Someone at School has AIDS: Sample School Policy

Description of tool:
This tool, a sample policy developed by the National Association of State Boards of Education in the United States, suggests guidelines for the development of education sector policies concerning HIV/AIDS.

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


Description of document:
This sample policy was initially developed in 1989 by the National Association of State Boards of Education in the United States in association with the U.S. Centers for Disease Control and Prevention’s Division of Adolescent and School Health. It has been recognized as an example of good practice both within the United States and internationally, and has served to guide the efforts of education authorities involved in HIV/AIDS policy development in many states and countries of the world. The policy was revised in 1996 and updated in 2001.

This information or activity supports Core Component #1 of the FRESH framework for effective school health: school health policies. It will have a greater impact if it is reinforced by activities in the other three components of the framework.
Someone at School has AIDS: Sample School Policy

Introduction

The sample policy presented here was initially developed in 1989 by the National Association of State Boards of Education in the United States in association with the U.S. Centers for Disease Control and Prevention’s Division of Adolescent and School Health. It has been recognized as an example of good practice both within the United States and internationally, and has served to guide the efforts of education authorities involved in HIV/AIDS policy development in many states and countries of the world.

Following the text of the most recent update of the policy, an example of one such adaptation, from the Wyoming State Department of Education, is provided. The Wyoming authorities made only minor changes to the basic NASBE text; however, they expanded the basic text significantly by developing rationales for each of the major sections of the policy. Their adaptation is highlighted here because it demonstrates the benefits of undertaking a process to “personalize” and build support for policies at the implementation level.

For example, it implies that the Wyoming policy makers adopted the NASBE guidelines only after determining that they were in accordance with the philosophies and practices they wish to see adopted in the schools under their administration. In addition, the rationales provide a greater level of detail about what the policy is meant to achieve, and a description of the scientific, medical and legal bases for the recommended actions. Multiple references are made to existing laws and regulations with which state school districts are required to comply, and up-to-date information about HIV/AIDS is provided to substantiate the recommendations. The addition of the rationales underscores the State authorities' endorsement of the policy and provides valuable material for advocacy efforts to gain support for the policy among stakeholders at local policy levels.

Foreword to the 2001 Update

Every state and school district needs policies that address serious issues raised by HIV infection. Sound policies provide essential guidance to educators; reassurance to families, students, and school staff members; legal protection for schools; and support for people with the virus. Well drafted and administered, they can also help to prevent or contain controversy.

Various laws establish parameters for policy options concerning HIV infection, notably the Americans with Disabilities Act and the Individuals with Disabilities Education Act. The policy development process should involve medical and legal experts and those affected by the policy, and welcome diverse points of view from the community. Locally developed procedures should accompany general statements of policy.

Education leaders need to actively communicate and engage in dialogue with the community about HIV-related school policies and procedures. Educators ought to work with their local health department to educate the public about medical and legal issues concerning HIV infection.
Finally, policymakers and educators should be aware that even if a state, school district, school or early childhood center has previously established policies regarding HIV infection, the challenge is not over. Policies adopted just a few years ago might not be adequate to deal with today's issues. New laws, scientific data, and lessons from experience continually emerge. This second edition of Someone at School has AIDS also aims to help those who are revising existing policies.

The following Sample Policy contains the essential areas of education policy concerning HIV infection that are covered in the guide.

**Preamble**

_**State/District/School**_ shall strive to protect the safety and health of children and youth in our care, as well as their families, our employees, and the general public. Staff members shall cooperate with public health authorities to promote these goals.

The evidence is overwhelming that the risk of transmitting human immunodeficiency virus (HIV) is extremely low in school settings when current guidelines are followed. The presence of a person living with HIV infection or diagnosed with acquired immunodeficiency syndrome (AIDS) poses no significant risk to others in school, day care, or school athletic settings.

**1. School Attendance**

A student with HIV infection has the same right to attend school and receive services as any other student, and will be subject to the same rules and policies. HIV infection shall not factor into decisions concerning class assignments, privileges, or participation in any school-sponsored activity.

School authorities will determine the educational placement of a student known to be infected with HIV on a case-by-case basis by following established policies and procedures for students with chronic health problems or students with disabilities. Decision makers must consult with the student's physician and parent or guardian; respect the student's and family's privacy rights; and reassess the placement if there is a change in the student's need for accommodations or services.

School staff members will always strive to maintain a respectful school climate and not allow physical or verbal harassment of any individual or group by another individual or group. This includes taunts directed against a person living with HIV infection, a person perceived as having HIV infection, or a person associated with someone with HIV infection.

**2. Employment**

The _**State/District/School**_ does not discriminate on the basis of HIV infection or association with another person with HIV infection. In accordance with the Americans with Disabilities Act of 1990, an employee with HIV infection is welcome to continue working as long as he or she is able to perform the essential functions of the position, with reasonable accommodation if necessary.
3. Privacy

Pupils or staff members are not required to disclose HIV infection status to anyone in the education system. HIV antibody testing is not required for any purpose.

Every employee has a duty to treat as highly confidential any knowledge or speculation concerning the HIV status of a student or other staff member. Violation of medical privacy is cause for disciplinary action, criminal prosecution, and/or personal liability for a civil suit.

No information regarding a person's HIV status will be divulged to any individual or organization without a court order or the informed, written, signed, and dated consent of the person with HIV infection (or the parent or guardian of a legal minor). The written consent must specify the name of the recipient of the information and the purpose for disclosure.

All health records, notes, and other documents that reference a person's HIV status will be kept under lock and key. Access to these confidential records is limited to those named in written permission from the person (or parent or guardian) and to emergency medical personnel. Information regarding HIV status will not be added to a student's permanent educational or health record without written consent.

4. Infection Control

All employees are required to consistently follow infection control guidelines in all settings and at all times, including playgrounds and school buses. Schools will operate according to the standards promulgated by the U.S. Occupational Health and Safety Administration for the prevention of blood-borne infections. Equipment and supplies needed to apply the infection control guidelines will be maintained and kept reasonably accessible. Designate shall implement the precautions and investigate, correct, and report on instances of lapse.

A school staff member is expected to alert the person responsible for health and safety issues if a student's health condition or behavior presents a reasonable risk of transmitting an infection.

If a situation occurs at school in which a person might have been exposed to an infectious agent, such as an instance of blood-to-blood contact, school authorities shall counsel that person (or, if a minor, alert a parent or guardian) to seek appropriate medical evaluation.

5. HIV and Athletics

The privilege of participating in physical education classes, athletic programs, competitive sports, and recess is not conditional on a person's HIV status. School authorities will make reasonable accommodations to allow students living with HIV infection to participate in school-sponsored physical activities.

All employees must consistently adhere to infection control guidelines in locker rooms and all play and athletic settings. Rulebooks will reflect these guidelines. First aid kits must be on hand at every athletic event.

All physical education teachers and athletic program staff will complete an approved first aid and injury prevention course that includes implementation of infection control guidelines. Student orientation about safety on the playing field will include guidelines for avoiding HIV infection.
6. HIV Prevention Education

The goals of HIV prevention education are to promote healthful living and discourage the behaviors that put people at risk of acquiring HIV. The educational program will:

- Be taught at every level, kindergarten through grade twelve;
- Use methods demonstrated by sound research to be effective;
- Be consistent with community standards;
- Follow content guidelines prepared by the Centers for Disease Control and Prevention (CDC);
- Be appropriate to students’ developmental levels, behaviors, and cultural backgrounds;
- Build knowledge and skills from year to year;
- Stress the benefits of abstinence from sexual activity, alcohol, and other drug use;
- Include accurate information on reducing risk of HIV infection;
- Address students’ own concerns;
- Include means for evaluation;
- Be an integral part of a coordinated school health program;
- Be taught by well-prepared instructors with adequate support; and
- Involve parents and families as partners in education.

Parents and guardians will have convenient opportunities to preview all HIV prevention curricula and materials. School staff members shall assist parents or guardians who ask for help in discussing HIV infection with their children. If a parent or guardian submits a written request to a Principal that a child not receive instruction in specific HIV prevention topics at school, and assures that the topics will be discussed at home or elsewhere, the child shall be excused without penalty.

The education system will endeavor to cooperate with HIV prevention efforts in the community that address out-of-school youth and youth in situations that put them at high risk of acquiring HIV.

7. Related Services

Students will have access to voluntary, confidential, age and developmentally appropriate counseling about matters related to HIV infection. School administrators will maintain confidential linkage and referral mechanisms to facilitate voluntary student access to appropriate HIV counseling and testing programs, and to other HIV-related services as
needed. Public information about resources in the community will be kept available for voluntary student use.

8. Staff Development

All school staff members will participate in a planned HIV education program that conveys factual and current information; provides guidance on infection control procedures; informs about current law and state, district, and school policies concerning HIV; assists staff to maintain productive parent and community relations; and includes annual review sessions. Certain employees will also receive additional specialized training as appropriate to their positions and responsibilities.


On an annual basis, school administrators will notify students, their family members, and school personnel about current policies concerning HIV infection, and provide convenient opportunities to discuss them. Information will be provided in major primary languages of students' families.

This policy is effective immediately upon adoption. In accordance with the established policy review process, or at least every three years, ___designate___ shall report on the accuracy, relevance, and effectiveness of this policy and, when appropriate, provide recommendations for improving and/or updating the policy.

Rationale

School Attendance--Sample Policy
A student with HIV infection has the same right to attend school and receive services as any other student, and will be subject to the same rules and policies. HIV infection shall not factor into decisions concerning class assignments, privileges, or participation in any school sponsored activity.

School authorities will determine the educational placement of a student known to be infected with HIV on a case-by-case basis by following established policies and procedures for students with chronic health problems or students with disabilities. Decision makers must consult with the student’s physician and parent or guardian; respect the student’s and family’s privacy rights; and reassesses the placement if there is a change in the student’s need for accommodations or services.

School staff members will always strive to maintain a respectful school climate and not allow physical or verbal harassment of any individual or group by another individual or group. This includes taunts directed against a person living with HIV infection, a person perceived as having HIV infection, or a person associated with someone with HIV infection.

Explanation
“To date, there has been no known case of HIV transmission in a school, day care center, or school athletic setting” (8). Current epidemiological data do not justify excluding children with HIV infection from school or isolating them in school to protect others. Children with HIV infection should be able to participate in all school activities with the same considerations as other children, to the extent that their health permits (9). Like other children with special health needs, children with HIV infection benefit from educational programs that provide necessary medical services, such as management of emergencies and administration of medications (9).

“Federal laws and the Supreme Court consider HIV infection and AIDS to be disabling conditions. Civil rights laws intended to protect the rights of persons with disabilities fully apply. These laws also protect uninfected people who are treated as if they have HIV infection and those who associate with people with HIV infection.” (8). Schools should have a written document outlining procedures to ensure fair and equitable treatment of both students and staff living with HIV/AIDS.

For guidance regarding accommodations required for Health Related Disabilities, schools should refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA) (3). For guidance regarding modification of learning activities, schools should refer to the Individuals with Disabilities Education Act (IDEA) and the State Board of Education Rules and Regulations for Serving Children with Disabilities (4).

Employment--Sample Policy
The [District / School] does not discriminate on the basis of HIV infection or association with another person with HIV infection, in accordance with the Americans with Disabilities Act of 1990. An employee with HIV infection is welcome to continue working as long as he or she is able to perform the essential functions of the position, with reasonable accommodation if necessary.
Explanation
An employee with HIV infection does not pose a risk of transmitting HIV to others in schools or other public places when current infection control guidelines are followed. Schools should have a written document outlining procedures to ensure fair and equitable treatment of staff living with HIV/AIDS.

Privacy--Sample Policy
Pupils or staff members are not required to disclose HIV infection status to anyone in the education system. HIV antibody testing is not required for any purpose.

Every employee has a duty to treat as highly confidential any knowledge or speculation concerning the HIV status of a student or other staff member. Violation of medical privacy is cause for disciplinary action, criminal prosecution, and/or personal liability for a civil suit.

No information regarding a person’s HIV status will be divulged to any individual or organization without a court order or the informed, written, signed, and dated consent of the person with HIV infection (or parent or guardian of a legal minor). The written consent must specify the name of the recipient of the information and the purpose for disclosure.

All health records, notes, and other documents that reference a person’s HIV status will be kept under lock and key. Access to these confidential records is limited to those named in written permission from the person (or parent or guardian) and to emergency medical personnel. Information regarding HIV status will not be added to a student’s permanent educational or health record without written consent.

Explanation
All school health records for all students and all employees should be treated as highly confidential at all times. Students and school district employees cannot be required to disclose HIV infection status to anyone in the educational system. However, voluntary disclosure to the district Superintendent, Principal, or school nurse can often benefit the person with HIV infection (8). The persons aware of a child’s HIV positive status should be strictly limited to those who need such knowledge to care for the child (9).

Schools must have a written policy outlining procedures to ensure the confidentiality of all student and all staff health records. Staff members who are well briefed on confidentiality and record keeping policies are better prepared if someone unexpectedly discloses HIV infection. Staff members need to know that they cannot share private medical information (either verbally or in writing) with anyone else without signed consent (8).

For additional guidance regarding confidentiality of school health records, refer to 34 CFR, Part 99, of FERPA (5). In addition, IDEA mandates the confidentiality of records of any student who receives special educational services.

Infection Control--Sample Policy
All employees are required to consistently follow infection control guidelines in all settings and at all time, including playgrounds and school buses. Schools will operate according to the standards promulgated by the U.S. Occupational Safety and Health Administration for the prevention of blood-borne infections. Equipment and supplies needed to apply the infection control guidelines will be maintained and kept reasonably accessible. (Designee) shall implement the precautions and investigate, correct, and report on instances of lapse.

A school staff member is expected to alert the designee indicated above, if a student’s health condition or behavior presents a reasonable risk of transmitting any infection.
If a situation occurs at school in which a person might have been exposed to an infectious agent, such as an instance of blood-to-blood contact, school authorities shall counsel that person (or, if a minor, alert a parent or guardian) to seek appropriate medical evaluation.

**Explanation**

The cornerstone for prevention of the spread of disease by blood borne pathogens is universal precautions. Everyone at school needs to consistently follow these guidelines, students and staff members alike, at all times (8). The principles of universal precautions include the use of safe practices and appropriate barriers (personal protective equipment) when contact is anticipated with blood or with body fluids that may transmit blood borne pathogens, such as HIV and the hepatitis B virus. Under universal precautions, everyone should be considered potentially infected with a blood borne pathogen, because infection status is usually unknown. Universal precautions apply when: a) touching blood or body fluids for which universal precautions apply, mucous membranes and non-intact skin, or b) handling items soiled with blood or body fluids, and c) when cleaning blood or body fluid contaminated surfaces with a bleach solution. The solution should be diluted 1:10 to 1:100 (three tablespoons per gallon) depending on the amount of body fluid present (2,8,9). A bleach mixture loses its strength in one day (8). Use of any other germicidal cleaning solutions should be OSHA approved.

Schools must have written infection control guidelines. Schools are encouraged to adopt the format for compliance provided by the *Bloodborne Pathogen Exposure Control Plan for Schools* (1997) which is produced by the Wyoming Department of Employment, Wyoming Worker’s Safety Program (10).

OSHA’s regulations call for employers to identify those who are “reasonably anticipated” to be exposed to blood as part of their job duties. The school must then offer the designated employees hepatitis B vaccine and intensive prevention training (7). This training is necessary for their own protection and so that they will possess the knowledge necessary to provide appropriate and timely advice to others who experience exposure incidents in the school setting.

For additional guidance concerning universal precautions and infection control procedures, refer to OSHA publication 3127, *Occupational Exposure to Bloodborne Pathogens and Wyoming General Rules 1910.1030* or call the Wyoming Department of Employment, Wyoming Worker’s Safety Program (307-777-7786). The WDE CSHE consultant can provide training videos on this topic.

Schools must have written procedures for handling exposure situations of students and staff. If a “high risk exposure” occurs at a school, school authorities shall counsel that person (or, if a minor, a parent or guardian) to seek appropriate medical attention, as soon as possible. A “high risk exposure” is defined as an event involving the introduction of blood into the blood stream, mucous membranes, and/or non-intact skin by splash or wound. The Wyoming Department of Health recommends that health care workers, who have experienced such an exposure incident, notify their local emergency room, preferably within one to two hours for guidance concerning the need for possible treatment (11).

It is also necessary for children to learn the principles of universal precautions. Children need this information so that they understand the proper course of action if they or another person is bleeding. This information is best presented in the context of Comprehensive School Health Education.
**HIV and Athletics--Sample Policy**

The privilege of participating in physical education classes, programs, competitive sports, and recess is not conditional on a person’s HIV status. School authorities will make reasonable accommodations to allow students living with HIV infection to participate in school-sponsored physical activities.

All employees must consistently adhere to infection control guidelines in locker rooms and all play and athletic settings. Rulebooks will reflect these guidelines. First aid kits must be on hand at every athletic event.

All physical education teachers and athletic program staff will complete an approved first aid and injury prevention course that includes implementation of infection control guidelines. Student orientation about safety on the playing field will include guidelines for avoiding HIV infection.

**Explanation**

People are often worried about HIV transmission in school sports programs because cuts, abrasions, and nosebleeds can be fairly common on the playing field (8). Therefore, adequate supplies to prevent blood borne infections should be available at all times.

For additional guidance concerning HIV and athletics, refer to the *Wyoming High School Activities Association Handbook*, Section 2.4.0 - Contagious Disease Policy.

**HIV Prevention Education--Sample Policy**

The goals of HIV prevention education are to promote healthful living and discourage the behaviors that put people at risk of acquiring HIV. The educational program will:

- be taught at every level, kindergarten through grade twelve
- use methods demonstrated by sound research to be effective
- be consistent with community standards
- follow content guidelines prepared by the Centers for Disease Control and Prevention
- be appropriate to students’ developmental levels, behaviors, and cultural backgrounds
- build knowledge and skills from year to year
- stress the benefits of abstinence from sexual activity, alcohol, and other drugs
- include accurate information on reducing risk of HIV infection
- address students’ own concerns
- include means for evaluation
- be an integral part of a coordinated school health program
- be taught by well-prepared instructors with adequate support
- involve parents, families, and communities as partners in education

Parents and guardians will have convenient opportunities to preview all HIV prevention curriculum and materials. School staff members shall assist parents or guardians who ask for help in discussing HIV infection with children. If a parent or guardian submits a written request to a principal that a child not receive instruction in specific HIV prevention topics at school, the child shall be excused without penalty.

The education system will endeavor to cooperate with HIV prevention efforts in the community that address out-of-school youth and youth in situations that put them at high risk of acquiring HIV.

**Explanation**

Each school district is strongly advised to organize a health advisory council to address school health and safety issues (6,7). Representatives of the school board, parents, school administrators and faculty and other staff, a school nurse, local health professionals, students,
minority groups, and other community members should be included. This council should develop policies and approve curriculum and other materials for school health education including K-12 HIV prevention education. The council should keep in mind the needs of minority students, out-of-school youth, those for whom English is not the primary language, and persons with visual or hearing impairments or other learning disabilities.

Students' health skills have to be built up year by year, just as their reading and math skills are. A single film, lecture, or school assembly is not sufficient to assure that students develop the complex understanding and skills needed to avoid HIV infection. However, non-curricular activities -- such as teen theater, presentations by persons living with HIV, and displaying panels of the AIDS memorial quilt -- are often very effective supplements to an HIV prevention curriculum. HIV prevention education is best presented as a component of Comprehensive School Health Education. The National Health Education Standards state that a minimum of 50 hours of classroom health instruction per school year, for grades K-12, is necessary to begin to affect student attitudes and practices (12). Opinion surveys consistently find overwhelming public and parental support for teaching HIV prevention in schools (8).

Adolescent health risk-taking behaviors are often clustered, that is, students who engage in one risky behavior often engage in other risky behaviors at the same time. Schools have the capacity to teach prevention skills before students become sexually active or use alcohol or other drugs. Most major HIV prevention curricula, designated for grades 7-12, are “abstinence based” and stress avoidance of all drugs (8).

Schools should refer to the WDE produced Comprehensive School Health Education Guidelines, section on disease prevention, and the National Health Education Standards for additional guidance (12, 13). We advise that all HIV prevention activities should be carefully monitored and process and outcome evaluation should be conducted on a regular basis.

For additional assistance with Comprehensive School Health Education or HIV Prevention Education, please contact the WDE CSHE consultant at 307-777-5315. The Wyoming Department of Education offers a variety of health education opportunities for schools to assist them in providing HIV prevention education to students. In addition to curriculum trainings, a variety of written materials and videos are available to schools at no cost. These materials have been previously reviewed and approved by the WDE Health Education Advisory Committee for use in school settings.

**Related Services--Sample Policy**

Students will have access to voluntary, confidential, age and developmentally appropriate counseling about matters related to HIV infection. School administrators will maintain confidential linkage and referral mechanisms to facilitate voluntary student access to appropriate HIV counseling and testing programs and to other HIV related services as needed. Public information about resources available in the community should be kept available for voluntary student use.

**Explanation**

Pupil services professionals such as counselors, psychologists, social workers and nurses should be ready to assist any member of the school community who has any concern about HIV infection (8).

For additional guidance concerning HIV testing and laws concerning STD counseling for minors, schools are encouraged to contact their county public health nursing office. School nurses should also refer to Recommendations for the School Health Nurse in Addressing HIV/AIDS with Adolescents (14). Copies of this booklet were mailed to all Wyoming public school nurses in the spring of 1998.
Staff Development--Sample Policy
All school staff members will participate in a planned HIV education program that conveys factual and current information; provides guidance on infection control procedures; informs about current law and state, district, and school policies concerning HIV; assists staff to maintain productive parent and community relations; and includes annual review sessions. Certain employees will also receive additional specialized training as appropriate to their positions and responsibilities.

Explanation
Schools should provide annual training to school personnel, including administrators, all teachers, coaches/athletic trainers, support personnel, counselors, school nurses and any other relevant staff about: a) the nature of the HIV virus and how HIV is spread; b) school policies concerning discrimination and confidentiality relevant to HIV positive students and staff; c) infection control guidelines including universal precautions and procedures for handling exposure situations. Additional training including the required OSHA information must be provided for designated personnel, such as custodians, coaches and nurses. In addition, a team of school personnel responsible for teaching HIV prevention education should receive more specific training, which may include one of the CDC’s research-based HIV prevention programs such as Reducing the Risk or Get Real About AIDS.

Staff development relating to infection control, non-discrimination, confidentiality, and HIV prevention education should be part of a district-wide HIV/AIDS education training plan. Training should be conducted at the start of each school year and should be evaluated and updated annually.

For assistance in planning and implementing HIV/AIDS staff development or HIV prevention education in your school, contact the Wyoming Department of Education’s Comprehensive School Health Education Consultant at 307-777-5315. The WDE has a wide variety of resources available for school use.

General Provisions--Sample Policy
On an annual basis, school administrators will notify students, their family members, and school personnel about current policies concerning HIV infection and provide convenient opportunities to discuss them. Information will be provided in major primary languages of students’ families.

Explanation
Families and communities should be informed about the district’s current HIV/AIDS policies. They should be provided an opportunity to voice concerns and provide input. Schools are further encouraged to develop guidelines for handling inquiries concerning student or staff HIV status as well as for handling voluntary disclosure by a person living with HIV or AIDS.

References Cited


**Additional HIV/AIDS Policy Resources**


---

Description of tool:
This tool provides essential information which school personnel at all levels can use to improve their ability to recognize and respond effectively to suspected or alleged child abuse. In addition, it is a very comprehensive and detailed example of appropriate guidelines for dealing with the problem(s) of child abuse which administrators and others responsible for student health issues at all levels could use to develop or improve their own school policies relating to this issue.

The information in this tool was excerpted by UNESCO from the following publication:


Description of document:
Recognizing that child abuse is a serious problem, both in terms of incidence and consequences, the Western Cape Education Department in South Africa developed this policy guide to assist educators to respond effectively to indications or allegations of such abuse. The policy provides detailed information to help users recognize the signs of potential abuse, and outlines the specific procedures to be followed by school district employees for managing suspected abuse, disclosures of abuse and alleged offenders. Though developed for educators, it includes important information for learners, parents and all others who seek to know more about the nature of child abuse, and how school personnel are obliged to respond to signs of child abuse among learners in their care.

This information or activity supports Core Component #1 of the FRESH framework for effective school health: school health policies. It will have a greater impact if it is reinforced by activities in the other three components of the framework.
Policy on Sexual Abuse in Schools: Sample from South Africa

1.1 Introduction

Child abuse is a serious problem that currently exists in communities and educational institutions throughout South Africa. Because of its high prevalence, this policy document has been developed to help institutions, employees and learners of the Western Cape Education Department (WCED) to deal with the problem in the most efficient and effective way.

The reporting procedures contained in this policy may be used by learners, educators, employees, parents, caregivers or any other person. All WCED employees must therefore ensure that they are fully conversant with the contents of this policy document and that they have a clear understanding of their role and function in managing the process of combating child abuse.

Effective management of child abuse can only be achieved, however, if procedures are based on a strong legal foundation. As a basis for this policy document all relevant legislation regarding children has been considered and applied.

1.2 Purpose

The purpose of this policy is to put measures and procedures in place to respect and protect the rights of learners, particularly their rights to safety, personal security, bodily integrity, equal treatment and freedom from discrimination, and especially to create an environment where learners can maximise their opportunity to learn, free from abuse.

1.3 Objectives

The main thrust of this policy document is to manage abuse where the learner is involved. All procedures provided in this document, therefore, have a clear educational focus (prevention, timely intervention, and support).

1.3.1 Primary objectives:

To provide procedures for:

- The identification of abuse;
- The management of suspected abuse;
- The management of disclosure; and
- Intervention.
1.3.2 Secondary objectives:

The protection of children is not the responsibility of statutory and formal welfare organisations only, but the legal duty of every citizen.

The secondary objectives, therefore, are:

- To develop and sustain a multi-disciplinary approach in order to involve the community and other departments as well as private individuals in the process of identification, referral, support and intervention.

- To develop a strategy for the effective management of child abuse by:
  - targeting certain employees at institutions and EMDCs by making them both accountable and responsible;
  - creating mechanisms and structures for effective reporting and investigation of complaints, and for intervention; and
  - developing a system of joint accountability at institutions and EMDCs in monitoring and reviewing complaints and incidents of child abuse.

1.4 Accountability and Responsibility

1.4.1 At institutional level –

- The manager of the institution is accountable for implementing, managing and sustaining the policy and procedures described in this document. These must be managed in such a manner that confidentiality is maintained at all times. The manager may be assisted in the process by a management committee.

- All educators are legally bound to report all matters of suspected child abuse (see paragraph 3.1.3, Step 1). Such matters must always be reported to the manager of the institution unless she or he is implicated in the abuse.

1.4.2 At EMDC level –

- The head of the Specialised Learner and Educator Support component will be responsible for managing the implementation of this policy in all institutions in the area of the EMDC. All incidents of abuse should be reported to this person.

Section 2

Definitions

In this policy document, unless the context indicates otherwise, the following definitions apply:

“Alleged Employee Offender” means the employee or educator against whom a complaint has been laid.

“Alleged Learner Offender” means the learner against whom a complaint has been laid.
“Alleged Other Offender” means any other person against whom a complaint has been laid.

“Alleged Parent Offender” means the parent or guardian or person legally entitled to custody of a learner, including the learner’s primary caregiver, who may not legally be deemed to be the learner’s parent or guardian, against whom a complaint has been laid.

“Child abuse” means any action or inaction which is detrimental to the physical, emotional and developmental well-being of the child. It includes (but is not limited to) neglect, emotional abuse, physical abuse, sexual harassment and sexual abuse.

“Complainant” means a learner who has lodged a complaint of child abuse, stalking, intimidation or the breach of an interim or final protection order granted in terms of the Domestic Violence Act, no. 116 of 1998.

“Documentation” includes the following:

- Notes or letters from parents;
- Medical certificates from medical practitioners;
- Notes and letters from the learner;
- Drawings made by the observing employee or educator of injuries on the body of the learner;
- Any other form of information or evidence that could be used to verify the complaint.

“EAP” means Employee Assistance Programme. This programme serves as a systemic and preventative approach to resolving problems that employees may experience. The programme also focuses on intervention strategies and professional assistance to employees through counselling and guidance.

“EMDC” means Educational Management and Development Centre.

“Emotional Abuse” means a pattern of degrading or humiliating conduct towards a complainant which may include:

- Repeated insults, ridicule or name-calling;
- Repeated threats to cause emotional pain; or
- Repeated exhibition of obsessive possessiveness or jealousy which is such as to constitute a serious invasion of a complainant’s privacy, liberty, integrity and/or security.

“Educator” means an educator as defined in the South African Schools Act, no. 84 of 1996, or the Employment of Educators Act, no. 76 of 1998.

“Employee” means an educator as defined above and also an employee, head, administrative staff-member, support staff-member or contract worker as well as any educator appointed under the Employment of Educators Act, no. 76 of 1998, or the Public Service Act of 1994.

“Governing body” means a governing body as defined in the South African Schools Act, no. 84 of 1996.
“Head: Specialised Learner and Educator Support (H: SLES)” means the person managing the Specialised Learner and Educator Support component at an EMDC.

“Institution Manager” means the head of any mainstream school, school for learners with special education needs (ELSEN school), college, technical college, or any other institution within the jurisdiction of the WCED.

“Institution” means a mainstream school, ELSEN school, college, technical college or any other institution within the jurisdiction of the WCED.

“Intimidation” means uttering or conveying a verbal or non-verbal threat, or causing a complainant to receive a threat, which induces fear. It includes:
- repeated threats to cause emotional pain, and
- repeated exhibition of obsessive possessiveness or jealousy which is such as to constitute a serious invasion of a complainant’s privacy, liberty, integrity and/or security.

“Labour Relations” means the Directorate: Labour Relations of the WCED.

“Learner” means any pupil enrolled in any institution within the jurisdiction of the WCED.

“Management” means the function of guiding the process and being responsible and accountable for the plan of action to be undertaken.

“Neglect” means any act or omission by a parent or any other person entrusted to care for a learner, which results in impaired physical functioning, impaired physical development, or injury or harm to the learner.

“Parent” means the biological, adoptive, foster- or step-parent or the guardian or person legally entitled to custody of a learner, including the learner’s primary caregiver (who may legally be deemed not to be the learner’s parent or guardian).

“Physical Abuse” means any act or threatened act of physical violence which may cause injury or even death to a learner.

“Referral” means the activation of the process in which the alleged child abuse will be followed up and the learner will receive support, therapy and/or counselling.

“Reporting” means giving all available information obtained from the learner to the appropriate body, either telephonically or by written report.

“SAPS” means the South African Police Services.

“Sexual Abuse” means any unlawful physical act of a sexual nature and includes indecent assault, sexual harassment, attempted rape and rape.

“Sexual Harassment” is unwanted conduct of a sexual nature. The unwanted nature of sexual harassment distinguishes it from behaviour that is welcome and mutual. Sexual attention becomes sexual harassment if:
- the behaviour is persisted in, although a single incident of harassment can constitute sexual harassment; and/or
• the recipient has made it clear that the behaviour is considered offensive; and/or
the perpetrator should have known that the behaviour is regarded as unacceptable.

Sexual harassment may include unwelcome physical, verbal or non-verbal conduct, and is not limited to the examples listed below:

(a) **Physical conduct** of a sexual nature includes all unwanted physical contact, ranging from touching to sexual assault and rape.

(b) **Verbal forms of sexual harassment** include:
- unwelcome innuendoes, suggestions, comments, advances and phone calls of a sexual nature;
- sex-related jokes and insults;
- unwelcome comments about a person's body made in a person's presence and directed towards that person;
- unwelcome and inappropriate enquiries about a person's sex life; and unwelcome whistling or suggestive sounds directed at a person or group of persons.

(c) **Non-verbal forms of sexual harassment** include:
- unwelcome gestures and indecent exposure;
- the unwelcome display of sexually explicit objects or publications (pictures and printed text); and
- the sending of letters, faxes and electronic mail containing remarks with sexual connotations.

(d) **Quid pro quo sexual harassment (sexual blackmail)** occurs when an employee or another learner influences or attempts to influence a learner's academic results, leadership position, standing at the school or sporting achievements in exchange for sexual favours.

“**Stalking**” means repeatedly following, pursuing, or accosting the complainant.

“**TST**” means the Teacher Support Team at an Institution as defined above.

---

**Note to the employee:**

- Although sexual harassment is included as a part of the definition of child abuse, the definition of sexual harassment, above, is provided to emphasise its seriousness.

- The definition is internationally accepted and is set out in the Code of Good Practice on the Handling of Sexual Harassment (Government Gazette, 17 July 1998).
3.1 The management of suspected child abuse

3.1.1 Flow chart of the process where an educator suspects child abuse:

The flow chart below shows the course to be followed by the various role-players responsible for managing child abuse.

![Flow chart of the process where an educator suspects child abuse](image)

3.1.2 The identification of suspected child abuse

3.1.2.1 Information-gathering

There are various reasons why children do not discuss child abuse. It is therefore the duty of the educator to be mindful of the symptoms and characteristics of child abuse and to be able to identify them.

**Note to the educator:**

The following symptoms and characteristics of physical abuse, neglect, sexual abuse, emotional abuse and rape trauma syndrome are provided to help you identify these different forms of child abuse.
### Physical Abuse

<table>
<thead>
<tr>
<th>Behaviour of an adult who abuses children</th>
<th>Behaviour of an abused child</th>
<th>Physical indications of child abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complains that the child is difficult to control;</td>
<td>• Cannot explain injuries, or gives inconsistent explanations;</td>
<td>• Injuries – bruises, cuts, burns, fractures;</td>
</tr>
<tr>
<td>• Little knowledge of child development. Makes unrealistic demands, e.g. expects good bowel control at too early an age;</td>
<td>• Absconds;</td>
<td>• Various injuries, various degrees of healing;</td>
</tr>
<tr>
<td>• May indicate that child is prone to injuries. Lies about how the child was injured;</td>
<td>• Cringes or withdraws when touched;</td>
<td>• Various injuries over a period of time;</td>
</tr>
<tr>
<td>• Gives contradictory explanations about how the child was injured;</td>
<td>• Babies stare with empty expression, rigid carriage, on guard;</td>
<td>• Head injuries on babies and pre-school children, e.g. cuts, bruises, burn marks, abrasions which cannot be satisfactorily explained;</td>
</tr>
<tr>
<td>• Inappropriate or excessive use of medical service;</td>
<td>• Extremely aggressive or withdrawn;</td>
<td>• Injuries such as fractures, abrasions, burns and bruises which cannot be explained;</td>
</tr>
<tr>
<td>• Seems unconcerned about the welfare of the child.</td>
<td>• Seeks attention from anyone who cares;</td>
<td>• Inappropriate clothing to cover the body.</td>
</tr>
</tbody>
</table>

### Neglect

<table>
<thead>
<tr>
<th>Behaviour of an adult who abuses children</th>
<th>Behaviour of an abused child</th>
<th>Physical indications of child abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Behaviour indicates rejection of the child, e.g. child is left in cot or bedroom for long periods of time;</td>
<td>• Listless and makes few or no demands, e.g. seldom cries;</td>
<td>• The child does not grow, and/or loses a lot of weight (though this may also indicate under-development. A medical examination is necessary to determine the case.)</td>
</tr>
<tr>
<td>• Ignores the child’s loving approaches, refuses to hold the child’s hand or hold her or him close;</td>
<td>• Little or no interest in the environment;</td>
<td>The following physical characteristics are often present in neglected children:</td>
</tr>
<tr>
<td>• Indicates the child is unwelcome;</td>
<td>• Little or no movement, e.g. lies still in bed;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does not react to strangers’ attempts to stimulate her or him;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The following physical characteristics are often present in neglected children:</td>
</tr>
</tbody>
</table>
- Indicates the child is difficult to care for, e.g. the child is “demanding” and “difficult to feed”.
- Shows little fear of strangers, e.g. does not react to them;
- Begs or steals food;
- Continually tired, listless or falling asleep;
- Says that nobody at home looks after her or him;
- Irregular attendance at school;
- Destructive and aggressive;
- Inappropriate clothing, poor personal hygiene, continually hungry;
- Physical and medical needs don’t receive attention.
- Child is pale and emaciated;
- Very little body fat in relation to build, e.g. folds on buttocks; skin feels like parchment owing to dehydration;
- Constant vomiting and/or diarrhoea;
- Developmental milestones not reached within normal age-ranges, e.g. neck still limp at 6 months, cannot walk at 18 months.

## Sexual Abuse

<table>
<thead>
<tr>
<th>Behaviour of an adult who abuses children</th>
<th>Behaviour of an abused child</th>
<th>Physical indications of child abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceptionally protective towards child and jealous;</td>
<td>Sexual play with self, others and toys;</td>
<td>Pain or unusual itching of genitals or in anal area;</td>
</tr>
<tr>
<td>Discourages contact with peer-group when there is no supervision;</td>
<td>Sexual vocabulary and/or behaviour not age-appropriate;</td>
<td>Torn, stained or bloodstained underwear;</td>
</tr>
<tr>
<td>Acts seductively towards child;</td>
<td>Drawings or descriptions with sex theme not age-appropriate;</td>
<td>Pregnancy;</td>
</tr>
<tr>
<td>Indicates that the spouses have marital problems;</td>
<td>Strange, sophisticated or unusual sexual knowledge, e.g. flirtation;</td>
<td>Injuries to genitals or anal area, e.g. bruises, swelling or infection;</td>
</tr>
<tr>
<td>Abuses alcohol and/or drugs.</td>
<td>Promiscuity and/or prostitution;</td>
<td>Sexually transmitted diseases;</td>
</tr>
<tr>
<td></td>
<td>Continual absconding;</td>
<td>Difficulty in sitting or walking;</td>
</tr>
<tr>
<td></td>
<td>Fear of seduction by members of the opposite sex;</td>
<td>Regular urinary infection;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Throat irritations and/or soreness or mouth sores owing to forced oral sex.</td>
</tr>
</tbody>
</table>
Emotional Abuse

<table>
<thead>
<tr>
<th>Behaviour of an adult who abuses children</th>
<th>Behaviour of an abused child</th>
<th>Physical indications of child abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Blames the child for own problems and disappointments – child is seen as a scapegoat;</td>
<td>• Aggression, depression or extreme withdrawal;</td>
<td>• Enuresis (bedwetting) and/or encopresis (soiling) for which there is no physical cause;</td>
</tr>
<tr>
<td>• Continually expresses negative feelings about the child to other people and the child;</td>
<td>• Extreme compliance; too well-mannered, too neat, too clean;</td>
<td>• Continual psychosomatic complaints, e.g. headache, nausea, stomach pain;</td>
</tr>
<tr>
<td>• Conduct towards the child expresses continual rejection;</td>
<td>• Extreme attention-seeking;</td>
<td>• Child does not grow and develop according to expectations.</td>
</tr>
<tr>
<td>• Withholds herself or himself from verbally or behaviourally expressing love to the child;</td>
<td>• Extreme control when she or he plays – suppresses own feelings.</td>
<td></td>
</tr>
<tr>
<td>• Continually trying to bribe, influence or terrify the child;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Continually trying to isolate the child, e.g. by prohibiting contact inside and outside the family.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Rape Trauma Syndrome
(Source: “Rape Trauma Syndrome” – Rape Crisis Cape Town Trust)

<table>
<thead>
<tr>
<th>Physical indications of rape</th>
<th>Behaviour of a rape survivor</th>
<th>Psychological / emotional indications of rape</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Immediately after a rape, survivors often experience shock; they are likely to feel cold, faint, become mentally confused (disorientated), tremble, feel nauseous and sometimes vomit.</td>
<td>• Crying more than usual.</td>
<td>• Intrusive thoughts and feelings about being dirty from (contaminated by) the rape. These feelings often make rape survivors wash or bath more frequently. These thoughts are known as obsessional thoughts.</td>
</tr>
<tr>
<td>• Pregnancy.</td>
<td>• Difficulty in concentrating.</td>
<td>• Flashbacks – the sudden feeling that the rape is happening again, which makes the survivor very frightened and upset.</td>
</tr>
<tr>
<td>• Sexually transmitted diseases like AIDS, syphilis and/or gonorrhoea; gynaecological problems like irregular, heavier and/or painful periods, vaginal discharges and bladder infections.</td>
<td>• Being restless, agitated and unable to relax, or on the other hand just sitting around and moving very little.</td>
<td>• Nightmares about the rape.</td>
</tr>
<tr>
<td>• Bleeding and/or infections from tears or cuts in vagina or rectum, depending on what happened during the rape.</td>
<td>• Not wanting to go out and/or socialise, or on the other hand socialising more than usual.</td>
<td>• Being very upset by anything that reminds the survivor of the rape.</td>
</tr>
<tr>
<td>• A soreness of the body. There may also be bruising, grazes, cuts, etc.; depending on the kind of force used during the rape.</td>
<td>• Not wanting to be left alone.</td>
<td>• Becoming extremely afraid of certain things that remind the survivor of the rape: such extreme fears are called phobias. Rape survivors often develop extreme fears of men, of strangers, of being alone, of leaving their homes, of going to school or to work, and of sex. These phobias are called traumaphobias, because they are caused by a trauma.</td>
</tr>
<tr>
<td>• Nausea and/or vomiting.</td>
<td>• Stuttering or stammering more than usual.</td>
<td>• A loss of memory of part or all of the rape, which is called psychogenic amnesia.</td>
</tr>
<tr>
<td>• Throat irritations and/or soreness owing to forced oral sex.</td>
<td>• Trying to avoid anything that reminds the survivor of the rape, e.g. someone who was raped at a party may stop going to parties.</td>
<td>• Being unable to feel certain feelings like happiness, or feeling very “flat”. On the other</td>
</tr>
<tr>
<td>• Tension headaches.</td>
<td>• Many rape survivors don’t want to talk about what happened, because it makes them remember the rape.</td>
<td></td>
</tr>
<tr>
<td>• Pain in lower back and/or stomach.</td>
<td>• More easily frightened or startled than usual; Rape survivors often get very scared when someone walks up behind them without warning.</td>
<td></td>
</tr>
<tr>
<td>• Sleep disturbances like difficulty falling asleep, waking up during the night, being woken by nightmares about the rape.</td>
<td>• Being very alert and watchful.</td>
<td></td>
</tr>
<tr>
<td>Reaction</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>rape, getting less sleep than usual, or on the other hand feeling</td>
<td>• Losing interest in things that used to be of interest to them before the rape.</td>
<td></td>
</tr>
<tr>
<td>exhausted and needing to sleep more than usual.</td>
<td>• Problems in relationships with people like family, friends, lovers and spouses. Rape survivors may become irritable and so may quarrel with others more easily; or they may withdraw from people with whom they had been close before the rape. They may also become very dependent on others, or on the other hand overly independent.</td>
<td></td>
</tr>
<tr>
<td>• Eating disturbances such as not feeling like eating, eating less than</td>
<td>• Sexual problems like a fear of sex, a loss of interest in sex or a loss of sexual pleasure.</td>
<td></td>
</tr>
<tr>
<td>usual and so losing weight, or on the other hand eating more than</td>
<td>• Changes in work or school, e.g. playing truant, dropping out of school, changing jobs, or stopping work altogether.</td>
<td></td>
</tr>
<tr>
<td>usual and so putting on weight.</td>
<td>• Moving house.</td>
<td></td>
</tr>
<tr>
<td>• Feeling that they will not live for very long and/or feeling very</td>
<td>• Increased use of substances like alcohol, cigarettes and/or drugs. A person who didn’t use a substance before the rape may start to use it afterwards.</td>
<td></td>
</tr>
<tr>
<td>negative about their future prospects.</td>
<td>• Increased washing and/or bathing, because of a feeling of being dirty from the rape.</td>
<td></td>
</tr>
<tr>
<td>• Feeling depressed and/or sad, and sometimes having thoughts of</td>
<td>• Acting as if the rape never happened.</td>
<td></td>
</tr>
<tr>
<td>suicide.</td>
<td>hand, rape survivors can feel emotionally confused and have mood swings (quick changes of mood).</td>
<td></td>
</tr>
<tr>
<td>• Feeling irritable and angry.</td>
<td>• Feeling more fearful and anxious than usual. Rape survivors are often very afraid that their assailant(s) will return, that they are pregnant and/or that they have been infected with a disease from the rape.</td>
<td></td>
</tr>
</tbody>
</table>
Note to the educator:
Use the following procedure to identify possible incidents of child abuse:

- Start gathering information as soon as you suspect child abuse. Continue to do so consistently, and document all information gathered. Treat all this information as confidential.
- Discuss your suspicions and the information that you have gathered with the institution manager (unless she or he is possibly implicated).
- Ensure confidentiality by opening a separate file for the particular learner. This file must be kept in the strongroom or safe (see note after Step 9, paragraph 3.2.1.2 in Section 3: Part 2).
- The institution manager and the educator must consult the list of criteria (see the tables above) to verify the information before making any allegations of child abuse.
- Remain objective at all times and do not allow personal matters, feelings or pre-conceptions to cloud your judgement.

Note to the educator:

- Any information to do with child abuse is confidential and must be handled with great discretion.
- The reporting and investigation of child abuse must be done in such a way that the safety of the learner is ensured.
- Justice must not be jeopardised, but at the same time the support needed by the learner and her or his family must not be neglected.

3.1.3 Management procedures when child abuse is suspected by the educator:

Step 1
Report your suspicions to the institution manager.

Note to the educator:

Section 15 of the Child Care Amendment Act 96 of 1996 states that a physician, nurse, social worker, or educator must report child abuse or the suspicion of child abuse. Educators are legally protected if their actions are well-intentioned. Failure to report child abuse or the suspicion thereof will be prosecuted.

Step 2
The institution manager and the educator will discuss the observations or incident with the H: SLES at the EMDC (for the attention of the school social worker) who will help the institution to determine:
• whether there are reasonable grounds to suspect child abuse; and
• which external role-players to involve in the process, such as the local welfare organisation(s) or the local social worker of the Department of Welfare, the SAPS, the Child Protection Unit, and (if an employee is involved) Labour Relations.

Step 3
If there are reasonable grounds for suspecting child abuse (as confirmed by, for example, an external role-player who is involved in the process), the institution manager will:

• discuss the matter with the parents or caregivers (unless the parent or caregiver is the suspected abuser); and
• report the case or incident to the H: SLES at the EMDC, who will keep a confidential record of all such cases or incidents.

**Note to the educator:**
If it appears that the learner and/or her or his family require support (e.g. by the TST or by the Specialised Learner and Educator Support component at the EMDC), the institution manager must ensure that this support is provided and sustained.

If the institution manager is the suspect, the educator must report directly to the H: SLES at the EMDC.

Step 4
The institution manager will maintain contact with the internal and external role-players and will forward a report to the H: SLES on progress in the matter.

**Note to the educator:**
Internal support (if needed) could be provided by the TST, e.g. in helping academic progress, or by the Specialised Learner and Educator Support component at the EMDC, e.g. in providing psychological or emotional support.

**Note to the educator:**
The best interests of the learner are paramount in every incident that involves her or him. It is therefore important to manage any suspected abuse effectively in order to protect the learner and the educator from additional and unnecessary trauma. The trust that the learner will experience and develop in you, as well as in the process (including the support provided) at this stage, will largely determine whether she or he will be prepared to lodge a complaint or disclose information.
4.2 The management of disclosure

3.2.1 The management of disclosure applicable to educators and other employees (hereinafter all referred to as “employees”):

3.2.1.1 Introduction

Disclosure is a process that usually takes time, especially in cases of sexual abuse. It is therefore seldom done in one single isolated event. Learners often disclose only small amounts of information at a time over a period, or write a letter to the employee pleading for help.

**Note to the employee:**

Disclosure reaches a key stage when a learner provides the employee with specific information about the fact that she or he has been or is being abused or when the learner lodges a complaint after being abused. Once a learner has done this, she or he is referred to as the **complainant** in the case.

**Note to the employee:**

- Disclosure can be a very traumatic experience. Prevent further emotional harm to the complainant. The details of the abuse should be related to as few people as possible.
- Display empathy, warmth and acceptance.
- Try to ensure the safety of the complainant against further abuse.
- Clarify confidentiality, but explain that other professional persons will have to be informed.
- Identify the other role-players who are to be involved, as well as their roles and functions.
- Explain the potential consequences of the disclosure, i.e. that the employee is legally bound to report the case e.g. to the SAPS.
- Cases of sexual abuse or rape must be reported as soon as possible.
- Under no circumstances should the incident of child abuse be discussed with the alleged offender.
- **DO NOT** interrogate the complainant in order to obtain information or to “investigate” the case.
**Note to the employee:**
When disclosure takes place it is necessary to communicate the following to the complainant:

- I believe what you are telling me.
- I acknowledge that you feel uncomfortable about the incident.
- I appreciate your courage in speaking to me.
- I am sorry to hear what has happened to you.
- It is not your fault.
- In order to help you, I will have to speak to another person.
- Whatever may happen to the alleged offender is not your fault.

**Note to the employee:**
- The complainant may be unwilling to lay a charge against the alleged offender because of intimidation.
- The complainant may feel powerless and may have been sworn to secrecy by the alleged offender.
- The complainant may be related to the alleged offender and may want to protect the family.
- The complainant may feel that she or he lacks support because no one will believe her or him.
- Often the mother has divided loyalties and protects the father (or boyfriend, uncle, brother, grandfather, etc.) because of financial or emotional dependence.
- The complainant may love the alleged offender and just want the abuse to stop.
- The complainant may be afraid of being removed from the family.

Effective management of the process of disclosure will ensure that both complainant and employee are protected from additional and unnecessary emotional trauma. It is therefore important to ensure that:

- the case is handled confidentially, and within a very short time;
- all relevant role-players are involved from the beginning of the intervention; and
detailed plans to manage support and intervention are made in the best interest of the complainant.

**Note to the employee:**

Disclosure by a learner may be traumatic for you. You can ask for personal professional assistance from the EAP or from the Specialised Learner and Educator Support component at the EMDC.

**Note to the employee:**

Documenting all the information gathered from the complainant helps you to develop a profile of her or him and of the possible abuse that is taking place. It will also help you when the SAPS takes a sworn statement, should a criminal case be made.

**Note to the employee:**

- You can use the 8 point list which follows as a guideline to ensure that you have enough information about the disclosure.
- You must, however, ensure that the information is obtained as objectively as possible.
- Avoid all risk of putting words in the complainant’s mouth.
- Do not use the list as a question-and-answer session. The complainant must be given the opportunity to speak spontaneously.

### DISCLOSURE INFORMATION GUIDELINES

1. **THE COMPLAINANT’S DETAILS:**
   - Name in full
   - Age
   - Sex
   - Present grade
   - Home address and telephone number
   - Details of parents or caregiver

2. **THE NATURE OF THE INCIDENT:**
   - What did the alleged offender say to the complainant?
   - What action did the alleged offender take against the complainant?
   - Where did the alleged offender touch the complainant?
   - Did the alleged offender threaten the complainant?
   - What did the complainant say or do during the incident?
3. **WHEN AND WHERE THE INCIDENT(S) TOOK PLACE:**
   - The date(s) when the incident(s) occurred;
   - The time(s) when the incident(s) occurred;
   - The place(s) where the incident(s) occurred.

4. **THE CIRCUMSTANCES SURROUNDING THE INCIDENT:**
   - Were there any other people present at the time of the incident?
   - Were there any other people who were in the surrounding area who might have witnessed the incident?
   - If there were witnesses, get their full particulars, i.e. for each:
     - Full name
     - Home address and telephone number
     - Age, sex and present grade
   - If the complainant does not know these details, ask her or him the following:
     - What were the physical attributes of the witness?
     - Sex and approximate age and height of the witness?
     - Did the witness have any distinguishing features?

5. **HOW DID THE COMPLAINANT EXPERIENCE THE INCIDENT?**
   - How did the complainant feel at the time of the incident?
   - Record the complainant's feelings in her or his own words.
   - How is she or he feeling now?
   - Is she or he experiencing any physical or psychological symptoms, and if so what are these symptoms?
   - Write down the words that the complainant uses to describe the incident.

6. **FIRST DISCLOSURE BY THE COMPLAINANT:**
   - Has the complainant related the details of the incident to anyone?
   - If so, obtain the following details:
     - Full name;
     - Home address and telephone number;
     - Age and sex;
     - Nature of the person's relationship to the complainant.
     - Has the complainant reported the incident to the South African Police Services?
     - If so, obtain the following details:
       - The case number;
       - The name of the police station and the investigating officer;
       - The date on which the incident was reported;
       - Details of any witnesses who have made statements to the SAPS.

7. **DETAILS OF ANY MATERIAL EVIDENCE:**
   - Has the complainant been to a hospital, general practitioner, district surgeon, social worker, clinic, psychologist or psychiatrist?
   - If so, obtain the following details:
     - The reference number, if any;
     - Information whether there is a J88;
     - The name of the hospital or clinic;
- The name and telephone number of the general practitioner, nurse, social worker, district surgeon, psychologist or psychiatrist;
- The dates on which the complainant attended one or more of these services.

- Obtain the originals or copies of any relevant documents in the complainant’s possession, including any letters or notes received from the alleged offender.
- Are there any clothes with stains or any other evidence of the incident? If so, obtain the originals or copies thereof, place them in a bag, and if the matter is reported to the SAPS, hand them over for forensic testing.

8. DETAILS OF THE ALLEGED OFFENDER:

- The full name of the alleged offender;
- Her or his position at the institution;
- If the complainant does not know these details, ask:
  - What were the physical attributes of the alleged offender?
  - What were her or his sex and approximate age and height?
  - Did she or he have any distinguishing features?

3.2.1.2 General steps to be followed after disclosure

The following flow chart shows the procedure for dealing with a complaint that has been lodged by a complainant with an employee.
STEP 1
Ensure the safety of the complainant. (In collaboration with the SAPS and the social worker, ensure that the complainant will not have direct contact with the alleged offender.)

**Note to the employee:**

It is important to ensure that the social worker and/or the SAPS become involved as soon as possible.

STEP 2
Clarify confidentiality, but explain to the complainant the potential consequences of the disclosure, i.e. that in order to help her or him, you are legally obliged to report the case to other role-players such as the social worker and/or the SAPS. Explain the roles they will play. Explain also the procedures that will be followed (Steps 3 – 9 below).

STEP 3
Inform the institution manager (unless she or he is implicated). No detailed information about the abuse needs to be disclosed at this stage.

STEP 4
The institution manager and the employee immediately contact the relevant role-players in order to decide on the process of intervention.

**Role-players to be contacted:**

The school social worker at the EMDC will help the institution manager and the employee to decide on the involvement of other relevant agencies, e.g.

- The Department of Welfare;
- The local welfare organisation;
- The school psychologist;
- The Child Protection Unit;
- The SAPS in the residential area of the complainant;
- Labour Relations, when employees are the alleged offenders;
- The complainant’s parent(s) (with the consent of the complainant, if she or he is over 14), provided that they are not the alleged offenders;
- The Child Protection Centre;
- The Department of Health school nurse (if available), or (if applicable) the ELSEN school nurse.

STEP 5
The institution manager and the employee compile a confidential report that will be used by the social worker and the SAPS. To protect its confidentiality this report must be kept locked in the strongroom or safe with all the relevant documentation on the case.
STEP 6
The institution manager and the employee will meet with the relevant role-players (mentioned in Step 4 above) to draw up a plan of action setting out the responsibility of each participant in the intervention process. Give the H: SLES this information for the attention of the school social worker.

STEP 7
The institution manager follows up with all participants on the progress of the intervention. All information is documented and reported to the employee and all others who will be supporting the complainant.

Pass on this information regularly to the H: SLES for the attention of the school social worker.

STEP 8
Keep the complainant and her or his parent(s) informed of the steps taken by the role-players and the outcome of the investigation.

STEP 9
The institution manager and the employee will monitor the complainant’s emotional, mental and physical health, discuss it with her or his parents, and refer it for further professional help if necessary.

Note to the employee:

- When a learner communicates a complaint to you or when you suspect abuse, open a folder or file for the case.
- All relevant statements and documents about the case must be placed in this folder. If the alleged offender is an employee, the original documents must be forwarded as confidential to the H:SLES at the EMDC for the attention of the Labour Relations officer and copies of the documents must be kept in the folder.
- Do not put a name on the folder, and entrust it directly to the institution manager.
- The institution manager must give the case a number, put this number on the folder, and record it in a confidential register which reflects the name and number of every case.
- So as not to reveal the identity of the complainant, both the folder and the confidential register must at all times be kept in a locked cabinet or safe to which only the institution manager has access. She or he is therefore the only person who can retrieve a folder or file when it is needed.

Note to the employee:

Once a complaint has been lodged with an employee by a complainant, the institution manager and the employee must refer the matter to the relevant role-players within three days.
3.2.1.3 Additional procedures after disclosure (or a complaint) has revealed that the alleged offender is a learner:

**Note to the employee:**

Young alleged offenders need to be supported by the system. This should be seen as an attempt to prevent them from committing further abuse. They must therefore be supported as described in the *previous nine steps*. It is important to note and implement the following if necessary:

- **3.2.1.3.1** Contact the alleged learner offender’s parents, inform them of the incident(s) and discuss a plan of action for support and intervention.
- **3.2.1.3.2** Refer the alleged learner offender to relevant role-players for emotional support and therapy (see Step 4, paragraph 3.2.1.2 above).
- **3.2.1.3.3** Depending on the seriousness of the offence, temporary suspension of the alleged learner offender can be arranged, but only if it is in the best interests of other learners and the school.
- **3.2.1.3.4** The institution manager shall refer the complaint to the governing body of the school. If the alleged offence was serious enough to merit suspension or expulsion, the procedures laid down for these in the *South African Schools Act (Act no. 84, 1996)*, paragraph 9, must be followed.

3.2.1.4 Additional procedures after disclosure (or a complaint) has revealed that the alleged offender is an employee:

- **3.2.1.4.1** The parent or employee to whom the disclosure was made informs the institution manager.
- **3.2.1.4.2** The institution manager informs the H: SLES at the EMDC of the incident, for the attention of the EMDC’s Labour Relations section.
- **3.2.1.4.3** The Labour Relations officer (helped by members of the multi-functional team at the EMDC) and the institution manager will determine a plan of action.

**Note to the employee:**

The Employment of Educators Act, no. 76 of 1998, as amended by the Education Laws Amendment Act of 2000 defines *Serious Misconduct* in Section 17 (1) thus:

- **An educator must be dismissed if she or he is found guilty of – …**
  
  (b) *Committing an act of sexual assault on a learner, student or other employee:*
  
  (c) *Having a sexual relationship with a learner of the school where she or he is employed:***
(d) Seriously assaulting, with the intention to cause grievous bodily harm to, a learner, student or other employee: …

(f) … causing a learner or a student to perform any of the acts contemplated in paragraphs (b) to (d).

- The process for managing serious misconduct (including child abuse) related to public service personnel is legislated in resolution 7/2000 (Public Service Co-ordinating Bargaining Council). The disciplinary process is similar to that of educators and if found guilty such offenders will be dismissed.

3.2.1.5 Additional procedures after disclosure (or a complaint) has revealed that the alleged offender is the institution manager:

3.2.1.5.1 The employee to whom the disclosure was made informs the H: SLES at the EMDC of the complaint or allegation (for the attention of the EMDC’s Labour Relations section), and forwards all documents involved to the H: SLES.

3.2.1.5.2 The Labour Relations officer (helped by members of the multi-functional team at the EMDC) will determine a plan of action (see Section 4: paragraph 4.2.9).

Note to the Head: Specialised Learner and Educator Support:

The procedure for managing recording and confidentiality at an institution is given after Step 9 in paragraph 3.2.1.2 above. Follow the same procedure.

Section 4

The Purpose of the Multi-Disciplinary Approach and the Role and Function of the Multi-Disciplinary Team

4.1 Purpose

Dealing effectively with child abuse demands a multi-disciplinary approach in order to provide holistically for the needs of the complainant. The effective management of abuse therefore depends on collaboration, co-ordination and co-operation between the various role-players and service providers during the intervention process, and each institution should formulate a way to liaise effectively with all of them (see Section 6).

4.2 The roles and functions of the various team-members are as follows:
4.2.1 The employee and the educator

The employee and the educator are accountable to all learners and their caregivers to:

- Educate learners in a safe and non-discriminating environment.
- Identify any possible form of child abuse.
- Report suspected cases of child abuse to the institution manager.
- Facilitate disclosure.
- Support the complainant through the process that follows disclosure.
- Keep the parents, and all others concerned, abreast of the progress of the process.
- Implement and sustain a preventative programme in the curriculum.

4.2.2 The institution manager

The institution manager is accountable to the learners, the employees, the parents and the community. The institution manager is also accountable to the WCED to ensure that the contents of this document are brought to the attention of all staff-members at the institution.

The institution manager’s responsibilities are to ensure that:

- The complainant does not have to do any unnecessary repeating of disclosure details.
- The matter is dealt with confidentially at all times.
- All employees receive ongoing training to equip them with the necessary skills, including how to deal with incidents of child abuse.
- The complainant's parents are informed of the plan of action and made aware of the support available to them.
- The incidents are reported to the relevant role-players, to follow up on the process and to make all the services provided by the WCED available to the learner and her or his caregivers.
- Intimidation of the complainant by other learners, employees or members of the community does not take place.
- Support is provided to the employee to whom the complainant has disclosed the abuse.
- An assessment of the facts available is made without interviewing the complainant.
- The safety of the complainant is assessed and assured.
- Information is not released to the media.
- A list of all service providers within the community is compiled and kept up to date.
- A management committee is established (if needed) as a sub-committee of the governing body to help in managing abuse in the institution. The function of this committee is not to discuss specific cases (and break confidentiality) but to ensure the implementation of this policy. In a school with a large enrolment, a representative of each school phase can be responsible to manage
implementation (and the accountability that goes with it). This committee should report monthly to the governing body.

- The whole matter of child abuse is integrated into the institution’s Life Orientation programme.
- A record of any findings made by Labour Relations is kept in the file of the alleged employee offender.
- All statistics on complaints lodged are forwarded monthly to the H: SLES at the EMDC.

4.2.3 Head office and EMDC personnel

Their responsibilities are to:

- Train and develop employees in order to provide them with skills in the management of incidents of child abuse.
- Help the institutions with the management of complaints.
- Provide the necessary professional services as required by learners, parents and employees.
- Use the services available in the community in the best interests of learners and institutions.
- Compile a register of all reported cases of child abuse.
- Ensure that the institution manager and employees implement the policy document.
- Ensure that the prevention of child abuse is dealt with in the curriculum and school programmes.

4.2.4 South African Police Services

The responsibilities of the SAPS are to:

- Receive and investigate complaints.
- Obtain sworn statements from (among others) the complainant and her or his parents.
- Arrest the alleged offenders.

4.2.5 Medical services or district surgeon

Their roles are to:

- Safeguard the complainant’s physical health.
- Collect forensic evidence for a possible court case.
- Refer the complainant for long-term medical care.

4.2.6 Parents

Their roles are:

- To give emotional support to the learner.
- Never to reproach, condemn or blame the learner.
- To use experts to help the learner and the family.

4.2.7 Department of Justice
Its **roles** are to:
- Protect the child from abuse by order in the Children’s Court.
- Protect the child from abuse by way of Protection Orders (Interdicts).
- Bring the alleged offender to trial.
- Subpoena the witnesses to appear in court.
- Sentence the offender (if convicted).

### 4.2.8 Social workers of the Department of Welfare and welfare organisations

Their **roles** are to:
- Ensure the safety of the complainant.
- Investigate the incident and compile a report for the Children’s Court and/or the Criminal Court.
- Prepare the complainant, parents and employee for the court procedure.
- Render reconstructive services to the complainant and her or his family.

### 4.2.9 The Directorate: Labour Relations of the WCED

**Note to the employee:**

The Directorate: Labour Relations is responsible for managing incidents of misconduct (when disclosure or a complaint has revealed that the alleged offender is an employee).

The **roles** of Labour Relations are to:
- Investigate all complaints (ensuring that the complainant’s safety, privacy and confidentiality are maintained at all times).
- Suspend an employee immediately as a precautionary measure when there is substantial evidence.
- Serve charges on the employee.
- Proceed with a disciplinary inquiry in a manner which protects the interests and the special needs of the child witness(es).
- Take a final decision on termination or continuation of service in terms of the Employment of Educators Act, 1998, as amended by the Education Laws Amendment Act, 2000.

### 4.2.9 The Safe Schools call centre:

The role of the Safe Schools call centre includes:
- Receiving and documenting all complaints received;
- Receiving complaints lodged by complainants and forwarding them to the institution manager;
- Setting up immediate support and help for the complainant.

### 4.2.10 The Safe Schools programme:

The role of the Safe Schools programme includes:
- Supporting institutions in the implementation of this policy;
- Providing training to employees when necessary.
Section 5

Conclusion

Child abuse is a complex community problem, which no single organisation or profession can prevent on its own. Dealing effectively with it demands a multi-disciplinary approach which provides for the needs of the abused child or youth in a holistic way. The public sector and the community should work together and accept joint responsibility for the protection of children in our society.

Employees and parents play a most significant role in all these proceedings and must concentrate all their energies on the eradication of child abuse. The WCED firmly believes that if this evil is combated with good management both at the level of the institution and at the level of the EMDC, the struggle to overcome it can indeed be won.

Section 6

Appendices

Appendix 1: Important Telephone Numbers
(insert)

Appendix 2: Database of Support Services within the Area
(insert)

Section 7

Acknowledgements

Abuse No More was developed with the help of a number of state departments, organisations and individuals. The WCED wishes to thank them all and to give particular acknowledgement to the following:

1. WCED components:
   • The Directorate: Special Education Services.
   • The members of the Safe Schools project.
   • The School Clinic Services, with special reference to the School Social Work Services.
   • The Circuit Managers.
   • The Subject Advisors.
   • The Directorate: Labour Relations
   • The Directorate: Communications
   • Edumedia
   • Language Services
2. The Departments of Health, Welfare and Justice.
4. The Women’s Legal Centre, “Violence Against Women Project”.
5. Legal Services: Provincial Administration Western Cape.

1 Excerpted from: Western Cape Education Department of South Africa. Abuse No More: Dealing Effectively with Child Abuse.
National HIV/AIDS Policy for the Education Sector:
Sample from South Africa

Description of tool:
This tool provides an example of existing national Education Sector policy on HIV/AIDS. It was approved by the Government of South Africa in August of 1999. It provides a sample which administrators and others responsible for school health at all levels could use to develop or improve their own policies and procedures related to this issue.

The information in this tool was excerpted by UNESCO from the following publication:

(Also available on the Western Cape Education Department website at: http://wced.wcape.gov.za/planning&devel/support/special_ed/hiv_aids/link_hiv_policy.html)

Description of document:
This is an official policy document of the Government of South Africa. As described in the Preamble, the guidelines it contains are intended to minimise the social, economic and developmental consequences of HIV/AIDS on the education system, all learners, students and educators; and to promote effective prevention and care within the context of the public education system in keeping with international standards and in accordance with education law and constitutional guarantees of the right to a basic education; the right not to be unfairly discriminated against; the right to life and bodily integrity; the right to privacy; the right to freedom of access to information; the right to freedom of conscience, religion, thought, belief and opinion; the right to freedom of association; the right to a safe environment; and the best interests of the child.

This information or activity supports Core Component #1 of the FRESH framework for effective school health: school health policies. It will have a greater impact if it is reinforced by activities in the other three components of the framework.
NOTICE NO. 1926 OF 1999  
DEPARTMENT OF EDUCATION  
NATIONAL EDUCATION POLICY ACT, 1996 (ACT NO. 27 OF 1996)  

NATIONAL POLICY ON HIV/AIDS, FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS, AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS  

The Minister of Education hereby publishes the national policy on HIV/AIDS for learners in public schools, and students and educators in further education and training institutions in terms of section 3(4) of the National Education Policy Act, 1996 (Act No. 27 of 1996), as set out in the Schedule.  

MINISTER OF EDUCATION  
AUGUST 1999  

SCHEDULE  

NATIONAL POLICY ON HIV/AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS  

PREAMBLE  

Acquired Immune Deficiency Syndrome (AIDS) is a communicable disease that is caused by the Human Immunodeficiency Virus (HIV).  

In South Africa, HIV is spread mainly through sexual contact between men and women. In addition, around one third of babies born to HIV-infected women will be infected at birth or through breast-feeding. The risk of transmission of the virus from mother to baby is reduced by antiretroviral drugs.  

Infection through contact with HIV-infected blood, intravenous drug use and homosexual sex does occur in South Africa, but constitutes a very small proportion of all infections. Blood transfusions are thoroughly screened and the chances of infection from transfusion are extremely low.  

People do not develop AIDS as soon as they are infected with HIV. Most experience a long period of around 5 – 8 years during which they feel well and remain productive members of families and workforces. In this asymptomatic period, they can pass their infection on to other people without realising that they are HIV infected.  

During the asymptomatic period, the virus gradually weakens the infected person’s immune system, making it increasingly difficult to fight off other infections. Symptoms start to occur and people develop conditions such as skin rashes, chronic diarrhoea, weight loss, fevers, swollen lymph glands and certain cancers. Many of these problems can be prevented or
treated effectively. Although these infections can be treated, the underlying HIV infection cannot be cured.

Once HIV-infected people have a severe infection or cancer (a condition known as symptomatic AIDS) they usually die within 1 to 2 years. The estimated average time from HIV infection to death in South Africa is 6 to 10 years. Many HIV infected people progress to AIDS and death in much shorter periods. Some live for 10 years or more with minimal health problems, but virtually all will eventually die of AIDS.

HIV-infected babies generally survive for shorter periods than HIV-infected adults. Many die within two years of birth, and most will die before they turn five. However, a significant number may survive even into their teenage years before developing AIDS.

No cure for HIV infection is available at present. Any cure which is discovered may well be unaffordable for most South Africans.

HIV/AIDS is one of the major challenges to all South Africans. The findings of the 1998 HIV survey among pregnant women attending public antenatal clinics of the Department of Health show that the HIV/AIDS epidemic in South Africa is among the most severe in the world and it continues to increase at an alarming pace. The rate of increase is estimated at 33.8%. Using these figures, it is estimated that one in eight of the country's sexually active population - those over the age of 14 years - is now infected. In the antenatal survey, the prevalence of HIV/AIDS among pregnant women under the age of 20 years has risen by a frightening 65.4% from 1997 to 1998.

According to the 1998 United Nations Report on HIV/AIDS Human Development in South Africa, it is estimated that almost 25% of the general population will be HIV positive by the year 2010. The achievements of recent decades, particularly in relation to life expectancy and educational attainment, will inevitably be slowed down by the impact of current high rates of HIV prevalence and the rise in AIDS-related illnesses and deaths. This will place increased pressures on learners, students and educators.

Because the Ministry of Education acknowledges the seriousness of the HIV/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, the Ministry is committed to minimise the social, economic and developmental consequences of HIV/AIDS on the education system, all learners, students and educators, and to provide leadership to implement an HIV/AIDS policy. This policy seeks to contribute towards promoting effective prevention and care within the context of the public education system.

In keeping with international standards and in accordance with education law and the constitutional guarantees of the right to a basic education, the right not to be unfairly discriminated against, the right to life and bodily integrity, the right to privacy, the right to freedom of access to information, the right to freedom of conscience, religion, thought, belief and opinion, the right to freedom of association, the right to a safe environment, and the best interests of the child, the following shall constitute national policy.

1. DEFINITIONS

In this policy any expression to which a meaning has been assigned in the South African Schools Act, 1996 (Act No. 84 of 1996), the Further Education and Training Act, 1998 (Act No. 98 of 1998) and the Employment of Educators Act, 1998 (Act No. 76 of 1998), shall have that meaning and, unless the context otherwise indicates –
"AIDS" means the acquired immune deficiency syndrome, that is the final phase of HIV infection;

"HIV" means the human immunodeficiency virus;

"institution" means an institution for further education and training, including an institution contemplated in section 38 of the Further Education and Training Act, 1998 (Act No. 98 of 1998);

"sexual abuse" means abuse of a person targeting their sexual organs, e.g. rape, touching their private parts, or inserting objects into their private parts;

"unfair discrimination" means direct or indirect unfair discrimination against anyone on one or more grounds in terms of the Constitution of the Republic of South Africa, 1996 (Act No.108 of 1996);

"universal precautions" refers to the concept used worldwide in the context of HIV/AIDS to indicate standard infection control procedures or precautionary measures aimed at the prevention of HIV transmission from one person to another and includes procedures concerning basic hygiene and the wearing of protective clothing such as latex or rubber gloves or plastic bags when there is a risk of exposure to blood, blood-borne pathogens or blood-stained body fluids;

"violence" means violent conduct or treatment that harms the person of the victim, for example assault and rape;

"window period" means 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.

2. PREMISES

2.1 Although there are no known cases of the transmission of HIV in schools or institutions, there are learners with HIV/AIDS in schools. More and more children who acquire HIV prenatally will, with adequate medical care, reach school-going age and attend school. Consequently a large proportion of the learner and student population and educators are at risk of contracting HIV/AIDS.

2.2 HIV cannot be transmitted through day-to-day social contact. The virus is transmitted only through blood, semen, vaginal and cervical fluids and breast milk. Although the virus has been identified in other body fluids such as saliva and urine, no scientific evidence exists to show that these fluids can cause transmission of HIV.

2.3 Because of the increase in infection rates, learners, students and educators with HIV/AIDS will increasingly form part of the population of schools and institutions. Since many young people are sexually active, increasing numbers of learners attending primary and secondary schools, and students attending institutions might be infected. Moreover, there is a risk of HIV transmission as a result of sexual abuse of children in our country. Intravenous drug abuse is also a source of HIV transmission among learners and students. Although the possibility is remote, recipients of infected blood products during blood transfusions (for instance haemophiliacs) may also be present at schools and institutions. Because of the increasing prevalence of HIV/AIDS in schools, it is imperative that each school must have a planned strategy to cope with the epidemic.
2.4 Because of the nature of HIV antibody testing and the "window period" or "apparently well period" between infection and the onset of clearly identifiable symptoms, it is impossible to know with absolute certainty who has HIV/AIDS and who does not. Although the Department of Health conducts tests among women attending antenatal clinics in public health facilities in South Africa as a mechanism of monitoring the progression of the HIV epidemic in South Africa, testing for HIV/AIDS for employment or attendance at schools is prohibited.

2.5 Compulsory disclosure of a learner's, student's or educator's HIV/AIDS status to school or institution authorities is not advocated as this would serve no meaningful purpose. In case of disclosure, educators should be prepared to handle such disclosures and be given support to handle confidentiality issues.

2.6 Learners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIV/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 practised against them. Infection control measures and adaptations must be universally applied and carried out regardless of the known or unknown HIV status of individuals concerned.

2.6.1 The risk of transmission of HIV in the day-to-day school or institution environment in the context of physical injuries can be effectively eliminated by following standard infection-control procedures or precautionary measures (also known as universal precautions) and good hygiene practices under all circumstances. This would imply that in situations of potential exposure, such as in dealing with accidental or other physical injuries, or medical intervention on school or institution premises in case of illness, all persons should be considered as potentially infected and their blood and body fluids treated as such.

2.6.2 Strict adherence to universal precautions under all circumstances in the school or institution is advised.

2.6.3 Current scientific evidence suggests that the risk of HIV transmission during teaching, sport and play activities is insignificant. There is no risk of transmission from saliva, sweat, tears, urine, respiratory droplets, handshaking, swimming-pool water, communal bath water, toilets, food or drinking water. The statement about the insignificant risk of transmission during teaching, sport and play activities, however, holds true only if universal precautions are adhered to. Adequate wound management has to take place in the classroom and laboratory or on the sports field or playground when a learner or student sustains an open bleeding wound. Contact sports such as boxing and rugby could probably be regarded as sports representing a higher risk of HIV transmission than other sports, although the inherent risk of transmission during any such sport is very low.

2.6.4 Public funds should be made available to ensure the application of universal precautions and the supply of adequate information and education on HIV transmission. The State's duty to take all reasonable steps to ensure safe school and institution environments is regarded as a sound investment in the future of South Africa.
2.6.5 Within the context of sexual relations, the risk of contracting HIV is significant. There are high levels of sexually active persons within the learner population group in schools. This increases the risk of HIV transmission in schools and institutions for further education and training considerably. Besides sexuality education, morality and life skills education being provided by educators, parents should be encouraged to provide their children with healthy morals, sexuality education and guidance regarding sexual abstinence until marriage and faithfulness to their partners. Sexually active persons should be advised to practise safe sex and to use condoms. Learners and students should be educated about their rights concerning their own bodies, to protect themselves against rape, violence, inappropriate sexual behaviour and contracting HIV.

2.7 The constitutional rights of all learners, students and educators must be protected on an equal basis. If a suitably qualified person ascertains that a learner, student or educator poses a medically recognised significant health risk to others, appropriate measures should be taken. A medically recognised significant health risk in the context of HIV/AIDS could include the presence of untreatable contagious (highly communicable) diseases, uncontrollable bleeding, unmanageable wounds, or sexual or physically aggressive behaviour, which may create the risk of HIV transmission.

2.8 Furthermore, learners and students with infectious illnesses such as measles, German measles, chicken pox, whooping cough and mumps should be kept away from the school or institution to protect all other members of the school or institution, especially those whose immune systems may be impaired by HIV/AIDS.

2.9 Schools and institutions should inform parents of vaccination/inoculation programmes and of their possible significance for the well-being of learners and students with HIV/AIDS. Local health clinics could be approached to assist with immunisation.

2.10 Learners and students must receive education about HIV/AIDS and abstinence in the context of life-skills education on an ongoing basis. Life-skills and HIV/AIDS education should not be presented as isolated learning content, but should be integrated in the whole curriculum. It should be presented in a scientific but understandable way. Appropriate course content should be available for the pre-service and in-service training of educators to cope with HIV/AIDS in schools. Enough educators to educate learners about the epidemic should also be provided.

2.10.1 The purpose of education about HIV/AIDS is to prevent the spread of HIV infection, to allay excessive fears of the epidemic, to reduce the stigma attached to it and to instil non-discriminatory attitudes towards persons with HIV/AIDS. Education should ensure that learners and students acquire age-and context-appropriate knowledge and skills in order that they may adopt and maintain behaviour that will protect them from HIV infection.

2.10.2 In the primary grades, the regular educator should provide education about HIV/AIDS, while in secondary grades the guidance counsellor would ideally be the appropriate educator. Because of the sensitive nature of the learning content, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for life-skills and HIV/AIDS education in the school and province. The educators should feel at ease with the content and should be role models with whom learners and students can easily identify. Educators should also be informed by the principal and educator unions of courses for educators to improve their knowledge of, and skills to deal with, HIV/AIDS.
2.10.3 All educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS.

2.11 In order to meet the demands of the wide variety of circumstances posed by the South African community and to acknowledge the importance of governing bodies, councils and parents in the education partnership, this national policy is intended as broad principles only. It is envisaged that the governing body of a school, acting within its functions under the South African Schools Act, 1996, and the Council of a Further Education and Training Institution, acting within its functions under the Further Education and Training Act, 1998, or any provincial law, should preferably give operational effect to the national policy by developing and adopting an HIV/AIDS implementation plan that would reflect the needs, ethos and values of a specific school or institution and its community within the framework of the national policy.

3. NON-DISCRIMINATION AND EQUALITY WITH REGARD TO LEARNERS, STUDENTS AND EDUCATORS WITH HIV/AIDS

3.1 No learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly. Educators should be alert to unfair accusations against any person suspected to have HIV/AIDS.

3.2 Learners, students, educators and other staff with HIV/AIDS should be treated in a just, humane and life-affirming way.

3.3 Any special measures in respect of a learner, student or educator with HIV should be fair and justifiable in the light of medical facts; established legal rules and principles; ethical guidelines; the best interest of the learner, student or educator with HIV/AIDS; school or institution conditions; and the best interest of other learners, students and educators.

3.4 To prevent discrimination, all learners, students and educators should be educated about fundamental human rights as contained in the Constitution of the Republic of South Africa, 1996.

4. HIV/AIDS TESTING AND THE ADMISSION OF LEARNERS TO A SCHOOL AND STUDENTS TO AN INSTITUTION, OR THE APPOINTMENT OF EDUCATORS

4.1 No learner or student may be denied admission to or continued attendance at a school or an institution on account of his or her HIV/AIDS status or perceived HIV/AIDS status.

4.2 No educator may be denied the right to be appointed in a post, to teach or to be promoted on account of his or her HIV/AIDS status or perceived HIV/AIDS status. HIV/AIDS status may not be a reason for dismissal of an educator, nor for refusing to conclude, or continue, or renew an educator’s employment contract, nor to treat him or her in any unfair discriminatory manner.

4.3. There is no medical justification for routine testing of learners, students or educators for evidence of HIV infection. The testing of learners or students for HIV/AIDS as a prerequisite for admission to, or continued attendance at, a school or institution in order to determine the incidence of HIV/AIDS at schools or institutions, is prohibited. The testing of educators for HIV/AIDS as a prerequisite for appointment or continued service is prohibited.
5. ATTENDANCE AT SCHOOLS AND INSTITUTIONS BY LEARNERS OR STUDENTS WITH HIV/AIDS

5.1 Learners and students with HIV have the right to attend any school or institution. The needs of learners and students with HIV/AIDS with regard to their right to basic education should as far as is reasonably practicable be accommodated in the school or institution.

5.2 Learners and students with HIV/AIDS are expected to attend classes in accordance with statutory requirements for as long as they are able to do so effectively.

5.3 Learners of compulsory school-going age with HIV/AIDS, who are unable to benefit from attendance at school or home education, may be granted exemption from attendance in terms of section 4(1) of the South African Schools Act, 1996, by the Head of Department, after consultation with the principal, the parent and the medical practitioner where possible.

5.4 If and when learners and students with HIV/AIDS become incapacitated through illness, the school or institution should make work available to them for study at home and should support continued learning where possible. Parents should, where practically possible, be allowed to educate their children at home in accordance with the policy for home education in terms of section 51 of the South African Schools Act, 1996, or provide older learners with distance education.

5.5 Learners and students who cannot be accommodated in this way or who develop HIV/AIDS-related behavioural problems or neurological damage, should be accommodated, as far as is practically possible, within the education system in special schools or specialised residential institutions for learners with special education needs. Educators in these institutions must be empowered to take care of and support HIV-positive learners. However, placement in special schools should not be used as an excuse to remove HIV-positive learners from mainstream schools.

6. DISCLOSURE OF HIV/AIDS-RELATED INFORMATION AND CONFIDENTIALITY

6.1 No learner or student (or parent on behalf of a learner or student), or educator, is compelled to disclose his or her HIV/AIDS status to the school or institution or employer. (In cases where the medical condition diagnosed is the HIV/AIDS disease, the Regulations relating to communicable diseases and the notification of notifiable medical conditions [Health Act, 1977] only require the person performing the diagnosis to inform the immediate family members and the persons giving care to the person and, in cases of HIV/AIDS-related death, the persons responsible for the preparation of the body of the deceased.)

6.2 Voluntary disclosure of a learner's, student's or educator's HIV/AIDS status to the appropriate authority should be welcomed and an enabling environment should be cultivated in which the confidentiality of such information is ensured and in which unfair discrimination is not tolerated. In terms of section 39 of the Child Care Act, 1983 (Act No. 74 of 1983), any learner or student above the age of 14 years with HIV/AIDS, or if the learner is younger than 14 years, his or her parent, is free to disclose such information voluntarily.

6.3 A holistic programme for life-skills and HIV/AIDS education should encourage disclosure. In the event of voluntary disclosure, it may be in the best interests of a
learner or student with HIV/AIDS if a member of the staff of the school or institution directly involved with the care of the learner or student, is informed of his or her HIV/AIDS status. An educator may disclose his or her HIV/AIDS status to the principal of the school or institution.

6.4 Any person to whom any information about the medical condition of a learner, student or educator with HIV/AIDS has been divulged, must keep this information confidential.

6.5 Unauthorised disclosure of HIV/AIDS-related information could give rise to legal liability.

6.6 No employer can require an applicant for a job to undergo an HIV test before he/she is considered for employment. An employee cannot be dismissed, retrenched or refused a job simply because he or she is HIV positive.

7. A SAFE SCHOOL AND INSTITUTION ENVIRONMENT

7.1 The MEC should make provision for all schools and institutions to implement universal precautions to eliminate the risk of transmission of all blood-borne pathogens, including HIV, effectively in the school or institution environment. Universal precautions include the following:

7.1.1 The basis for advocating the consistent application of universal precautions lies in the assumption that in situations of potential exposure to HIV, all persons are potentially 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.

(a) Blood, especially in large spills such as from nosebleeds, and old blood or blood stains, should be handled with extreme caution.

(b) Skin exposed accidentally to blood should be washed immediately with soap and running water.

(c) 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.

(d) 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.

(e) Blood splashes to the face (mucous membranes of eyes, nose or mouth) should be flushed with running water for at least three minutes.

(f) Disposable bags and incinerators must be made available to dispose of sanitary wear.

7.1.2 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.
7.1.3 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 a disinfectant, such as Milton, to it.

7.1.4 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 eliminate the risk of HIV transmission effectively. Bleeding can be managed by compression with material that will absorb the blood, e.g. a towel.

7.1.5 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.

7.1.6 Blood-contaminated material should be sealed in a plastic bag and incinerated or sent to an appropriate disposal firm. Tissues and toilet paper can readily be flushed down a toilet.

7.1.7 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.

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

7.2 All schools and institutions should train learners, students, educators and staff in first aid, and have available and maintain at least two first-aid kits, each of which should contain the following:

- two large and two medium pairs of disposable latex gloves;
- two large and two medium pairs of household rubber gloves for handling blood-soaked material in specific instances (for example when broken glass makes the use of latex gloves inappropriate);
- absorbent material, waterproof plasters, disinfectant (such as hypochlorite), scissors, cotton wool, gauze tape, tissues, containers for water and a resuscitation mouth piece or similar device with which mouth-to-mouth resuscitation could be applied without any contact being made with blood or other body fluids;
- protective eye wear; and
- a protective face mask to cover nose and mouth.

7.3 Universal precautions are in essence barriers to prevent contact with blood or body fluids. Adequate barriers can also be established by using less sophisticated devices than those described in 7.2, 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;
− spectacles; and
− a scarf.

7.4 Each classroom or other teaching area should preferably have a pair of latex or household rubber gloves.

7.5 Latex or household rubber gloves should be available at every sports event and should also be carried by the playground supervisor.

7.6 First-aid kits and appropriate cleaning equipment should be stored in one or more selected rooms in the school or institution and should be accessible at all times, also by the playground supervisor.

7.7 Used items should be dealt with as indicated in paragraphs 7.1.6 and 7.1.7.

7.8 The contents of the first-aid kits, or the availability of other suitable barriers, should be checked each week against a contents list by a designated staff member of the school or institution. Expired and depleted items should be replaced immediately.

7.9 A fully equipped first-aid kit should be available at all school or institution events, outings and tours, and should be kept on vehicles for the transport of learners to such events.

7.10 All learners, students, educators and other staff members, including sports coaches, should 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.

7.10.1 Learners, students, educators and other staff members should be trained to manage their own bleeding or injuries and to assist and protect others.

7.10.2 Learners, especially those in pre-primary and primary schools, and students should be instructed never to touch the blood, open wounds, sores, breaks in the skin, grazes and open skin lesions of others, nor to handle emergencies such as nosebleeds, cuts and scrapes of friends on their own. They should be taught to call for the assistance of an educator or other staff member immediately.

7.10.3 Learners and students should be taught that all open wounds, sores, breaks in the skin, grazes and open skin lesions on all persons should be kept covered completely with waterproof dressings or plasters at all times, not only when they occur in the school or institution environment.

7.11 All cleaning staff, learners, students, educators and parents should be informed about the universal precautions that will be adhered to at a school or an institution.

7.12 A copy of this policy must be kept in the media centre of each school or institution.
8. PREVENTION OF HIV TRANSMISSION DURING PLAY AND SPORT

8.1 The risk of HIV transmission as a result of contact play and contact sport is generally insignificant.

8.1.1 The risk increases where open wounds, sores, breaks in the skin, grazes, open skin lesions or mucous membranes of learners, students and educators are exposed to infected blood.

8.1.2 Certain contact sports may represent an increased risk of HIV transmission.

8.2 Adequate wound management, in the form of the application of universal precautions, is essential to contain the risk of HIV transmission during contact play and contact sport.

8.2.1 No learner, student or educator may participate in contact play or contact sport with an open wound, sore, break in the skin, graze or open skin lesion.

8.2.2 If bleeding occurs during contact play or contact sport, the injured player should be removed from the playground or sports field immediately and treated appropriately as described in paragraphs 7.1.1 to 7.1.4. 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.

8.2.3 Blood-stained clothes must be changed.

8.2.4 The same precautions should be applied to injured educators, staff members and injured spectators.

8.3 A fully equipped first-aid kit should be available wherever contact play or contact sport takes place.

8.4 Sports participants, including coaches, with HIV/AIDS should seek medical counselling before participation in sport, in order to assess risks to their own health as well as the risk of HIV transmission to other participants.

8.5 Staff members acting as sports administrators, managers and coaches should ensure the availability of first-aid kits and the adherence to universal precautions in the event of bleeding during participation in sport.

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

9. EDUCATION ON HIV/AIDS

9.1 A continuing life-skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Measures must also be implemented at hostels.

9.2 Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and students, and should be integrated in the life-skills education programme.
for pre-primary, primary and secondary school learners. This should include the following:

9.2.1 providing information on HIV/AIDS and developing the life skills necessary for the prevention of HIV transmission;

9.2.2 inculcating from an early age onwards basic first-aid principles, including how to deal with bleeding with the necessary safety precautions;

9.2.3 emphasising the role of drugs, sexual abuse and violence, and sexually transmitted diseases (STDs) in the transmission of HIV, and empowering learners to deal with these situations;

9.2.4 encouraging learners and students to make use of health care, counselling and support services (including services related to reproductive health care and the prevention and treatment of sexually transmitted diseases) offered by community service organisations and other disciplines;

9.2.5 teaching learners and students how to behave towards persons with HIV/AIDS, raising awareness on prejudice and stereotypes around HIV/AIDS;

9.2.6 cultivating an enabling environment and a culture of non-discrimination towards persons with HIV/AIDS; and

9.2.7 providing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse and immorality, the use of condoms, faithfulness to one’s partner, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, avoiding traumatic contact with blood, and the application of universal precautions.

9.3 Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in language and terms that are understandable.

9.4 Parents of learners and students must be informed about all life-skills and HIV/AIDS education offered at the school and institution, the learning content and methodology to be used, as well as values that will be imparted. They should be invited to participate in parental guidance sessions and should be made aware of their role as sexuality educators and imparters of values at home.

9.5 Educators may not have sexual relations with learners or students. Should this happen, the matter has to be handled in terms of the Employment of Educators Act, 1998.

9.6 If learners, students or educators are infected with HIV, they should be informed that they can still lead normal, healthy lives for many years by taking care of their health.

10. DUTIES AND RESPONSIBILITIES OF LEARNERS, STUDENTS, EDUCATORS AND PARENTS

10.1 All learners, students and educators should respect the rights of other learners, students and educators.

10.2 The Code of Conduct adopted for learners at a school or for students at an institution should include provisions regarding the unacceptability of behaviour that may create the risk of HIV transmission.
10.3 The ultimate responsibility for the behaviour of a learner or a student rests with his or her parents. Parents of all learners and students:

10.3.1 are expected to require learners or students to observe all rules aimed at preventing behaviour which may create a risk of HIV transmission; and

10.3.2 are encouraged to take an active interest in acquiring any information or knowledge on HIV/AIDS supplied by the school or institution, and to attend meetings convened for them by the governing body or council.

10.4 It is recommended that a learner, student or educator with HIV/AIDS and his or her parent, in the case of learners or students, should consult medical opinion to assess whether the learner, student or educator, owing to his or her condition or conduct, poses a medically recognised significant health risk to others. If such a risk is established, the principal of the school or institution should be informed. The principal of the school or institution must take the necessary steps to ensure the health and safety of other learners, students, educators and staff members.

10.5 Educators have a particular duty to ensure that the rights and dignity of all learners, students and educators are respected and protected.

11. REFUSAL TO STUDY WITH OR TEACH A LEARNER OR STUDENT WITH HIV/AIDS, OR TO WORK WITH OR BE TAUGHT BY AN EDUCATOR WITH HIV/AIDS

11.1 Refusal to study with a learner or student, or to work with or be taught by an educator or other staff member with, or perceived to have, HIV/AIDS, should be pre-empted by providing accurate and understandable information on HIV/AIDS to all educators, staff members, learners, students and their parents.

11.2 Learners and students who refuse to study with a fellow learner or student or be taught by an educator or educators, and staff who refuse to work with a fellow educator or staff member or to teach or interact with a learner or student with, or perceived to have, HIV/AIDS and are concerned that they themselves will be infected, should be counselled.

11.3 The situation should be resolved by the principal and educators in accordance with the principles contained in this policy, the code of conduct for learners, or the code of professional ethics for educators. Should the matter not be resolved through counselling and mediation, disciplinary steps may be taken.

12. SCHOOL AND INSTITUTIONAL IMPLEMENTATION PLANS

12.1 Within the terms of its functions under the South African Schools Act, 1996, the Further Education and Training Act, 1998, or any applicable provincial law, the governing body of a school or the council of an institution may develop and adopt its own implementation plan on HIV/AIDS to give operational effect to the national policy.

12.2 A provincial education policy for HIV/AIDS, based on the national policy, can serve as a guideline for governing bodies when compiling an implementation plan.

12.3 Major roleplayers in the wider school or institution community (for example religious and traditional leaders, representatives of the medical or health care professions or
12.4 Within the basic principles laid down in this national policy, the school or institution implementation plan on HIV/AIDS should take into account the needs and values of the specific school or institution and the specific communities it serves. Consultation on the school or institution implementation plan could address and attempt to resolve complex questions, such as discretion regarding mandatory sexuality education, or whether condoms need to be made accessible within a school or institution as a preventive measure, and if so under what circumstances.

13. HEALTH ADVISORY COMMITTEE

13.1 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.

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

13.2.1 be set up by the governing body or council and should consist of educators and other 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;

13.2.2 elect its own chairperson who should preferably be a person with knowledge in the field of health care;

13.2.3 advise the governing body or council on all health matters, including HIV/AIDS;

13.2.4 be responsible for developing and promoting a school or institution plan of implementation on HIV/AIDS and review the plan from time to time, especially as new scientific knowledge about HIV/AIDS becomes available; and

13.2.5 be consulted on the provisions relating to the prevention of HIV transmission in the Code of Conduct.

14. IMPLEMENTATION OF THIS NATIONAL POLICY ON HIV/AIDS

14.1 The Director-General of Education and the Heads of provincial departments of education are responsible for the implementation of this policy, in accordance with their responsibilities in terms of the Constitution of the Republic of South Africa, 1996, and any applicable law. Every education department must designate an HIV/AIDS Programme Manager and a working group to communicate the policy to all staff, to implement, monitor and evaluate the Department’s HIV/AIDS programme, to advise management regarding programme implementation and progress, and to create a supportive and non-discriminatory environment.

14.2 The principal or the head of a hostel is responsible for the practical implementation of this policy at school, institutional or hostel level, and for maintaining an adequate standard of safety according to this policy.
14.3 It is recommended that a school governing body or the council of an institution should take all reasonable measures within its means to supplement the resources supplied by the State in order to ensure the availability at the school or institution of adequate barriers (even in the form of less sophisticated material) to prevent contact with blood or body fluids.

14.4 Strict adherence to universal precautions under all circumstances (including play and sports activities) is advised, as the State will be liable for any damage or loss caused as a result of any act or omission in connection with any educational activity conducted by a public school or institution.

15. REGULAR REVIEW

This policy will be reviewed regularly and adapted to changed circumstances.

16. APPLICATION

16.1 This policy applies to public schools which enrol learners in one or more grades between grade zero and grade twelve, to further education and training institutions, and to educators.

16.2 Copies of this policy must be made available to independent schools registered with the provincial departments of education.

17. INTERPRETATION

In all instances, this policy should be interpreted to ensure respect for the rights of learners, students and educators with HIV/AIDS, as well as other learners, students, educators and members of the school and institution communities.

18. WHERE THIS POLICY MAY BE OBTAINED

This policy may be obtained from The Director: Communication, Department of Education, Private Bag X895, Pretoria, 0001, Tel. No. (012) 312-5271.

This policy is also available on the Internet at the following web site:

http://education.pwv.gov.za

---

Integrating HIV/STI Prevention in the School Setting: a UNAIDS Position Paper

Description of the tool:
UNAIDS is the main advocate of the United Nations for global action on HIV/AIDS. It leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS and alleviating the impact of the epidemic. This tool sets out the position of the United Nations Inter-agency Working Group in respect of the prevention of HIV/STI in schools.

The information in this tool was excerpted by UNESCO from the following publication:

Description of the document:
This paper develops the overall position of the UNAIDS inter-agency working group (a mechanism for coordination that includes specialists from UNESCO, UNFPA, UNICEF, WHO and the World Bank) in respect of the prevention of HIV/AIDS in schools. The full text of this document is available at the following address: www.unesco.org/education/educprog/pead/GB/AIDSG/B/AIDSGtx/School/PosPapGB.pdf

This information falls under Core Component #1 of the FRESH framework for effective school health: school health policies. It will have a greater impact if it is reinforced by activities in the other three components of the framework.
Integrating HIV/STI Prevention in the School Setting:  
a UNAIDS Position Paper

1. RATIONALE

Young people (10 to 24 years) are estimated to account for up to 60% of all new HIV infections worldwide. Many young people can be reached relatively easily through schools; no other institutional system can compete in terms of number of young people served. Prevention and health promotion programmes should extend to the whole school setting, including students, teachers and other school personnel, parents, the community around the school, as well as school systems. Such activities are a key component of national programmes to improve the health and development of children and adolescents.

2. HIV/STI PREVENTION AND HEALTH PROMOTION

HIV/STI-related programmes provide an opportunity to strengthen and accelerate existing health promotion activities in schools. Education to prevent HIV/STI should be integrated into education about reproductive health, life skills, alcohol/substance use, and other important health issues; included in other subject areas as appropriate and established by official policies; enhanced by school practices that foster self-esteem, caring, respect, decision-making, self-efficacy, and conditions that allow for the healthy development of students and staff. This is done, inter alia, through materials development, teacher training, supervision, and the participation of parents and communities.

3. POLICIES

Developing and monitoring a range of policies will be essential for effective programmes. This includes policies on: human rights (right to education, to non-discrimination, to confidentiality, to protection of employment, to protection from exploitation and abuse); access to school by students and school workers living with HIV/AIDS; pre- and in-service teacher training; community/parent participation; content of curricula and extra-curricular activities, and link with health services capable of providing diagnosis and treatment of STI for young people as well as the means of protection against unwanted pregnancy and HIV/STI, including contraceptives and condoms. Policies are developed at different levels, according to the degree of centralization of the school system.

4. LEARNING HOW TO COPE

For young people to develop healthy and responsible behaviour patterns, and avoid infection, it is not sufficient to lean the biomedical aspects of sexual and reproductive health. Equally important is learning now to cope with the increasingly complex demands of relationships, particularly gender relations and conflict resolution; how to develop safe practices, and how to relate with the increasing number of people living with HIV and AIDS.
5. **AGE**

Prevention and health promotion programmes should begin at the earliest possible age, and certainly before the onset of sexual activity. They should reach students before most of them leave or drop out of school, particularly in countries where girls tend to leave at a younger age. This means that age-appropriate programmes should start at primary school level.

6. **LIFE SKILLS**

A life skills approach is important in such programmes. Skills that enable young people to manage situations of risk for HIV/STI are also essential for the prevention of many other health problems. Such skills include how to respond adequately to demands for sexual intercourse/offers of drugs; how to take responsible decisions about difficult options; how to apply risk reduction techniques; how to refuse unprotected sex when sexually active, and how to seek appropriate support and care, including health services and counselling.

7. **RESPONSE OF SCHOOL SYSTEMS**

Although prevention education through school settings is recognized by almost all countries as necessary, significant institutional, political, religious and cultural barriers to its implementation will need to be resolved. In each country, the school system as a whole must respond to HIV/STI and AIDS, in close collaboration with the Ministries of Education, Health, Youth and other government sectors, teachers' associations and other NGOs and the wider community.

8. **UNAIDS ACTION**

UNAIDS will (i) facilitate the strengthening of national capacity to develop, implement, monitor and evaluate programmes that integrate HIV/STI prevention, health promotion and non-discrimination into school policies, curricula as well as extra curricular activities, and training; and (ii) identify effective and innovative policies, strategies and action in this area.

9. **GOALS BY THE YEAR 2000**

By the year 2000, UNAIDS will aim to:

- increase significantly the number of countries which have developed detailed policies and implemented programmes for non-discrimination and HIV/STI prevention in the school setting; and
- increase towards full coverage the percentage of young people attending school, who learn how to avoid discrimination and reduce the risk of infection.

---