS focusing on challenging underlying stereotypes.
- ❖ **Community-based mobilization for a supportive environment.** Youth peer educators of both sexes can serve as community role models for gender equality and responsible behaviour. Parents, key family relatives, teachers, and other members of the community should be sensitized on the realities of gender, sexual health and HIV issues in youth. Emphasis should be placed on developing non- judgmental and open attitudes that will enable the fulfillment of duties towards young people. Addressing prevailing cultural norms to enable the empowerment and protection of girls' rights and needs, while promoting values based on equity and equality between the sexes.
- ❖ Teaching negotiation skills for safer sexual practices for boys and girls.
- ❖ Training for peer educators, and other school personnel should emphasize gender-sensitive interpersonal skills and counseling for young people on open communication, relationship issues, sexual health and sexuality.



- ❖ Services should safeguard rights to non-discrimination, confidentiality and privacy, and pay particular attention to the specific challenges boys and girls may face in negotiating voluntary, safer sexual relations or delaying sexual initiation.
- ❖ Outreach efforts should consider single-sex as well as mixed group strategies focused on gender, reproductive health and rights, and HIV issues;
- ❖ At all levels of programming, the active participation of specialized Non-governmental Organizations should be pursued, as should the participation of people living with HIV and AIDS;

In programme monitoring and evaluation, gender-disaggregated data should be collected and analyzed and gender-sensitive indicators developed that can help ascertain programme impact. Quantitative and qualitative indicators should include those related to changes in power relations between women and men, such as: women's empowerment in sexual and reproductive decision-making; changes in boys' and men's attitudes and male responsibility; use of female and male condoms; and changes in expectations among youth of girls' and boys' capacities, shared rights and responsibilities.

## **9. Referring Sexually Active Students to Reproductive Health Services**

Recognizing that sexual activities begin at an early age in Jamaica, with the median age for initiation being 13.4 years old for boys and 15.9 years old for girls<sup>1</sup> and recognizing also the annual increase in HIV infection rates among adolescents, it is critical that proactive steps are taken in reversing the trends. According to data from the Ministry of Health, the highest infection rates are in the 10-19 years old group, with the rate growing 2.3 times faster in girls than in boys<sup>2</sup>. Within this context referrals should be made where significant appreciation is shown for the genders and the appropriate care, services and products that are necessary to meet the varying demands is provided.

<sup>1</sup> National Policy for The Promotion of Healthy Lifestyle in Jamaica, Ministry of Health, page 11

<sup>2</sup> National Policy for The Promotion of Healthy Lifestyle in Jamaica, Ministry of Health, page 11



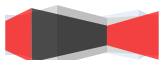
The policy action to refer sexually active students to reproductive health services should be undertaken with a great level of sensitivity, respect and diplomacy given our cultural and social mores. The Ministry of Education hereby assumes a lead role as the agency of government with responsibility for educational development of our children and the adoption of appropriate attitudes and behaviours, particularly those related to their health and wellbeing. This area lends itself for inter-sectoral approach/partnership and therefore the Ministry of Health's Reproductive Health Policy Guidelines for Health Professionals are instructive.

The Ministry of Education's intention to refer students for reproductive health services supports the drive to provide opportunities for students to access friendly health services; while strengthening implementation of the Reproductive Health Policy Guidelines which is appended to the National Policy for the Management of HIV and AIDS in Schools.

Schools have a responsibility to ensure that all students are in need of the reproductive health services are referred for such as per Jamaica's legal framework. In addition to referral the institution will provide pre and post referral counselling while monitoring the child's psychosocial development during the referral and intervention phase.

In referring sexually active students to reproductive health services, the school administration should be guided by the following:

- ❖ The best interests of the child should be the operative or guiding principle as provided within the UN Convention on the Rights of the Child (1989) as well as the Child Care and Protection (2004);
- ❖ Referrals must be made by the person designated by the Authorizing Officer (i.e. the principal) such as the Guidance Counsellor and/or School Nurse or a designate with the relevant skills and competencies for schools with neither a school nurse nor a guidance counselor. Teachers, student/peer leaders, social workers and other members of the school community who become



knowledgeable of a student's real or perceived need for services may refer such to the Principal/Guidance Counsellor only for the appropriate measures (including referrals) to be taken. School nurses should be given leeway to accompany sexually active students to health care facilities or provide further counselling.

- ❖ Where it is ascertained that a child is sexually active, he/she should be counselled and encouraged to involve his/her parent(s) or guardian(s) in any discussion regarding appropriate measures to be taken; The parent should be involved following consultation with the child.
- ❖ The child's wishes if he/she does not wish to inform his or her parent(s) or guardian(s) are to be respected; and where the child is over the age of sixteen years old, he/she should be referred to a client-friendly health care facility. The rights of the child must be taken into account and therefore the matter must be conducted in a manner of confidentiality, privacy and respect; which is non-discriminatory and non-judgmental.
- ❖ Where the child is below the age of sixteen years, the matter must be reported to The Children's Registry. Whether the child is desirous of the matter to be disclosed or not, he/she must be informed of the requirement to report to the Children's Registry as guided by the Child Care and Protection Act. The Children's Registry should notify the other State agencies (such as the Child Development Agency, Police etc.) depending on the nature and magnitude of the case.
- ❖ The Child Care and Protection Act requires mandatory reporting of rape cases (including any case of sexual knowledge of children below the age of sixteen years).
- ❖ A child involved in statutory rape is in need of Care and Protection;



- ❖ The school's Guidance & Counselling Services Unit is responsible for offering follow-up counselling and appropriate care to all students (including those sixteen years and under) who are in need of such. In cases where a school does not have a guidance counsellor on staff, the school nurse, other health care and psychosocial service providers in close proximity to the institution may be asked to provide follow-up counselling.

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## ROLES AND RESPONSIBILITIES OF STAKEHOLDERS

The Ministry of Education through the Principals and Heads of Institutions has direct responsibility for coordination of the MOE Policies for Schools

Other major role-players in the wider institution community (for example religious and community leaders, representatives of the medical or health care professions) should be involved in the implementation of this policy.

- ❖ The Ministry of Education should establish partnerships between educational institutions, the private/public sector, Non Government Organisations and parents/guardians/caregivers, to implement and disseminate policies.
- ❖ The Ministry of Education should develop communication strategies through various media: school, Parent Teacher Associations, community, church, radio, television, newspaper, flyers, billboards, and the Internet.
- ❖ School Principals should proactively implement and disseminate policies within the school and wider school community.
- ❖ Programme planners should address groups such as street children; out of school youth and other marginalized groups in their programming.
- ❖ Vulnerable groups such as children, adolescents and youth should be given the right to participate during programme planning and implementation.
- ❖ Civil society including the media, the church and business organisations should be mobilized to support implementation of the Policy by also offering services where appropriate to their members.



## Key Stakeholders

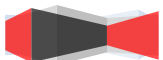
Bringing about wide-spread and enduring changes in social attitudes to reduce HIV/AIDS related stigma and discrimination requires mobilizing stakeholders including:

- Persons living with and affected by HIV and AIDS;
- Orphans and Children Made Vulnerable By HIV/AIDS (OVCS)
- Teachers and Other School Personnel
- Students and Youth Leaders
- Faith-Based Organisations
- Non-Governmental and Community-Based Organisations
- The Business Community and Workers Organisations
- Medical Personnel and Health Care Workers
- Policymakers
- Parents/Guardians
- School Boards

## Health Advisory Committee

Where community resources make this possible, it is recommended that each school and institution should establish its own Health Advisory Committee as a committee of the governing body or council. Where the establishment of such a committee is not possible, the school or institution should draw on expertise available to it within the education and health systems. The Health Advisory Committee may as far as possible use the assistance of community health workers led by a nurse, or local clinics.

Where it is possible to establish a Health Advisory Committee, the Committee should:



- ❖ be set up by the governing body or council and should consist of principals or his/her representative, academic and non-academic staff, representatives of the parents of learners at the school or students at the institution, representatives of the learners or students, and representatives from the medical or health care professions;
- ❖ elect its own chairperson.
- ❖ advise the governing body or council on all health matters, including HIV and AIDS;
- ❖ be responsible for developing and promoting a school or institution plan of implementation on HIV and AIDS and review the plan from time to time, especially as new scientific knowledge about HIV and AIDS becomes available; and
- ❖ include a person living with HIV on the Committee.

## **Principal**

The role of the Principal is to ensure the establishment of the Health advisory Committee and to monitor the activities of the Committee.



## Monitoring and Evaluation

The policy will be periodically reviewed to ensure that it remains relevant to the needs of the education sector and to take into account any new developments in the methods of infection and treatment of persons living with HIV.

## Conclusion

The spread of the HIV/AIDS epidemic in Jamaica can only be controlled through interventions which address the behaviour of the populace.

Special attention must be paid to children and young people as they are not only at particular risk, but their responsible sexual behaviour is essential in advancing HIV prevention and containment.

The role of educational institutions in imparting knowledge and skills regarding HIV and AIDS has proven internationally and provides an important opportunity in reducing the impact of the epidemic on our society.

Issues covered in this policy will provide institutions with the information and guidelines for implementation required to make a change in the spread of infection amongst our youth. The policy also advances a positive view of interacting with those persons who are already living with or affected by HIV.

Development of a policy for schools in a world with HIV and AIDS, while very important, will only have the desired impact if it is implemented effectively.



## Appendix I

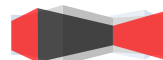
### BASIC FACTS ON HIV

The Human Immunodeficiency Virus (HIV) causes AIDS (Acquired Immune Deficiency Syndrome). HIV only affects humans. It does so by gradually weakening the immune system making it difficult for the body to fight infection. HIV is microscopic and can only survive in cells that are living while destroying them

#### Modes of Transmission

HIV is transmitted from an infected person to another through blood and blood products, semen (and pre-ejaculation fluid), vaginal fluids and breast milk. Transmission of HIV takes place in four main ways:

- ◆ Unprotected sexual intercourse with an infected partner – anal (high-risk), vaginal (high-risk), oral (low-risk);
- ◆ blood and blood products (through for example, infected transfusions, organ or tissue transplants or the use of contaminated injection or other skin piercing equipment);
- ◆ from infected mother to child in the womb or at birth (15% to 45% chance of transmission to child without treatment and as low as 5% chance of transmission with treatment and infant-feeding substitutes to breast milk);
- ◆ through breast-feeding






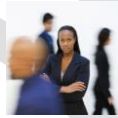
## HIV is NOT spread during everyday casual contact



- ◆ **HIV CANNOT be transmitted during casual, physical contact with an HIV positive person such as coughing, sneezing, kissing, hugging, sharing utensils, toilets and washing facilities or consuming food or beverages handled by the person.**

- ◆ Mosquitoes and other insects do **NOT** spread this virus. A person CANNOT get HIV from the air, from food and from water. 

- ◆ A person cannot get HIV by handling or coming into contact  with the tears, sweat, saliva and urine of an HIV infected person. There is insufficient concentration of HIV in these body fluids to cause infection.



- ◆ It is not possible to determine someone's HIV status by just looking at the person. Someone infected with HIV can look and feel well for up to 10 or more years without showing signs and symptoms of illness. This person however, can transmit the virus to others especially during unprotected sexual intercourse.

- ◆ Early symptoms of AIDS include chronic fatigue, diarrhoea, fever, mental changes such as memory loss, weight loss, persistent cough, severe recurrent skin rashes, herpes and mouth infections and swelling of the lymph nodes. Opportunistic infections such as cancers, meningitis, pneumonia and tuberculosis may also take advantage of the body's weakened immune system. AIDS is fatal, although periods of illness may be interspersed with periods of remission. There is still no cure for AIDS. While research continues to develop a vaccine against HIV/AIDS, none is as yet viable. Jamaica is able to increase access to antiretroviral



drugs because public/private sector partnerships and a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria have helped to lower the cost to a person living with HIV/AIDS. Typically, ARV drugs are expensive and therefore out of the reach of the majority of those needing them.



## Prevention

- ◆ HIV is fragile and is only able to survive in a limited range of conditions. It can only enter the body through naturally moist places and cannot penetrate unbroken skin. To prevent transmission of HIV, it is recommended:
- ◆ That all sexually active persons use a barrier to the virus such as a latex male condom during every episode of sex. The female condom is also recommended.
- ◆ To prevent transmission through accidental exposure to blood and other (relevant) body fluids, universal precautions should be adopted. This requires the use of protective equipment such as rubber masks and gloves in situations involving exposure to blood and other body fluids from an infected person.
- ◆ Skin-piercing equipment should not be contaminated by re-use without proper sterilization. Bleach, strong detergents and hot water kill the virus rapidly, which is unable to survive outside of a living human body.
- ◆ Persons who are exposed to blood accidentally through skin puncture by an injection needle or those raped need to undergo HIV testing and post exposure prophylaxis.





### Prevention of Sexual Transmission

- ◆ Abstain - This method of prevention is strongly recommended for children and adolescents and is appropriate for anyone who practises delaying sex until “the right time”.
- ◆ Be faithful to one sexual partner who is uninfected and mutually faithful.
- ◆ Correct and consistent condom use.
- ◆ Do get tested for HIV.



### Prevention of Blood Transmission

- ◆ Universal Precautions.
- ◆ Post Exposure Prophylaxis.
- ◆ Protected national blood supply.
- ◆ Advocacy to prevent sharing of IV drug needles including provision of sterilized needles.



### Prevention of Mother-To-Child Transmission

- ◆ Universal HIV Testing of Pregnant Women.
- ◆ ARV treatment for all HIV positive pregnant women.
- ◆ Counselling for all HIV positive pregnant women on treatment.
- ◆ Access to information, counselling and follow-up care and support for all HIV positive pregnant women, including family planning services and nutritional support.
- ◆ Advocacy for the provision of specific guidance and support to ensure adequate replacement feeding.



### How To Tell Your HIV Status

- ◆ Get tested.
- ◆ **ELISA TEST** — A common method of HIV testing in Jamaica is the use of the ELISA (Enzyme-linked Immunosorbent Assay) test for screening and the Western Blot test to confirm the result. If the result is positive for both tests, it means that antibodies to HIV have been found in the blood.



- ◆ **RAPID HIV TEST** - The Rapid Test is being made available at many centres throughout the four health regions. This method is fast but positive results must be confirmed by further tests.
- ◆ **VCT (Voluntary Counselling & Testing)** – HIV testing should be voluntary and with informed consent. It should be preceded (pre-test) and followed (post-test) by counselling. Through counselling the client is able to understand what the negative test result means and what the positive test result means. The appropriate sexual behaviour for any kind of result should be discussed with the client during counselling. Group education may be provided in lieu of individual pre-test counselling. However, all post-test counselling should be individually conducted without breaching the privacy and confidentiality of the client.

### ● **Window Period**

- ◆ When a person is exposed initially to HIV – that is becomes infected through contact with an infected person – it may take between six weeks and up to three months before antibodies to HIV are detected in the blood. Antibodies are created as the immune system tries to fight off the infection from the virus.
- ◆ The HIV test looks for antibodies. When these antibodies are detected the person is diagnosed HIV positive.
- ◆ A person can be HIV infected and the test shows negative because the test was carried out soon after infection during the “window period”, before the body develops antibodies.

### ● **Who Needs To Take A HIV Test**

- ◆ Sexually active people – This includes even those who are currently abstaining who were sexually active up to 10 years ago.
- ◆ People with more than 1 sex partner – This applies also to those who have been engaged in serial monogamy.
- ◆ People who have unprotected sex.



- ◆ People who use condoms inconsistently and incorrectly.
- ◆ People who have doubts that their sex partner is faithful.
- ◆ Anyone who was raped should get tested for HIV.
- ◆ Anyone who got accidentally stuck by an injection needle while attending to a client/patient.



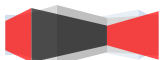
### **Taking the HIV Test**

- ◆ The client should:
  - know what the test results mean before and after taking the test.
  - get counselling before and after taking the test.
  - use condoms during every sexual encounter or abstain.



### **How To Use the Male (Latex) Condom**

- ◆ Ensure there are sufficient latex condoms within easy reach. Check the expiry date and the manufacturer's date on the package. Feel the package before opening to detect air, which means the product, is not damaged. The penis must be erect before putting on the condom.
- ◆ Open the package carefully to avoid damage to the condom. Avoid the use of sharp openers such as teeth or nails. After removing the outer package, hold the tip of the condom between the thumb, middle and index fingers and expel the air.
- ◆ Ensure that the condom is on the side that will roll out naturally. Roll the condom two notches down to allow for sufficient space at the tip. While holding the tip of the condom unroll it onto the penis keeping the position until your hand reaches the base of the penis.
- ◆ Use a water-based lubricant with the condom. Some condoms are already lubricated.
- ◆ After the male partner ejaculates (cum), hold the condom on the base of the penis and pull out the penis while it is still hard to prevent the spillage of semen. Remove the condom carefully ensuring that your fingers do not come in contact with the semen in the tip of the condom. Take note of the colour of the semen in the condom. Discoloured semen may



indicate the presence of another sexually transmitted infection (STI). Once the condom is removed tie the end of it and dispose in the garbage bin. Wash hands.

- ◆ If the couple desires to continue having sex, wait until the penis gets hard again and put on a new condom.



### How To Use The Female Condom

- ◆ The female condom can be inserted up to eight hours before sex. Most women insert between 2 to 20 minutes before sex.
- ◆ The female condom is for one-time use and should be removed before the woman stands.
- ◆ Practise using the female condom without having sex. To insert the condom, find a comfortable position such as standing with one leg up on a chair, or sitting with knees apart or laying on back.
- ◆ Ensure that the inner ring is at the bottom, closed end of the pouch. The condom is lubricated; however, extra lubricant may be added to the tip of the pouch and to the outer ring.
- ◆ Hold the pouch with the open end hanging down. While holding the outside of the pouch, squeeze the inner ring with the thumb and middle finger. Place the index finger between the thumb and the middle finger and keep squeezing the inner ring.
- ◆ While squeezing the female condom with three fingers, use other hand to spread the lips of the vagina and insert the squeezed female condom.
- ◆ If the female condom is slippery during insertion, let it go and start over.
- ◆ Use the index finger to push the inner ring and the rest of the pouch into the vagina. The inner ring should go just past the pubic bone, which can be felt with the index finger.
- ◆ Ensure that the female condom is not twisted when it enters the vagina.
- ◆ About one inch of the open end of the female condom will remain outside of the body. Once the penis enters, the vagina will expand and the slack will decrease. Use your hand to guide the penis into the female condom in the vagina.
- ◆ To remove the female condom, squeeze and twist the outer ring to keep the seminal fluids inside the pouch. Pull out gently. Discard the used condom in the trash bin.





## **Sexually Transmitted Infections and HIV Transmission**

- ◆ People who have been diagnosed with another sexually transmitted infection (STI) are at risk for HIV. Persons with STIs are more likely to have sores and small breaks in the skin and lining of their genitals. It is easier for HIV to enter the body through these breaks. (Herpes, Syphilis, Gonorrhoea, other STIs with sores). If a person has an STI or has had one, he/she could have contracted HIV because of unprotected sex.

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### Universal Precautions

Basic first aid principles, including how to deal with bleeding and how to use the necessary safety precautions MUST be inculcated in students from an early age.

1.1 The basis for advocating the consistent application of universal precautions lies in the assumption that in situations of potential exposure to blood or body fluids, all persons are potentially HIV infected and all blood should be treated as such. All blood, open wounds, sores, breaks in the skin, grazes and open skin lesions, as well as all body fluids and excretions which could be stained or contaminated with blood (for example tears, saliva, mucus, phlegm, urine, vomit, faeces and pus) should therefore be treated as potentially infectious.

- ◆ Blood, especially in large spills such as from nosebleeds, and old blood or blood stains, should be handled with extreme caution.
- ◆ Skin exposed accidentally to blood should be washed immediately with soap and running water.
- ◆ All bleeding wounds, sores, breaks in the skin, grazes and open skin lesions should ideally be cleaned immediately with running water and/or other antiseptics.
- ◆ If there is a biting or scratching incident where the skin is broken, the wound should be washed and cleansed under running water, dried, treated with antiseptic and covered with a waterproof dressing.
- ◆ Blood splashes to the face (mucous membranes of eyes, nose or mouth) should be flushed with running water for at least three minutes.

1.2 All open wounds, sores, breaks in the skin, grazes and open skin lesions should at all times be covered completely and securely with a non-porous or waterproof dressing or plaster so that there is no risk of exposure to blood.



- 1.3 Cleansing and washing should always be done with running water and not in containers of water. Where running tap water is not available, containers should be used to pour water over the area to be cleansed. Schools without running water should keep a supply, e.g. in a 25-litre drum, on hand specifically for use in emergencies. This water can be kept fresh for a long period of time by adding bleach.
- 1.4 All persons attending to blood spills, open wounds, sores, breaks in the skin, grazes, open skin lesions, body fluids and excretions should wear protective latex gloves or plastic bags over their hands to effectively eliminate the risk of HIV transmission. Bleeding can be managed by compression with material that will absorb the blood, e.g. a towel.
- 1.5 If a surface has been contaminated with body fluids and excretions which could be stained or contaminated with blood (for instance tears, saliva, mucus, phlegm; urine, vomit, faeces and pus), that surface should be cleaned with running water and fresh, clean household bleach (1:10 solution), and paper or disposable cloths. The person doing the cleaning must wear protective gloves or plastic bags. Adequate barriers can also be established by using less sophisticated devices such as:
- ◆ unbroken plastic bags on hands where latex or rubber gloves are not available;
  - ◆ common household bleach for use as disinfectant, diluted one part bleach to ten parts water (1:10 solution) made up as needed.
- 1.6 Blood-contaminated material should be sealed in a plastic bag and incinerated.
- 1.7 Tissues and toilet paper can readily be flushed down a toilet.
- 1.8 If instruments (for instance scissors) become contaminated with blood or other body fluids, they should be washed and placed in a strong household bleach solution for at least one hour before drying and re-using.



1.9 Needles and syringes should not be re-used, but should be safely disposed of.

1.10 Proper facilities should be made available for the disposal of infectious waste.

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## Appendix III

### **Referrals**

The Ministry of Education through the teacher, guidance counsellor or school nurse should refer the student needing reproductive health services contraception or condoms to the Health centre where the guidelines should be followed.

### **Providing Contraceptives to Persons Under 16 Years**

This policy applies to the provision of contraceptive advice, counselling and treatment to persons under sixteen years by Health Professionals at a Health Facility.

#### **Clinic Clerk**

A clerk at the health facility will:

- i. Register any individual requesting services, whether or not the person is accompanied by an adult, has a referral or visits on individual volition.
- ii. Direct such person to a health professional.

#### **Health Professional Provides Counselling**

The health professional has an ethical obligation to:

- i. Ascertain whether the minor is in the care and control of a parent or guardian
- ii. Seek to persuade the minor to involve his/her parent or guardian
- iii. Ensure that the minor does not wish the health professional to inform his/her parent or guardian
- iv. Respect the minor's wishes (if (s)he is not so inclined) not to involve his/her parent or guardian
- v. Provide contraceptive related services (where his/ her best interests warrants this) which are:



- Confidential, provides non-judgmental health information; and shows respect for the individual at all times and in all circumstances.
- Where confidentiality must be breached, as in cases of STIs, pregnancy, sexual violence, the health professional should inform the individual that (s)he intends to disclose the information, and the consequences of such disclosure.
- Counselling should include interpersonal relations, mental health, sexually transmitted infections, including HIV/AIDS, contraception and gender-based violence



### **Health Professional Promotes Abstinence**

The health professional should urge the individual to delay initiation of sexual intercourse with full explanation of the benefits of abstinence for the individual.



### **Health Professional Provides Non-surgical Contraceptive**

The health professional should exercise his/her best judgment in determining that the individual:

- ◆ Is likely to begin or continue having sexual intercourse with or without the use of contraception.
- ◆ Physical, or mental health or both, are likely to suffer unless (s)he receives contraceptive advice or treatment
- ◆ Is given detailed and clear information on all non-surgical contraceptive options available (including information on any side effects
- ◆ Receives preferred choice of non-surgical contraception.
- ◆ Understands the nature and effects of the treatment given
- ◆ Is encouraged to use dual protection to reduce the risk of acquiring sexually transmitted infections.



- ◆ If the health professional refuses to provide contraceptive advice and/or treatment, the individual may wish to have his/her case reviewed by another health professional; and this should be facilitated.

### **Health Professional Schedules Follow-up Visit**

Provides written instructions as to date, time and place for follow up to the individual to whom any contraceptive is given.

The Policy approach proposed by the Ministry of Health is not motivated by a desire to sanction or encourage the engagement of children in sexual activities. It is based on the reality of the high incidence of sexual activities involving children of 16 years and under. It is based on the recognition of the need for action to be taken to prevent unwanted pregnancies and the transmission of sexually transmitted infections. This policy seeks to deal effectively with this issue at the level of the health professionals, who are the persons outside the family that have the responsibility to advise and counsel children on safe sexual practice, including abstinence.

- ◆ In the case of STIs confidentiality can be breached for disclosure and the Health professional should so inform the client. Abstinence should first be promoted in an attempt to delay the initiation of sexual intercourse, however the health professional may use his or her best judgment to provide non surgical contraception if the individual is likely to begin or continue having sexual intercourse with or without the use of contraception. The client should also be encouraged to use dual protection to reduce the risk of acquiring sexually transmitted infections. The Policy approach proposed by the Ministry of Health is not motivated by a desire to sanction or encourage the engagement of children in sexual activities but on the reality of the high incidence of sexual activities involving children of sixteen years and under and on the recognition of the need for action to prevent unwanted pregnancies and the transmission of STI.



## Appendix IV

### **Recognition of HIV/AIDS As A Workplace Issue:**

HIV/AIDS is a workplace issue and should be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce but also because the workplace being part of the local community has a role to play in the wider struggle to limit the spread and effects of the epidemic.

### **Non-discrimination**

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against persons on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.

### **Gender Equality**

The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.

### **Healthy work environment**

The work environment should be healthy and safe, so far as is practicable for all concerned parties in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention. A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.



## **Social Dialogue**

The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government where appropriate with the active involvement of workers infected and affected by HIV/AIDS,.

## **Non-screening For Purposes Of Exclusion From Employment Or Work Processes**

HIV/AIDS screening should not be required of job applicants or persons in employment.

## **Confidentiality**

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a workers HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers personal data.

## **Continuation of Employment Relationship**

HIV infection is not a cause for termination of employment. As with many other conditions persons with HIV related illness should be able to work for as long as medically fit in available appropriate work.

## **Care and support**

Solidarity, care and support should guide the response to HIV and AIDS in the world of work. All workers including workers with HIV are entitled to affordable health services. There should be no discrimination against them and their dependents in access to and receipt of benefits from statutory social security programmes and



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References:

1. United Nations Educational, Scientific and Cultural Organization (2007) UNESCO's Strategy for Responding to HIV and AIDS
2. Global Campaign on Education (2004)

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