Policy for Infectious Diseases for Health Professional Students

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Responsible Officer: Manager, Health Sciences Admissions
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Purpose

The information contained in this policy document concerns important issues, which affect students in health care professions and patients with whom they come in contact. The document sets out in detail the reason for the steps students are required to take in order to comply with Divisional requirements for students who are infected with a blood-borne virus. Students are encouraged to discuss this policy with the Faculty/School’s Infectious Diseases Officer or the Dean or his/her representative if there are any matters requiring clarification. All enquiries will be welcomed and treated on a confidential basis.

Students are required to read, understand and comply with this policy because of its importance in relation to certain procedures in circumstances where a student carries a blood-borne virus. Compliance with the policy is of the utmost importance.

Organisational Scope

This policy applies to the following courses offered by the Division: Bachelor of Dental Surgery, Bachelor of Dental Surgery (Hons), Bachelor of Dental Technology, Bachelor of Dental Technology (Hons), Bachelor of Physiotherapy, Bachelor of Physiotherapy (Hons), Bachelor of Medicine and Bachelor of Surgery, Bachelor of Pharmacy, Bachelor of Medical Laboratory Science, Bachelor of Radiation Therapy, Bachelor of Oral Health, Master of Nursing Science and any other Health Sciences course to which this policy may apply.

See Appendix A: Requirements for programme specific information.
Definitions

For full information refer to Appendix A

Definition
Community Viral Infection.
• Measles
• Mumps
• Rubella
• Polio
• Varicella-Zoster
• Human papilloma virus

Definition
Community Bacterial Infections
• Diphtheria
• Tetanus
• Pertussis
• Mycobacterium tuberculosis
• Methicillin-resistant Staphylococcus aureus (MRSA)
• Encapsulated Bacteria

Definition
Blood Borne Viral Infections
Included in this group are a number of viruses which circulate in the blood of an infected person, in some cases for many years, and which can be transmitted to other people when they come into contact with this infected blood. The main viruses of importance in this group HBV, HCV and HIV. HCW are potentially at risk of acquiring these infections as they are in frequent contact with blood and other body fluids, which may contain the viruses
• Human Immunodeficiency Virus
• Hepatitis B Virus
• Hepatitis C Virus

Content

1. Summary

All students enrolled in professional health courses in the Division of Health Sciences at the University of Otago, and who will have patient contact during their course, are expected to comply with specific requirements set out in the Infectious Diseases Policy. This policy applies to undergraduate and graduate-entry health professional students and to students enrolled in some postgraduate health professional courses. The University is required to comply with national regulations and is committed to providing a safe teaching and learning environment for patients, students and staff.

Students should understand the risks of infection that may occur between health care workers (HCW) and their patients or contacts. These risks cannot be totally eliminated, but it is essential that procedures known to be safe are consistently followed to minimise them. The Division’s Infectious Diseases Policy has direct relevance to the participation of students in the professional programmes. Consequently, it is important that students consider these important issues before considering a course as they may have an impact on their future career pathways. Students who are not able to demonstrate freedom from specified blood-borne viral infections are warned that their university education or career options may be narrower than they expect.

Certain blood-borne viruses such as hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV) are of particular significance in health care settings. Following infection with these viruses, individuals may carry virus in their blood and remain infectious for many years, even life-long. Many people infected with these viruses feel completely well and are unaware of their
HCW may be involved in the transmission of these viruses. Infectious diseases affect HCW and students during their training and in their professional lives in three ways:

HCW may transfer infectious agents (bacteria, viruses, parasites) from patient to patient.
HCW may become infected with infectious agents acquired from patients.
HCW who are incubating, ill or carrying infectious agents, may infect patients or other HCW.

In the absence of any clear exposure to blood or body substances, patients are at an extremely low risk of acquiring blood-borne infections. Appropriate infection control practices will, except in exceptional circumstances, protect patients (and HCW).

One of the major advances in control of infectious diseases has been the availability of vaccines. In New Zealand routine childhood immunisations have been provided as part of the New Zealand National Immunisation Schedule for many years for diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, measles, mumps, and rubella (German measles). In more recent years, immunisations for Haemophilus influenza type b, human papillomavirus (HPV), pneumococcal infections, and varicella have been added. Information on the National Immunisation Schedule, and regular update information, is available at: http://www.moh.govt.nz/moh.nsf/indexmh/immunisation-schedule

Health professional students enrolled in professional health courses in the Division of Health Sciences are expected to be fully immunised as per the tables below, to lower their risk of acquiring and hence possibly transmitting vaccine preventable diseases during their study and work. The Division of Health Sciences will appoint a specialist physician, who is a specialist medical practitioner experienced in the management of blood-borne viral infections and other infectious disease who will be known as the Divisional Infectious Diseases Physician, to advise on these matters. The Divisional Infectious Diseases Physician will be Dunedin-based, but will liaise with nominated colleagues in Wellington and Christchurch for students based in these campuses.

2. Student requirements and responsibilities

1. Throughout their course of study students must learn and practise standard infection control precautions that are relevant to their professional training.

2. Students have a responsibility to ensure that they are protected from infection with the vaccine-preventable diseases associated with health care. Those with personal health issues that might preclude vaccination should discuss this with the Divisional Infectious Diseases Physician.

3. Students have a responsibility to take measures to prevent transmission of acute infectious diseases from themselves to others and between patients.

4. Students have a responsibility to know their immune/infectious status for HBV, HCV, HIV, measles, mumps, rubella, varicella and pertussis. All students undertaking the Bachelor of Dental Surgery, Bachelor of Dental Technology, Bachelor of Physiotherapy, Bachelor of Medicine and Bachelor of Surgery, Bachelor of Pharmacy, Bachelor of Medical Laboratory Science, Bachelor of Radiation Therapy and Bachelor of Oral Health degrees, Master of Nursing Science (or any other Health Sciences programmes to which this policy may apply) must be tested for these infectious diseases before commencing studies, and undertake ongoing periodic testing as considered appropriate in relation to ongoing risk through occupational or other activities. All students have the responsibility to seek advice after a risk event whether it is an occupational issue or a personal event.

5. Each Faculty/Clinical School/School or Programme will appoint an Infectious Diseases Officer who will liaise with the Dean/Associate Dean/ Programme Director, the Divisional Infectious Diseases Physician and the Health Sciences Admissions Manager on these matters.
6. Any student at the Dunedin campus who is found to be chronically infected with a blood-borne virus or with tuberculosis (TB) will be advised of this by Student Health who will arrange an appointment for the student with the Divisional Infectious Diseases physician if required. The student is required to consult with, and follow any advice provided by, the Infectious Diseases physician or his/her nominee regarding the nature of the virus, extent of infection, likelihood of transmission and the student’s ability to undertake particular clinical and coursework activities within accepted professional standards. In addition, the student must make an appointment to discuss these issues with their Dean or his/her representative on a confidential basis within two weeks of consulting the Infectious Diseases physician. Wellington and Christchurch based students will be required to discuss these issues with a local physician nominated by the Divisional Infectious Diseases physician prior to meeting with the Head of School. As appropriate (e.g. for medical and physiotherapy students) information relating to these issues will be passed on to the Dean or leader of a subsequent school/programme.

a. Students with chronic HBV infection (manifest as circulating hepatitis B surface antigen) will require medical assessment and advice as above, and may not be able to perform exposure-prone procedures. The degree of infectiousness of hepatitis B carriers depends on their hepatitis B antigen and antibody status, and their circulating concentration of hepatitis B viral DNA and possibly other investigations.

b. Students with a positive test for antibody to HCV may not be able to perform exposure-prone procedures while such infection persists. Curative treatment is now available for some people with some types of HCV infection.

c. Students with confirmed HIV infection may not be able to perform certain exposure-prone procedures.

d. Students with a positive QuantiFERON Gold (TB) blood test will be required to have a clinical review with a designated GP, followed by a chest Xray. Referral to an Infectious Diseases Consultant may be necessary. "Clinical clearance " (ability of the student to have usual patient contact) will be required from the Infectious Diseases Physician or the designated GP.

e. Further clinical assessment, specialist assessment and documentation may be advised for students identified with any of these conditions.

7. All students in the Division of Health Sciences are expected to have knowledge of the immunisations they have received and supply a copy of their personal immunisation record or declaration at the time of entry to professional classes. Serological assessment to determine the presence of protective antibodies will be required.

8. Students are required to have blood samples taken at the beginning of the first semester of the commencement of their professional programme, before classes commence. The blood samples will be taken at designated laboratories.

9. Students are required to comply with any additional screening requirements of institutions in which they do clinical attachments or work e.g. MRSA testing

10. Students will provide the Division with a signed declaration by the prescribed date for the particular course of study indicating that they:

a. have provided to Student Health staff a statement of previous immunisations, where available, to the diseases listed in the New Zealand National Immunisation Schedule ([http://www.moh.govt.nz/moh.nsf/indexmh/immunisation-schedule](http://www.moh.govt.nz/moh.nsf/indexmh/immunisation-schedule))

b. if not immunised to the standard of New Zealand National Immunisation Schedule, will undertake to complete any outstanding immunisations and testing as per the recommendations in the Tables below by the relevant date prescribed by the Division

c. will be tested for chronic infection with HBV, HCV and HIV
d. if found to be infected with a blood-borne virus, will obtain advice from the Divisional Infectious Diseases physician or nominee regarding the nature of the virus, extent of the infection, likelihood of transmission and ability to undertake particular clinical and coursework activities within accepted professional standards and advised their Dean or his or her representative on a confidential basis of this advice, within two weeks of receiving the advice.

e. will provide their consent to the Division to liaise with the Infectious Diseases physician and any other relevant medical personnel regarding the matters outlined in (d) above, and

f. understand the importance of infection control precautions and of the need for ongoing periodic testing with agreement to undertake ongoing periodic testing.

Related Policies, Procedures and Forms

See Appendix B for additional information including strategies to minimise infectious disease risks, programme requirements, standard and additional precautions

Contact for further information about this Policy

If you have any queries regarding the content of this policy, procedure or guideline or need further clarification, contact Manager, Health Science Admissions on beth.stephenson@otago.ac.nz

Keywords

Health Sciences Professional Programme Health and Conduct procedure.

Consultation

Policy developed by the Working Group on Infectious Diseases Screening and Immunisation Policy, Division of Health Sciences comprising:
Professor Alison Rich (Chair)
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Ms Nicola Hoodless (administrative support).
Additional consultation undertaken with Health Sciences Divisional Executive, Health Sciences Professional Programmes Admissions Deans/Programme Directors, Student Health Services and International Office.
Revision in consultation with Divisional Infectious Diseases Physician, Student Health Services, Masters of Nursing Science and the Health Sciences Divisional Academic Board

Implementation Process

All Policies, Procedures, Guidelines and Codes of Practice must include an implementation plan, which should respond to each of the following headings:

| Person responsible | Manager, Health Science Admissions |

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Appendix A:

Community Viral Infections

- **Measles**
  Measles is a virus which infects primarily the respiratory tract. It is not common because of widespread vaccination but cases are still seen in those without immunity who come into contact with a case, usually introduced from outside the community. It is highly infectious. The infection consists of fever, red eyes, runny nose, cough and a widespread red blotchy rash. Pneumonia may develop and middle ear infection is a common complication. Mortality is significant in those under 5 years.

  Incubation period: 7-18 days, typically 10. Period of infectivity: from 4 days before rash onset, to 4 days after rash onset.

- **Mumps**
  Mumps is a viral infection causing painful enlargement of the salivary glands (parotid, sublingual, submandibular). It may also affect the testes, ovaries and mammary glands and uncommonly may result in sterility.

  Incubation period: 14-25 days. Period of infectivity: from up to 7 days before parotitis onset to 9 days after onset.

- **Rubella**
  It is a very common viral infection in childhood and in this age group it usually causes no problems. Symptoms of the illness include fever, tiredness, loss of appetite, swollen glands in the head and neck and a rash. When the infection occurs in adults it may produce a more significant illness and complications like arthritis and encephalitis (inflammation of the brain, a rare complication) are more common than in children. The infection is most serious when it occurs in pregnant women because it can be transmitted to the developing foetus with disastrous effects. If the affected baby is born alive it may suffer from the congenital rubella syndrome, a collection of birth defects including microcephaly (abnormally small head), mental retardation, abnormally small eyes, blindness, deafness, bleeding disorders and abnormal heart valves. For this reason, a pregnant woman who is not immune to rubella must avoid contact with the virus at all costs. Even a woman who is immune should avoid contact as reinfections can sometimes occur. Rubella is spread in the form of droplets from the respiratory tract. The incubation period (time between first contact and first symptoms) ranges from 14 to 23 days. Infection may be asymptomatic. It is important to realise that a person infected with the virus may be infectious to others even before the onset of symptoms. An infected person is infectious for about a week before the onset of symptoms until at least 4 days after the onset of the rash. Infection with rubella produces immunity to further infections. In addition, immunity may be achieved by vaccination. Reinfection with rubella has been described but is uncommon and is more likely to occur in someone who has achieved immunity through vaccination rather than by natural infection.

  Incubation period: 4-23 days. Period of infectivity: from 1 week before to 4 days after onset of rash.

- **Polio**
  Polio is a paralytic disease caused by a member of the enterovirus group. The infection is spread by the faecal-oral route and is common in developing countries where poor social conditions and low standards of hygiene are prevalent. A generation ago the infection was common in Western communities but it has essentially been eradicated in such populations by vaccination. In its most common form the illness consists of symptoms of meningitis, which are then followed by the onset of muscle pain and paralysis. This may range from weakness of a single muscle to complete quadriplegia. Disability is common after symptomatic infection, but the bulbar form of the disease results in high mortality due to respiratory and circulatory collapse. Maintenance of immunity in HCW is important, particularly those contemplating working in developing countries.
Incubation period: 3 - 35 days, commonly 7-14. Period of infectivity: difficult to assess but most infectious for several days before and after onset of symptoms; virus may be found in faeces for 3-6 weeks after infection.

- **Varicella-Zoster**
  This virus causes chickenpox and it may be reactivated as shingles. Chickenpox is a common infection of children and usually produces only tiredness, low-grade fever, loss of appetite and a very itchy rash consisting of small blisters. Adults who become infected with this virus may suffer from more severe symptoms and are more likely to get complications of pneumonitis or encephalitis. Once a person has been infected with this virus it stays in their body forever remaining hidden in the dorsal root ganglia, small structures of the nervous system close to the spine. In some people, later in life, the virus can become reactivated and travel down the nerve to the skin where it produces a red and blistered skin rash called shingles or zoster. This very painful condition affects only that segment of the skin supplied by the nerve involved. Two main groups of people should avoid contact with varicella-zoster virus (VZV) if they are not immune to it. These are the immunocompromised (people whose immune systems are impaired by things such as cancer or drugs or HIV infection) and pregnant women. Immunocompromised people if infected by VZV can get an overwhelming and fatal infection. Non-immune pregnant women if infected by the virus may experience a number of problems. Firstly, in non-immune adults, primary varicella infection may be more serious resulting in a severe and potentially fatal pneumonitis. Secondly in the non-immune pregnant women, the developing foetus may be infected and suffer from the foetal varicella syndrome, a collection of birth defects including scarring of the skin, abnormally small limbs, abnormal eyes and mental retardation. Thirdly, if a non-immune pregnant woman comes down with chickenpox within several days before or after birth, her baby may suffer from a severe chickenpox infection after birth with a high mortality. VZV is spread by respiratory droplets or by contact with virus from the skin rash. It is highly infectious. The incubation period ranges from 2-3 weeks. The period of infectivity is from two days before the onset of the rash until 5 days after the appearance of the last lot of vesicles. It should be noted that a non-immune person can get chickenpox from another case of chickenpox or from someone with shingles. A person can only get shingles from reactivation of their own latent VZ virus. Immunity is gained from either natural infection or from vaccination.

If exposure to primary or disseminated varicella in a person with no history of chickenpox and/or negative anti-varicella IgG; varicella zoster immune globulin is indicated for those who are at greatest risk for complications (immunocompromised such as HIV, malignancies and non-immune pregnant women).

Incubation period: 2-3 weeks, commonly 14-16 days. Period of infectivity: from up to 5 days before onset of rash until all lesions are crusted.

- **Human papilloma virus**
  Human papilloma virus (HPV) is a common virus that infects keratinocytes of the skin and mucous membranes. It is transmitted through skin-skin contact. Most members of the papillomavirus family do not cause significant disease but females infected with particular types of HPV are at significant risk for cervical cancer. These high-risk HPVs are also associated with cervical oropharyngeal, penile and anal cancer in males and females. HPV vaccines prevent infection with HPV 16 and 18 that cause most HPV-associated neoplasms. Once an HPV enters a keratinocyte there is active infection and the virus can be transmitted. Several months to years may elapse before an HPV-associated lesion becomes clinically apparent.

**Community Bacterial Infections**

- **Diphtheria**
  This infection, caused by the bacterium Corynebacterium diphtheriae, is rarely seen in New Zealand because of vaccination. The bacterium infects the superficial tissue of the nasopharynx and sometimes further down the airways. It results in production of a very thick exudate or membrane; this, and associated inflammatory swelling, may result in death by asphyxiation. It may uncommonly produce skin ulceration. The bacterium also produces a toxin which is absorbed into the body to produce effects in the heart, (myocarditis leading to heart failure) and peripheral nerves (difficulty breathing, swallowing; muscle weakness).
Incubation period: 2-5 days. Period of infectivity: 2 weeks, sometimes 4.

- **Tetanus**
  This infection occurs when hardy spores of the bacterium Clostridium tetani are introduced into a wound contaminated by soil, faeces or other organic matter. Deep puncture type wounds provide the type of anaerobic environment which favours the growth of the bacteria in the soft tissues. The bacteria produce a powerful neurotoxin which blocks inhibitory nerve impulses to skeletal muscle. This results in unopposed muscle contraction manifesting as muscle spasms. Affected patients develop lockjaw (spasms of the jaw muscles), facial spasms, neck stiffness, difficulty swallowing, trunk and leg spasms and convulsions. Muscular spasm can result in the inability to breathe, one of the causes of death in those with the infection. The spasms can continue for months requiring prolonged intensive care management. Mortality is significant, particularly in those parts of the world where intensive hospital care is not available. The disease can be actively vaccinated against using tetanus toxoid. In addition, tetanus immunoglobulin (TIG) can be used prophylactically in individuals who have not been vaccinated and who sustain a tetanus prone wound.

Incubation period: 3-21 days, average 10. Period of infectivity: Not transmitted from person to person.

- **Pertussis**
  Pertussis, or whooping cough, is a respiratory infection caused by the bacterium Bordetella pertussis. Bacterial toxins damage the ciliated cells of the trachea, resulting in a severe coughing illness, which may persist for months. Classical whooping cough is described in young children as having three stages: the catarrhal stage in which increased upper respiratory tract secretions are present, the paroxysmal stage, in which severe bouts of coughing may lead to respiratory arrest, and the convalescent phase, in which coughing episodes persist for months before gradually diminishing. The mortality of whooping cough is significant, particularly in infants less than 1 year of age. In recent years, whooping cough has become increasingly recognised as an adult infection. Routine vaccination of children between 2 months and 4 years of age has shifted the peak incidence of the infection into the adolescent years but with the majority of cases spread across adulthood. This results from a waning of vaccine-induced immunity. It is prudent for adolescents who have missed childhood pertussis vaccinations to have catch-up vaccinations. Whooping cough in adults does not usually manifest in the classical manner described in infected children and may thus be unrecognised. Maintenance of adult immunity is important, as infected adults are source of life threatening infection to infants who have not yet been vaccinated.

Incubation period: 7-20 days. Period of infectivity: highest during catarrhal stage (up to a week before coughing paroxysms) and during the following 3 weeks; for 5 days after commencement of effective antibiotics.

- **Mycobacterium tuberculosis**
  Mycobacterium tuberculosis is the cause of tuberculosis (TB), a bacterial infection usually involving the lungs but which may spread to many other tissues of the body. This bacterium is spread from actively infected patients in respiratory droplets, produced by coughing, sneezing or talking. The bacterium is highly infectious and may float in the air in the vicinity of an infected patient for a period of time even if the patient has left the area. It is estimated that a third of the world's population is currently infected with M. tuberculosis, most cases occurring in the developing world where spread is enhanced by crowded living conditions and disease results from poor resistance. There is increasing resistance of M. tuberculosis to the medications used to treat it.

Tuberculosis is a chronic disease and may exist in the host for many years without causing symptoms. This can make infection difficult to diagnose unless the disease has reached a fairly advanced state. Interferon-gamma release assays (IGRA) such as QuantiFERON gold is a blood test which indicates an immune response to M. tuberculosis. It does not distinguish between latent and active TB.
BCG is a vaccine, mainly useful in infants and children in parts of the world where the risk of infection is high. It does not prevent infection with M. tuberculosis but in these children it is effective in preventing clinically apparent disease and particularly deaths from tuberculous meningitis. Its usefulness in other populations is debated, particularly as the overall efficacy of the vaccine has been estimated to be only 50 per cent.

Incubation period: To first demonstrable lung lesion +ve QuantiFERON gold assay 2-10 weeks. Period of infectivity: As long as viable bacteria are present in sputum, potentially for years. Infectivity ceases within several weeks of effective antimicrobial therapy commencing.

- **Methicillin-resistant Staphylococcus aureus (MRSA)**
  Staphylococcus aureus is a common bacterium which lives harmlessly on the bodies of many healthy people. S. aureus can also be a virulent and dangerous pathogen and commonly causes infections such as boils and other skin infections, abscesses in many soft tissues, bone and joint infections, and infections of the blood. Most strains of S. aureus are resistant to penicillin because they can produce an enzyme called beta-lactamase which can destroy this antibiotic. Antibiotics such as methicillin, flucloxacillin and cephalaxin have been produced which are resistant to this bacterial enzyme, making treatment of the above infections possible. However, there are strains of S. aureus which are resistant to even these special antibiotics and sometimes to a range of other antibiotics too. It is for this reason that screening is necessary for all new health professionals, for all staff who have worked in other clinical settings deemed at risk, and returning to the clinical setting. If positive, treatment is mandatory and MRSA cleared as per DHB (district health board) infection control policy. – It is in this way that we protect those most vulnerable such as young children the elderly and those who are immunocompromised.

- **Encapsulated Bacteria**
  Certain bacteria are surrounded by capsules which help them to evade the host's immune defences, making these bacteria more able to produce serious infections. Two major organisms of concern are Neisseria meningitidis and Haemophilus influenzae type b. Serious disease with the latter is rarely encountered in this community now as it is vaccinated against in childhood. Neisseria meningitidis is a cause of life threatening septicaemia and meningitis which may occur in outbreaks. Invasive infection by these organisms is usually preceded by a period of asymptomatic nasopharyngeal carriage, although carriage does not mean that invasive disease will always follow. Carriers are responsible for passing the infection to others, who may develop invasive disease. The infections they produce may be severe and life threatening, particularly in debilitated people those with impaired immune systems and those who have had their spleens removed following trauma or for medical reasons. HCW may come into contact with patients suffering from infections with these bacteria and run the risk of being colonised themselves and becoming carriers. They may then pass the organism on to others or may themselves suffer from invasive infection. In the case of N. meningitidis and H. influenzae type b, HCW and others who have had significant contact with a case of invasive disease may be given a short course of antibiotics in order to eradicate the carrier state if it has been established. People who are considered to be significant contacts are:
  - kissing contacts within the preceding 10 days
  - household contacts within the preceding 10 days
  - those who have had vomit or respiratory secretions from an active case splashed onto their faces

Incubation period (N. meningitides): 2-10 days, commonly 3-4 days. N. meningitidis period of infectivity: As long as bacteria are present in nasopharyngeal secretions; ceases within 24 hrs of commencing appropriate antibiotic therapy.

**Blood-borne Viral Infections**
Included in this group are a number of viruses which circulate in the blood of an infected person, in some cases for many years, and which can be transmitted to other people when they come into contact with this infected blood. The main viruses of importance in this group HBV, HCV and HIV. HCW are potentially at risk of acquiring these infections as they are in frequent contact with blood and other body fluids, which may contain the viruses.
• **Human Immunodeficiency Virus**

This virus is found in the blood of an infected person and in the following bodily fluids: breast milk, semen, cervical and vaginal fluids, saliva, tears, cerebrospinal fluid, urine, alveolar fluid and joint fluid. However, not all of these fluids have been implicated in the transmission of the virus. Most cases of transmission have been associated with blood (contaminated blood transfusions, blood products, contaminated needles in IV drug users) and with sexual intercourse. In developing countries, mother to infant transmission is a significant mode of transmission. In the occupational setting, HCW have become infected with HIV primarily from contact with blood or blood-containing bodily fluids. This is most likely to occur following penetration of the skin by a needle (“needle stick injury”) or by another sharp instrument which is contaminated with blood from an infected patient, or by contact of such infected blood with mucous membranes (eyes, mouth) or nonintact skin. The estimated risk of acquiring HIV infection from a needlestick injury from an infected patient is 0.3%. Following mucous membrane contact with infected blood the estimated risk of infection is 0.09%. Following HIV infection the virus may enter a number of different cells in the body, but those most susceptible are lymphocytes, a type of white blood cell important in the immune response. Following entry of the virus into these cells, the genetic material of the virus inserts itself into the genetic material of the cell. After 3 to 6 months antibodies against HIV are produced by the infected human host and these may be measured by laboratory tests. The period following infection and the point in time when these antibodies can be detected is called the "window period". At the time of the appearance of these antibodies the host may experience a nonspecific flu-like illness called the seroconversion illness. The effect of HIV infection on the host is that the cells of the immune system are gradually destroyed, leaving the host less able to fight off infections and particular types of cancer. For a period averaging ten years, the latent period, the untreated patient may remain outwardly well while the virus continues to replicate and destroy the immune system. When the immune system is damaged beyond a particular point the host begins to experience infections, often caused by microorganisms which do not usually cause problems in people with healthy immune systems. In addition, unusual types of cancers may be seen when these events begin to take place, the patient is said to have AIDS, the Acquired Immunodeficiency Syndrome.

To date there is no vaccine effective against HIV. A number of antiviral drugs have been shown to slow the replication of the virus and to improve the health of those infected. Following a risk exposure such as a needle stick injury from an infected patient, the use of these drugs alone or in combination for a period of several weeks can reduce the odds of infection in the recipient by 80 per cent. This is more likely to be effective if the drugs are given early after the exposure rather than later, so it is important to seek advice as soon as possible after such an injury.

Incubation period: Variable; to seroconversion illness, 5-70 days, typically 22 days; to onset of AIDS, typically 10 years. Period of infectivity: Variable: from shortly after infection and for duration of life; influenced by viral load and effectiveness of treatment.

• **Hepatitis B Virus**

This blood borne virus is more likely to be encountered by HCW than is HIV, and it is also many more times infectious than is HIV. Fortunately however, infection with HBV can be prevented by vaccination. HBV is a virus which infects the cells of the liver. Most infections do not cause symptoms, and in those who become ill with hepatitis most recover within 6 months. Symptoms of hepatitis may be severe or mild and include headache, malaise, fever, nausea, vomiting, jaundice and abdominal pain. About 1% of cases may be fulminant, that is severe liver failure and seizures, often leading to death. A small number of cases, perhaps 10%, will become chronically infected and of this group some will develop cirrhosis (a serious form of liver damage) and some will develop cancer of the liver. Those with chronic infection are the major source of transmission to others. As the virus replicates in the liver it spills out into the bloodstream and it can be detected here and in a number of body fluids. These are semen, cervicovaginal secretions, breast milk, saliva, urine, bile, sweat, tears, cerebrospinal fluid and joint fluid. HBV is transmitted by similar routes to HIV although is much more infectious. The most common routes of transmission are sexual intercourse, sharing of contaminated needles by intravenous drug users and from mother to infant. The virus may be transmitted on objects such as toothbrushes, eating utensils, razors, baby bottles and toys. Transmission in the hospital setting may occur from patient to HCW and vice versa, and from patient to patient on
contaminated equipment. The risk of transmission following a needlestick injury from an infected patient is estimated to be from 27-40% if the patient is HBeAg positive (refer to information below).

A number of tests are used to diagnose hepatitis B or to show immunity to it. During active infection, two components of the virus are usually looked for in the blood, surface antigen (HBsAg) and 'e' antigen (HBeAg). Both of these indicate that the patient is actively infected and infectious to others. The presence of HBeAg indicates high infectivity. As disease resolves these components disappear from the blood and antibodies to them appear, namely HBsAb and HBeAb. Another antibody, HBCab, is directed against the 'core' antigen which is found in the liver during active infection but not in the blood. Those who become chronically infected do not clear the surface antigen (HBsAg) from their blood and do not develop antibody to surface antigen (HBsAb). They may also have HBeAg in the blood. Infection with HBV can be effectively prevented by the use of a vaccine. The vaccine gives rise to HBsAb in those vaccinated. The course of vaccination consists of 3 injections, the second 1 month after the first and the third one at 6 months. Although the vaccine produces protective levels of HBsAb in over 90% of individuals, failure to respond to the vaccine occurs in some and is related to increasing age, obesity, smoking and injection in the buttock rather than the upper arm. If non-immune after a series of three vaccinations – further vaccination will be implemented to attain protective levels.

For those who do not have immunity to hepatitis B and who receive a needlestick injury or other risk exposure, protection from infection is available by other means. If a risk is thought to exist, then the person receiving the needlestick can be injected with hepatitis B immune globulin (HBIG). This is HBsAb derived from the serum of people who already have high levels of HBsAb, and the process is known as passive immunisation. Administration of HBIG must be carried out within 72 hours of the exposure to be fully effective, and it is followed by a course of the vaccine. The aim of this Policy is to ensure that all students will be immune to hepatitis B in advance of any such injury occurring, so that the process of passive immunisation is not necessary.

Incubation period: 45-180 days, average 60-90 days. Period of infectivity: As long as HBsAg is present in blood; from many weeks before onset of symptoms and during the period of the acute illness; for the duration of viral carriage in those chronically infected.

Hepatitis C Virus

HCV is transmitted mainly by contaminated blood or blood products, and many cases in the community were acquired from blood transfusions in the days before specific tests were available to screen blood donations for this virus. Another group at risk of acquiring hepatitis C infection is intravenous drug users sharing contaminated needles. Many people with the infection have no history of blood transfusion or IV drug use. Sexual transmission is not thought to be responsible for many cases. The infection may be transmitted from mother to baby but the rate of transmission is not high. The illness caused by HCV is very similar to that caused by HBV. However, HCV is of major concern because 50-70% of infections will become chronic infections, unlike the 10 per cent chronic infection rate with HBV. As in the case of chronic HBV infection, chronic HCV infection may lead to cirrhosis and hepatocellular carcinoma. Laboratory tests for HCV are relatively limited in their scope. Following infection there is a window period before antibodies to HCV can be detected in the blood, and this averages 6-8 weeks. The presence of HCV antibodies in a blood test gives no indication as to when the infection occurred or whether the infection is active or inactive. Another test is available to detect HCV genetic material in the blood using the polymerase chain reaction, and the presence of this indicates active viral replication in the liver. There is no vaccine against HCV, nor any form of passive immunisation although curative treatment is now available for some people with some types of HCV infection.

Incubation period: 2 weeks to 6 months, commonly 6 - 9 weeks. Period of infectivity: for several weeks before onset of symptoms and for duration of infection in chronic carriers.
Appendix B: Additional Information
Strategies to Minimise Infectious Disease Risks

Infection Control Strategies
Early in their studies students will be taught infection control strategies known as "standard and additional precautions". These include assessing the risk posed by persons with particular infections and clinical syndromes, hand washing, aseptic technique, disposal of sharps and clinical waste, use of single-use only equipment, aspects of sterilisation and disinfection of re-useable equipment, the use of personal protective equipment (such as gloves, gowns, masks and eye protection), and managing patients in various forms of isolation. Competent performance of these precautions is a key professional skill.

Transmission of Blood-borne Viruses
The risk of transmitting a blood-borne virus from an infectious HCW to a patient (or an infectious patient to a HCW) depends on several factors, including the particular virus, and the infectiousness of the infected person (the concentration of virus in the blood). The procedure being performed by the HCW is the other very important consideration. An exposure-prone procedure is any situation where there is a potentially high risk of transmitting a blood-borne virus between a HCW and a patient. In particular, exposure-prone medical or dental procedures pose a risk for direct contact between the skin (usually finger or thumb) of the HCW and sharp surgical instruments, needles, or sharp tissues (broken bone or teeth) in poorly seen or confined body sites (including the mouth) of the patient. There is evidence to suggest that incidents are more likely to occur when the procedure is being undertaken by an inexperienced clinician.

Vaccination
Vaccination provides protection against many of the infectious hazards of health care settings. Vaccines are usually highly effective but occasionally individuals may not respond. The required and recommended vaccinations for students in the Division of Health Sciences is shown in the Tables below.
Programme Requirements

Student Immunisation
The Division requires all health professional students to take the tests, immunisations and services as per the Tables below.

The Division requires all students who have a positive TB or blood-borne virus result to consult with and take the advice of the Divisional Infectious Diseases physician or his/her nominee (via referral from Student Health GP or if in Christchurch or Wellington from the designated Medical Practice) and with the Dean or his/her representative no more than two weeks later to discuss this result and any relevant considerations on a confidential basis.

Medical Students
Medical students who test positive for a blood-borne virus or TB must make an appointment to discuss this with the Infectious Diseases physician and the Dean as above. Medical students may not be able to participate in exposure-prone procedures but adjustments may be made which will nonetheless enable them to complete the course. Students should however note that some specialist medical professions are not able to accept clinicians who test positive for blood borne viruses. Students may want to approach the Medical Council of New Zealand for further information in this regard.

Dental and Oral Health Students
Dental and oral health students who test positive for a blood-borne virus or TB must make an appointment to discuss this with the Infectious Diseases physician and the Dean as above. Where it has been determined that dental or oral health students are not able to participate in exposure-prone procedures because of their blood-borne virus status they may not be able to complete their course. Students may want to approach the Dental Council for information on the implications for registration with positive results for a blood-borne virus.

Dental Technology Students
Dental Technology students who test positive for a blood-borne virus or TB must make an appointment to discuss this with the Infectious Diseases physician and the Dean as above. Adjustments may be made to the programme which will enable them to complete the course.

Medical Laboratory Science Students
Medical Laboratory students who test positive for a blood-borne virus or TB must make an appointment to discuss this with the Infectious Diseases physician and the Head of the Programme as above. Adjustments may be made to the programme which will enable them to complete the course.

Radiation Therapy Students
Radiation Therapy students who test positive for a blood-borne virus or TB must make an appointment to discuss this with the Wellington—based nominee of the Infectious Diseases physician and the Dean/Head of Department as above. Radiation Therapy students may not be able to participate in exposure-prone procedures but adjustments may be made which will nonetheless enable them to complete the course. Students may want to approach the Medical Radiation Technologists Board for information regarding the implications for registration and subsequent practice.

Pharmacy Students
Pharmacy students who test positive for a blood-borne virus or TB must make an appointment to discuss this with the Infectious Diseases physician and the Dean as above. Pharmacy students may not be able to participate in exposure-prone procedures but adjustments may be made which will nonetheless enable them to complete the course. Students may want to approach the Pharmacy Council for information regarding the implications for registration and subsequent practice.

Physiotherapy Students
Physiotherapy students who test positive for a blood-borne virus or TB must make an appointment to discuss this with the Infectious Diseases physician and the Dean as above. Physiotherapy students may not be able to participate in exposure-prone procedures but adjustments may be made which will nonetheless enable them to complete the course. Students may want to approach the Physiotherapy Board of New Zealand for information regarding the implications for registration and subsequent practice.
Master of Nursing Science

Master of Nursing Science students who test positive for a blood-borne virus or TB must make an appointment to discuss this with the Infectious Diseases physician and the Dean as above. Nursing students may not be able to participate in exposure-prone procedures but adjustments may be made which will nonetheless enable them to complete the course. Students may want to approach the Nursing Council of New Zealand for information regarding the implications for registration and subsequent practice.
<table>
<thead>
<tr>
<th>Which Students</th>
<th>Testing for</th>
<th>Results held with Student Health</th>
<th>Further Action</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required for Year 2 BDS Year 1 BOH Year 1 BDentTech Year 2 MB ChB Year 2 BPhty Year 2 BPharm Year 2 BMLSc Year 1 BRT Year 1 MNSc</td>
<td>Varicella zoster virus antibody</td>
<td>+ve</td>
<td>none</td>
<td>Vaccinations as per Ministry of Health guidelines</td>
</tr>
<tr>
<td></td>
<td>-ve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles/Mumps/ Rubella antibodies</td>
<td>+ve</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-ve</td>
<td>MMR vaccination(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B antibody</td>
<td>+ve</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B antibody Hepatitis B surface antigen</td>
<td>-ve</td>
<td>In the absence of infection, vaccination &amp; follow up as per Ministry of Health Guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-ve</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B surface antigen</td>
<td>+ve</td>
<td>Refer to Infectious Diseases physician for discussion re management</td>
<td>Refer to Infectious Diseases physician and Dean</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-ve</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C antibody</td>
<td>+ve</td>
<td>Refer to Infectious Diseases physician for discussion re management</td>
<td>If further testing (HCV RNA) confirms HCV infection refer to Infectious Diseases physician and Dean</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-ve</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV antibody</td>
<td>+ve</td>
<td>Refer to Infectious Diseases physician for discussion re management</td>
<td>Refer to Infectious Diseases physician and Dean</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-ve</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB testing (Quantiferon TB Gold test)</td>
<td>+ve</td>
<td>Chest X ray and referral to Respiratory Physician and Infectious Diseases physician for discussion re management.</td>
<td>Follow Public Health guidelines</td>
<td></td>
</tr>
</tbody>
</table>
### Table 2: Required Vaccinations

<table>
<thead>
<tr>
<th>Which Students?</th>
<th>Vaccination</th>
<th>Further Action</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All students</strong></td>
<td>Pertussis</td>
<td>Combined vaccine – eg Diphtheria, tetanus and pertussis (Boostrix)</td>
<td>All students will be vaccinated unless documentary proof of vaccination in the two years prior to commencing professional course</td>
</tr>
<tr>
<td><strong>All students</strong></td>
<td>Diphthería Polio Tetanus</td>
<td>Vaccination required</td>
<td>Most students will have completed vaccination in childhood. If incomplete, catch up vaccinations or full primary course will be required</td>
</tr>
</tbody>
</table>
### Table 3: Other Immunisations to be considered

<table>
<thead>
<tr>
<th>Which Students?</th>
<th>Vaccination</th>
<th>Further Action</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All students</td>
<td>Seasonal influenza annually</td>
<td>Vaccination highly</td>
<td>Recommended annually to protect themselves, patients and reduce community spread</td>
</tr>
<tr>
<td></td>
<td></td>
<td>recommended</td>
<td></td>
</tr>
<tr>
<td>All Students</td>
<td>Vaccination recommended</td>
<td></td>
<td>Particularly recommended for those living in residential colleges or shared flats</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>(relevant strains)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Students</td>
<td>Vaccination recommended</td>
<td></td>
<td>Recommended for health care workers exposed to faeces</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All students</td>
<td>Vaccination recommended</td>
<td></td>
<td>Many students will have completed vaccination</td>
</tr>
<tr>
<td>HPV</td>
<td></td>
<td></td>
<td>Fully subsidised for all NZ residents up to age 27 years</td>
</tr>
<tr>
<td>Overseas electives</td>
<td></td>
<td></td>
<td>Other vaccinations may be recommended in particular circumstances e.g. on electives. Students undertaking overseas electives, particularly clinical electives, need to be aware of potential risks and of ways to minimise risks. This should be discussed with the Elective Co-ordinator and a specialist travel clinic at least 2-3 months prior to travel (this service is provided by Student Health Service).</td>
</tr>
</tbody>
</table>
Standard Precautions & Additional Precautions

Standard Precautions are work practices required for a basic level of infection control. They include good hygiene practices, particularly washing and drying hands before and after patient contact, may include the use of protective barriers such as gloves, gowns, plastic aprons, masks, eye shields or goggles, appropriate handling and disposal of sharps and other contaminated or infectious waste, and use of aseptic techniques. Standard Precautions also apply to dried blood and other body fluids.

Standard Precautions are recommended for the treatment and care of all patients, regardless of their perceived infectious status, and in the handling of: blood, all other body fluids, secretions and excretions (excluding sweat) regardless of whether they contain visible blood

- non-intact skin
- mucous membranes

The main goal of following Standard Precautions is to minimise the risk of acquiring blood borne viruses from contact with patients. In order to make such work practices effective, it must be assumed that all patients are potentially infected with such viruses. To only follow these precautions with those patients who are known to be infected gives a false sense of security and engenders risky work practices.

Additional Precautions are used for patients known or suspected to be infected or colonised with epidemiologically important or highly transmissible pathogens that can cause infection:

- by airborne transmission (eg. Mycobacterium tuberculosis, measles virus, chickenpox virus)
- by droplet transmission (eg. mumps, rubella, pertussis, influenza)
- by direct or indirect contact with dry skin (eg. colonisation with MRSA), or with contaminated surfaces
- by any combination of these routes

Additional Precautions are designed to interrupt transmission of infection by these routes and should be used in addition to Standard Precautions when transmission of infection might not be contained by using Standard Precautions alone. Additional Precautions may be specific to the situation for which they are required or may be combined where microorganisms have multiple routes of transmission. Additional Precautions implies a two tiered approach to infection control, and assumes that in cases where transmission of infection may not be contained by Standard Precautions alone Additional Precautions will be applied in addition to Standard Precautions.
Kia Ōrite - Code Of Practice

New Zealand Code of Practice for an Inclusive Tertiary Education Environment for Students with Impairments

Forward

Equity of access and opportunity is an important part of the vision for our tertiary education system, outlined in the Tertiary Education Strategy 2002/07. The Strategy sets objective for people with impairments to be achieving skills and qualifications in greater numbers. The Disability Strategy 2001 establishes a similar vision: to improve post compulsory education options for people with impairments.

When the government released the Tertiary Education Strategy 2002/07 it was envisaged that providers, communities and government agencies would work together to create the vision that the Strategy outlined.

I’m delighted that the tertiary sector group ACHIEVE has initiated and developed a Code of Practice to address issues for people with impairments. Congratulations to ACHIEVE for their work on Achieving Equity: New Zealand Code of Practice for an Inclusive Tertiary Environment for Students with Impairments. ACHIEVE’s knowledge, experience and understanding of issues for people with impairments undertaking tertiary study, is reflected in this document. I note also that the Code has been subject to consultation throughout New Zealand and that the Ministry of Education and the Tertiary Education Commission were involved in its development.

The benefits of tertiary education need to be available to people with impairments. Tertiary education enhances peoples’ lives by contributing to their general knowledge, understanding, increasing their incomes and standard of living and widening their experiences and interests.

This Code of Practice is a significant new resource. Providers will undoubtedly find it useful in working towards equity of access and opportunity for their students with impairments. It will help in developing further the kinds of tertiary environments that enable people with impairments to achieve to their full potential.

My colleague Hon Ruth Dyson and I commend the Code of Practice to you and hope that tertiary providers will take it up as you assist people with impairments to participate successfully in tertiary education.

Hon Steve Maharey, Associate Minister of Education (Tertiary Education)

Hon Ruth Dyson, Minister for Disability Issues

Part 1 - INTRODUCTION

1.1 Preamble

People with impairments have a right to education and to realise their potential.
Tertiary education enhances our lives and our society. A fully inclusive tertiary education system is one that recognises and values diversity and enables wide ranging participation by offering flexible learning pathways to the more than twenty percent of New Zealanders who have an impairment\[1 (resources/kia-orite-code-of-practice/#Anchor1)].

There has been a broad movement of change in tertiary education towards social inclusion as tertiary education providers recognise that diversity is fundamental to their successful functioning, and as they seek to reflect and shape community aspirations by ensuring social justice and equity for all members of society.

In the New Zealand Disability Strategy\[2 (resources/kia-orite-code-of-practice/#Anchor2)] released in 2001, the Government adopted a vision of a more inclusive society for people with impairments. Through implementing the Strategy, barriers to people with impairments participating and contributing fully to society will be removed.

The Government recognises that New Zealand’s economic growth and improved social outcomes depend on equal access and equal opportunities for all learners\[3 (resources/kia-orite-code-of-practice/#Anchor3)]. Despite this, statistics show that people with impairments are one of the most educationally disadvantaged groups in New Zealand. It is important, therefore, that barriers to their academic achievement and participation are identified and removed.

The trend towards social inclusion and the introduction of the Special Supplementary Grant: Tertiary Students with Disabilities has seen an increase in both awareness of disability issues and the numbers of students with impairments within tertiary education. Some institutions have become more proactive in developing inclusive teaching practices, enhancing support services and improving their policies relating to students with impairments. However, the results of the 2002 ‘Code of Practice Consultation Survey’\[4 (resources/kia-orite-code-of-practice/#Anchor4)] indicate that while progress has been made, there are still a number of barriers that people with impairments confront on a daily basis in tertiary education.

The Code of Practice is designed to assist tertiary education providers to achieve a fully inclusive environment through the ongoing identification and removal of barriers in areas of campus life. It is a tool to assist all staff within an institution in meeting their responsibilities, and is not just for those working in Disability Support Services.

For information to assist with implementation, visit the ACHIEVE website (http://achieve.org.nz/).

"Ko te teo herenga waka."
‘The stake for tying up the canoe.’

A mooring place for the canoe is a symbol for reliability. The canoe is an image for all the people on the journey.

Ngā Pāpeha a Ngā Tūpuna VUW Press 2001

1.2 Achieve

ACHIEVE, The National Post-Secondary Education Disability Network Incorporated, is a national network established to ensure equal opportunity and access to post-secondary education and training for people with impairments. ACHIEVE advocates and lobbies for people with a range of impairments who are transitioning into or studying post-secondary education. It also provides members with information and opportunities to network.

1.3 Acknowledgements

The Code of Practice was produced with the generous assistance of many people throughout New Zealand. While ACHIEVE was instrumental in initiating and driving this project, the Code of Practice could not have been written without the support of these people.

We particularly wish to thank the Code of Practice Steering Committee, the ACHIEVE Executive Committee and Victoria Manning, the first coordinator for the project. We are grateful for their feedback and guidance offered throughout its development.

We also acknowledge the Codes of Practice from Australia and the United Kingdom that have provided both inspiration and a basis for this work.

During 2002 a survey was completed to provide a guide for the development of this code. Regional Forums were also held in the first half of 2003 to discuss and gain feed about the ‘Draft Code of Practice’. People also had the opportunity to provide individual feedback and submissions.

We wish to thank the various people and organisations who offered feedback, distributed surveys, supported the hosting of Regional Forums, and gave financial and administrative support. This includes various tertiary education providers and the Ministry of Education. The Code of Practice could not have been produced without this generous assistance.

Ava Gibson, Chairperson, Code of Practice Steering Committee

Grant Cleland, Project Coordinator, Code of Practice

1.4 The Relationship between The Code of Practice and the Treaty of Waitangi
Central to the Treaty partnership and the implementation of Treaty principles is a common understanding that any strategies for Māori associated with the Code of Practice should be developed and implemented in partnership with Māori. This should also occur in good faith with mutual respect, co-operation and trust.[5 (/resources/kia-orte-of-practice/#Anchor5)]

The 2001 New Zealand Disability Survey shows that twenty percent of Māori had an impairment of some kind.[6 (/resources/kia-orte-code-of-practice/#Anchor6)] The Steering Committee overseeing the development of the Code of Practice acknowledges the importance of involving Māori in consultation processes and are aware of the potential shortcomings of the brief consultation process necessary for the development of the Code of Practice.

We view the Code of Practice as an evolving document with ongoing development and implementation processes, which will need to occur in partnership with Māori. This includes tertiary education providers consulting with Māori as they use the Code of Practice to create an inclusive environment for all people with impairments.

Part 2 - SETTING THE SCENE

2.1 Purpose of the Code of Practice

Key Objective:
To assist tertiary education providers create a fully inclusive tertiary education environment for students with impairments within New Zealand.

Aims:
The Code of Practice aims to:
1. Set out 'Best Practice' standards that describe the outcomes needed to create a fully inclusive tertiary education environment for students with impairments.
2. Assist tertiary education providers to:
   1. Understand the status of people with impairments in tertiary education in New Zealand.
   2. Evaluate their progress towards an inclusive environment.
   3. Identify potential barriers to participation and achievement that people with impairments face.
   4. Improve tertiary outcomes for students with impairments.
   5. Be aware of policy and legal obligations relating to people with impairments in tertiary education.

2.2 Definitions of Disability

Various definitions of disability exist. The definition used in The New Zealand Disability Strategy is different from that used by Statistics New Zealand for the 2001 Disability Survey and in the Human Rights Act, 1993.

The New Zealand Disability Strategy states that, "disability is not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual or other impairments." Instead, "disability is the process which happens when one group of people create barriers by designing a world for their way of living, taking no account of the impairments other people have."[7 (/resources/kia-orte-code-of-practice/#Anchor7)]

For the purposes of the Code of Practice we have used the New Zealand Disability Strategy definition of disability[8 (/resources/kia-orte-code-of-practice/#Anchor8)]. In document we will refer to people or students with impairments. This includes people with permanent impairments, those with impairments resulting from long or short-term injury or illness, the Deaf community and people with other impairments such as learning disability, neurological or cognitive difficulties, mental illness and other more hidden impairments.

2.3 Scope of this Code of Practice

Students with impairments are involved in the full range of tertiary courses at all levels of learning. This includes foundation courses, life skills, and vocational and academic programmes. The Code of Practice is intended to have an impact on the participation and achievement of students with impairments at all of these levels of learning and at all types of tertiary providers, including universities, polytechnics, private training establishments, wananga and colleges of education.

It is imperative that students with impairments are able to access the full tertiary experience; therefore this Code of Practice also applies to the wider aspects of tertiary life such as the social, cultural and recreational areas.

It should also be noted that the implementation of many of the Best Practice Standards would also have a positive impact on staff, particularly those staff that have or develop impairments.

2.4 The Rationale for Using the Code of Practice
New Zealand needs to develop the skills and abilities of its entire population, including people with impairments. Students with impairments are as valuable as all other students and have the ability to contribute to the community through education.

The Code of Practice can assist tertiary education providers to:

1. Improve tertiary education outcomes for students with impairments.
2. Meet their specific obligations relating to students with impairments under the New Zealand Disability Strategy, the Tertiary Education Strategy, STEPS, and Charters and Profi
3. Avoid the possibility of an institution or organization receiving a disability-related complaint under the Human Rights Act or other legislation, through the proactive identification and removal of barriers to participation and achievement.
4. Review services for students with impairments thus enabling them to get the greatest value out of resources.


The next section is divided into a number of topic areas covering different aspects of an inclusive environment. It is important that all topic areas are given attention.

Under each topic area there is:

1. A vision of an inclusive environment for that area.
2. A set of Best Practice Standards indicating the outcomes required.
3. Some ideas and examples to amplify the reader’s understanding of the standards.

Kia Orite - Best Practice Standards 3.1 [resources/kia-orite-code-of-practice/best-practice-standards-3-1/]
Kia Orite - Best Practice Standards 3.2 [resources/kia-orite-code-of-practice/best-practice-standards-3-2/]
Kia Orite - Best Practice Standards 3.3 [resources/kia-orite-code-of-practice/best-practice-standards-3-3/]
Kia Orite - Best Practice Standards 3.4 [resources/kia-orite-code-of-practice/best-practice-standards-3-4/]
Kia Orite - Best Practice Standards 3.5 [resources/kia-orite-code-of-practice/best-practice-standards-3-5/]
Kia Orite - Best Practice Standards 3.6 [resources/kia-orite-code-of-practice/best-practice-standards-3-6/]
Kia Orite - Best Practice Standards 3.7 [resources/kia-orite-code-of-practice/best-practice-standards-3-7/]
Kia Orite - Best Practice Standards 3.8 [resources/kia-orite-code-of-practice/best-practice-standards-3-8/]
Kia Orite - Best Practice Standards 3.9 [resources/kia-orite-code-of-practice/best-practice-standards-3-9/]
Kia Orite - Best Practice Standards 3.10 [resources/kia-orite-code-of-practice/best-practice-standards-3-10/]
Kia Orite - Best Practice Standards 3.11 [resources/kia-orite-code-of-practice/best-practice-standards-3-11/]
Kia Orite - Best Practice Standards 3.12 [resources/kia-orite-code-of-practice/best-practice-standards-3-12/]
Kia Orite - Best Practice Standards 3.13 [resources/kia-orite-code-of-practice/best-practice-standards-3-13/]

Part 4 - THE POLICY AND LEGAL FRAMEWORK FOR USING THE CODE OF PRACTICE

This section provides an overview of the status of people with impairments in tertiary education, the barriers to participation and achievement that many face, and the policy and legal framework for using the Code of Practice.

For consistency of language throughout this document, we continue to use ‘people or students with impairments’. The documents referred to in this section use a mixture ‘people with disabilities’ and ‘disabled people’.

Kia Orite - Policy and Legal Framework 4.1 [resources/kia-orite-code-of-practice/policy-and-legal-framework-4-1/]
Kia Orite - Policy and Legal Framework 4.2 [resources/kia-orite-code-of-practice/policy-and-legal-framework-4-2/]
Kia Orite - Policy and Legal Framework 4.3 [resources/kia-orite-code-of-practice/policy-and-legal-framework-4-3/]
Kia Orite - Policy and Legal Framework 4.4 [resources/kia-orite-code-of-practice/policy-and-legal-framework-4-4/]

Part 5 - APPENDICES

5.1 Glossary [36 [resources/kia-orite-code-of-practice/#Anchor36]]
Access - Ability to join and participate in all facets of life in tertiary education institutions or organisations (e.g. access to: buildings, programmes and facilities; courses; educational materials and other relevant social/cultural information; ceremonial events; communication access).

Accommodations - Adaptations that remove barriers to enable equal participation. These are based on the premise that students with impairments should be neither disadvantaged nor advantaged relative to other students. Students can be treated differently if it is achieving equity.

Assistive Technology - Equipment or software designed or modified to enable people with impairments to meet their information, communication and mobility needs.

Barriers - Social and environmental processes preventing or disadvantaging access, participation and achievement of students with impairments in tertiary education.

Best Practice Standards - Steps that a tertiary education institution or organisation can take to create a fully inclusive tertiary education environment for people with impairments. These may be enhanced through quality reviews.

Codes of Practice - A guide for tertiary education providers detailing what is expected of their inclusion of students with impairments. Similar codes are found at the following websites:

British Code of Practice (http://www.qaa.ac.uk/en)

Equitable Learning Environment - Reasonable accommodations have been made to enable students with impairments to participate in a course and compete on equal terms with other students.

Equity - Principles that ensure fairness to people with impairments in providing the opportunity for them to participate in and successfully complete studies in tertiary education.

Flexible Delivery - Adoption of a range of teaching strategies in a variety of learning environments to cater for differences in learning styles, learning interests and needs, variations in learning opportunities.

Inclusive Educational and Learning Environment - One in which diversity among students is valued and procedures are implemented to facilitate equitable access, participation and outcomes for all students.

Staff - Everyone employed by the tertiary institution or organisation, including teaching staff consisting of lecturers, tutors, teachers, instructors, workplace trainers, assessors and mentors.

Student - A person who is enrolled by a tertiary institution or organisation to participate in any educational activity.

Tertiary Education Provider - A tertiary education provider means all or any of the following, but does not include an industry training organisation:

1. an institution (i.e. a university, polytechnic, college of education or wananga);
2. a registered private training establishment;
3. a government training establishment; and
4. any organisation that provides tertiary education and receives government education funding (a community education provider for example).

Part 5 - APPENDICES

5.2 References


FOOTNOTES


FURTHER INFORMATION

Deciding what to study
Talk to the University Liaison Officer
Tel 03 479 7375
Or 0800 80 80 98
Fax 03 479 7375
Email liaison@otago.ac.nz

Financing study
StudyLink
www.studylink.govt.nz

Scholarships
www.otago.ac.nz/study/scholarships
www.otago.ac.nz/disabilities
www.fis.org.nz

Resources and Support
For students with permanent, recurring or temporary impairments

PLEASE CONTACT US DIRECTLY IF YOU HAVE ANY ENQUIRIES.
Disability Information and Support,
University of Otago
PO Box 56
Dunedin 9054
New Zealand
Tel 03 479 8235
Or 0800 80 80 98
Fax 03 479 5873
Email disabilities@otago.ac.nz

Office Hours: Monday – Friday 8.30am - 5.00pm
www.otago.ac.nz/disabilities
VISION AND ROLE
Disability Information and Support (DI&S) is a student support service at the University of Otago. Our vision is to work in partnership to promote an inclusive environment that celebrates diversity, promotes comprehensive academic support, and empowers individuals with impairments to achieve their full potential.

Our role is to provide learning support, advice, advocacy and information to students with permanent, recurring or temporary impairments.

SUPPORT FOR STUDENTS
Our Student Advisors are available to discuss each student's requirements and work collaboratively to put together a support plan.

The information that a student provides DI&S in relation to their impairment and support requirements will be held in confidence. In addition, the support received is not documented on a student's academic record or marked on their qualification.

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<td>• Access to the hearing loop system or other devises</td>
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Introduction

Kupu Whakataki

Te Whare Wānanga o Otago is committed to a culture of excellence in equity and diversity that supports all students and staff to achieve to their fullest potential. The Equity and Diversity Strategic Framework articulates this commitment.

The University has long championed equity, and has a proud history of leading social change in support of this. Notable firsts at the University of Otago have included educating Emily Siedeberg, the first female medical graduate in New Zealand (1896), and Sir Peter Buck – Te Rangi Hiroa, the first Māori medical graduate educated in Aotearoa New Zealand (1904). ¹

The University sees diversity to be a precondition for, and an indication of, a flourishing intellectual culture. Diversity is a vital component of the freedom of discourse that underpins our institutional role as critic and conscience of society. ²

The University's engagement with equity and diversity has broadened over time. Equity and diversity are now seen to comprise multiple attributes of the individual, including age, ethnicity, culture, disability, gender and gender identity, marital status, political opinion, religious belief, sexual orientation, socioeconomic status, and Māoritanga and Iwitanga, among other things.

The University understands that equity and diversity will continue to evolve as New Zealand society evolves. This progress will entail new challenges to the status quo and will require the University to both accommodate change within its own domain and to lead the way for others. Operating from an evidence base, the University will adapt and respond meaningfully to new equity and diversity circumstances as they arise.

¹ Other examples include New Zealand's first female barrister and solicitor, Ethel Benjamin (graduated 1897), and New Zealand's first Māori Professor of Law, Jacinta Ruru.
² Education Act 1989 [162(4)(vi)].
Equity and Diversity Strategic Framework
Te Rautaki Ararau Tōkeke

Context
Te Horopaki

The University of Otago has high-level legal obligations around equity and non-discrimination under the provisions of Te Tiriti o Waitangi, the New Zealand Bill of Rights Act 1990, the Human Rights Act 1993, and the Employment Relations Act 2000, among others. The Equity and Diversity Strategic Framework provides an overarching context for a suite of policies and plans\(^3\) that express the University’s commitment to excellent equity practice in all of its activities.

The University has a Government-mandated responsibility to boost achievement among priority equity groups. The Tertiary Education Strategy 2014-2019 makes explicit the Government’s expectations around this in Priority 3: “Boosting achievement of Māori and Pasifika”. In addition to detailing how providers should strengthen their support for Māori and Pacific learners, Priority 3 also exhorts tertiary education providers to support improved achievement by learners from low socio-economic backgrounds, people with disabilities, and refugee and migrant learners; and to support improved participation in certain areas such as women in trades and engineering.\(^4\) The Government “expects that activity of this kind will continue to be built upon so that all learners experience an inclusive tertiary education system that supports achievement and therefore improves outcomes from study”.

The University of Otago has formalised its commitments to Māori and Pacific students and staff in the Māori Strategic Framework 2016-2022, the Pacific Strategic Framework 2013-2020, and the University of Otago Statement of Objectives [updated annually]. The Equity and Diversity Strategic Framework supports these frameworks.

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\(^3\) Including: the Equity and Diversity Action Plan, The Equity and Diversity Policy, The Equal Employment Opportunity Policy, the Equal Education Opportunity Policy, Affirmative Action Policy, Campus Design for Access and Mobility Policy, Good Employer Policy, Māori Language Policy, Māori Strategic Framework, Pacific Strategic Framework and new policies as they are developed.

Equity and Diversity Strategic Framework

Te Rautaki Ararau Tōkeke

Vision

Te Pae Tawhiti

Guiding Principles

Mātāpono Arataki

The University of Otago promotes and upholds equity in its processes and values the individual differences that enrich its community. The University recognises equity and diversity as integral to its strategic goals.

This commitment is expressed in core values articulated in the University of Otago Strategic Direction to 2020:

- Excellence in learning and living environments that enrich the experience of students and staff.
- Knowledge, encompassing its relevance to the needs of students, employers, industry and society.
- Leadership in the development of graduates equipped to shape the future.
- Ethical Standards, encompassing institutional and individual conduct of the highest level; and respecting and valuing others.
- Equity and Social Justice, encompassing equity in employment; equity in educational opportunities; support for full and equal participation and outcomes for all groups in society.

The Equity and Diversity Strategic Framework promotes the University's core values via the following principles:

- The University recognises Māori as tangata whenua and is committed to upholding Te Tiriti o Waitangi.
- The University aims to support a safe, supportive, respectful and inclusive environment for all members of its community and recognises its role in cultivating that environment.
- The University's equity and diversity goals are achieved through an Action Plan and associated self-assessment.
- The University values equity and diversity and opposes discrimination on the basis of individual attributes.
- The University will fulfill its legal obligations under all relevant national laws and adhere to UN declarations and conventions on human rights.
Equity and Diversity Policy
Kaupapa Here Ararau Tōkeke

Category: Human Resources
Type: Policy
Approved by: Council
Date Policy Took Effect: 11 September 2017
Last Approved Revision: 4 October 2017
Sponsor: Equity Advisory Committee
Responsible Officer: Chair, Equity Advisory Committee
Review Date: 11 September 2019

Purpose

A campus-wide culture of equity and commitment to diversity supports organisational excellence and outstanding student experiences. It enhances the University’s reputation and its ability to recruit, retain, and support talented students and staff. This culture and commitment are essential to meeting the University’s obligations under the Education Act of 1990, Te Tiriti o Waitangi, and other national policies.

The purpose of this policy is to ensure that the University of Otago’s processes and practices uphold and promote equity outcomes, reflecting an environment in which all individuals are valued and different ways of thinking are embraced, and in which diversity, inclusivity and respect are key components of the University’s overall commitment to excellence.

Organisational Scope

The policy applies University wide and includes all staff, students, visitors and contractors at the University.
Definitions

**Equity**
Fair treatment, access, participation, opportunity and advancement in every stage of education or career.

**Diversity**
Recognition of and respect for the differences among individuals.

**Equity outcomes**
Measurable results of equity strategies, policies, plans, and actions.

**LGBTIQ**
Lesbian/gay, bisexual, transgender, intersex, questioning and/or queer.

Policy Content

1. General Principles/Mātāpono Matua

(a) The University of Otago is committed to equity and diversity and seeks to provide an accessible, inclusive, respectful and welcoming environment in which all students and staff are supported towards achieving their full potential. The Equity and Diversity Policy affirms this commitment and summarizes mechanisms to achieve these goals.

(b) The University recognises that members of equity groups are more likely than others to experience barriers to achieving their full potential and/or to be underrepresented. Proceeding from an evidence base, the University will prioritise support for members of identified equity groups.

(c) The University recognises Māori as tangata whenua and is committed to upholding Te Tiriti o Waitangi. Māori students and staff have a distinct status at the University under the provisions of the Treaty. This Policy supports the Māori Strategic Framework.

(d) The University recognises the special status of Pasifika staff and students and this Policy supports the Pacific Strategic Framework.

(e) The University recognises the following equity groups:

   i. Students and staff with disability and/or impairment

   ii. Students who are first in their family to attend university

   iii. LGBTIQ students and staff

   iv. Students from low socio-economic backgrounds

   v. Students and staff from migrant and/or refugee backgrounds and those whose first language is not English

   vi. Women where there are barriers to access and/or success.
2. Actions/Tukanga

(a) The University will promote equity and create an environment in which diversity and inclusivity are valued:

   i. All relevant University policies, procedures and guidelines, and associated processes will be consistent with the University’s commitment to equity and diversity.

   ii. University leadership will plan and take action to achieve equity outcomes established in the Equity and Diversity Strategic Framework and Action Plan, and will monitor performance in respect of this.

   iii. Internal and external communication will reflect the University’s commitment to a culture of equity and diversity.

(b) The University will monitor and report on existing, new or changed equity and diversity circumstances so that issues may be addressed where and when they aris(e) The University is committed to reporting its findings so that the university community is engaged in this process.

(c) The University will identify and support best equity and diversity practic(e)

(d) Given the distinct status of Māori as tangata whenua under the provisions of Te Tiriti o Waitangi the University will prioritise support for Māori through the Māori Strategic Framework and other support initiatives and mechanisms.

(e) The University will prioritise support for Pasifika students and staff through the Pacific Strategic Framework.

Related Policies, Procedures and Forms

University Policies and Strategies:

- Affirmative Action Policy
- Campus Design for Access and Mobility Policy
- Code of Student Conduct
- Equal Employment Opportunities Policy
- Equity and Diversity Strategic Framework
- Ethical Behaviour Policy
- Good Employer Policy
- Māori Language Policy - Ngā Kaupapa mō te reo Māori
- Māori Strategic Framework
- Pacific Strategic Framework
- Research Consultation with Māori Policy
Other:

- Code of Practice for the Pastoral Care of International Students
- Education Act 1989
- Employment Relations Act 2000
- Equal Pay Act 1972
- Health and Disability Commissioner Act 1994
- Human Rights Act 1993
- Kia Ōrite: Achieving Equity – New Zealand Code of Practice for an Inclusive Tertiary Education Environment for Students with Impairments
- New Zealand Bill of Rights Act 1990
- State Sector Act 1988
- The New Zealand Sign Language Act 2006
- United Nations Universal Declaration of Human Rights
- United Nations Declaration on the Rights of Indigenous Peoples
- United Nations Convention Relating to the Status of Refugees
- United Nations Convention on the Rights of Persons with Disabilities
- Tertiary Education Strategy 2014-2019

Contact for Further Information

If you have any queries regarding the content of this policy or need further clarification, contact the Chair of the Equity Advisory Committee on christina.hulbe@otago.ac.nz
Equal Educational Opportunities Policy

Category: Administration and Management
Type: Policy
Approved by: Council, 16 December 1993
Date Policy Took Effect: 1 January 1994
Last Approved Revision: 6 November 2014
Sponsor: Deputy Vice-Chancellor (Academic)
Responsible Officer: Manager, Academic Policy and Compliance, Academic Services
Review Date: 6 November 2019

Purpose

This policy sets out the University's obligations given its commitment to the principle of equal educational opportunities.

Organisational Scope

This Policy applies University-wide.

Policy Content

(a) The University of Otago is committed to the principle of equal educational opportunities for both men and women regardless of race, disability, age, marital status, sexual orientation, religious or ethical beliefs.

(b) Consistent with this principle, the University will act:
(i) To identify and eliminate all aspects of policies, procedures and other institutional barriers that cause or perpetuate, or tend to cause or perpetuate, inequality in respect of the educational opportunities of any person or group of persons.

(ii) To ensure greater participation and representation of Māori as students of the University.

(iii) To ensure greater participation and representation of ethnic or minority groups as students of the University.

(iv) To promote equal educational opportunities as an integral part of University policies and practices.

(v) To monitor, review and evaluate progress towards achieving equal educational opportunities.

Related Policies, Procedures and Forms

- Equal Employment Opportunities Policy

Contact for Further Information

If you have any queries regarding the content of this policy or need further clarification, contact the Manager, Policy and Compliance, Academic Services, on chris.stoddart@otago.ac.nz.