

**SOUTH AFRICAN LAW COMMISSION**

**Project 85**

**THIRD INTERIM REPORT ON  
ASPECTS OF THE LAW RELATING TO AIDS**

**HIV/AIDS AND DISCRIMINATION IN SCHOOLS**

**April 1998**

(i)

To Mr A M Omar, M P, Minister of Justice

I am honoured to submit to you in terms of section 7(1) of the South African Law Commission Act, 1973 (Act 19 of 1973), for consideration the Commission's third interim report on **Aspects of the law relating to AIDS.**

**I MAHOMED**

**Chairperson**

**April 1998**

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## **ACKNOWLEDGEMENT**

The Commission is indebted to Prof Christa van Wyk (project committee member) who undertook additional research for Discussion Paper 73, and who assisted in compiling this interim report.

The project committee particularly records its appreciation for the unrelenting hard work and commitment of the researcher, Mrs Anna-Marié Havenga.

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## **INTRODUCTION**

The South African Law Commission was established by the South African Law Commission Act, 1973 (Act 19 of 1973).

The members of the Commission are -

The Honourable Mr Chief Justice I Mahomed (Chairperson)

The Honourable Mr Justice PJJ Olivier (Vice-Chairperson)

The Honourable Madam Justice Y Mokgoro

Adv JJ Gauntlett SC

Mr P Mojapelo

Prof RT Nhlapo

Ms Z Seedat

The members of the Project Committee for this investigation are -

The Honourable Mr Justice E Cameron (Chairperson)

The Honourable Mr Justice PJJ Olivier (Vice-Chairperson of the Commission)

Prof RT Nhlapo (Full-time member of the Commission)

Mr Z Achmat

Dr PJ Haasbroek

Ms M Makhalemele

Dr MJ Matjila

Dr GJ Mtshali

Ms L Seftel

Ms AE Strobe

Prof CW van Wyk

The project leader is Mr Justice E Cameron. The researcher responsible for the investigation is Mrs A-M Havenga.

The Secretary is Mr W Henegan. The Commission's offices are on the 12th floor, Sanlam Centre, cor Schoeman and Andries Street, Pretoria. Correspondence should be addressed to:

The Secretary

Telephone: (012)322-6440

South African Law Commission

Private Bag X668

Fax : (012)320-0936

PRETORIA 0001

E-mail : lawcom@salawcom.org.za

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## 1 INTRODUCTION

- 1.1 The South African Law Commission has been investigating reform of the law relating to AIDS and HIV since 1993. An extensive discussion document (Working Paper 58) was published for general information and comment in September 1995. A reconstituted project committee - assisting the Commission in resolving differences of opinion between interest groups reflected in the comments on Working Paper 58 and in developing final recommendations - decided to adopt an incremental approach to this large and difficult task.
- 1.2 The Commission has already adopted the project committee's first interim report. In this report<sup>1</sup> the project committee addressed matters which are largely uncontroversial and which commanded almost universal support. The report deals with disposable syringes, needles and other hazardous material; universal work place infection control measures (universal precautions); a national compulsory standard for condoms; descheduling of HIV/AIDS as a communicable disease in the Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions<sup>2</sup> (the 1987 Regulations)<sup>3</sup>; and a national policy on HIV testing and informed consent. This interim report was tabled in Parliament by the Minister of Justice on 28 August 1997. The National Assembly resolved on 18 September 1997 that the recommendations in the First Interim Report should be implemented urgently by the government.
- 1.3 The project committee's second interim report addresses the question whether statutory intervention to prohibit pre-employment testing for HIV is warranted. The Commission approved a draft interim report in this regard on 17 April 1998.
- 1.4 The current interim report covers the issue of HIV/AIDS and discrimination in

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1 **SALC First Interim Report on Aspects of the Law Relating to AIDS.**

2 GN R 2348 in GG 11014 of 30 October 1987.

3 This recommendation does not concern the notification of HIV or AIDS.

schools and contains final recommendations with regard to the promulgation of a national policy on HIV/AIDS in public schools. Preliminary recommendations in this regard were presented in Discussion Paper 73 which was distributed for comment during the latter half of 1997.

1.4.1 Background information on the work of the previous project committee with regard to HIV/AIDS in schools and further progress since the appointment of the present project committee in 1996 are recorded in Chapter 2. Comments on Discussion Paper 73 are set out in Chapter 5 and evaluated in Chapter 6.

1.4.2 Extensive legal comparison was done in compiling Working Paper 58. Part of this is reflected in Chapter 2. The current interim report is based on the research done for Working Paper 58. Where new developments in other countries came to our attention, these were incorporated in the text and footnotes of the current interim report.

1.4.3 It was from the outset the Commission's intention to protect children (learners<sup>4</sup>) in public<sup>5</sup> and independent schools. These are schools that enroll learners in one or more grades between grade zero and grade 12. The recommendations in Discussion Paper 73 were drafted with this age group in mind. Strong submissions were however received from commentators to expand the policy to cover the entire education setting (including pre-schoolers, students in tertiary institutions, teachers [educators] and administrative staff at schools). These submissions were given careful consideration but the Commission has resolved to limit its recommendations to the age group originally intended. The research recorded in this interim report is accordingly limited to the position of learners between grade zero and grade 12. Submissions regarding the expansion of the preliminary recommendations are evaluated and the applicability of the

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4 The term "learner" is used in this interim report in accordance with its meaning in sec 1 of the South African Schools Act 84 of 1996 (the Schools Act) ("any person receiving education or obliged to receive education in terms of [the] Act"). Reference to "school children" is retained in the discussion of research done by the former Commission as recorded in Chapter 2 below.

5 "Public schools" is defined in fn 201, par 3.17 below.

proposed national policy to independent schools is dealt with in Chapter 6.<sup>6</sup>

1.5 Senior officers of the Department of Education have been closely involved throughout the Commission's consultation process in the development of the recommendations and policy contained in this interim report. Conversely, project committee members participated in a number of departmental meetings. Details of the Department's involvement are recorded in Chapter 2.<sup>7</sup>

1.6 It is to be noted that this interim report deals only with the issue of HIV/AIDS and discrimination in schools. Subsequent interim reports will deal with other matters identified for reform.

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<sup>6</sup> Par 6.11-6.29.2 below. See also par 3.17.2, fn 210 and par 3.58 for the position of independent schools, and par 6.70 and 6.73 for the Commission's recommendation in this regard.

<sup>7</sup> See par 2.14-2.16 and the accompanying footnotes.

## 2 BACKGROUND

### A) **WORKING PAPER 58: 1995**

2.1 The previous project committee did valuable research in respect of HIV/AIDS in schools, which was reflected in Working Paper 58.<sup>8</sup> In general it found that there were no uniform or sufficient measures or policy guidelines regarding HIV/AIDS in schools and that a real need for a uniform national policy existed.

2.2 The Commission came to the following preliminary conclusions in Working Paper 58:<sup>9</sup>

2.2.1 The risk of HIV transmission in schools, under normal circumstances, is effectively excluded.<sup>10</sup> There were at that time also no known cases of transmission of HIV in the school environment.<sup>11</sup>

2.2.2 In terms of the Constitution of the Republic of South Africa Act, 1993<sup>12</sup> (the 1993 interim Constitution) every person had the right to basic education and to equal access to educational institutions, and unfair discrimination was prohibited.<sup>13</sup>

2.2.3 In the light of the negligible risk of transmission of HIV in the school environment, compulsory testing of all school children as a prerequisite for admission to any school, or any unfair discriminatory treatment (for instance by refusing continued school attendance solely on the basis of the HIV status of a

8 This research was reflected in par 3.163-3.179 of **SALC Working Paper 58** published by the SALC in September 1995.

9 Par 3.171 -3.179.

10 **AIDS The Legal Issues** 192-194; **Someone at School has AIDS 5; Ontario Report** 44-45.

11 Van Wyk 1988 **THRHR** 328; Jarvis et al 78-79.

12 Act 200 of 1993.

13 The 1993 Constitution, sec 32 and 8(2).

child) would be unjustified. There would, however, be justification for withdrawing a child from school in cases where he or she posed a significant health risk to others (for instance when such a child had a serious secondary infection which could not be treated and could be transmitted to other persons) or where his or her health condition permanently restricted his or her ability to attend classes or to work.<sup>14</sup> This approach was in accordance with the Commission's premise<sup>15</sup> that persons with HIV/AIDS had to be accommodated in society to the extent that their infection did not expose others to significant risks that could not be eliminated by ordinary measures or reasonable adaptations.<sup>16</sup>

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14 Cf sec 33 of the 1993 interim Constitution; cf also **AIDS The Legal Issues** 196-197 and **Someone at School has AIDS** 8-9.

15 Cf par 2.21 of **SALC Working Paper 58**. A number of premises were adopted by the Commission, *inter alia*, that AIDS is a unique condition, that information and education should play a primary role in any strategy for the prevention of AIDS, that the 1993 interim Constitution did not necessarily apply between private parties and that measures taken should not discriminate unfairly against infected persons.

16 Cf eg the position in England where guidelines indicate that children with HIV are permitted freely to attend school and that they should be treated in the same way as other pupils (Viinika **HIV Infection and Children in Need** 49). In Canada too, the Ontario Law Reform Commission recommended in 1992 that compulsory testing of school children for HIV, as well as any prejudicial treatment of HIV infected school children would be unjustified (**Ontario Report** 44-45). In the United States of America (US) the position differs from state to state. In general it can be said that if legislation in a specific state requires that children of a certain age attend school, such children could be excluded from attending school only if the exclusion is justified (Jarvis et al 80-82). In this regard it was held that there was no rational basis for a school to exclude children known to have HIV (**District 27 Community School v Board of Education** 502 NYS 2d 325, 130 Misc 2d 398 [NYSCt 1986]), 82, 86, 92; see also Jarvis et al 82-84). The rationale behind this decision was that since it was likely that there were other children with HIV attending school, whose identity was not known to school authorities and who posed the same minimal risk of infection, it would not be rational to exclude only those children of whose condition the authorities were aware. Furthermore, legislation at state and federal levels aimed at discrimination against the disabled in general (eg the Vocational Rehabilitation Act, 1973, and later the Americans with Disabilities Act, 1990), as well as federal legislation dealing with the education of disabled children, is the main source of protection for pupils with HIV (**Someone at School has AIDS** 24-25; Jarvis et al 84-85). Sec 504 of the Vocational Rehabilitation Act 1973, which applies to virtually all public schools in the US, prohibits discrimination against the disabled who are "otherwise qualified" (Jarvis et al 88; **AIDS The Legal Issues** 200; **Someone at School has AIDS** 24). In the context of contagious diseases and school attendance this provision has been interpreted by the US Supreme Court in **School Board of Nassau County, Florida v Arline** (480 US 273, 94 L ed 307 [1987]) so as to provide maximum protection for persons with contagious diseases against one or another form of discrimination (eg exclusion from attending school) when the infection does not pose a significant risk of transmission to others (Jarvis et al 90-91). This principle has been applied by the lower federal courts in several decisions in instances where HIV infection was in issue (Jarvis et al 90-91). The Education for All Handicapped Children Act, 1975, further protects the right of disabled children to a free and appropriate public education (**AIDS The Legal Issues** 197; **Someone at School has AIDS** 24). The education of a disabled child who falls under this Act is to be integrated in the normal school programme if it would not significantly disrupt the programme of other pupils or create significant risks to other pupils (Jarvis et al 86). However, it was held that this legislation is not in general applicable to pupils with asymptomatic HIV infection (**District 27 Community School Board**

2.2.4 The medical and other facts would from occasion to occasion be decisive regarding continued school attendance and the management of school children with HIV infection. This would of course be possible only if the child's HIV status was known.

2.2.5 A call for the disclosure of AIDS-related information<sup>17</sup> could, however, be justified only if its confidentiality was ensured, and if it was not used as a basis for discriminatory behaviour against children with HIV infection.<sup>18</sup> This information could also be of real value only if there were clear policy guidelines regarding the management of children in respect of whom this kind of information had in fact been disclosed. The Commission took cognisance of national policy guidelines which had been issued in this regard in the United States of America (US).<sup>19</sup> They provide that with the consent of the infected child or his or her parent or guardian,

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**v Board of Education supra**; see also Jarvis et al 86) and in cases where it is applicable (eg because of complications resultant from HIV infection) such a child should be accommodated to the extent possible in the regular school programme consistent with the known low risk of transmission of HIV in the school environment (cf Jarvis et al 88).

17 Although the disclosure of AIDS-related information in school context is made compulsory by the 1987 Regulations (see reg 7(1)(a) and (2)), this position will probably change in the near future. For more detail see par 3.8 - 3.9 below.

18 In the US provision has, for instance, been made in certain states that the health authorities to whom HIV infection or AIDS is reported, must disclose this information to school principals (**U S State AIDS Laws 1988** 2). The US national education authority has, furthermore, issued a comprehensive, uniform policy document with guidelines to principals on what should be done with this information, and how children with HIV infection should be managed (**Someone at School has AIDS** 8, 10-16, 18-24). The guidelines make it clear that pupils with HIV infection may not be discriminated against and that the highest degree of confidentiality regarding AIDS-related information should be maintained. They also contain directions as to which persons may be informed of the HIV status of a pupil and how his or her continued school attendance should be decided upon; what the policy concerning testing of pupils for HIV is; which universal precautions should be applied in the school environment and which guidelines regarding AIDS education and information should be followed. See also **AIDSScan** December 1992 9 for the successful school placement policy for children with HIV in the city of Baltimore. Important policy components include strict protection of confidentiality, clinical investigation of each case, a review panel, a restricted setting for certain children, a school site visit for each placement, and continued monitoring of the school placement by school nurses. According to guidelines for education services in England, persons informed of the HIV status of a pupil should be strictly limited to "those that need to know" (Viinikka **HIV Infection and Children in Need** 49).

19 In the guidelines it was proposed that if the education authority was notified that a pupil was infected with HIV, decisions concerning the management of such a pupil had to be taken by the authorities in co-operation with the pupil him- or herself, his or her parent or guardian, the pupil's personal doctor and a public health official. Depending on the directions regarding the notifiability of HIV infection in the state concerned, it would not always be necessary to identify a pupil by name to the public health official (**Someone at School has AIDS** 8, 10-16, 18-24).

additional persons could be notified (for instance the principal of the school concerned).<sup>20</sup> This small group of persons would then act as decision makers, who, according to the circumstances of each case, had to ascertain whether the infected child posed a "medically recognised risk"<sup>21</sup> to other children, whether such a child could continue with normal school attendance, and what measures had to be taken to ensure his or her and others' safety (for instance the application of universal precautions, and the suspension of his or her participation in contact sport). It was emphasised in these guidelines that the utmost confidentiality had to be observed throughout this process.<sup>22</sup>

2.2.6 South African legislation<sup>23</sup> which ensured the education of "handicapped" children would not necessarily include children with HIV.<sup>24</sup> It was also uncertain whether the 1993 interim Constitution<sup>25</sup> would provide protection to persons with HIV infection against unfair discrimination on the basis of "disability".<sup>26</sup> In the light of this the Commission was of the opinion that legislation could be employed to regulate the right to equal access.

2.2.7 The Commission noted that it was widely accepted that education and information regarding HIV and HIV transmission offer the greatest hope for containing the epidemic.<sup>27</sup> Early sexual activity and intravenous drug abuse by teenagers were recognised as important potential sources of HIV transmission.<sup>28</sup> In the light of this and of the general ignorance regarding HIV/AIDS<sup>29</sup> and the modes by which the virus is spread, especially among school children in South

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20 Ibid.

21 Ibid 10 (the presence of a secondary infection like tuberculosis, may constitute such a risk).

22 Ibid.

23 See fn 173 below.

24 Cf also the comment in **AIDS The Legal Issues** 99 and Jarvis et al 88 in respect of similar legislation in the US.

25 Sec 8(2).

26 See par 2.17 of **SALC Working Paper 58**. In this paragraph the question whether HIV infection as such would constitute a disability for the purposes of sec 8(2) of the 1993 interim Constitution, was discussed.

27 Lamers **AIDS: Principles, Practices and Politics** 182; cf also **Reducing the Risk** 10; **WHO AIDS Series 10**, 1.

28 Jarvis et al 93.

29 Cilliers **AIDS in Context** 75-76; Visser et al **AIDS Research Feedback 1993** 7.

Africa,<sup>30</sup> the Commission was of the opinion that it was of cardinal importance that school going children receive information and education regarding HIV/AIDS and its prevention.

2.2.8 With regard to HIV/AIDS education in schools, a divergence of opinion among the then existing Education Departments on this issue was apparent<sup>31</sup> from evidence before the Commission.<sup>32</sup> The nature and extent of AIDS information to school children at that time varied between the supply of no information to full information.<sup>33</sup> With the exception of the then Department of Education and Training, the various former national education departments each issued policy guidelines concerning the management of HIV infection and AIDS in schools.<sup>34</sup>

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30 Visser 1995 **SAJE** 130-138. See also Mathews et al 1990 **SAMJ** 511-516; Karim et al 1992 **SAMJ** 107-110. It was also found that (female) college students are in need of better education about protection against sexually transmitted diseases (STD's) and AIDS (study quoted in **AIDSScan** June 1992 7).

31 This divergence was already evident from a survey conducted at the end of 1987. See Cilliers **AIDS in Context** 77-83.

32 Evidence before the Commission on 15 April 1994 on behalf of the Department of Education and Training and the Education and Culture Service (Ex Administration: House of Assembly).

33 In respect of children in public schools under the former Transvaal, Orange Free State and Natal Provincial Administrations AIDS information and education had for some time been part of the compulsory curriculum from standard two to matric. Parents were informed about these programmes and had to give their written consent for the transmission of "sensitive information" (evidence before the Commission on 15 April 1994 on behalf of the Education and Culture Service [Ex Administration: House of Assembly] and the former Transvaal Education Department). In the case of children in public schools under the former Cape Provincial Administration, AIDS information and education were at that time supplied on an experimental basis to selected groups (evidence before the Commission on 15 April 1994 on behalf of the Education and Culture Service [Ex Administration: House of Assembly]). In the case of children in public schools under the Department of Education and Training, AIDS education had not yet been supplied to pupils, and a start had just then been made with the education of teachers in this regard. Problems were experienced with the presentation of AIDS information as part of the compulsory curriculum, with supply of personnel for this purpose and with the funding of an information and education programme (evidence before the Commission on 15 April 1994 on behalf of the Department of Education and Training). In respect of children in public schools under the Department of Education and Culture, Administration: House of Delegates, AIDS education and information had to be supplied to all children with the consent of their parents, but the presentation thereof as part of the compulsory curriculum or only on an after-hours basis was left in the discretion of school principals (AIDS Education E C Circular No 32 of 16 August 1991 [Department of Education and Culture, Administration: House of Delegates]). In respect of children in public schools under the former Department of Education and Culture, Administration: House of Representatives, an intensive education programme regarding HIV for pupils was prescribed - guidance about such a programme and its implementation were left to individual school principals (VIGS-beleid vir Skole Onderwysbulletin: S5/93 November 1993 [Department of Education and Culture, Administration: House of Representatives]).

34 AIDS Education E C Circular N0 32 of 16 August 1991 (Department of Education and Culture, Administration: House of Delegates); VIGS-beleid vir Skole Onderwysbulletin: S5/93 November 1993 (Department of Education and Culture, Administration: House of Representatives); Die Hantering van Persone met HIV en VIGS en die Voorkoming van HIV-besmetting Riglyne vir Opvoedkundige Inrigtings

The premises of the different sets of guidelines were, however, not uniform in all respects: some were still based on the 1987 Regulations as discussed in paragraph 3.8 to 3.9 below, and others were aimed at AIDS education only.<sup>35</sup> It was clear that, for various reasons, most children in South Africa did not receive such education.

2.2.9 The Commission was aware of the fact, and it had been confirmed in evidence,<sup>36</sup> that HIV education was a controversial matter involving complex issues. Questions of philosophical, political and religious tenets, sex education and the appropriate age level at which this type of information should be supplied, arose. There was tension too between facts and moral judgments, and the participation of parents in the education process complicated the matter.<sup>37</sup>

2.2.10 The Commission concluded that a real need existed for a uniform national

Mei 1993 (Department of Education and Culture, Administration: House of Assembly). According to evidence before the Commission some of the former Provincial Education Departments also issued additional guidelines concerning the management of HIV and AIDS in schools (evidence by Prof J Löt, Education and Culture Service (Ex Administration: House of Assembly) on 15 April 1994 - cf in the latter regard *inter alia* "Chapter 44 School Health and Dental Services" in the **TED Manual for General School Organisation**).

35 According to information, the compilation of national guidelines with a view to an uniform policy, was at that time being considered (information supplied to the researcher on 23 August 1994 by Prof J Löt, Education and Culture Service [Ex Administration: House of Assembly]).

36 Evidence by representatives of the Department of Education and Training, Education and Culture Service (Ex Administration: House of Assembly) and the former Transvaal Education Department on 15 April 1994; cf also **AIDS The Legal Issues** 204-205.

37 Cf **AIDS The Legal Issues** 204-205. In England for instance, legislation has empowered school governing bodies since 1986 to decide whether, and, if so, in what form, sex education (which provides a forum for education regarding HIV) should be provided at a specific school. It is essential that the governors approve the syllabus for sex education. Parents must be consulted on the matter and are allowed to withdraw their children from these lessons. Education about HIV has been introduced into the national education curriculum as part of the science syllabus since 1992. This might possibly be a way of ensuring that (notwithstanding the view of the governors) children are educated on HIV in a subject area which is beyond the control of the governors. According to the literature, this procedure has, however, already elicited controversy (Viinikka **HIV Infection and Children in Need** 51-52). Since as far back as 1986 the US government has called for compulsory sex education (which includes information regarding HIV/AIDS) in schools. Consequently, compulsory education regarding HIV/AIDS has been instituted by way of legislation in various states, but as a result of the controversy which accompanies this, it has been provided in some states that parents may withdraw their children from these programmes. In certain educational circles it was, for instance, believed that AIDS education must be explicit in order to be effective. This elicited so much controversy that the use of federal funds for "offensive" AIDS education material was prohibited, and the screening of such material by community bodies was required (Jarvis et al 93-96; **AIDS The Legal Issues** 203-205; **Reducing the Risk** 3-4).

policy regarding HIV and AIDS in schools in which aspects such as continued school attendance, management of persons with HIV infection, confidentiality of AIDS-related information, and HIV/AIDS education were addressed.

2.3 The Commission at that time therefore made the following preliminary recommendations:

- \* **That legislation should confirm -**
  - + that HIV testing may not be a prerequisite for admission to schools or for continued school attendance;
  - + that a child may not be barred from continued school attendance solely on the ground of his or her HIV infection; and
  - + that confidentiality of AIDS-related information must be maintained.
- \* That the education authorities be compelled by legislation to provide AIDS information and education as part of the compulsory curriculum to primary and secondary school children, but that the parent or guardian of a child be permitted to refuse in writing that the child concerned attend such a programme.
- \* That the education authorities establish a clear and comprehensive national policy regarding the management of children with HIV infection. In such a policy document, aimed at the education corps, principles and practical guidelines should be set out and the confidentiality of AIDS-related information, continued education for children with HIV infection, the application of relevant universal precautions, and the supply of information and education on HIV/AIDS should be ensured.

2.4 Comments were received on Working Paper 58 between October 1995 and February 1996. Twenty four of the 49 comments received on Working Paper 58 as a whole included reference to HIV/AIDS in schools.

2.5 The Medical Association of South Africa, the Afrikaanse Handelsinstituut, and the

City Health Department of the City of Cape Town unreservedly agreed with all the Commission's preliminary recommendations on HIV/AIDS in schools.

2.6 The Department of Education, Mrs ME Olckers (Member of the Executive Committee [MEC] for Education and Cultural Affairs, Western Cape), the Dutch Reformed Ministry of Caring, the AIDS Legal Network (ALN) and the Department of Health endorsed the Commission's recommendations in general. The Dutch Reformed Ministry of Caring however added that an infected child should only be accommodated if he or she does not pose a health risk to others and if his or her health condition does not permanently restrict his or her ability to attend classes or to work; and the ALN and the Department of Health emphasised that there was no need for school authorities to be notified of a child's HIV infection.

2.7 Two respondents commented on some of the recommendations only. The South African Association of Social Workers in Private Practice agreed that children with HIV should be permitted to attend regular schools while the South African Council of Churches believed that HIV testing in schools should be discouraged at all costs as this would perpetuate discrimination against black children in previously white schools.

2.8 Several commentators agreed with the recommendations of the Commission but expressed concern about the possibility of transmission of HIV in the course of contact sport.

2.8.1 NACOSA (Western sub-province of Eastern Cape), the ALN and the Department of Health submitted that proper regulation of contact sport had to take place. The ALN and the Department of Health added that precautions had to be taken with all wounds, and not just with those of children known to be infected.

2.8.2 The City Health Department of the City of Durban believed that more consideration had to be given to children at risk of exposure to blood in play

situations and contact sport, and that the protection of the HIV negative child was essential. IL Hay (human resources manager) agreed with this and emphasised the risk of becoming infected in assisting an infected child in an accident. Mr RJ Elliott (on behalf of Sappi Health Advisory Committee) in general agreed with the recommendations, but believed that a teacher should be informed of the infection of children in his or her care, in order that uninfected children may be safeguarded against risk of infection.

2.8.3 The South African Nursing Council recommended that consideration be given to ensuring that all schools have the necessary information concerning universal precautions in cases of injuries or accidents involving school children.

2.8.4 AB Bluhm (private citizen) proposed that a principal should have the authority to prohibit an infected child from participation in sport, without making known his or her condition. The Association of Law Societies agreed that a child with HIV should be prohibited from taking part in contact sport.

2.9 A number of respondents generally supported the recommendations, but expressed concern about, or emphasised, sexuality education and AIDS education.

2.9.1 The Department of Community Health of the University of Cape Town welcomed the recommendation that education authorities be obliged to provide sexuality education.

2.9.2 The Department of Health and the ALN did not agree with the recommendation that parents should have the authority to withdraw their children from AIDS education, but believed that sexuality education should be both compulsory and examinable. The City Health Department of the City of Durban strongly supported the provision of AIDS information and education in schools and suggested that sexuality education be made compulsory and examinable.

- 2.9.3 Mrs ME Olckers supported the right of a parent or guardian to arrange that a child be excluded from HIV/AIDS education lessons, but believed that such parents should be compelled by the education authorities to provide suitable AIDS information and education to the child(ren) concerned. RJ Elliot argued that parents' right to prevent children attending an AIDS education programme should be the same as their rights in respect of any other part of the compulsory curriculum, and that parents should be given the opportunity to comment on the AIDS education programme content in order to win their support.
- 2.9.4 Rashid Patel and Company (attorneys) commented that the nature of the (AIDS) education to be given in schools should take into account existing moral, religious and social implications. They suggested that parents and other interested parties should be consulted when the curriculum is drawn up.
- 2.9.5 The Superintendent of the Sterkfontein Hospital proposed that principles of universal precautions (including the use of mechanical devices in mouth to mouth or nose resuscitation) needed to be taught to all care givers such as educators; that children should be told about AIDS to their level of understanding at an early age; that they should be taught how to manage a friend's bleeding nose or wound, and that programmes about the effect of drug abuse in schools should include the effects of intravenous drug abuse.
- 2.10 Two commentators were not supportive of the recommendations of the Commission.
- 2.10.1 Mrs Robin Collett (private citizen) expressed concern about the recommendation that children with HIV should be admitted to schools, and that no testing could take place to know who was infected and who not. She was also concerned about accidents on the playground and on the sport field and about young children not knowing how to protect themselves.

2.10.2 Dr HGV Küstner (former Director: Epidemiology, Department of National Health and Population Development), believed that to play down the risks of uninfected school children becoming infected at school, was dangerous, especially as the rates of infection were rising. He also questioned the "Western paradigm" which was followed in dealing with HIV. He referred to an address by Ms Dawn Mokhobo at an AIDS Congress in 1988 in which she outlined sexual attitudes amongst blacks (at that time) with special reference to AIDS and the problems concerning trans-cultural sexuality and AIDS education, which (according to her) militated heavily against the probability of successfully conducting effective health education programmes.

2.11 Business South Africa and the Chamber of Mines of South Africa accepted the broad principles of non-discrimination and confidentiality in the school context. They nevertheless believed that it should be left to the education authorities (and private education facilities) to determine their own admission criteria and curricula on matters such as HIV/AIDS education and drug abuse. Although both saw the merit of national guidelines for the management of school children with HIV infection, the Chamber of Mines of South Africa did not believe that HIV infection should be specifically catered for. In general the Chamber of Mines felt that a fair balance should be struck between the rights of infected persons and the rights of uninfected individuals, other legal persona and the community at large.

**B) FURTHER PROGRESS SINCE 1996: DISCUSSION PAPER 73**

2.12 The project committee appointed in 1996 concluded from the responses received to the Commission's 1995 preliminary recommendations that from a scientific and medical viewpoint, the matter of HIV/AIDS in schools is relatively uncontroversial and that a large measure of consensus exists on the need for a national policy on HIV/AIDS in schools.

2.13 The well-publicised crisis caused by the application in early 1997 by Nkosi

Johnson (an eight-year-old boy with AIDS) to be admitted to a public school in Johannesburg, the reaction of some members of the public and the apparent absence of a national education policy on this issue,<sup>38</sup> underscore the lesson that the practical situation has not improved since 1995. This is despite the fact that the South African Schools Act<sup>39</sup> (the Schools Act) was passed in 1996, giving effect to both the spirit and letter of the Constitution of the Republic of South Africa 1996<sup>40</sup> (the 1996 Constitution) by protecting learners from unfair discrimination and by guaranteeing them their rights to basic education and to equal access to public schools.<sup>41</sup>

2.14 In view of the Commission's initial work on the matter, the project committee has, since the Nkosi Johnson incident, engaged in extensive discussions and liaison with the Department of Education to ascertain whether and to what extent the Commission's 1995 proposals have been implemented, whether they were acceptable and whether the Commission could be of assistance in advancing resolution of the matter.<sup>42</sup> It was confirmed that the Department of Education, with the Department of Health, is in the process of developing ways to deal with HIV in schools and that the Department of Health favours the adoption of a national policy.<sup>43</sup> The project committee consequently

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38 The application on behalf of Nkosi Johnson and the dearth of policies on provincial or national level on this issue, were reported in the **Sunday Times** 23 February 1997; **Sowetan** 25 February 1997; **Beeld** 28 February 1997; and **Sunday Times** 2 March 1997. The latter newspaper also discussed the case of a Grade 11 learner who was kept in isolation in a school hall and then suspended because she was suspected of having HIV.

39 Act 84 of 1996.

40 Act 108 of 1996.

41 Cf the joint statement by Prof SME Bengu, Minister of Education and Dr ND Zuma, Minister of Health of 25 February 1997 in which the following was said: "We are disturbed by the reaction of some members of the public to an eight year old HIV positive child's attempt to exercise his democratic right to attend a public school. This occurs in spite of the constitutional stipulations and new education legislative framework ... (which) gives effect to both the spirit and letter of the Constitution by protecting and guaranteeing the rights of all learners to basic education and equal access to public schools ... Any attempt to deny a child admission to a public school on the basis that he or she is HIV positive is a gross violation of that child's rights as guaranteed by the Constitution. We want to state categorically that no governing body has the right to deny a child access to a public school ...".

42 The Commission's 1995 proposals were again brought to the Department of Education's attention for consideration at a Departmental meeting on 27 February 1997 through informal discussions between Prof T Nhlapo (full-time member of the Commission and member of the project committee) and Ms S Sisulu (ministerial adviser, Department of Education).

43 This was confirmed, on behalf of the Department of Education, by Dr TA Coombe (Deputy Director-General: Education Services) in a telephone conversation with the researcher on 5 March 1997; and on behalf of the Department of Health, by Dr Glaudine Mtshali (Chief Director: National Programmes and member of the project committee) at the project committee's meeting on 6 March 1997. Dr CCP Madiba

compiled a discussion document (Discussion Paper 73) proceeding from the 1995 proposals (with the addition of a proposed national policy) in order to assist the Department of Education and the Minister of Education in developing solutions to the problem of HIV-related discrimination in schools and in order to conclude the work of the Commission initiated by the 1995 proposals. The proposals and policy in Discussion Paper 73 were developed in a joint consultative process with the Department of Education and were the result of input and guidance received from the Department.<sup>44</sup> By including this input, the project committee attempted to be responsive to the needs of the Department and to utilise the expertise at the Department's disposal.

2.15 Discussion Paper 73 was published for general comment in August 1997. Written comments were received from 66 respondents (a list of which is attached as ANNEXURE A). In general the comments reflected overwhelming support for a national policy on HIV/AIDS for schools.<sup>45</sup>

2.16 Senior officers of the Department of Education have again been included in the project committee's work when comments on Discussion Paper 73 were processed and the final recommendations and policy contained in the current interim report were formulated.<sup>46</sup>

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(Chief Director: Education Systems and Co-ordination) indicated at a project committee meeting on 25 March 1997 that the Commission's consultation process would greatly assist the Department of Education in formulating and finalising a national policy.

44 The project committee's provisional draft discussion paper and proposed national policy were considered and discussed with senior members of the Department of Education (Dr CCP Madiba, Chief Director: Education Systems and Co-ordination and Dr M Lane, Chief Educational Specialist) at the project committee's meeting on 25 March 1997. The provisional policy was further deliberated at a Branch Meeting of the Department of Education on 4 April 1997 attended by Ms Ann Strode (project committee member). Further comment on the provisional draft (which included comment from the Department's Curriculum Task Team) was contained in departmental letter 1/2/3 of 23 April 1997 addressed to Mr W Henegan, Secretary of the Commission.

45 The comments are recorded in Chapter 5 and evaluated in Chapter 6 of this interim report.

46 Senior officers of the Department of Education (Adv E Boshoff, Director: Legal Services and Legislation; Dr M Lane, Deputy Director: Legal Services and Legislation; and Dr N Louw, Member of the National Task Team: Life Skills and HIV/AIDS Education Programme) were consulted informally on 24 February 1997 by Prof Christa van Wyk (project committee member) and the researcher in preparing the draft for this interim report. The draft was thereafter submitted to the Department and considered in conjunction with senior officers of the Department (Dr TA Coombe, Deputy Director-General: Education Services; Dr CCP Madiba, Chief Director: Education Systems and Co-ordination; and Dr M Lane Acting Director: Legal Services and Legislation) at a project committee meeting on 14 March 1998. Dr Coombe

## C) WHAT IS HIV/AIDS AND HOW DOES IT IMPACT ON CHILDREN?<sup>47</sup>

2.17 AIDS is the acronym for "acquired immune deficiency syndrome". It is the clinical definition given to the onset of certain life-threatening infections in persons whose immune systems have ceased to function properly.<sup>48</sup> The condition is acquired in the sense that it is not hereditary - it is generally accepted that it is caused by a virus (HIV) which invades the body from outside. The genetic material of HIV (the abbreviation for "human immunodeficiency virus") becomes a permanent part of the DNA<sup>49</sup> (the genetic material of all living cells and certain viruses) of the infected individual with the result that this person becomes a carrier of HIV for the rest of his or her life (and can therefore infect other individuals). Moreover, HIV is unique in the sense that it attacks and may ultimately destroy the body's **immune** system. Consequently, the body's natural defence mechanism cannot offer any resistance against illnesses, even those that normally do not involve an extraordinary danger to healthy people. **Syndrome** implies a group of specific symptoms that occur together and that are characteristic of a particular pathological condition. AIDS is described as a syndrome precisely because it does not manifest itself as one disease. It is rather a collection of several conditions that occur as a result of damage which the virus causes to the immune system. Persons thus do not die of AIDS as such. They die of one or more diseases or infections (such as pneumonia, tuberculosis

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indicated at this meeting that the Education Department profoundly appreciates the work done by the Commission and stressed that the Department would not have been able to do it on its own in the way it was done (which included publication of a discussion paper and draft national policy for comment).

47 This chapter consists mainly of edited extracts from **SALC Working Paper 58** (cf par 1.4 - 1.25, par 3.122- 3.124, par 3.143 - 3.146 and par 3.163 -3.179). Virtually every source consulted for the purposes of this investigation presents the medical and empirical facts (as known at the time) with regard to AIDS - some more comprehensively than others. For purposes of this document a relatively simple and synoptic description of HIV/AIDS is presented. South African sources consulted in this regard include the following: **AIDS Unit Strategy 1991** 1-13; Arendse 1991 **ILJ** 218-219; De Jager 1991 **TSAR** 212-216; FitzSimons **Facing up to AIDS** 13-33; Swanevelder **Epi Comments** May 1992 80-92; Van Dyk 1-22; Van Wyk 1-80; Van Wyk 1988 **De Jure** 326-329; Van Wyk 1988 **THRHR** 317-320; Whiteside **Facing up to AIDS** 3-12. Foreign sources consulted on the medical background of AIDS include: **Australia Report on Privacy and HIV/AIDS** 9-12; Green **AIDS and the Law** 28-36; Gunderson et al 9-29; Jarvis et al 5-26; Miller 1-20; Volberding **AIDS: Principles, Practices and Politics** 97-112; Krim **AIDS an Epidemic of Ethical Puzzles** 15-20; Carr **AIDS in Australia** 2-23; Crofts **AIDS in Australia** 24-32; Gostin **AIDS and Patient Management** 3-8.

48 For a complete discussion of medical aspects of HIV and AIDS, see Abrams et al **AMFAR AIDS/HIV Treatment Directory** June 1996 135-137. See also Nolan **AIDS an Epidemic of Ethical Puzzles** vii; De Witt 8; Evian 4-9.

49 DNA is the abbreviation for "deoxyribonucleic acid".

or certain cancers) that are described as "opportunistic" because they attack the body when immunity is low. AIDS can therefore be defined as a syndrome of opportunistic diseases, infections and certain cancers that eventually cause a person's death.

- 2.18 Infection of a person with HIV does not necessarily entail that a person is sick. A person with HIV infection can remain otherwise healthy and without symptoms for a number of years.<sup>50</sup> He or she can live without notice of infection. HIV infection during this period is called asymptomatic infection.<sup>51</sup> During asymptomatic infection a person is capable of performing all of his or her daily activities, and can thus lead a full and productive life.<sup>52</sup> At this stage the person does not have AIDS. A person has AIDS only when he or she becomes ill as a result of one or more opportunistic illnesses. AIDS is the final clinical stage of HIV infection.<sup>53</sup>

\* **Transmission of HIV<sup>54</sup>**

- 2.19 As soon as a person is infected with HIV he or she is able to transmit the infection to other people irrespective of whether the infected person shows any symptoms at that stage. However, HIV is not easily transmitted (in contrast with many other serious diseases such as certain sexually transmitted diseases and certain other viral infections<sup>55</sup>).

- 2.20 HIV has been identified in blood, semen, vaginal and cervical discharge, breast milk, the brain, bone-marrow, cerebrospinal fluid, urine, tears, foetal material and saliva. However, current scientific knowledge indicates that only blood, semen, vaginal and cervical discharge and breast milk contain a sufficient concentration of the virus to be able

50 Gostin et al 1986 *AMJLM* 8.

51 Ibid.

52 See also par 2.32 and 2.40 below.

53 Although some scientists apparently no longer wish to differentiate between persons with HIV and AIDS (cf Van Wyk 25), this differentiation is nevertheless maintained in the majority of sources consulted and is explicitly accepted in Canada and Australia where recommendations for law reform were made in 1992 (**Ontario Report** 6-7; **Australia Report on Privacy and HIV/AIDS** 9).

54 See the sources referred to in fn 47 above.

55 Eg hepatitis B (Van Dyk 22).

to transmit HIV. Transmission can occur only through specific and limited routes.

2.21 At present no scientific evidence exists that HIV can be transmitted in any other mode than the following:

- \* By hetero- or homosexual intercourse.
- \* By receipt of or exposure to the blood, blood products,<sup>56</sup> semen, tissues or organs of a person who is infected with HIV. This can occur *inter alia* by the use of dirty or used syringes and/or needles for intravenous drugs.<sup>57</sup>
- \* By a mother with HIV to her foetus before or during birth, or to her baby after birth by means of breast-feeding (also called perinatal transmission).

2.22 To infect a person, HIV must reach the blood stream or lymphatic system. HIV may possibly be transmitted via mucous membranes.<sup>58</sup> The virus cannot be spread by other forms of personal contact than those described above. Outside the human body and especially outside body fluids, HIV has an extremely limited life span of a few seconds only.<sup>59</sup> The virus is also destroyed by disinfectant.<sup>60</sup>

2.23 There is thus no risk of HIV transmission from casual contact. HIV cannot be transmitted by daily social contact such as breathing, coughing, shaking hands or hugging.

56 In comment on Discussion Paper 73, the Department of Health pointed out that this mode of transmission is extremely rare and that "blood transfusion in South Africa is as safe as it could possibly be". The Department also pointed out that Factor XII is heat treated.

57 Intravenous drug users inject drugs directly into their bloodstream. To ensure that the needle has struck a vein, they usually draw blood into the syringe before the drug is injected (without removing the needle). Thus a small amount of blood always remains in the needle and/or syringe and is consequently injected directly into the bloodstream of the next injector (Van Dyk 18).

58 Recently a case was reported in the US of HIV transmission as a possible result of deep kissing. Both the man and the woman involved however had mouth lesions and blood stained saliva (CDC **Morbidity and Mortality Weekly Report** 11 July 1997 620 et seq).

59 Researchers say HIV can stay alive outside the body but still in body fluids, eg blood, for 24 hours or longer, while it can only live from 20 to 60 seconds outside body fluids (Van Dyk 19); CDC **Morbidity and Mortality Weekly Report** 12 July 1991 5, 7.

60 Van Wyk 1988 **De Jure** 328; **Transvaler** 21 July 1992; **The Star** 22 July 1992; Van Dyk 29-30.

It cannot be transmitted through food preparation, by toilet seats, or by sharing food, water or utensils. Even if blood contact did take place, the chances of being infected are small. (The incidence of infection, for instance, among health care workers who received injuries from needle sticks and other sharp objects contaminated with blood known to be HIV infected, is calculated to be approximately three in 1 000.<sup>61</sup> Where the status of the blood was not established, but surgical procedures were prone to expose a person to blood, the risk of infection was considered to be at most one in 42 000.<sup>62</sup>)

2.24 Not every person exposed to HIV becomes infected. Similarly, it is possible that not every person who is infected with HIV eventually develops AIDS. Scientists are as yet uncertain of the precise position.<sup>63</sup> There is apparently reasonable consensus that 45-50% of infected persons will develop AIDS after 10 years, but it has also been estimated that between 65-100% of infected persons are likely to develop the disease within 16 years.<sup>64</sup>

+ *Transmission and incidence of HIV in children*

2.25 The ways in which children can become infected with HIV are by vertical transmission (perinatally from mother to baby); receiving infected blood, blood products or organs; intravenous drug abuse, early sexual activities<sup>65</sup> and sexual abuse.<sup>66</sup> Breastfeeding has been implicated for being responsible for a dramatic increase in vertical

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61 Tereskerz et al 1996 **New England Journal of Medicine** 1150-1153 (as quoted in **AIDSScan** March 1997 9). In a similar study the risk of HIV infection after percutaneous exposure (i.e. exposure resultant from absorption through the skin) to HIV-infected blood was concluded to be 0,36%, while no health care workers whose mucous membrane or skin was exposed to HIV-infected blood, seroconverted (**AIDSScan** March 1994 6).

62 **Doe v University of Maryland Medical System Corporation** 50 F 3d 1261 (1995).

63 One study went as far as to suggest that 20% of infected individuals could remain symptom-free for at least 25 years. Only observation over time will provide meaningful percentages (**AIDSScan** March/April 1996 6).

64 Keir **AIDS Analysis Africa** December 1990/January 1991 9; Van Wyk 1988 **De Jure** 328; Krim **AIDS an Epidemic of Ethical Puzzles** 19; Carr **AIDS in Australia** 7.

65 Grossman **AIDS: Principles, Practices and Politics** 167.

66 Cf the response of the AIDS Legal Network to **SALC Working Paper 58**.

transmission of HIV.<sup>67</sup>

2.26 Amongst children the most important route of HIV transmission by far is vertical transmission.<sup>68</sup> According to statistics available towards the end of 1995<sup>69</sup> vertical transmission was at that time responsible for approximately 11% of the total number of AIDS cases<sup>70</sup> and was constantly increasing. In 1992 the prevalence of pediatric AIDS in South Africa was already reported to be very high in comparison with that of the US, the situation in South Africa corresponding with that in other African countries.<sup>71</sup> It is accepted that vertical transmission increases at the rate at which heterosexual transmission of HIV increases.<sup>72</sup> Estimates based on the eighth national HIV survey carried out in South Africa at the end of 1997, are that 16,01% of women attending antenatal clinics of the public health services nationally were infected with HIV by the end of 1997.<sup>73</sup> Compared to the infection rate of 14,17% of 1996, the prevalence level of HIV infection increased by 12,99% during the past year.<sup>74</sup> At the end of 1996 it was estimated that 1,4 million women were infected with HIV, and that almost 58 000 HIV-infected babies were born in 1996 (4% of the total of 1,34 million babies born during that year).<sup>75</sup> The number of babies with HIV born between 1990 and end 1996 is estimated to be 157 000.<sup>76</sup>

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67 Dr A Grimwood, Medical Officer of the City of Cape Town stated in his comments on **SALC Discussion Paper 73** that the percentage (25-30%) of babies born with HIV as a result of their mothers being infected increases to 50% after two years in the event of infected mothers breastfeeding.

68 Grossman **AIDS: Principles, Practices and Politics** 168; Berer and Ray 72.

69 **Epi Comments** September 1995 218.

70 **Epi Comments** February 1995 45-46.

71 **UNICEF Children and Women in SA** June 1993 48.

72 Berer and Ray 72. Women are physically more susceptible to infection during heterosexual intercourse than men (Arnott **Innes Labour Brief** June 1996 32). Towards the end of 1995 more than 73% of reported cases of clinical AIDS in South Africa were the result of heterosexual intercourse and transmission from mother to baby.

73 "Summary Results of the Eighth National HIV Survey of Women Attending Antenatal Clinics of the Public Health Services in South Africa in 1997" released by the Department of Health on 10 March 1998.

74 Ibid. For the 1996 infection rate see **Epi Comments** December 1996/January 1997 6.

75 **Epi Comments** December 1996/January 1997 10-11. Similar estimates for 1997, based on the Eighth National HIV Survey, were not yet available when the current interim report was compiled. It was estimated at the end of 1996 that there would be about 90 000 new cases of clinical AIDS in South Africa during 1997 and that 20 000 of those would be children born to mothers with HIV (Commentary on the Seventh National HIV Survey - Oct/Nov 1996 by Mr Peter Doyle of Metropolitan Life - an incubation period of eight to nine years on average was assumed for these estimates.)

76 **Epi Comments** December 1996/January 1997 6. Figures including babies born during 1997 were not available at the time of compiling the current interim report.

2.27 Recent national and international studies of HIV seroprevalence reveal that adolescent females are now being infected at increasing rates as a result of early sexual activity - in some developing countries at rates higher than those reflected in respect of adults.<sup>77</sup> The eighth national HIV survey carried out in South Africa at the end of 1997, indicated that the 20-24 year group was the group most infected (19,67%), closely followed by the 25-29 year old group (18,18%). Of teenagers attending antenatal clinics, 12,90% tested HIV positive during 1996, compared to 9,5% a year earlier.<sup>78</sup> This figure is of particular concern as pregnancies at such a young age are often unplanned. It reveals sexual activity (experimenting) and an increased risk of contracting HIV amongst children of secondary school age.<sup>79</sup> It is now being realised that most young adults were infected during adolescence and that certain behavioural and psychological factors put adolescents at high risk.<sup>80</sup> These factors include exploration of sexual identity, an unrealistic view of the future, a sense of immortality, irresponsibility and lack of knowledge about sexuality.<sup>81</sup> Statistics indicate that adolescents and young adults account for a disproportionate share of the increase in HIV/AIDS infection in South Africa.<sup>82</sup>

2.28 Because of the high incidence of rape and sexual abuse involving children, these crimes are ways in which children can become infected with HIV.<sup>83</sup> Researchers found that children and adolescents who are subjected to sexual abuse are increasingly found to be infected with HIV.<sup>84</sup> This is regarded as a disturbing feature of the whole scenario of HIV infection.<sup>85</sup>

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77 **AIDSScan** June 1995 10. See also the comments of Prof Anthon Heyns, Medical Director, SA Blood Transfusion Service, Johannesburg, on the increased HIV infection among black school going children between the ages 16 to 20 in **AIDSScan** June/July 1996 7.

78 **Epi Comments** December 1996/January 1997 10. The figure for 1997 was not available at the time of compiling the current interim report.

79 Ibid.

80 Lachman 454.

81 Ibid 454-455.

82 The KwaZulu Natal 1997 monthly average for new infections in the age group 15-19 years is, for instance, 277 (Kwitshana [Unpublished 1]). It has also been said that one fifth of all people with AIDS are in their twenties and are likely to have become infected during their adolescence (Ibid).

83 See eg the comments of the Early Resource Unit on **SALC Discussion Paper 73**.

84 Confirmation of sexual abuse was eg found in 14 of 96 HIV-positive children in a paediatric AIDS unit at Duke University USA in a study reported on in 1991 (Lachman 477).

85 Lachman 477.

2.28.1 The risk of HIV transmission related to sexual abuse is borne out by statistics on the incidence of rape, sodomy and incest involving children in South Africa.<sup>86</sup> Several respondents to Discussion Paper 73 emphasised the increasing risk of HIV transmission caused by sexual abuse of children.<sup>87</sup> The dangerous myth that sex with a virgin or a young girl will either cure or prevent AIDS has also stimulated an increase in child sexual exploitation.<sup>88</sup> Furthermore, increasing numbers of AIDS orphans who have to take care of younger siblings turn to the option of selling their bodies.<sup>89</sup> In a 1996 Human Science Research Council/Child Protection Unit Study on patterns of child abuse, 42% of the sexually abused children came from female-headed families. It was pointed out that black single women have no decision-making power and that the children of these women are accorded a very low status which would make them especially prone to sexual exploitation.<sup>90</sup>

2.29 Intravenous drug abuse as a route of infection has received scant attention in South Africa. Of the 8 784 cases of clinical AIDS reported as on 30 November 1995, only 3 were a result of intravenous drug abuse.<sup>91</sup> This route should nevertheless be recognised as an important potential source of HIV transmission.

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86 Due to under-reporting it is impossible to determine how many children in South Africa are actually victims of sexual crimes. Statistics show that 5 313 cases of rape, sodomy and incest were dealt with by the Child Protection Unit of the South African Police Service for the period January - December 1993, while 7 968 cases of the same nature were dealt with in the period January - July 1996 (Pienaar 1996 **In Focus Forum** 17-18). According to the official statistics released by the Crime Information Management Centre of the South African Police Service, statistics regarding sexual abuse of children are even higher: 22 133 cases of sodomy, rape and attempted rape, intercourse with girls under the prescribed age and/or female imbeciles, and incest with persons under the age of 17 years were recorded for the period January - December 1996 (information supplied by the Crime Information Management Centre, departmental letter 26/1/1 of 5 February 1998).

87 For more detail on these comments see par 5.13-5.14.2 below.

88 Pienaar 1996 **In Focus Forum** 17-18.

89 Ibid.

90 Ibid 30.

91 **Epi Comments** October 1995 234. (These are apparently the last available statistics issued by the Department of Health on drug abuse as a mode of HIV transmission.)

\* **Course of AIDS<sup>92</sup>**

2.30 The course of HIV infection is generally divided into four different stages: the acute or initial phase; the asymptomatic phase; the third phase (during which less serious opportunistic diseases occur); and the final phase during which the patient has full-blown or clinical AIDS.

+ ***Initial phase: Preceding seroconversion***

2.31 The initial phase begins very shortly after a person has been infected with HIV. Symptoms that present are similar to those of influenza (fever, night sweats, headaches, muscular pain, skin rashes and swollen glands). This phase continues until seroconversion occurs (when antibodies develop in the person's blood in an ineffective attempt to protect the body against HIV). Seroconversion takes place on average six to twelve weeks after exposure (in exceptional cases even later). This period between infection and seroconversion is known as the "window period". Blood tests<sup>93</sup> generally used to determine whether a person has been infected with HIV cannot trace HIV itself, but react to the presence of antibodies. The fact that antibodies are formed only after a lapse of time entails that blood tests conducted during the window period may deliver false negative (seronegative) results. Where antibodies have not yet developed, the blood test for antibodies will be negative in spite of infection. During the window period an infected person can transmit HIV but will not test positive for the virus.

***Second phase: Asymptomatic seropositivity***

2.32 During this phase the person is infected with HIV; antibodies have already developed and will be indicated by antibody tests from this stage onwards; but he or she

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<sup>92</sup> See the sources referred to in fn 47 above.

<sup>93</sup> For more detail see par 2.41-2.45 below.

shows no symptoms of illness. However, the body's resistance and immune response are slowly being impaired. This second phase can continue for many years while the infected person remains otherwise healthy. In this phase infected persons are often not aware that they have HIV; they can therefore unknowingly transmit the virus to others.

+ ***Third phase: AIDS-related symptoms***

2.33 This phase (referred to in the past as "AIDS-related complex" [ARC]) can also continue for several years. Symptoms of the opportunistic diseases that cause death in the final phase now occur. These include swelling of the lymph glands in the neck, groin and armpits as well as drastic loss of body weight, thrush and chronic diarrhoea.

+ ***Final phase: Clinical AIDS***

2.34 Only during the final phase can a person be said to have AIDS. As a result of the compromised immunological response because of the HIV infection, a person during this stage is prone to infections by organisms that normally are present but do not cause disease in otherwise healthy and uninfected persons. This type of infection is referred to as opportunistic infection. In this phase such a person's body is no longer capable of withstanding opportunistic diseases, the symptoms of which were observed in the preceding phase. Unless effectively treated the person may no longer be able to work productively. He or she usually dies within two years as a result of these diseases.

2.34.1 Diseases that generally occur are pneumonia, tuberculosis and Kaposi's sarcoma (a rare type of skin cancer). Neurological and psychiatric disorders (known as AIDS dementia) may also occur in this final phase (and in rare cases may occur also earlier).<sup>94</sup> Symptomatic presentation differs from continent to continent. The most important opportunistic diseases in Africa are tuberculosis and chronic diarrhoea. A form of pneumonia (caused by *Pneumocystis carinii* [PCP]) is responsible for the majority of deaths among persons with AIDS in Europe and North America.<sup>95</sup> However the disease conditions from which people with AIDS suffer are generally not transmissible. Persons with AIDS usually pose no threat of infecting others with opportunistic diseases as opposed to the

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94 AMFAR AIDS/HIV Treatment Directory June 1996 135-138.

95 Hawkes and McAdam 1993 *Medicine International* 70-71.

transmission of HIV itself. A notable exception is untreated tuberculosis. Tuberculosis is transmissible in itself.<sup>96</sup> It is thus important that patients with pulmonary tuberculosis be on treatment so as not to expose others to active disease.<sup>97</sup>

2.35 The course of HIV infection varies from person to person. The period before seroconversion can last on average from six to twelve weeks. The average duration in Africa of the asymptomatic phase is estimated to be seven years, and it is generally accepted that the average period of time from infection with HIV until full-blown AIDS develops is less than 10 years. The final phase lasts on average from one to two years. However, the life expectancy of persons with HIV differs according to their general state of health, their living conditions, available health services and treatment, and the opportunistic disease in question. Although the course of the disease follows the same overall pattern in developed and developing countries, the period between becoming infected and death is much shorter in the latter. This can probably be ascribed to the prevalence of endemic diseases (for instance tuberculosis) and to a lack of adequate medical treatment.<sup>98</sup> In South Africa, severe poverty and malnutrition could possibly be included as reasons why patients with HIV have a shortened life expectancy.<sup>99</sup>

2.36 Not all persons with HIV go through all four phases. Some do not even show symptoms before they develop clinical AIDS (the final phase). During periods of symptomatic infection, a person with HIV may be able to live and work actively, but may experience fatigue or brief periods of illness.<sup>100</sup>

2.37 In regard to the typical course of the disease, the window period, the long latent phase and the occurrence of AIDS dementia especially, have particular implications for the law and ethics.

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96 Lachman 202. Cf **AMFAR AIDS/HIV Treatment Directory** June 1996 97-134.

97 Comment on **SALC Discussion Paper 72** by the City of Cape Town Health Department.

98 Ibid; Carr **AIDS in Australia** 8.

99 Comment on **SALC Discussion Paper 72** by the City of Cape Town Health Department.

100 Evian 1991 16.

+ *Course of AIDS in children*

2.38 As far as the course of the disease in infants who acquire HIV perinatally is concerned, symptoms appear in 80% of actually infected babies by approximately six months after birth.<sup>101</sup> The earlier symptoms and disease appear, the more likely an infant is to die at a very young age. This is because the infant's immune system is not fully developed and immunity to many diseases has not yet been acquired.<sup>102</sup> It has also been found that in infants whose infection is maternally acquired, the rate of disease progression varies directly with the severity of the disease in the mother at the time of delivery: the further the course of AIDS has developed in the mother, the higher the risk of death for her child.<sup>103</sup> By the end of their first year of life 25%-33% of these children have already developed full-blown AIDS or have already died of some or other AIDS-related infection. This scenario will improve with advances in testing techniques, more effective intervention<sup>104</sup> and aggressive early treatment.<sup>105</sup> Although progression of the disease in

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101 Gibb and Peckham 1993 **Medicine International** 65-66; **WHO AIDS Series** 8 4; Newell and Peckham **HIV Infection and Children in Need** 14; McIntyre (Unpublished) 42.

102 Berer and Ray **Women and HIV/AIDS** 72.

103 This part of the French Prospective Cohort Study, dealing with the relationship between the course of HIV infection in children and the severity of the disease in their mothers at delivery, is discussed in **AIDSScan** June 1994 7.

104 Malloy 1996 **American University Law Review** (Internet accessed 31 October 1997). A number of studies that use short courses of ante-retroviral therapy during pregnancy are being undertaken in the developing world. These appear to show that a combination of AZT and 3TC reduces the risk of transmission of HIV to infants. Figures from the Centers for Disease Control in the US show that the number of infants infected perinatally drops by 43% if their mothers were given a full course ante-retroviral drugs (**Pretoria News** 1 December 1997 9). Recent media reports in South Africa (**Diamond Fields Advertiser** 20 February 1998; **The Mail and Guardian** 27 February-5 March 1998) confirmed that similar studies undertaken by the Centers for Disease Control and Prevention in Thailand indicated a 51% reduction in mother-to-child transmission of HIV if women were given short courses of AZT late in pregnancy. The Thai study however only provided information about women who did not breast-feed. Breast-feeding carries an additional risk of HIV transmission of about 15%. It has been reported that fruitful discussions on the introduction of the new therapy in South Africa have already been held with government and provincial authorities (Ibid; see also CDC **Morbidity and Mortality Weekly Report** 6 March 1998 151-154 and the press release "South African Researchers Welcome Breakthrough in Preventing HIV Infection of Babies" by the Perinatal HIV Research Unit, Chris Hani Baragwanath Hospital, 19 February 1998).

105 American literature indicates that the symptom-free period (depending on the application of aggressive therapy) may last up to five years (Crossley 1993 **Columbia LR** 1597-1598).

the remaining 66%-75% of children is slower,<sup>106</sup> some scientists estimate that the life-spans of most infected children are shorter than three or four years.<sup>107</sup> In South Africa the majority of children with HIV are unlikely to reach school going age.<sup>108</sup> However, recent studies show that some children with HIV may remain symptom-free up to the age of seven years<sup>109</sup> and will therefore reach school going age. In other cases, despite the onset of symptomatic AIDS, children may survive to reach school going age.

2.39 In a study done at the then Baragwanath Hospital, it was found that children with HIV presented with complaints including lymphadenopathy, failure to thrive, respiratory distress, pneumonia, cardiac involvement, serious bacterial infections and neurodevelopmental abnormalities.<sup>110</sup> In a similar study at the King Edward VIII Hospital in Durban, it was found that the main presenting complaints in small children with HIV (those between three months and 30 months of age) are chronic cough, persistent diarrhoea and vomiting.<sup>111</sup> According to Lachman changes in behaviour or poor cognitive and cerebellar functioning during the first year of life may be the first clues to HIV infection.<sup>112</sup> Data from Ga-Rankuwa Hospital mention clinical presentations such as failure to thrive, diarrhoea and gastro-enteritis, recurrent chest infections, tuberculosis and pneumonia, kwashiorkor, and generalised lymphadenopathy. Other symptoms reported include candidiasis, vomiting, meningitis, stomatitis, and perianal rash.<sup>113</sup> Failure to gain weight and height at the expected rate is a significant symptom during puberty.<sup>114</sup> The main obstacle to diagnosis is that some of these presenting symptoms are also the most frequent causes of morbidity and mortality among Third World children in general.<sup>115</sup> However, the most disturbing manifestation of HIV infection in children, and

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106 Gibb and Peckham 1993 **Medicine International** 66; Newell and Peckham **HIV Infection and Children in Need** 14-15.

107 Grossman **AIDS: Principles, Practices and Politics** 169; McIntyre (Unpublished) 42-43.

108 **Guidelines - SA National Council for Child and Family Welfare** 16; cf also Grossman **AIDS: Principles, Practices and Politics** 181.

109 **AIDSScan** December 1994 10.

110 Friedland and McIntyre 1992 **SAMJ** 90-94.

111 Bobat et al 1990 **SAMJ** 524-527.

112 Lachman 437.

113 **AIDSScan** June 1994 13.

114 Lachman 437.

115 **AIDSScan** February/March 1991 3.

perhaps the most devastating, is neuro-psychological deterioration with loss of developmental milestones and intellectual function which occur in most patients.<sup>116</sup>

- 2.40 Children with HIV who are in the asymptomatic phase are capable of performing all the daily activities and to attend school. When they became ill as a result of the opportunistic diseases mentioned above, and have AIDS, this may no longer be possible. Their ability to work and to attend school may be severely restricted.

\* **Testing for HIV**<sup>117</sup>

- 2.41 The most general manner in which it can currently be determined whether a person is infected with HIV is by blood tests for the presence of antibodies to HIV. Although available, blood tests to detect HIV itself (in contradistinction to the test for antibodies) are not at present generally used in the public sector.<sup>118</sup>

- 2.42 The blood tests that have been used throughout the world since 1985 to detect the presence of HIV antibodies are the enzyme-linked immunosorbent assay (ELISA) and the Western Blot (WB) tests.<sup>119</sup> The ELISA test for HIV antibodies is very sensitive and reacts beyond the window period positively to nearly any infection. Because of its high sensitivity, a single test can deliver a false positive result. For this reason it is necessary to carry out a second, more specific, test to confirm HIV positivity. It is also advisable to perform the tests on a second, different, blood specimen. The WB test, which is such a more specific test, is traditionally used to confirm an initial positive test. However, the

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116 Lachman 444.

117 See the sources referred to in fn 47 above. See also Levine and Bayer **AIDS an Epidemic of Ethical Puzzles** 21-22; **Confronting AIDS** 304-307; Moodie 1988 **SA Journal of Continuing Medical Education** 58-63.

118 See par 2.45 below. The City of Cape Town Health Department in its comment on **SALC Discussion Paper 72** pointed out that viral load testing is extensively used for private patient management and for monitoring of patients in drug treatment trials.

119 **CDC Morbidity and Mortality Weekly Report** 14 August 1987 509; Chavey et al 1994 **Journal of Family Practice** 249 et seq.

WB is expensive<sup>120</sup> and can therefore not always be used in practice. Different types of ELISA tests with a higher degree of specificity have consequently been developed and the World Health Organisation (WHO) has compiled guidelines which indicate the circumstances under which multiple (different types of) ELISA tests will suffice in order to establish HIV infection.<sup>121</sup> South Africa has accepted the WHO recommendations to diagnose HIV infection with at least two positive ELISA test results.<sup>122</sup>

2.43 The result of a blood test to detect HIV antibodies is potentially available within approximately 24 to 48 hours after the blood sample is taken.<sup>123</sup>

2.44 Currently a positive HIV antibody test means that the person concerned is infected with HIV, will remain infected for life, and can infect other persons. The ELISA and WB tests do not indicate the stage of infection which the person tested has reached. A negative HIV antibody test means that no antibodies to HIV have been traced in the blood of the person concerned. This could mean that the person is not infected. But it could mean merely that antibodies to the virus have not yet developed<sup>124</sup> and thus he or she is infected but is in the window period. To obtain a reliable result such a person will after a period of time have to be tested for HIV again.<sup>125</sup>

2.45 It is alleged that where the standard test procedure (an ELISA test followed by one or more confirmatory tests) is followed, a correct result will be obtained in more than 99% of HIV infections.<sup>126</sup> New tests are available that test for HIV itself, rather than

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120 The cost of a WB test is approximately R276 to R751; the cost of an ELISA test carried out by a private body varies from R74 to R203 (information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997).

121 According to the WHO guidelines the prevalence of HIV in the population to which the person belongs on whom the blood test is performed, is decisive. The scientific premise is that the higher the prevalence of HIV infection, the greater the probability that a person who in the first instance tests positive, is truly infected (cf Fleming and Martin 1993 **SAMJ** 685-687).

122 Fleming and Martin 1993 **SAMJ** 685-687.

123 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997. See also Gostin 1991 **AMJLM** 110.

124 Gostin et al 1986 **AMJLM** 10; Banta 5.

125 A very small percentage of infected people never develop antibodies to HIV and will therefore repeatedly show false negative tests (Van Dyk 13).

126 **Australia Report on Privacy and HIV/AIDS** 11; cf also the remarks of Van Dyk 12 and Van Wyk 1988 **De Jure** 327 on the accuracy of the tests. Moodie (1988 **SA Journal of Continuing Medical Education**

antibodies to the virus.<sup>127</sup> These may shorten the window period to about 16 days.<sup>128</sup> In addition, some of these tests (for instance viral load tests<sup>129</sup>) may more accurately predict future health status.<sup>130</sup> However, because of their cost they are not yet recommended for general use.<sup>131</sup> Tests which detect HIV in the urine, and saliva may be less sensitive than tests on blood. The polymerase chain reaction technique (internationally known as the PCR), which detects the virus itself in the blood, is also available. It is however, complicated and difficult to execute and is thus performed only in specialised or reference laboratories.<sup>132</sup> PCR may reduce the window period to 11 days.<sup>133</sup>

+ *HIV testing of children*

2.46 The same blood tests to detect the antibodies to HIV in adults, discussed above,<sup>134</sup> are generally used in respect of children. However, the use of the antibody test in respect of infants have specific implications.

2.47 It is said that approximately 50% of babies born of mothers with HIV will carry

63) alleges that the Western Blot test theoretically provides "the ultimate confirmation" while Volberding (**AIDS: Principles, Practices and Politics** 102) is of the opinion that if a combination of antibody tests is properly carried out in population groups with a high prevalence of HIV infection, such testing is "highly accurate".

127 Orthmann **Law and Policy Reporter** April 1996 55.

128 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997.

129 Viral load testing is the direct measurement of the amount of HIV virus in the blood of people with HIV infection. (HIV mostly lives in the lymph system. Only 2% lives in the blood.) It is currently regarded as the best marker for the progression of HIV disease and is becoming a standard of HIV treatment monitoring. Studies have eg determined that patients who have a higher virus load will progress more quickly to AIDS than persons with lower virus loads. Viral load testing is therefore used as an adjunct in treating HIV and is not used to initially diagnose HIV infection (Viral Load Testing - Reports from the Vancouver AIDS Conference [Internet accessed on 10 November 1997]; HIV- Infogram: Viral Load Testing [Internet accessed on 10 November 1997]; The Body: Viral Load Testing [Internet accessed on 10 November 1997]).

130 Saag et al 1996 **National Medicine** 625-629.

131 Colebunders and Ndumbe 1993 **The Lancet** 601; Chavey et al 1994 **Journal of Family Practice** 249. But see also Volberding 1996 **The Lancet** 71-73.

132 Information supplied by Prof A Heyns of the S A Blood Transfusion Service on 27 October 1997; see also van Dyk 12; Crofts **AIDS in Australia** 26-27.

133 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997.

134 Par 2.41-2.45 above.

antibodies to HIV at birth.<sup>135</sup> However, some of these babies will merely reflect the mother's HIV status and will not themselves be infected. The problem is complicated by the fact that the mother's HIV antibodies can be reflected in the baby up to an average age of 15 to 18 months and that the real state of affairs regarding the HIV status of such a baby can be established with certainty only then.<sup>136</sup> The polymerase chain reaction technique (PCR), referred to above,<sup>137</sup> may be used to detect the virus itself in the blood of newborn babies. However, as indicated above, this test is not generally used. Scientific estimates of the percentage of births to mothers with HIV where HIV transmission occurs differ and estimates of 7%-39%,<sup>138</sup> 15%-40% (in respect of European and American studies),<sup>139</sup> and even as high as 60% (in respect of studies done in Africa)<sup>140</sup> have been recorded. The rate of transmission for South Africa is currently accepted to be around 30%.<sup>141</sup> The accuracy of a negative test result in a newborn baby is likewise uncertain. It is, however, generally accepted that if a baby still tests negative by the age of three months, it will not have HIV.<sup>142</sup>

\* **Treatment**

2.48            There is at present no cure for HIV infection or AIDS. The best-known drug for the treatment of persons with HIV infection and AIDS, until recently has been AZT

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135        Evidence before the Commission by Dr R Crookes of the SA Blood Transfusion Service on 7 February 1994.

136        Ibid; Newell and Peckham **HIV Infection and Children in Need** 13; **WHO AIDS Series 8** 36-37; Gibb and Peckham 1993 **Medicine International** 65; Lachman 436. Cf however the opinion expressed by Malloy that this period is six months (Malloy 1996 **American University Law Review** [Internet accessed 31 October 1997]).

137        Cf par 2.45 above. A sensitive and specific PCR assay to be used in the case of infants has recently been developed by a South African researcher, Ms J Marnewick (**MRC Newsweek** 19-23 May 1997).

138        Newell and Peckham **HIV Infection and Children in Need** 14.

139        Ibid; McIntyre (Unpublished) 42.

140        McIntyre (Unpublished) 42.

141        **AIDSScan** October 1996 4. In a discussion of a study on the effect of breastfeeding on the vertical transmission of HIV in Soweto this was confirmed (**AIDSScan** October 1996 13). Doyle **Facing up to AIDS** 98 accepts a 35% mother-to-child infection rate.

142        Evidence before the Commission by Dr R Crookes of the SA Blood Transfusion Service on 7 February 1994.

(zidovudine).<sup>143</sup> This drug does not cure AIDS, but brings temporary relief for persons with symptomatic HIV infection: AZT delays the increase of HIV in the body, decreases the number of opportunistic infections and increases the number of healthy cells.<sup>144</sup> New treatments are currently being developed that extend the life expectancy of people with HIV and AIDS.<sup>145</sup> Many of these are expensive.<sup>146</sup> Not enough is yet known about their long term efficacy. There is some hope that HIV and AIDS may eventually, for those who can afford treatment, become manageable in ways similar to diabetes, epilepsy, and heart disease.<sup>147</sup>

+ *Treatment of children*

2.49 HIV infection in children can be managed by anti-HIV drugs. These include AZT which is available as a syrup and is well tolerated by children. (It has, however, been suggested that drugs used to treat HIV may cause side effects which can lead to aggressive behaviour, and that educators should be aware of this.<sup>148</sup>) Prophylactic treatment is strongly recommended against opportunistic and bacterial infections (such as immune globulin therapy after exposure to chickenpox or measles). Complications can be treated. Other regimes include optimum nutrition, physiotherapy for lung disease and supportive measures for developmental problems.

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143 Havlir and Richman 1993 **Medicine International** 62; Plummer **AIDS in Australia** 82; Van Wyk 60-61; Van Dyk 15.

144 Tindall et al **AIDS in Australia** 218; Van Wyk 60-61; Havlir and Richman 1993 **Medicine International** 63; Penslar **AIDS an Epidemic of Ethical Puzzles** 174.

145 Discoveries made during 1996/97 regarding the use of a combination of anti-retroviral therapies to reduce viral load to undetectable levels in blood and lymphatic tissue, may provide the means of maintaining immunological function and substantially postponing disease progression and death. Application of these treatments may also improve results of prophylaxis for HIV transmission, reducing perinatal transmission and the risk of HIV infection for health care workers (Cohn 1997 **BMJ** 487-491; **BMJ** [ SA Ed] August 1997 487). Cf also Groopman **The New Republic** 12 August 1996; Gyldmark and Tolley **The Economic and Social Impact of AIDS in Europe** 30-37.

146 Cf Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487; Papaevangelou et al **The Economic and Social Impact of AIDS in Europe** 70.

147 Cf Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487; Farnham 1994 **Public Health Reports** 312.

148 McNary-Keith 1995 **Journal of Law and Education** 69-80.

2.50 It has been suggested that infected children should receive all immunisations,

with certain provisos.<sup>149</sup> Children with HIV have an increased risk of acquiring, or developing complications from several diseases for which vaccines exist.<sup>150</sup> They can actually benefit from immunisation to protect them against such common, naturally occurring diseases before their immune defence mechanisms are further compromised.<sup>151</sup>

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149 Paediatricians may prefer to use killed polio vaccine. BCG should be withheld from children with symptomatic disease. See Gibb and Peckham 1993 **Medicine International: Southern African Edition** 64.

150 Lachman 451.

151 The US Public Health Service, for instance, recommends that children with HIV should receive inactivated polio vaccine, MMR and influenza vaccine. US researchers advised that possibly also BCG could be given in areas of high tuberculosis prevalence (Lachman 451, 453).

### 3 HIV/AIDS IN SCHOOLS<sup>152</sup>

#### D) **THE IMPACT OF HIV/AIDS IN SCHOOLS**

3.1 HIV/AIDS will undoubtedly affect most schools if not directly, then in an indirect way.<sup>153</sup> Learners may be faced with the illness of their parents or that of educators. Learners may have to take time off to look after young ones at home, care for a sick parent and carry out household tasks. This is not only emotionally draining to the learner but may also disrupt the learning process.

3.2 Because of the rise in infection rates, learners with HIV will increasingly form part of the school population. More and more children born with HIV will, with better medical care, reach school going age and attend primary schools. Indications that adolescents are sexually active, mean that increasing numbers of learners attending secondary schools might be infected. Intravenous drug abuse may also become an increasingly important source of HIV transmission among learners. (Recipients of infected blood transfusions, primarily haemophiliacs, may be present at school, although very rarely so.) Sickness and death of a learner may also impact on both other learners and educators. In the latter stages of AIDS a sick learner may be absent for almost 80% of school days. There could be increasing discrimination because of stigma.

3.3 Because of the nature of HIV antibody testing and the window period, discussed above, it is not readily possible to know with absolute certainty who is infected and who not. Even if mandatory screening for HIV of all learners were implemented it would be impossible to know with certainty who were infected and who not, or to effectively exclude infected (or subsequently infected) learners.<sup>154</sup>

3.4 There are as yet no known cases of HIV transmission in schools and HIV cannot

152 Refer also to par 3.163-3.170 of **SALC Working Paper 58**.

153 Cf the remarks of Kwitshana (Unpublished).

154 Par 2.41-2.45 above.

be transmitted through day to day social contact. It has been stated above that the virus is transmitted by limited ways and only through blood, semen, vaginal and cervical discharge, and breast milk. Although the virus has been identified in other body fluids such as saliva and urine, no scientific evidence exists that these fluids can cause transmission of HIV.<sup>155</sup> Even in the sport environment there is no risk of transmission from sweat, swimming pool water, communal bathwater, saliva or respiratory droplets.<sup>156</sup> In the present interim report the Commission's premise as set out in Working Paper 58 is confirmed, namely that "persons with HIV/AIDS have to be accommodated in society to the extent that their infection does not expose others to significant risks that cannot be eliminated by ordinary measures or reasonable adaptations (for instance the use of universal precautions)".<sup>157</sup> Children with HIV 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. Their infection as such does not expose others to significant risks within the school environment. However, if it is ascertained that an infected learner poses a "medically recognised significant health risk" to others owing to secondary infections or behaviour which may give rise to HIV transmission, appropriate measures may be taken.

- 3.5 "Universal precautions" is a concept used world-wide 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. These measures include instructions concerning basic hygiene and the wearing of protective clothing (such as rubber gloves) when dealing with blood spills or body fluids. The basis for advocating its consistent application lies in the assumption that in situations of potential exposure to HIV, all persons are potentially infected and all blood and body fluids that may be contaminated with blood should be treated as such. The insignificant risk of transmission of HIV in the school environment can be effectively excluded by following these control procedures and precautionary measures. In the school environment this would mean that **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 should

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155 Par 2.20-2.23 above.

156 **Draft Position Statement: HIV/AIDS in Sport 1997** 4.

157 **SALC Working Paper 58** par 2.21

be handled in a prescribed manner.

- 3.6 Some respondents to Discussion Paper 73 pointed to the danger of exposing learners with HIV to common infections by accommodating them in the school environment. However, this risk is probably set off by the positive impact of "normal" peer relationships, stimulation and education. The South African Paediatric Association observed in its comments that "(C)hildren with HIV infection have the normal needs for socialisation and play, stimulation and education. They bear the additional burden of a family affected by anxiety, social stigma, serious disease and bereavement. They therefore have greater emotional needs. They may be ill themselves, for them 'normal' peer relationships and educational care is vital".<sup>158</sup> The precautionary measures or good hygiene practices referred to in the previous paragraph would in any event also include that learners with illnesses such as measles, whooping cough and mumps should be kept from school to protect all other learners, and especially those whose immune systems may be impaired by HIV.

## **B) RELEVANT LEGAL PROVISIONS**

- 3.7 The rights and duties of learners can be evaluated on different levels. Constitutional provisions, national and provincial legislation, statutory regulation, common law provisions and international instruments to which South Africa is a party, are all relevant in respect of HIV/AIDS in schools.<sup>159</sup> Equal access to education, the management and education of learners with HIV, confidentiality of AIDS-related information, and the supply of information and education regarding HIV/AIDS to learners, are all legal aspects which need discussion.

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158 Cf also the US decision in **District 27 Community School Board v Board of Education** 502 NYS 2d 328 (1986) on the positive impact of main-stream education on children with HIV's psychological and intellectual well-being.

159 Cf Visser 1997 **Obiter** 15-17.

\* **Legislation regulating public health and school health services**

3.8 The Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987<sup>160</sup> (the 1987 Regulations) are currently the only statutory provisions directly addressing HIV infection<sup>161</sup> and AIDS. The 1987 Regulations contain far-reaching measures regarding "communicable diseases" in schools. Because AIDS is by definition a communicable disease and because it is listed<sup>162</sup> in an ANNEXURE to the 1987 Regulations, certain coercive measures apply mandatorily to it.<sup>163</sup> In terms of regulation 7(2) a parent or guardian of a learner must, for instance, inform the principal of a teaching institution of his or her child's HIV infection.

3.9 The 1987 Regulations have, as far as could be ascertained, never been applied in respect of schools.<sup>164</sup> They have been widely criticised<sup>165</sup> and have in draft been revised. Draft Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions<sup>166</sup> (the Draft Regulations) had been published for comment in 1993 but were not finalised by early 1998. In the Draft Regulations AIDS, although still a communicable disease, is no longer listed with the result that the far-reaching provisions discussed above,<sup>167</sup> will apparently not be applicable in respect of AIDS in future. Also, the Draft Regulations explicitly prohibit a principal from refusing a learner who is "a

160 GN R 2438 of 1987 in **GG** 11014 of 30 October 1987.

161 Cf eg the reference to "carrier of a communicable disease" in reg 14(1).

162 See Annexure I of the 1987 Regulations. Note that AIDS (but not HIV infection) is listed. The terminology used in the 1987 Regulations is followed in this section.

163 These include the following: The parents of a child who has been in contact with a person suffering from AIDS, shall immediately inform the principal thereof (reg 7(2)). If a principal is aware, or suspects, that a pupil (currently referred to as "learner" in legislation) or a person employed at the school suffers from AIDS, or has been in contact with a person suffering from AIDS, he or she shall without delay inform the medical officer of health (reg 7(1)(a)). The principal may not, except on the strength of a medical certificate, allow such pupil or employee to enter the school (reg 7(1)(b)). When AIDS is present in a particular district, a local authority or medical officer of health may close a school and restrict attendance thereat by any person (reg 2). A medical officer of health may medically examine (and therefore have a test for HIV carried out on) any pupil or employee in order to prevent or restrict the spread of AIDS (reg 6), and may also have a pupil or employee removed to a hospital or place of isolation (reg 14(3)), or place such person under quarantine (reg 2(1)).

164 Cameron and Swanson 1992 **SAJHR** 217; cf also Van Wyk 449; .

165 A more detailed discussion followed in Chapter 4 of **SALC Working Paper 58**; see also par 5.4-5.9 of **SALC First Interim Report on Aspects of the Law Relating to AIDS**.

166 Published under Notice 703 of 1993 in **GG** 15011 of 30 July 1993.

167 See fn 163 above.

carrier" of HIV (or who is suspected of being "a carrier"), attendance at school on this ground only.<sup>168</sup> In the Commission's First Interim Report on Aspects of the Law Relating to AIDS, referred to in paragraph 1.2 above, it is recommended that the Draft Regulations be finalised and promulgated, subject to certain amendments.<sup>169</sup>

- 3.10 Other legislation,<sup>170</sup> and regulations<sup>171</sup> resulting therefrom, regulate school health services and provide for the medical examination of pupils under certain circumstances. However, HIV infection or AIDS are not directly addressed in these provisions, and the regulations have, with regard to medical examinations in general, as far as could be ascertained, not been applied to testing for HIV or the exclusion of learners with HIV from school attendance. Legislation also provides for the education of "handicapped" (disabled) children.<sup>172</sup> The definition of "handicapped" child in the different Acts is of such a nature that a child with asymptomatic HIV infection is probably not included.<sup>173</sup> The medical model of "disability" has in any event been rejected in education circles as a basis on which to model children with HIV.<sup>174</sup>

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168 The Draft Regulations, draft reg 7(4). See also **SALC First Interim Report on Aspects of the Law Relating to AIDS** par 5.2.

169 Which will remove unnecessary restrictions on the conveyance of the body of a person who was known to have been a "carrier of HIV" at the time of his or her death (**SALC First Interim Report on Aspects of the Law Relating to AIDS** par 5.8, 5.9 and 5.15).

170 Education and Training Act 90 of 1979, sec 41(1), (2) and (3)(e); Education Affairs Act 70 of 1988, sec 112(fA); Coloured Persons Education Act 47 of 1963, sec 34(i); Indians Education Act 61 of 1965, sec 33(i).

171 Reg 2 of the Regulations relating to Medical, Psychological and Dental Examinations of Pupils at Public Schools, GN R 707 of 1990 in **GG** 12381 of 30 March 1990 (made in terms of Act 90 of 1979); reg 2 and 3 of the Regulations regarding the Medical Examination of Pupils in Schools, GN R 2088 of 1979 in **GG** 6665 of 21 September 1979 (made in terms of Act 70 of 1988); and reg 2 of the Regulations relating to Medical and Psychological Inspections at Indian Schools, GN R 1799 of 1966 in **GG** 1591 of 11 November 1966 (made in terms of Act 61 of 1965). (As far as could be ascertained similar regulations have not been made in terms of Act 47 of 1963.)

172 Education and Training Act 90 of 1979, sec 1 and 5; Education Affairs Act 70 of 1988, sec 1 and 12(1)(d); Coloured Persons Education Act 47 of 1963, sec 1 and 3(1)(a); Indians Education Act 61 of 1965, sec 1 and 3(1)(a).

173 The definitions of "handicapped" child in the Acts mentioned in the previous fn are virtually the same and require that such a child "deviates to such an extent from the majority of persons of his age in body, mind or behaviour that he - (a) cannot derive sufficient benefit from the instruction normally provided in the ordinary course of education; (b) requires special education to facilitate his adaptation to the community; and (c) should not attend an ordinary class in an ordinary school because such attendance may be harmful to him or to other pupils in that class" (cf sec 1 of each of the Acts mentioned in the previous fn).

174 Cf the representative of the Commission on Special Needs in Education who stated this view at a Department of Education Branch meeting attended by project committee member A Strode on 4 April

\* **Law relating to rights and duties in the school environment**

+ *The right to equality and to dignity*

3.11 The 1996 Constitution provides that neither the state, nor any person,<sup>175</sup> may unfairly discriminate directly or indirectly against anyone. The 1996 Constitution therefore prohibits unfair discrimination not only vertically (between the state and its

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175 1997.  
Sec 9(4) provides that national legislation must be enacted to prevent or prohibit unfair discrimination between private parties.

subjects) but also horizontally (between individuals and juristic persons).<sup>176</sup> The Constitution in this way expressly attaches horizontal application to the right to equality. It is further provided that national legislation must be enacted to prevent or prohibit unfair discrimination. Legislation therefore seems to be the indicated mechanism by which horizontal application should be put into operation. However, this probably does not imply that the right to equality is dependent upon the promulgation of such legislation for its horizontal operation.<sup>177</sup> In other cases a fundamental right may apply horizontally "if, and to the extent that it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right".<sup>178</sup> Apart from the right to equality everyone has inherent dignity and the right to have their dignity respected and protected.<sup>179</sup>

3.12 The prohibition against unfair discrimination would thus apply vertically in respect of public schools<sup>180</sup> (as organs of state) as well as horizontally in respect of independent schools (as juristic persons). Independent schools will therefore not be allowed to unfairly discriminate against learners.<sup>181</sup>

3.13 Specific grounds are mentioned in the 1996 Constitution on which discrimination may not be based. These include "disability". However, the same uncertainty as that expressed in Working Paper 58 exists about the interpretation the courts will attach to "disability" and whether HIV infection would be regarded as such. The grounds mentioned do not constitute a *numerus clausus* and the courts may extend them.

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176 Sec 9(3) and (4). Subsection (4) provides expressly that "(N)o person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3)". Sec 8(2) provides that "(A) provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right".

177 See sec 9(4) of the 1996 Constitution. Cf also Van Wyk (Unpublished) 9-10.

178 The 1996 Constitution sec 8(2).

179 Ibid sec 10.

180 Public schools are *inter alia* defined as schools that are funded by the provincial legislatures, and include ordinary public schools and public schools for learners with special education needs (sec 1(xviii) and Chapter 3 of the Schools Act). See **Baloro v University of Bophuthatswana** 1995 4 SA 197 (B) 235-246 in which Friedman JP held universities to be organs of state as they were institutions established by statute and under the control of the Minister of Education. The same arguments could apply to public schools which are funded by the state (sec 34(1) of the Schools Act). These arguments may possibly even apply to independent schools which are registered by the Head of an Education Department (Ibid, sec 46) and which may receive subsidies from the state (Ibid, sec 48).

181 Cf also Van Wyk (Unpublished) 10.

3.13.1 In **Prinsloo v Van der Linde**<sup>182</sup> the Constitutional Court held that these (additional) grounds should be interpreted in the light of the South African past and would have a bearing on unfair discrimination which seriously impairs human dignity. The Court also foresaw future extension which does not bear upon human dignity.<sup>183</sup> In extending the grounds on which unfair discrimination may not take place, the onus of proof is however reversed and there would be no *prima facie* presumption in favour of the unfairness of the discrimination.<sup>184</sup> It could be argued that HIV infection should be recognised by the courts as an additional ground on the basis of which unfair discrimination is not allowed. In the light of the **Prinsloo** decision it would then probably have to be proved that differentiation on ground of HIV infection is not only irrational, but also impairs the human dignity of individuals, and is therefore unfair.<sup>185</sup>

3.14 The Schools Act<sup>186</sup> (which applies to all school education in South Africa and thus covers both public and independent schools admitting learners between grades zero and twelve<sup>187</sup>) confirms the constitutional prohibition on unfair discrimination. In its preamble the Act states, among other things, that all forms of unfair discrimination and intolerance are to be combatted, that the rights of all learners, parents and educators are to be upheld, and that uniform norms and standards for school education are to be set throughout South Africa.

3.15 The National Education Policy Act<sup>188</sup> (the Policy Act) also enhances the

182 1997 (6) BCLR 759 (CC). See also **President of the Republic of South Africa v Hugo** 1997 4 SA 1 (CC) (1997 (6) BCLR 708 (CC)).

183 "Where discrimination results in treating persons differently in a way which impairs their fundamental dignity as human beings, it will clearly be a breach of section 8(2). Other forms of differentiation, which in some other way affect persons adversely in a comparably serious manner, may well constitute a breach of section 8(2) as well" [Referring to the 1993 interim Constitution] (**Prinsloo v Van der Linde** supra 774).

184 Cf also van Wyk (Unpublished) 11.

185 Ibid 11-12.

186 See fn 39. This Act became operative on 1 January 1997.

187 See sec 1(xix) read with sec 2(1) of the Schools Act.

188 Act 27 of 1996. This Act became operative on 24 April 1996.

constitutional right to equality and protection against unfair discrimination.

3.15.1 National policy for education (which has to be determined and implemented by the Minister of Education)<sup>189</sup> has to be directed toward the advancement and protection of the fundamental rights of every person guaranteed in terms of the 1996 Constitution, and in terms of international conventions ratified by Parliament.<sup>190</sup> South Africa on 16 June 1995 ratified the **United Nations Convention on the Rights of the Child (1989)**.<sup>191</sup>

3.15.2 National policy for education has, in particular, to advance and protect the right of every person to be protected against unfair discrimination in education on any ground whatsoever. Such policy is to be directed towards endeavouring to ensure that each student attains full personal development and that no person is denied the opportunity to receive an education to the maximum of his or her ability as a result of physical disability.<sup>192</sup>

189 The Policy Act sec 1 read with sec 2.

190 The Policy Act sec 4(a).

191 The Convention was adopted by the United Nations General Assembly on 20 November 1989 and came into force on 2 September 1990. For the purpose of the Convention a child means every human being below the age of 18 years, unless under the law applicable to the child, majority is attained earlier (article 1). States Parties *inter alia* undertake to ensure children such protection and care as is necessary for their well-being, to ensure to the maximum extent possible the survival and development of children and to ensure that children have access to information and material aimed at the promotion of *inter alia* their physical health. States Parties shall furthermore respect the responsibilities, rights and duties of parents, and the right of the child to freedom of association and to freedom of conscience and religion; and shall recognise that every child has the inherent right to life (art 3, 5, 6, 14, 15 and 17). Significantly, the Convention requires that in all actions concerning children, the best interest of the child shall be a primary consideration (art 3). Furthermore, guidelines regarding the protection of human rights in the context of HIV and AIDS which were adopted by resolution of the United Nations Commission on Human Rights at its 57<sup>th</sup> meeting on 11 April 1997 include the following: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups and people with HIV or AIDS from discrimination and emphasise education (Guideline 5); States should ensure that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation (Guideline 2); States, in collaboration with and through the community should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups (Guideline 8); States should promote the wide and ongoing distribution of creative education and training, explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV/AIDS to understanding and acceptance (Guideline 9); States should ensure that governments develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice with accompanying mechanisms to implement and enforce these codes (Guideline 10); and States should ensure monitoring and enforcement mechanisms to guarantee the protection of HV-related human rights (Guideline 11).

192 The Policy Act sec 4(b) and (d).

+ *The right to a basic education*

3.16 The 1996 Constitution provides that everyone has the right to a basic education (including adult basic education).<sup>193</sup> The state has the duty to respect, to protect, to promote and to fulfil the right to a basic education.<sup>194</sup> The beneficiary has the right to require positive assistance or a benefit from the state.<sup>195</sup> It has been submitted that the duties created for the state by the Constitution and the right to a basic education of the individual may be linked to compulsory school attendance by children between seven and fifteen years (or grade 9).<sup>196</sup> Written reasons must be supplied for absence. Public schools may not refuse a learner admission on the grounds that his or her parent is unable to pay or has not paid school fees.<sup>197</sup> Children between the ages of seven and fifteen would thus be able to enforce their basic right to education against the state.<sup>198</sup>

3.16.1 However, if the nature of the right and the nature of any duty imposed by the right<sup>199</sup> is taken into account, the right to basic education would probably not be regarded as a right which also applies horizontally to independent schools in all four respects mentioned above. Independent schools would, for example have to respect learners' right to a basic education, but would not be expected to fulfil this right.<sup>200</sup>

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193 Sec 29(1). This section in addition provides that everyone has the right to "further education which the state must make progressively available and accessible through reasonable measures".

194 Sec 7(2) of the 1996 Constitution.

195 De Vos 1995 S A Public Law 245-246.

196 Van Wyk (Unpublished) 13-14. Sec 3 of the Schools Act requires that every parent must cause every learner for whom he or she is responsible to attend a school from the first school day of the year in which such learner reaches the age of seven years until the last school day of the year in which such learner reaches the age of fifteen years or the ninth grade, whichever occurs first. Any parent who, without just cause, prevents a learner who is subject to compulsory attendance from attending a school, is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding six months (sec 3(6)(a)). In fact any other person who, without just cause, prevents a learner who is subject to compulsory attendance from attending a school, is guilty of an offence and liable on conviction to a fine or to imprisonment of a period not exceeding six months (sec 3(6)(b) of the Schools Act).

197 The Schools Act sec 5(3).

198 Cf also Van Wyk (Unpublished) 14.

199 Cf sec 8(2) of the 1996 Constitution.

200 Cf the discussion in par 3.41 and par 6.24 et seq below.

3.17 The Schools Act confirms the constitutional right to a basic education. It provides that a public school<sup>201</sup> must admit learners<sup>202</sup> and serve their educational requirements without unfairly discriminating in any way.<sup>203</sup> Provinces have to provide public schools for the education of learners.<sup>204</sup> In terms of the Act "the provision of public schools" may include "the provision of hostels for the residential accommodation of learners".<sup>205</sup> The Act further provides for the administration, control and maintenance of school property, including school hostels.<sup>206</sup> It would seem that the definition of "public school" includes school hostels.<sup>207</sup>

3.17.1 In terms of this Act the governing body of a public school may not administer any test related to the admission of a learner to a public school, or direct or authorise the principal of the school or any other person to administer such test.<sup>208</sup> It is submitted that "any test" is wide enough to include tests for

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201 Sec 1(xviii), read with chapter 3 of the Schools Act, defines "public schools". They are schools that are funded by the provincial legislatures and may be ordinary schools or schools for learners with special education needs. Public schools for learners with special education needs include schools for the physically disabled; schools for children with behavioural deviations (clinic schools); schools for mentally disabled children; hospital schools; schools of industry, reform schools and places of safety for learners who have found themselves in trouble with the law or are in need of protection (**Special Needs Report 1997** 30; information supplied by Dr Nelia Louw, Member of the National Task Team: Life Skills and HIV/AIDS Education Programme on 24 February 1998). The Member of the Executive Council (MEC) responsible for education in a specific province must, where reasonably practicable, provide education for learners with special education needs at ordinary public schools and provide relevant educational support services for such learners. The MEC must take all reasonable measures to ensure that the physical facilities at public schools are accessible to disabled persons (sec 12 of the Schools Act). The governance of public schools vests in governing bodies (Ibid sec 16).

202 Sec 1(ix) defines a "learner" as any person receiving education or obliged to receive education in terms of this Act. Cf sec 3(1) on compulsory education.

203 Sec 5(1).

204 Sec 3(3), sec 12(1) and sec 34.

205 Sec 12(1) and (2).

206 Sec 20(1)(g) and 21(1)(a).

207 According to sec 1(xviii) a "public school" means "a school contemplated in Chapter 3" of the Act. Chapter 3 (sec 12(2)) provides as follows: "The provision of public schools referred to in subsection (1) [which requires the MEC to provide public schools for the education of learners out of funds appropriated for this purpose by the provincial legislature] may include the provision of hostels for the residential accommodation of learners". In an informal discussion with senior officers of the Department of Education on 24 February 1998 it was indicated that the Department, on the basis of these provisions, regards hostels to be included in the definition of a "public school"(see fn 46 for particulars regarding the discussion with the Department).

208 Sec 5(2). Cf also sec 3(6)(b) - this subsection is referred to fully in fn 196 above

HIV. This would mean that no learner who applies for admission to a public school may be required to undergo a test for HIV. HIV testing may therefore not be a prerequisite for admission to public schools. In addition, if public schools were to require a negative HIV test result as a prerequisite for admission, this would in any event probably be considered to be unfair and irrational discrimination in view of the limitations of HIV antibody testing discussed above.<sup>209</sup>

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209 See par 2.41-2.45.

3.17.2 No such prohibition, however, exists with regard to independent schools.<sup>210</sup> According to the Schools Act<sup>211</sup> and the 1996 Constitution<sup>212</sup> independent schools are merely required to maintain standards not inferior to the standards in comparable public schools, and their admission policies may not discriminate on the grounds of race. They would also not for instance be required to admit learners whose parents are not able to pay the school fees.<sup>213</sup>

3.18 The Schools Act provides for compulsory education (education from age seven up to the ninth grade or the age of fifteen).<sup>214</sup> The Act also provides for special education needs that learners may have. In determining the placement of a learner with special education needs the Head of Department and principal must take into account the rights and wishes of the parents of such learner.<sup>215</sup> A learner may be totally, partially or conditionally exempted from compulsory school attendance if it is in the best interests of the learner.<sup>216</sup> Parents may also apply to the Head of an Education Department<sup>217</sup> for the registration of a learner to receive education at the learner's home. This will be granted if it is in the interests of the learner, and if the education at home will meet the minimum

210 Independent schools may not be established or maintained unless they are registered by the Head of the Education Department which is responsible for education in a province (sec 46(1) of the Schools Act). The Head of the Education Department must register an independent school if he or she is satisfied that the standards to be maintained by such school will not be inferior to the standards in comparable public schools, the admission policy of the school does not discriminate on the grounds of race, and the school complies with the grounds for registration which the MEC has given notice of in the **Provincial Gazette** as grounds on which the registration of an independent school may be granted (sec 46(2) and (3)). Independent schools may be subsidised by provincial funds under certain circumstances (sec 48 and sec 50).

211 Sec 46(3).

212 Sec 29(3).

213 Van Wyk (Unpublished) 16.

214 Sec 3(1) provides that every parent must cause every learner for whom he or she is responsible to attend a school from the first school day of the year in which such learner reaches the age of **seven years** until the last school day of the year in which such learner reaches the age of **fifteen years** or the **ninth grade**, whichever occurs first. Any parent who fails to comply, and any other person who prevents such learner to attend school, is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding six months (sec 3(6)). "Parent" is defined in sec 1(xiv) of the Schools Act as "(a) the parent or guardian of a learner; (b) the person legally entitled to custody of a learner; (c) the person who undertakes to fulfill the obligations of a person referred to in paragraphs (a) and (b) towards the learner's education at a school".

215 Sec 5(6) of the Schools Act.

216 Sec 4(1).

217 Meaning the Department established by sec 7(2) of the Public Service Act, 1994 which is responsible for education in a province (sec 1(iii) and (vii) of the Schools Act).

requirements of the curriculum at public schools and will be of a standard not inferior to education at public schools.<sup>218</sup>

- 3.19 The constitutional right to a basic education is also enhanced by the Policy Act. National education policy has to be directed toward the advancement and protection of the fundamental rights of every person guaranteed in terms of Chapter 2 of the 1996 Constitution, and in particular the right of every person to a basic education and equal access to education institutions.<sup>219</sup>

+ *The right to privacy*

- 3.20 The 1996 Constitution protects every person's right to privacy.<sup>220</sup>

- 3.21 According to our common law every human being is entitled to recognition of his or her right to privacy. The right to privacy protects personal information concerning the individual's state of seclusion and is excluded from the knowledge of others; and it is for individuals themselves to decide on the content and extent of their interests in their privacy.<sup>221</sup>

- 3.22 A child is entitled to the same common law and constitutional rights in respect of the protection of his or her privacy as an adult and such rights are limited to the same extent.<sup>222</sup> For example, a doctor treating a child is bound by the same ethical and legal obligations of confidentiality that protect adults,<sup>223</sup> and the Interim South African Medical and Dental Council (SAMDC) Guidelines do not distinguish between adults and

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218 Sec 51(1) and (2).

219 The Policy Act sec 4(a)(ii).

220 Sec 14.

221 Neethling 31 et seq.

222 Cf also Viinikka **HIV Infection and Children in Need** 41 and **AIDS The Legal Issues** 201.

223 Par 3.47-3.57 of **SALC Working Paper 58**. In these paragraphs the confidentiality of AIDS-related information is discussed.

children.<sup>224</sup> Likewise a principal to whom confidential information regarding the HIV infection of a learner is divulged, will be ethically and legally bound to keep that information confidential.

3.23 The legal and ethical duty of confidentiality is not absolute, as there are other interests which may be more important and which may justify or necessitate the breach of confidentiality.<sup>225</sup> In general, disclosure can be justified if the individual gives his or her informed consent thereto; if legislation requires that the information be disclosed;<sup>226</sup> if a doctor or school principal is ordered by court to disclose the information; or if disclosure would be in the overriding public interest. HIV transmission involves serious potential harm for individuals and society and it is generally accepted that an overriding public interest could constitute justification for the removal of the duty of confidentiality. However, in view of the specific and limited modes by which HIV is transmitted, particular third parties whose interests may be affected are persons (such as care givers and health care workers) who have been exposed to the body fluids or blood of learners with HIV.<sup>227</sup>

3.24 The HIV status of a child may, therefore, not be disclosed without justification, such as consent.<sup>228</sup> The consent will usually be given by the child's parent or guardian.<sup>229</sup> According to the Child Care Act 74 of 1983, a child over the age of 14 years is competent to consent, without the assistance of his or her parent or guardian, to the performance of

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224 See par 3.54-3.56 of **SALC Working Paper 58** for relevant extracts from the **SAMDC Guidelines**. One such guideline is: " The principle of professional secrecy applies in respect of the patient. The decision whether to divulge the information to other parties involved must therefore be in consultation with the patient. If the patient's consent cannot be obtained, the health care worker should use his or her discretion whether or not to divulge the information to other parties involved. Such a decision must be made with the greatest care, after explanation to the patient and with acceptance of full responsibility at all times". (The parents of a child under 14 will of course be informed by a medical practitioner of the child's medical condition.)

225 Van Wyk AH 1991 **Stell LR** 46; cf also Strauss **Huldigingsbundel vir WA Joubert** 145; Van Wyk 386-388; **Jansen Van Vuuren v Kruger** 1993 4 SA 842 (A); cf the limitation clause, sec 36, of the 1996 Constitution.

226 Provided that this legislation conforms to the provisions of sec 36 of the 1996 Constitution. See eg the 1987 Regulations which requires that a child's HIV status be disclosed to the school principal - refer to par 3.8-3.9 above.

227 Cf Strauss 15; Van Wyk 1993 **De Jure** 145.

228 Cameron **AIDS Bulletin** March 1993; cf also Neethling 258-259.

229 Cameron **AIDS Bulletin** March 1993; cf also Viinikka **HIV Infection and Children in Need** 41.

any medical treatment of him- or herself or his or her child.<sup>230</sup> This legal principle is in accordance with international findings indicating the age of 14 to 15 years as the approximate age that marks the transition from incompetence to universal competence regarding any medical treatment (which would include an HIV test) or surgical procedure.<sup>231</sup> This is regarded as the age at which children acquire a competence roughly comparable with that of adults.<sup>232</sup> It is submitted that a person who is competent to consent to an HIV test is also competent to consent to the disclosure of such test result. The Child Care Act therefore implies that a child above the age of 14 years and older may also consent to the disclosure of his or her HIV status.<sup>233</sup> If such a child gives consent, he or she would have to be "intellectually mature enough to understand the implications of his (or her) acts".<sup>234</sup> By analogy, a mother of 14 years and older, may consent to the disclosure of the HIV status of her baby to third parties.<sup>235</sup>

- 3.25 Breach of confidentiality without justification could lead to an action for damages against the person who disclosed the information.<sup>236</sup> Educators may also be disciplined by the South African Council for Educators (SACE) if they do not respect learners' rights to privacy.<sup>237</sup>

+ ***The right to freedom of association***

- 3.26 The 1996 Constitution provides that everyone has the right to freedom of association.<sup>238</sup> This means *inter alia* that a parent may send his or her child to any school (public or independent) that he or she wishes.<sup>239</sup> Children also have the right of freedom of association and in this context refusal to study with a learner with HIV may present itself. This right of learners therefore may need to be balanced with other rights (such as

230 See sec 39(4)(b). (In the case of an operation this age limit is 18 years - sec 39(4)(a).)  
 231 Ngwena 1996 **Acta Juridica** 138.  
 232 Ibid.  
 233 The Child Care Act sec 39(4)(b); see also Cameron **AIDS Bulletin** March 1993.  
 234 Neethling 259, 97-98 (our translation).  
 235 Cf the Child Care Act sec 39(4)(b).  
 236 Neethling 268 et seq.  
 237 Par 3.57 below.  
 238 The 1996 Constitution sec 18.  
 239 Visser 1997 **TSAR** 628.

the right to equality and the right to a basic education).

3.27 In respect of independent schools the right to freedom of association is of paramount importance. This right would allow for the establishment of institutions based on, for instance, a common language, culture or religion.<sup>240</sup> The Schools Act implies that independent schools and their governing bodies may structure their admission policies freely provided that they may not discriminate on grounds of race.<sup>241</sup> However, the horizontal application of the constitutional prohibition against unfair discrimination will have to be borne in mind.

+ ***The right to life, bodily integrity and an environment that is not harmful to health or well-being***

3.28 The 1996 Constitution provides that everyone has the right to life.<sup>242</sup> It furthermore provides that everyone has the right to bodily and psychological integrity<sup>243</sup> and to an environment that is not harmful to his or her health or well-being.<sup>244</sup> In essence these provisions confirm the common law protection of the right to physical and psychological integrity, and physical and mental well-being of individuals.<sup>245</sup>

3.29 The state has to respect, protect, promote and fulfil the right of a learner to a healthy environment, and to refrain from directly infringing this right. The state also has a duty not to take any action which would deprive a learner of this right except where such infringement is justifiable in terms of section 36 of the 1996 Constitution.<sup>246</sup> In practice this would entail a duty on the state and governing bodies of public schools to

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240 Cf sec 4(a)(vi) of the Policy Act.

241 The Schools Act sec 46(3)(b).

242 The 1996 Constitution sec 11.

243 Ibid sec 12(2).

244 Ibid sec 24(a).

245 Neethling et al 29 et seq.

246 De Vos 1995 S A Public Law 253-254.

take reasonable steps to ensure a safe school environment.<sup>247</sup> In accordance with the general principles of the law of delict, where all reasonable precautions have been taken to prevent the eventuation of a foreseen and possible harm, the loss created by that harm, if it ensues nevertheless, must lie where it falls. This means that someone suffering loss when damage ensues in these circumstances has no claim in law for recompense.

3.30 The preamble to the Schools Act states that the rights of all learners have to be upheld, while the Policy Act confirms that the fundamental rights of every person are to be protected.<sup>248</sup> The Policy Act refers to international conventions ratified by Parliament and the rights contained in these.<sup>249</sup> In this regard the **United Nations Convention on the Rights of the Child (1989)** is of importance. The Convention recognises every child's inherent right to life.<sup>250</sup>

3.31 Criminal or civil liability for a person with HIV could ensue as a result of exposing others to HIV infection.

3.31.1 In terms of the criminal law and the law of delict children under the age of seven years are irrebuttably presumed to lack criminal and delictual capacity.<sup>251</sup> There is a presumption that children between the ages of seven and 14 years are criminally and delictually unaccountable. But this presumption becomes rebuttable and weakens as the child approaches the age of 14 years. On attaining the age of 14 a child is regarded in law as being no different to an adult in respect of criminal and delictual accountability. People above the age of 14 are rebuttably considered to possess criminal and delictual capacity. In the context of HIV in schools this would imply that learners from the age of 14 years could be held liable criminally<sup>252</sup> and delictually<sup>253</sup> for exposing others to HIV infection.

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247 Visser 1997 **Obiter** 21. Governance of public schools is vested in its governing bodies (sec 16 of the Schools Act).

248 Sec 4.

249 See par 3.15.1 above for more detail.

250 Article 6.

251 Burchell 83-84; Burchell and Hunt 158 et seq.

252 In terms of our common law intentionally exposing somebody to HIV could constitute a crime, while transmitting HIV could, depending on the circumstances, amount to assault, attempted murder,

3.31.2 A parent could be held liable for a delict committed by his or her child if the parent negligently failed to prevent the child from causing harm: "As to negligence, the parent's duty of supervision is not an absolute one: he is required to avert foreseeable harm by taking the precautions that a reasonable man would have taken in the circumstances. He need not have been present when the damage was caused, however it suffices that he should have foreseen and could have prevented it".<sup>254</sup>

3.31.3 Even criminal liability of a parent for the crimes of his minor children could, according to Boberg, ensue. He premises his view on the following: The parent is deemed to have condoned to the commission of an offence by the child "if the child probably would not have committed the offence if he [the parent] had taken proper care of the child".<sup>255</sup>

+ ***The right of access to information***

3.32 The 1996 Constitution provides for everyone's right of access to information<sup>256</sup> held by the state as well as any information that is "held by another person and that is

manslaughter or even murder.

253 In terms of delictual law children could be held liable for causing damage to another person. A delict is an unlawful, blameworthy (i.e. intentional or negligent) act or omission which causes another person damage to person or property or injury to personality and for which a civil remedy for recovery of damages is available (Burchell 10). In **Venter v Nel** 1997 4 SA 1014 (D) the court granted the plaintiff damages on the ground that the defendant had infected her with HIV during sexual intercourse. Damages were granted for future medical expenses as well as for the possibility of a reduction in life expectancy, psychological stress, contumely and pain and suffering. It was held that the plaintiff's condition was one which called for "extremely high damages". Factors taken into account by the court in assessing the damages were *inter alia* the stress and inevitable fear of the unknown, the feelings of helplessness and hopelessness, the adverse effects that the condition had on her general relationship with all others, the adverse effects on her sex life and psychological and social suffering.

254 Boberg 677-678.

255 Ibid 660.

256 According to Alkema 1996 **HRCLJSA** 32-35, South Africa is the only country in the world which recognises this right as a constitutional right. He argues that the aim of the right of access to information is to create a participatory and accountable form of government on all levels.

required for the exercise or protection of any rights"<sup>257</sup> (not necessarily being the applicant's rights). Until such time as legislation is enacted to give effect to this right,<sup>258</sup> persons have the right of access to information only against the state and its organs: they have the right of access to all information held by the state or any of its organs in any sphere of government in so far as that information is required for the exercise or protection of any of their rights.<sup>259</sup>

3.32.1 The Schools Act gives further effect to the constitutional right of access to information and provides that all schools (whether public or independent) must make information available for inspection by any person, insofar as that information is required for the exercise and protection of such person's rights.<sup>260</sup>

3.32.2 Parents, or learners themselves, could argue that the 1996 Constitution enables them to have access to state-held information regarding learners with HIV in public schools, the latter being conceived as "organs of state"<sup>261</sup> or that the Schools Act itself affords them access to such information in any school (public as well as independent<sup>262</sup>). Parents or learners would have to show that they need this information to protect their specific right(s).<sup>263</sup> The right need not be a fundamental right<sup>264</sup> (such as the fundamental right to life<sup>265</sup> or to bodily integrity<sup>266</sup>) but may indeed be any other right.

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257 Sec 32(1).

258 Sec 32(2). This legislation has to be enacted within three years of the date the 1996 Constitution took effect (sec 23(3) of the Transitional Arrangements). The Open Democracy Bill (published under General Notice 1514 of 1997 in **Government Gazette** 18381 of 18 October 1997), aims to give the public a right of access to information held by governmental and private bodies.

259 Sec 32(1) of the 1996 Constitution read with sec 23(2) of Schedule 6 (Transitional Arrangements).

260 Sec 59(1).

261 See fn 180 above.

262 The Schools Act sec 59(1) read with the definition of "school" in sec 1(xix) of the Act.

263 Cf sec 32(1) of the 1996 Constitution read with sec 23(2) of the 1993 interim Constitution; see also sec 59(1) of the Schools Act.

264 **Uni Windows CC v East London Municipality** 1995 8 BCLR 1091 (E). Cf **Director Advertising Cost Cutters v Minister for Post, Telecommunications and Broadcasting** 1996 3 SA 800 (T) and **Van Niekerk v City Council of Pretoria** [1997] 1 AllSA 305 (T).

265 The 1996 Constitution sec 11.

266 Ibid sec 12(2).

3.33 On the other hand, it could be argued that the constitutional right of access to information in order to protect rights, means that learners have a right to general information about HIV/AIDS held by the state and its organs (such as the prevalence of HIV infection in the country and the modes of transmission and prevention) in order to be able to protect their health. It could be argued that this kind of information would be in the best interests of children as protected in the 1996 Constitution,<sup>267</sup> that it would promote the constitutional right of access to (reproductive) health care<sup>268</sup> and that it would have a significant positive impact on public health.<sup>269</sup> Studies have shown that publicity about AIDS has resulted in beneficial change in the sexual practices of teenagers.<sup>270</sup>

3.33.1 Those in favour of AIDS education argue that schools have the capacity and responsibility to ensure that young people understand the nature of the AIDS epidemic and the specific actions they can take to prevent HIV infection, especially during their adolescence and young adulthood.<sup>271</sup> It is further argued that the education departments appear, through their attempts in the past, to have accepted this responsibility to provide learners with education on HIV/AIDS and sexuality,<sup>272</sup> and that schools do have the economic resources to implement such programmes without taking away money allocated for traditional core courses. In the US it has been found that teacher-delivered curricula could favourably modify AIDS-related knowledge and risk behaviour among learners.<sup>273</sup> The argument is further that issues of sexuality should be discussed before teenagers become sexually active, as they are less likely to listen to messages of sexual abstinence or

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267 Ibid sec 28(2).

268 Ibid sec 27(1)(a).

269 American studies have shown that sex education programmes favourably influenced high risk behaviour (**AIDSScan** October 1996 10). A national survey in the United Kingdom also found that children who received sex education at school experienced first intercourse later than children who gained the information from friends (**AIDSScan** March/April 1995 8-9).

270 Studies quoted in **AIDSScan** November 1989 7.

271 **Morbidity and Mortality Weekly Report** 29 January 1988 2; McNary-Keith 1995 **Journal of Law and Education** 69; Lachman 454.

272 Cf Strode and Small **Rights** December 1995 29.

273 See **AIDSScan** December 1993 6 for a discussion of a study carried out among multi-ethnic high school children in New York City.

safety precautions once they are already sexually active. The message needs to reach them before they reach puberty.<sup>274</sup> The "window of opportunity" in Africa is said to refer to children under nine years of age.

+ ***The right to freedom of conscience, religion, thought, belief and opinion***

3.34 The 1996 Constitution provides that everyone has the right to freedom of conscience, religion, thought, belief and opinion.<sup>275</sup>

3.34.1 The Schools Act,<sup>276</sup> the Policy Act,<sup>277</sup> as well as the **United Nations Convention on the Rights of the Child (1989)**<sup>278</sup> reaffirm these rights.

3.34.2 Independent schools will be able to rely on their right to freedom of association discussed above<sup>279</sup> and the right to freedom of conscience, thought, belief and opinion in order to establish education institutions based on a common language, culture or religion, as long as there is no discrimination on the ground of race.<sup>280</sup> It has been pointed out above that in addition independent schools will

274 With regard to AIDS sexuality education, it has been recommended that teenagers should be informed that sexual intercourse is imprudent in people under the age of 17. Although it may be difficult, the message should be brought across that teenagers should delay intercourse as long as possible but that they should use effective precautionary measures when they do become sexually active. Policies that promote abstinence should not be silent regarding appropriate action if a young person decides to become sexually active. Abstinence and condom promotion should therefore not be seen as conflicting strategies or as mutually exclusive goals for HIV prevention in teenagers. Teenagers and young adults should know how to engage in sexual intercourse in as safe a manner as possible. For a discussion of this viewpoint, see **AIDSScan** June 1995 10.

275 Sec 15(1).

276 See the preamble and sec 7 of the Act.

277 Sec 4(a)(i)-(viii) provides that national policy shall be directed towards the advancement and protection of *inter alia* the right of every person to the freedom of conscience, religion, opinion and association within education institutions.

278 For more detail see fn 191 above.

279 Par 3.27 above.

280 Sec 4(a)(vi) of the Policy Act. In a pending application before the Pretoria High Court against an independent school and the Education Department, a parent has recently applied for her child's right to freedom of belief to be respected in terms of the 1996 Constitution. The 15-year-old learner is allegedly forced to attend compulsory prayer sessions and instruction in the Christian religion. According to a media report the learner's parent submits that instruction in the Christian religion with the exclusion of other religions trenches upon her child's right to freedom of belief. The governing body of the school

not be allowed to discriminate unfairly in terms of the 1996 Constitution.<sup>281</sup>

- 3.34.3        The Schools Act furthermore includes parents in public school governance and establishes the idea of a partnership in which parents play a vital role.<sup>282</sup> This would entail that parents should, to a certain extent, be involved in the development of a school's HIV/AIDS policy - especially with regard to the ethos and values contained in such policy.
- 3.35        Educating young people about becoming infected through sexual contact can be controversial and may infringe on parents' freedom of conscience and opinion in relation to their children's best interests. This is even more so when issues such as safer sex practices, the use of condoms and mechanisms to make condoms available to learners in schools, are considered. Parents fear that sexuality education only increases and encourages sexual activity, undermines the morality of young adults and conveys the message that sexual activity is permissible as long as it is "safe".
- 3.36        Some proponents of parental rights want sexuality and HIV/AIDS education not to form part of the school curriculum, or parents to have the right to remove their children from sexuality education programmes. They contend that parents have a right not to have sexually suggestive and morally offensive material presented in school, and to control the dissemination of materials related to sexuality education with respect to AIDS, including condom use. The basis for their assertion is rooted in moral and religious grounds and the belief that parents have the right to rear their children as they please.<sup>283</sup> Proponents of parental rights maintain that the latter overrides the concern for public health.

+        *The child's best interests*

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holds that the Constitution does not bind an independent school. It is reported that the school receives an annual subsidy of R700 000 from the government (**Beeld** 12 March 1998 6).

281        Cf par 3.12 and 3.27 above.

282        Visser 1997 **TSAR** 636.

283        See discussion of and comments on challenges to sexuality education courses and the American experience in **AIDSScan** October 1996 10-11.

3.37 The 1996 Constitution provides that the child's best interests are of paramount importance.<sup>284</sup> In terms of section 28(3) of the 1996 Constitution a "child" means "a person under the age of 18 years".

3.38 This principle is confirmed in article 3 of the **United Nations Convention on the Rights of the Child (1989)**<sup>285</sup> and forms part of our South African common law.<sup>286</sup>

3.38.1 The inclusion of the "best interests of the child" as a general standard for the protection of children's rights in the 1996 Constitution can be regarded as a general benchmark for review of all proceedings in which decisions are taken regarding children. It implies that courts and administrative authorities are constitutionally bound to give consideration to the effect their decisions will have on children's lives.<sup>287</sup> It provides a minimum guarantee that the interests of the child cannot be ignored.<sup>288</sup>

3.38.2 The "best interests of the child" refers to the best interests of all children - those without HIV and those with HIV. "Best interests of the child" is not constitutionally defined.<sup>289</sup>

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284 Sec 28(2).

285 Article 3 states that: "(1) In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. (2) States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures. (3) States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision".

286 Sloth-Nielsen 1996 **Acta Juridica** 8.

287 Ibid 25.

288 Some writers regard this principle as the "determinative criterion" in matters pertaining to the child: "... any rights that the parent might have ... will simply be factors to take into account prior to reaching a decision consonant with the best interests of the child ..." (Ngwena 1996 **Acta Juridica** 146).

289 It has been suggested that "the child's best interests" refers to a paramountcy test - that is, the child's best interests (or his or her "welfare" as it was for instance previously referred to in sec 64 of the Australian Family Law Act 1975) is to be the court's paramount consideration in any matter concerning a child (Bailey-Harris and Dewar 1997 **FamLQ** 161-162).

+ *Corresponding duties*

3.39 The existence of rights of course is indicative of corresponding duties and burdens placed on the state or others to respect these rights.<sup>290</sup> In the African context the idea of collective and individual responsibilities and duties is also emphasised.<sup>291</sup> When learners do not accept responsibilities an orderly school environment will not be possible.<sup>292</sup> All fundamental rights obviously have to be seen against the background of the requirements and aims of a proper and valid school education system.<sup>293</sup>

3.40 The "obligation clause" in section 7(2) of the 1996 Constitution instructs the state to "respect, protect, promote and fulfil the rights in the Bill of Rights". These obligations entail a combination of negative and positive duties, and apply to all rights. The negative duty amounts to the state and other relevant institutions refraining from infringing the stated rights directly, while the positive duty obliges the state to take steps to make sure that the enjoyment of the right is effective.<sup>294</sup> However, the exact scope and extent of the duty in respect of each right will depend on the nature of the right and the

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290 Cf also Visser 1997 *Obiter* 22-23.

291 It has been suggested that concern expressed by Mahomed (DP - as he then was) in **Fraser v Children's Court, Pretoria North** 1997 2 BCLR 153 (CC) that new legislation should take account of the reality of the conditions that prevail for women and children in South Africa today, has placed the "Africanisation" of new legislation firmly on the agenda (Sloth-Nielsen and Van Heerden 1997 *Stell LR* 265). In contrast to the Western notion of individual rights, the African ethos places "rights" within the context of collective and individual responsibilities. The main difference, for instance, between the **United Nations Convention on the Rights of the Child (1989)** and the **Organisation of African Unity Charter** is that the latter includes a section on the responsibilities of children, which is entirely absent from the former (Parry-Williams 1993 *Int J of Children's Rights* 49 57-58, as referred to by Sloth-Nielsen and Van Heerden 1997 *Stell LR* 274). An indication of this African nuance is to be found in Ghanaian legislative proposals for reform of the Law for Children (1996) where it is expressly provided that "the proposals try to give effect to the notion that the child needs less protection and takes on more responsibility for her actions as she gets older" (Sloth-Nielsen and Van Heerden 1997 *Stell LR* 274). In recent Namibian draft legislation reference is also made to the child's "responsibility for ... obligations" (Ibid.) Although South Africa is to date not a signatory to the African Charter, the possible inclusion of children's responsibilities in proposed child care and protection legislation has been raised in various forums in our country: The opinion has been expressed that children's rights cannot be viewed in isolation and that emphasis should not be placed solely on children's rights to the exclusion of the rights of their parents and the community at large (Ibid.)

292 Visser 1997 *Obiter* 22-23. Cf also fn 16 above for the proviso in US legislation that the (education) programme of other learners should not be disrupted by learners with HIV.

293 Ibid.

294 De Vos 1997 *SAJHR* 79-83.

way in which the relevant constitutional provision was drafted.<sup>295</sup>

3.40.1 Few, if any rights are formulated in such a way that the protected conduct or interest may never be restricted. Both the general limitations clause<sup>296</sup> (which may contain indications that infringement of the right could be justifiable) and specific internal qualifications regarding the scope of the obligations engendered by the rights in question are at stake here. Even in the case of the strongest internal limitation (requiring the state to "take reasonable measures to achieve the progressive realisation of the rights within its available resources" - *which limitation is not included in any of the constitutional provisions discussed in this interim report with respect to the protection of learners' rights*) the obligation exists independently of an increase in resources.<sup>297</sup> The right to a healthy environment<sup>298</sup> is internally qualified in that the state is obliged to "take reasonable legislative and other measures" to realise the right. It is accepted that this internal qualification indicates that the state is under an obligation to initiate steps towards the full realisation of the relevant right.<sup>299</sup> This *inter alia* requires the adoption of economic measures.<sup>300</sup> The right to a basic education<sup>301</sup> has no internal qualification. The state therefore has the obligation to have in place laws and policies required to enforce the proper protection of this right, and to create a framework in which learners will be able to realise their entrenched right without interference from others.<sup>302</sup> The state

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295 Ibid.

296 Sec 36 of the 1996 Constitution. This section operates as a uniform qualification on the scope of the obligations engendered by all the rights included in the Bill of Rights. According to this section the rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including *inter alia* the nature of the right, the nature and extent of the limitation and less restrictive means to achieve the purpose. Sec 36 will be relevant specifically where the obligation engendered by the right is limited in terms of "law of general application" (which would include the common law) (Cf De Vos 1997 **SAJHR** 92).

297 De Vos 1997 **SAJHR** 91-97. (This limitation is eg present in sec 26 [Access to housing] and 27 [Access to health care, food, water and social security] of the 1996 Constitution.)

298 See also par 3.28 and 3.29 above regarding the duties engendered by this right.

299 De Vos 1997 **SAJHR** 94.

300 Ibid 95.

301 See also par 3.16 above regarding the duties engendered by this right.

302 De Vos 1997 **SAJHR** 67-101.

must create conditions in which the right to a basic education can be realised by the individual learner.<sup>303</sup>

3.41 Although the 1996 Constitution applies mainly vertically against the state (which brings about duties for the state and its organs, for example public schools acting through their governing bodies and the school principal<sup>304</sup>), section 8(2) stipulates that a provision of the Bill of Rights binds also natural and juristic persons (for instance learners) if and to the extent that it is applicable, taking into account the nature of the right and any duty imposed by the right. While this provision has not yet been canvassed by our courts, it can be confidently stated that private individuals (i.e. learners) have to respect the fundamental rights (for instance, to life, bodily integrity, freedom of association, access to information and a safe environment) of other learners and educators. The same argument would apply in respect of independent schools.<sup>305</sup>

3.42 Another source of duties will be the common law, which (especially through the law of delict) regulates the degree of care to be exercised in conduct which is potentially detrimental to others.<sup>306</sup> For example, civil liability for a person with HIV could ensue as a result of exposing others to HIV,<sup>307</sup> and breach of confidentiality without justification could lead to an action for damages against the person who disclosed the information.<sup>308</sup>

3.43 The Code of Conduct to be drawn up by every public school will constitute a further important and practical source of duties of learners.<sup>309</sup>

3.43.1 The governing body of a school must first consult with learners, parents and educators of the school before it may adopt a Code of Conduct.<sup>310</sup> The aim of the Code will be to establish a disciplined and purposeful school

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303 Ibid.

304 The Schools Act sec 16.

305 Visser 1997 **Obiter** 18-19.

306 Ibid 24.

307 Refer to the discussion in par 3.31 above.

308 Par 3.25 above.

309 Visser 1997 **Obiter** 19.

310 The Schools Act sec 8(1).

environment.<sup>311</sup> A learner is obliged to comply with the Code of Conduct but may endeavour to claim that it violates his or her constitutional right(s).<sup>312</sup> Such constitutional rights (as the right to equality) will then have to be balanced against the demands of a disciplined and safe school environment.

3.43.2 It has been said that learners (and especially those who know or believe that they have HIV infection) should be taught that they may not expose others to their body fluids or blood and that they have certain duties towards society in this regard.<sup>313</sup> Moreover, a school's Code of Conduct should contain provisions regarding behaviour which may create risk of HIV transmission (for instance aggressive sexual behaviour). The Schools Act provides for the suspension or expulsion of a learner from a public school.<sup>314</sup> A learner may be expelled from a public school if, after a fair hearing, he or she is found guilty of serious misconduct.<sup>315</sup> If the learner is between seven and 15 years of age (i.e. subject to compulsory school attendance) an alternative arrangement must be made for his or her placement at a public school. In terms of the Schools Act this may include a gender-specific school.<sup>316</sup> Behaviour which may constitute serious misconduct and the disciplinary proceedings to be followed in such cases must be determined by notice in the Government Gazette by the MEC responsible for education in a specific province.<sup>317</sup> It has been suggested that learners who know or believe that they have HIV and who expose others to a significant risk should at least be guilty of serious misconduct and that clear guidelines should be set in this regard in a Code of Conduct.<sup>318</sup> Unacceptable behaviour in general should also be addressed in such Code.<sup>319</sup>

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311 Ibid sec 8(2).  
 312 Ibid sec 8(4) and sec 9. See also Visser 1997 **Obiter** 24.  
 313 Van Wyk (Unpublished) 8-9.  
 314 The Schools Act sec 9.  
 315 Ibid sec 9(2).  
 316 Ibid sec 9(5) and 12(6).  
 317 Ibid sec 9(3).  
 318 Eg in instances of biting (Van Wyk [Unpublished] 22).  
 319 Ibid.

3.43.3 Learners with, for instance, pulmonary tuberculosis should be on treatment before allowing them back to school.<sup>320</sup> Learners taking part in contact sport should know that they are not allowed to take part with open wounds.

## C) BALANCING RIGHTS AND DUTIES

3.44 The consistent application of universal precautionary measures is better able to protect learners in the school environment from infection than HIV antibody testing and the refusal of admission of those identified as HIV positive. This approach would also be much less invasive of the rights of learners. Therefore it would probably be irrational and unfair to attempt to determine which learners are HIV positive and to discriminate against learners so identified. It could also possibly be successfully argued that irrational discrimination on the ground of HIV status alone would trench upon their human dignity as protected in section 10 of the 1996 Constitution.

3.45 In the light of current scientific knowledge, and of the (competing) fundamental rights set out above, compulsory testing of learners as a prerequisite for admission to any school (public or independent), or any unfair discriminatory treatment, is not justified.

3.46 However, there could be justification for withdrawing a learner with HIV from school or reasonably accommodating him or her elsewhere (such as allowing him or her to receive education at home) in cases where he or she poses a medically recognised significant health risk to others which cannot be excluded by ordinary precautionary measures. A significant health risk would for instance be present where a learner has a serious secondary infection which cannot be treated and could be transmitted to other persons in the course of day to day contact, or where the learner behaves in an aggressive manner (sexually or otherwise). In instances like these, discrimination would probably be

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320 The Department of Education's draft policy on admission of learners to public schools will, according to information received from representatives of the Department (see fn 46) require that learners should have received immunisation against (other) communicable diseases before they are admitted to public schools.

fair and rational. Where his or her health condition permanently restricts a learner's ability to attend classes, such learner should be accommodated elsewhere. This approach is in accordance with the 1996 Constitution, the Schools Act, the Policy Act and the premise already adopted in Working Paper 58, namely that persons with HIV/AIDS should be accommodated in society to the extent that their infection does not expose others to significant risks which cannot be eliminated by ordinary measures or reasonable adaptations.

3.47 Although disclosure to the school principal is probably not legally enforceable (in view of the fact that the 1987 Regulations have apparently never been applied and will probably shortly be replaced by new Regulations), it may generally be in the best interests of the learner with HIV if the principal, or other member of staff directly involved with the learner's care, is informed of his or her condition either by his or her parents or guardians (in the case of learners under the age of 14) or by the learner him- or herself (if the learner is above the age of 14 years).

3.47.1 Awareness of a learner's HIV infection would facilitate informed decisions regarding his or her management. It would also allow a person in direct care of such learner to offer the learner support and understanding, and would enhance mutual trust between parents, learners and the school.

3.47.2 It is acknowledged that an effective policy of confidentiality, as well as what has been called an "enabling environment", needs to be created for such disclosures to occur.<sup>321</sup> It may also generally be in the interest of all other learners to inform members of staff of a learner's HIV infection. The National Department of Sport and Recreation, for instance, advised in their Draft Position Statement: HIV/AIDS in Sport (July 1997) that sports participants should inform

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321 See the joint statement by the Ministers of Health and of Education dated 25 February 1997 in which is stated: "... The South African public needs to be made aware that the most effective way to combat the spread of the HIV/AIDS virus is to demystify the disease and remove the unfortunate and unnecessary stigma attached to it ... This stance is in line with international trends ... (and) would greatly assist the commendable efforts of HIV/AIDS activists, create an enabling environment for disclosure, and a conducive climate for counselling and comfort ... We believe that the introduction of a life skills programme at an early age in schools should help change our attitudes about HIV/AIDS ...".

medical personnel of their HIV infection if they sustain an open wound or skin lesion during sport so that these can be managed appropriately.<sup>322</sup>

3.47.3 HIV-related information may not be used as a ground for unfair discrimination against learners with HIV and the confidentiality of information should be ensured. Other parents, or other learners, would have no right of access to such information if they are unable to show that they need this information to protect their specific right(s). If universal precautions are adhered to in all circumstances, it would in any event be difficult to conceive of a right which may be threatened by maintaining confidentiality.

3.48 The question arises whether the learner above the age of 14 years, or the parent of a learner below 14 years, could incur liability by not disclosing HIV status to the school authorities.

3.48.1 It could be argued that during school hours the school acts in the place of the parent and assumes responsibility for learners in its care.<sup>323</sup>

3.48.2 It is furthermore accepted that in certain circumstances an omission to prevent harm to others may lead to delictual liability.<sup>324</sup> Community values will be decisive in this regard. Factors that have been accepted in our law as being indicative of a positive duty to act in order to prevent harm to others include the following:

\* Taking control of a dangerous or potentially dangerous situation.<sup>325</sup>  
(Schools taking control of learners - some of whom will have HIV - fall into this category).

\* Creating a particular relationship between parties.<sup>326</sup> (Schools have a

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322 See par 6.39 et seq below for more detail.

323 Cf the discussion of parents' duties in par 3.31.2 and 3.31.3 above.

324 **Minister van Polisie v Ewels** 1975(3) SA 590 (A). See also Neethling, Potgieter and Visser 59.

325 Ibid 60, 63.

326 Ibid 65.

particular duty to create a safe environment and to protect the well-being of all learners in their care.)

3.48.3 In view of the common law position set out above (namely that schools have to take positive steps to create a safe school environment), and in view of the 1996 Constitution and other relevant legislation providing for the right to a basic (school) education and for compulsory school attendance, the Commission is of the view that the primary duty to protect the well-being and health of all learners lies with the state and public schools. Parents have a right to be informed by schools about the precautionary measures taken to prevent the transmission of HIV. Parents should also be informed of any coercive measures to be taken in terms of a school's Code of Conduct. Parents should be able to rely and insist on the adequacy of these measures to prevent the transmission of HIV in the school environment.

3.48.4 As the law of delict regulates the degree of care to be exercised in conduct which is potentially detrimental to others, the question arises of how the potential detrimental situation is to be handled. If adequate precautionary measures are adhered to, it could be argued that the potential detrimental effect to others is averted. According to this argument there would consequently be no legal duty on parents (or learners) to disclose HIV status. However, when disclosure of HIV status would be the only way of averting potential harm from others, a legal duty to disclose will arise.<sup>327</sup> In view of comments on Discussion Paper 73 stressing the need for openness, the Commission is of the opinion that the genuine voluntary disclosure of HIV status should be welcomed since this could be in the interests of all learners.

3.48.5 The common law duty of schools to act positively to ensure a safe learning environment is confirmed by the Schools Act. The Act provides that the

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327 See Van Wyk 1993 *De Jure* 147 for a different viewpoint, namely that even where precautionary measures are in place, a duty to inform remains.

state is to be held 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 and for which such public school could have been liable but for the provisions of section 60 of the Act.<sup>328</sup>

3.48.5.1 Schools should be sensitised to HIV/AIDS and the need for universal precautions. Furthermore, no learner may be refused admission to a public school on the grounds that his or her parent has refused to enter into a contract in terms of which the parent waives any claim for damages arising out of the education of the learner.<sup>329</sup> The state is in any event strictly liable for damage in respect of which a public school as a juristic person would normally have been liable. Educators and staff may in specific instances be held personally liable for damage or loss.<sup>330</sup> It is not exactly clear what the position will be if a school for some reason requires a parent to sign an agreement limiting the amount of damages payable in some instances, or excluding the personal liability of members of its staff or of people not employed by the state.<sup>331</sup>

3.49 It is submitted that learners have a right to be educated on HIV infection, sexuality, healthy lifestyles, and life skills in order to protect themselves against HIV infection and to be able to cope in society. The public interest in containing the epidemic also necessitates the provision of such education. It should further be borne in mind that the state, through the courts, is the upper guardian of all children and that parental rights regarding the education and upbringing of children are not unlimited. It has been submitted that parental rights will be viewed by the courts not as intrinsic rights but as incidents of responsibilities or duties owed to children and that they will be enforced only

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328 The Schools Act sec 60(1). (See also the provisions of the State Liability Act 20 of 1957 which would apply to any such claim.)

329 Ibid sec 5(3).

330 Cf Burchell 215 et seq.

331 Visser 1997 **TSAR** 630.

to the extent that they are necessary to protect the child.<sup>332</sup> Any rights that the parent might have will simply be factors to be taken into account prior to reaching a decision consonant with the best interests of the child.<sup>333</sup> It is however acknowledged that there is a need for consultations with parent communities in an open manner to help allay any unfounded fears, improve understanding<sup>334</sup> and above all, inform them that sexuality education will accord with universally accepted values.<sup>335</sup> The information about AIDS should be designed to fit the developmental level and background of learners.

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332 Ngwena 1996 **Acta Juridica** 141. In the US the Supreme Court has interpreted the US Constitution as giving parents substantial autonomy and discretion in child-rearing. The rationale for this approach has been a presumption that parents are the best or most appropriate decision-makers for their children, and that to interfere with how they raise their children would be a violation of parents' constitutionally implied right to privacy. The Supreme Court has however held that parents' interests have to be balanced against other interests, including the child's interest in making private and independent decisions, provided he or she has the requisite capacity (Ngwena 1996 **Acta Juridica** 142).

333 Ibid 146.

334 Gie et al 1993 **SAMJ** 636-637.

335 Sec 4(m) of the Policy Act provides that national policy should be directed to ensuring broad public participation in the development of such policy.

## D) A NATIONAL POLICY ON HIV/AIDS IN SCHOOLS

### \* The need for a national policy

3.50 The general legal position with regard to issues relevant to HIV/AIDS in the school environment has, since publication of Working Paper 58 in 1995, not changed. Rather, the legal requirements with regard to non-discrimination have been strengthened by the 1996 Constitution and the Schools Act as indicated in the preceding discussion in this Chapter. Moreover, as stated at the outset of this interim report, the need for clarity and practical guidance is as strong as it was in 1995.

3.50.1 Although it may be argued that the recent constitutional and legislative inhibitions on unfair discrimination and the disclosure of confidential information in the school environment are sufficient, this assumes extensive knowledge regarding HIV and the ability to apply this knowledge effectively.

3.50.2 Recent experience confirmed the need for a precisely directed and clearly targeted policy that would create legal certainty and help prevent injustice to learners with HIV. It would also signal a clear public and governmental commitment to action against unfair discrimination, and eliminate misconceptions and uncertainties.

3.50.3 Furthermore, a clear national policy on a core curriculum on HIV/AIDS education and on universal precautions to prevent infection with HIV in the school environment, including contact sport, will bring about much needed guidance on these issues.

### \* The National Education Policy Act, 1996

3.51 As stated above, the Policy Act provides for, *inter alia*, the determination and

implementation of national policy for education by the Minister of Education.<sup>336</sup>

3.51.1 The Policy Act provides that national policy for education has to be determined in accordance with the provisions of the 1996 Constitution and of the Act itself,<sup>337</sup> and that in determining such national policy for education at education institutions,<sup>338</sup> the Minister shall take into account the competence of the provincial legislatures in terms of the 1996 Constitution<sup>339</sup> and the relevant provisions of any provincial law relating to education.

3.51.2 In terms of the 1996 Constitution the national and provincial legislatures have concurrent legislative competence on education at all levels, excluding tertiary education.<sup>340</sup> If there is a conflict between national legislation and provincial legislation on education, the national legislation that applies uniformly with regard to the country as a whole prevails over provincial legislation if *inter alia* the national legislation deals with a matter that, to be dealt with effectively, requires uniformity across the nation, and the national legislation provides that uniformity by establishing norms and standards, frameworks or national policies.<sup>341</sup>

3.51.3 Whenever the Minister wishes a particular national policy to prevail over the whole or a part of any provincial law on education, the Minister has to "inform the provincial political heads of education accordingly", and has to make

336 The Policy Act sec 2, read with sec 1.

337 Ibid sec 3(1).

338 "Education institution" means any institution providing education, including early childhood education, primary, secondary, further or higher education, other than a university or technikon, and also an institution providing specialised, vocational, adult, distance and community education (sec 1 of the Policy Act).

339 Sec 3(2) of the Policy Act still refers to sec 126 of the 1993 interim Constitution. Provinces had concurrent competence with Parliament to make laws for the province with regard to matters falling within the functional areas specified in Schedule 6, including education at all levels, excluding "university and technikon" education. An Act of Parliament would prevail only to the extent that it dealt with a matter which could, *inter alia*, not be regulated effectively by provincial legislation, or required uniform norms throughout the country, or was necessary to set minimum standards.

340 Schedule 4 of the 1996 Constitution. (Schedule 6 of the 1993 interim Constitution contained a similar provision - see fn 339 above.)

341 See sec 146 of the 1996 Constitution. Cf also **In re: The National Education Policy Bill No 83 of 1995** 1996 4 BCLR 518 (CC).

a specific declaration in the policy instrument to that effect.<sup>342</sup>

3.51.4 The Minister must determine national policy on matters such as financing and staffing,<sup>343</sup> and may determine national policy for *inter alia* development in education, compulsory school<sup>344</sup> education, the admission of students<sup>345</sup> to education institutions, curriculum frameworks, core syllabuses, education programmes, and education support services (including health and welfare development and counselling).<sup>346</sup> It is specifically provided that the Minister's powers include determining national policy for "the organisation, management, governance,<sup>347</sup> funding, establishment and registration or education institutions".<sup>348</sup> An "education institution" is defined in the Policy Act as "any institution providing education, whether early childhood, education, primary, secondary ... education and also an institution providing specialised ... education".<sup>349</sup> It is accordingly submitted that "education institution" is wide enough to also include independent schools.

\* **Responsibility for implementation of a national policy on HIV/AIDS in schools**

+ ***Funding***

3.52 The state's duties with regard to the right to a basic education and the right to a safe environment have been set out above.<sup>350</sup> In addition to the positive duties referred

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342 Sec 3(3) of the Policy Act.

343 After consultation with stakeholders such as the organised teaching profession, and with the concurrence of the Minister of Finance in so far as the policy involves expenditure from the State Revenue Fund (sec 5(1) and (2) of the Policy Act).

344 "School" means a pre-primary, primary or secondary school (sec 1 of the Policy Act).

345 "Student" means any person enrolled in an education institution (sec 1). For the meaning of "education institution", see fn 338 above.

346 The Policy Act, sec 3(4).

347 In terms of sec 16 of the Schools Act, the *governance* of every public school is vested in its governing body, while the professional *management* of a public school must be undertaken by the principal under the authority of the Head of Department.

348 The Policy Act sec 3(4)(g).

349 Ibid sec 1. See also fn 337 above.

350 Par 3.40-3.40.1 above.

to and the fact that the right to a safe environment would require the state to take (reasonable) economic measures, it is further accepted that the obligation to ensure the achievement of rights exists independently of resources.<sup>351</sup> Regardless of constraints on resources, the state will have to demonstrate that it is taking steps to realise the rights in question. The state has a "minimum core obligation" that would ensure, at the very least, minimum essential levels of the protected rights. Failure will constitute a prima facie breach of guaranteed rights. Every effort has to be made to use all resources that are at its disposal in an effort to satisfy, as a matter of priority, those minimum obligations. Vulnerable members of society, can and must be protected by the adoption of relatively low-cost targeted programmes.<sup>352</sup>

3.53 According to section 34 of the Schools Act, the state must fund public schools from public revenue on an equitable basis in order to ensure the proper exercise of the rights of learners.<sup>353</sup> Section 12 of the Act further provides that the MEC (of a province who is responsible for education in that province) must, provide public schools<sup>354</sup> for the education of learners out of funds appropriated for this purpose by the provincial legislature.<sup>355</sup> The state must, on an annual basis, provide sufficient information to public schools regarding the funding referred to, to enable public schools to prepare their budgets for the next financial year.<sup>356</sup> In terms of the Act the Minister of Education may moreover determine norms and minimum standards for the granting of subsidies to independent schools.<sup>357</sup>

3.53.1 It is further provided that a governing body of a public school must take all reasonable measures within its means to supplement the resources supplied by the state in order to improve the quality of education provided by the

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351 Cf par 3.40.1 above.

352 Cf De Vos 1997 **SAJHR** 97-98.

353 The Schools Act sec 34(1).

354 The provision of public schools may include the provision of hostels for the residential accommodation of learners (The Schools Act sec 12 (2)).

355 The Schools Act sec 12(1).

356 Ibid sec 34(2).

357 Ibid sec 48(1).

school to all learners at the school.<sup>358</sup> This would have to be done from the school fund (which would include school fees and voluntary contributions).<sup>359</sup>

3.53.2 Section 3(4) of the Policy Act provides that the Minister of Education may in general determine national policy for the financing, management, governance and well-being of the education system. Particularly, he may determine national policy for the funding of education institutions<sup>360</sup> and such policy should be directed toward cost-effective use of education resources and sustainable implementation of education services.<sup>361</sup>

3.53.3 From the above exposition of the statutory provision it is deduced that the state should facilitate the implementation of a national policy on HIV/AIDS for schools by providing funding required for such implementation.<sup>362</sup> Indeed HIV/AIDS education represent an investment in the country's future for which the state itself is duty bound to make adequate provision. It would however, not be wrong, to expect a governing body to contribute to this if it is within its means to do so.<sup>363</sup>

+ ***Practical implementation***

3.54 As regards responsibility for the practical implementation of a national policy on HIV/AIDS at each school, the principal,<sup>364</sup> as the professional manager of a school in terms of the Schools Act,<sup>365</sup> would be the proper person to take responsibility.

358 Ibid sec 36.

359 Ibid sec 37(1), (2) and (6). Sec 37(6) *inter alia* provides that the school fund must be used only for educational purposes, at or in connection with the school; the performance of the functions of the governing body; or another educational purpose agreed on between the governing body and the Head of Department.

360 The Policy Act sec 3(4)(g).

361 Ibid sec 4(n).

362 Cf also De Vos 1997 **SAJHR** 97-98.

363 Eg by raising money for additional first aid kits. Cf sec 36 of the Policy Act.

364 I e the educator appointed or acting as the head of a school (sec 1(xv) of the Schools Act).

365 The Schools Act sec 16(3).

\* **Possible mechanisms for enforcement of a national policy on HIV/AIDS in schools**

3.55 The Policy Act provides for the annual monitoring and evaluation of standards of education by the Department of Education, in co-operation with the provincial departments of education. The object is to assess progress in complying with the provisions of the 1996 Constitution and with national education policy.<sup>366</sup> The Department prepares and publishes a report on the results of each investigation after providing an opportunity for the competent authority to comment.<sup>367</sup> If this report indicates that the standards of education do not comply with the 1996 Constitution or with national policy, the Minister is required to inform the provincial political head of education concerned and require the submission within 90 days of a plan to remedy the situation. This plan is prepared by the provincial education department in consultation with the national Department of Education, and tabled in Parliament with the Minister's comments.<sup>368</sup>

3.56 In addition, the Educators' Employment Act 1994<sup>369</sup> provides for the discharge of an educator on account of incompetence or inability to perform the duties attached to his or her post, and on account of misconduct. (Misconduct is defined as contravening or failing to comply with any provision of the Act or any law relating to education, and as negligence or indolence in the performance of duties.<sup>370</sup>) Other action can include transfer to another post and even lowering of salary or rank or both.<sup>371</sup> It has to be borne in mind, however, that this Act does not apply to educators employed in independent schools. These educators however constitute a small minority of educators in South Africa.<sup>372</sup>

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366 The Policy Act sec 8(1) and (3).

367 Ibid sec 8(5).

368 Ibid sec 8(6) and (7).

369 Proclamation 138 of 1994, sec 8(1)(d).

370 Ibid sec 12(1)(a) and (d).

371 Ibid sec 19.

372 According to the latest verified statistics (those for 1995) of the Department of Education 8 359 educators are employed in independent schools while 253 328 educators are employed in public schools (figures

3.57 Thirdly, a Code of Conduct was adopted by SACE<sup>373</sup> and will eventually apply to educators registered with SACE. It is envisaged that all educators<sup>374</sup> (excluding educators in independent schools, independent colleges, universities and technikons<sup>375</sup>) will register with SACE in the course of 1998.<sup>376</sup> Although educators in independent schools, independent colleges, universities and technikons fall outside the definition of educators obliged to register, they are nevertheless invited to also register. It is envisaged by SACE that the Code of Conduct will become operative in June 1998. Complaints against educators registered with SACE may be investigated, a fine of up to R1 000 may be levied and an educator's name struck from the register if he or she is found guilty of a breach of the Code - which implies that such educator can no longer teach in a public school in South Africa. By registering, educators undertake, among other things, to respect the fundamental rights of learners, (including their right to privacy and confidentiality), to help each learner attain his or her full potential, to take reasonable steps to ensure the safety of learners, not to be negligent or indolent in the performance of their professional duties, to recognise that schools serve their communities, to accept their professional obligation towards the education profession and to accept the disciplinary powers of SACE.<sup>377</sup> Although the Code will not be applicable to educators in independent schools (unless they register of their own accord with SACE), the Code

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made available to the researcher on 16 June 1997 by Mr F Kruger, Directorate: Labour Relations in the Department of Education).

373 The decision to establish SACE (the South African Council for Educators) was taken in the Education Labour Relations Council in 1994. This was done in terms of sec 12(5)(a)(xiv) of the Education Labour Relations Act 146 of 1993. This Act has been repealed in its entirety by the Labour Relations Act, 1995, but the Education Labour Relations Council continues to exist as a bargaining council. SACE was established as a statutory body under GG Notice No 16037 of 17 October 1994. The primary role of the Council is the maintenance and enhancement of professional standards. It seeks to do this by establishing minimum criteria for the registration of educators, maintaining a register of educators eligible for appointment, and exercising its disciplinary powers. The 48 members of the Council represent the Department of Education and the organised teaching profession (see **SACE Brochure 1** [available from the Chief Executive Officer: Mr Reg Brijraj, SACE, PO Box 8228, Pretoria 0001]).

374 As defined in the Educators' Employment Act, 1994 (as amended by sec 63 of the Schools Act).

375 These categories are not covered by the definition of "educational institution" in the Educators' Employment Act, which definition in turn is used to define "educator". See also **SACE Brochure 1**.

376 Although the **SACE Code of Conduct** mentions the cut-off date of end 1997, this date was extended and educators are still registering with SACE. Registration certificates will only be issued by SACE as from middle June 1998 when it is envisaged that the Code will become operative (information supplied by Ms C Ngobeni, Registrar of SACE on 19 March 1998).

377 **SACE Code of Conduct.**

is likely to carry moral authority even in the case of such educators.

\* **The position of independent schools**

3.58 Although the definition of "education institution" in the Policy Act is wide enough to include independent schools, and the national policy may conceivably be made applicable to independent schools by the Minister of Education, there is at present no mechanism by which to ensure compliance with the policy in independent schools. The Educator's Employment Act does not apply to educators in independent schools. Nor does SACE's Code of Conduct. Independent schools will of course be free to adopt the policy of their own accord.

3.58.1 A mechanism whereby compliance with the proposed policy could be ensured in the case of independent schools is for the relevant MEC to determine compliance with the national policy to be a ground on which the registration of an independent school may be granted.<sup>378</sup> Such determination will have to be done by notice in the Provincial Gazette.<sup>379</sup> The Commission recommends in paragraph 6.26 below that this route should be followed.

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378 Cf sec 46(2) of the Schools Act. See also fn 210 above.  
379 Ibid.

4 PRELIMINARY RECOMMENDATIONS IN DISCUSSION PAPER  
73

4.1 The adoption of a national policy on HIV/AIDS in schools was proposed in Discussion Paper 73. The motivation for this is evident from Chapter 3 above.<sup>380</sup>

4.2 It was pointed out in Discussion Paper 73 that, in order to be effective, the policy will require uniformity. It therefore needed to be embodied in a national statutory instrument.<sup>381</sup> As stated earlier, the 1996 Constitution provides that in such an event, national legislation may prevail over any existing and conflicting provincial legislation.<sup>382</sup>

4.2.1 From the discussion in Chapter 3 above it was clear that the Minister of Education may determine national policy on HIV/AIDS for educational institutions which, it was submitted in Discussion Paper 73, would include both public and independent schools. The Policy Act further provides for the publication, implementation and monitoring of such national policy.<sup>383</sup> The project committee was of the view that this should be done, as envisaged in the Policy Act, after prescribed consultation with various bodies and the necessary publication have taken place.<sup>384</sup>

4.3 However, in order to ensure broad community participation, and in acknowledging the different needs of different school communities to enunciate their own ethos and values with regard to HIV/AIDS, it was recommended (and provided for in the proposed national policy contained in Discussion Paper 73) that the governing body of a school may adopt an HIV/AIDS policy at school level to give operational effect to the

380 See especially par 3.50-3.50.3 above.

381 Cf par 3.51.1-3.51.4 above.

382 Sec 146 of the 1996 Constitution.

383 Sec 3 deals with the determination of policy, sec 4 deals with the directive principles for national education policy, sec 5 sets out requirements with regard to consultation which must take place before policy is determined, sec 7 deals with publication of policy, and sec 8 deals with monitoring and evaluation of education and compliance with national policy.

384 Cf The Policy Act sec 7.

national policy.

4.3.1 If the Minister of Education determines, publishes and implements national policy as envisaged, it will apply to every public school.<sup>385</sup> The Schools Act provides that governing bodies of public schools must, among other functions, promote the best interests of the school and strive to ensure its development through the provision of quality education for all learners at the school.<sup>386</sup> A governing body also has to discharge functions as determined by the Minister of Education or the MEC.<sup>387</sup> The functions of the governing body of a school could therefore include the adoption of an HIV/AIDS policy for a specific school provided however that the policy does not infringe upon the norms and minimum standards of national policy determined by the Minister of Education.

4.3.2 The project committee was of the view that, apart from the composition of governing bodies as prescribed by the Schools Act,<sup>388</sup> a public health official, medical doctor or health care worker, and other community representatives could also usefully be co-opted in implementing an HIV/AIDS school level policy.<sup>389</sup> It was consequently proposed that a Health Advisory Committee (a committee of the school governing body) could be established on which representatives of the medical or health care professions and the community, together with members of the academic and administrative staff, and representatives of the parents could serve. It was considered that a Health Advisory Committee could review the school level policy on HIV/AIDS (including the provisions on universal precautions and those in respect of

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385 Cf sec 3(3) of the Policy Act as well as par 3.51 et seq above.

386 Governing bodies may further apply to the Head of Department to be allocated other functions consistent with the Schools Act and any applicable provincial law (see sec 20(1)(a) and sec 21(1)(e)).

387 Sec 20(1)(m) of the Schools Act.

388 Learners in secondary schools (from the eighth grade) have to be represented in the governing body (sec 23(2)(d) of the Schools Act). Governing bodies further have to comprise members of the academic and administrative staff, and representatives of the parent and student bodies.

389 According to sec 23(6) of the Schools Act a governing body may co-opt a member or members of the community to assist it in discharging its functions. Such co-opted member(s) would however have no voting rights (sec 23(8)).

contact sport) from time to time, and could advise the governing body on this.

4.3.3 It was thus envisaged that a national policy on HIV/AIDS in schools would constitute a set of basic principles from which the governing bodies of schools would not be allowed to deviate while the school level policy would reflect the needs, ethos and values of a specific school and its communities within the framework of the national policy. It was provided that in the absence of a school level policy the national policy would apply.

4.4 The proposed national policy covered admission to schools, school attendance, universal precautionary measures, and education on general health and safe lifestyles, of which sexuality education is to form part. The project committee was of the view that HIV/AIDS education would fit in comfortably with the Department of Education's curriculum on life skills or life orientation for schools.

4.5 The chief focus of the policy was considered to be children under 18 years<sup>390</sup> and it was recommended that it should therefore be made applicable to all schools (public and independent) as defined in the Schools Act: that is schools admitting learners between grades zero and twelve. It was noted that the definition of "education institution" in the Policy Act encompassed too many and varied institutions to be of use in defining a target group for the proposed policy. This definition includes, among other institutions, also distance and community education institutions. The Policy Act, as well as the Schools Act, in any event does not apply to university and technikon education.

4.6 It was the project committee's view that the national policy need not at this stage expressly provide for condom distribution in schools since this issue is regarded as highly controversial and in some communities as offensive. However, it was acknowledged that the 1996 Constitution expressly provides for the right to have access to "reproductive health care".<sup>391</sup> The proposed national policy therefore endeavoured to reflect this general

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390 Cf sec 28(3) of the 1996 Constitution.

391 Cf sec 27(1)(a) of the 1996 Constitution.

constitutional entitlement. It was further submitted that if necessary, provision could be made for condom distribution by the governing body in a school level policy.

4.7 The proposed policy focussed on the principle of non-discrimination in respect of learners. It therefore did not deal with issues concerning employment in education. It was submitted that most of these issues are adequately dealt with in existing legislation.<sup>392</sup> It was noted that the South African Council for Educators was at the time attending to a policy for educators with HIV.<sup>393</sup> A first draft for a National Policy on HIV/AIDS for Educators has in fact since become available.<sup>394</sup>

4.8 The proposed policy did not deal with other diseases, but only with non-discrimination in the context of HIV/AIDS. In this regard the project committee submitted that the scale of the AIDS epidemic is singular and the stigma and discrimination associated with it are such that special measures are required.

4.9 The proposed policy also did not directly address problems in the school environment associated with HIV infection and intravenous drug abuse. It was suggested that this issue could possibly be dealt with in a Code of Conduct for learners to be developed by governing bodies.

4.10 Although all previous policy guidelines on HIV/AIDS sexuality education<sup>395</sup> allowed parents to withdraw their children from such education sessions, the project committee was of the view that, in view of the singular urgency of the matter, HIV/AIDS education had to be made part of the compulsory curriculum.

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392 The Educators' Employment Act (Proclamation 138 of 1994) and the Labour Relations Act 66 of 1995 (cf sec 2) deal with the rights of educators as employees. Cf also the Basic Conditions of Employment Act 75 of 1997. The South African Law Commission's Second Interim Report on Aspects of the Law Relating to AIDS contains proposals to prohibit pre-employment HIV testing except in narrowly defined circumstances. The Commission's First Interim Report on Aspects of the Law Relating to AIDS (cf par 1.2 above) dealt with universal work place infection control measures (universal precautions) which will also apply to educators and other school staff.

393 Cf departmental letter 1/2/3 of 23 April 1997 from the Director-General, Department of Education addressed to Mr W Henegan, Secretary of the Commission.

394 See par 6.29.2 for more detail.

395 Cf fn 33 above.

4.11 On its assumption that the definition of "schools" in the Schools Act does not in general include school hostels,<sup>396</sup> and in view of the fact that the Policy Act applies to institutions providing "education" and not accommodation as such, the project committee was of the view that the proposed policy should apply primarily to schools and not also to school hostels. The proposed policy's underlying principles would nevertheless be clearly applicable. The policy did therefore not directly address additional measures which may be necessary in respect of cohabitation of learners under residential circumstances in school hostels.

4.12 The proposed national policy in Discussion Paper 73 included the following principles:

- \* Compulsory testing of learners as a prerequisite for admission to any school, or any unfair discriminatory treatment (for instance by refusing continued school attendance solely on the basis of the HIV status of the learner), is not justified.
- \* However, it was recognised that special measures in respect of learners with HIV may be necessary. These must be medically indicated or in the learner's best interests.
- \* Learners' rights in respect of privacy were confirmed: Where AIDS-related information is disclosed to the educational authorities, the policy provided that, except where statutory or other legal authorisation exists, it may be divulged only with the written consent of the learner (above the age of 14 years) or in other cases with that of his or her parent or guardian.
- \* The needs of learners with HIV should, as far as is reasonably practicable, be accommodated within the school environment.

- \* All learners have a right to be educated on AIDS, sexuality and healthy lifestyles, in order to protect themselves against HIV infection. The policy recognised the need for consultations with parent communities in order to ensure that sexuality education will accord with the community ethos and values. The policy required that information be given in an accurate and scientific manner.
  
- \* Universal precautions should be implemented by all schools to further minimise the negligible risk of transmission of HIV in the school environment. The policy contained specific provisions on participation in contact sport.

4.13           The following draft policy was included in Discussion Paper 73 for comment, and especially for comment on whether it should also apply to school hostels, and if so, whether additional policy measures are necessary in the latter regard:

**NOTICE NO ... OF 1997****DEPARTMENT OF EDUCATION****PROPOSED NATIONAL POLICY ON HIV/AIDS FOR SCHOOLS**

I, Sibusiso Mandlenkosi Emmanuel Bengu, Minister of Education, hereby give notice in terms of section 3 of the National Education Policy Act, 1996 (Act No. 27 of 1996) that, after consultation with such appropriate consultative bodies as has been established for that purpose in terms of section 11 of that Act or any applicable law, I have determined the national policy to be applied in respect of HIV/AIDS for schools as set out in the Schedule hereto.

**SCHEDULE****NATIONAL POLICY ON HIV/AIDS FOR SCHOOLS**

There are no known cases of the transmission of HIV in the educational setting. 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 that these fluids can cause transmission of HIV.

Because of the increase in infection rates, learners with HIV/AIDS will increasingly form part of the school population. More and more children born with HIV will, with better

medical care, reach school going age and attend primary schools. Indications that young people are sexually active, mean that increasing numbers of learners attending secondary schools might be infected. Intravenous drug use may also become an increasingly important source of HIV transmission among learners. Recipients of infected blood transfusions, primarily haemophiliacs, may also be present at schools.

It is impossible to know who is infected and who not. Even if mandatory screening for HIV of all learners were implemented, it would be impossible to know with certainty who were infected and who not, or to effectively exclude infected (or subsequently infected) learners.

Children 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. Their infection as such does not expose others to significant risks within the educational setting. However, if it is ascertained that an infected learner poses a "medically recognised risk" to others owing to secondary infections, appropriate measures may be taken.

The negligible risk of transmission of HIV can be further minimised by following standard infection control procedures and good hygiene practices under all circumstances. In the educational setting this means that **all** blood, open wounds, breaks in the skin, grazes and infected skin lesions, as well as all body fluids, should be handled in a prescribed manner by a member of staff. Strict adherence to universal precautions under all circumstances 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.

Good hygiene practices also include that learners with illnesses such as measles, whooping cough and mumps should be kept from school to protect all other learners, and especially those whose immune systems may be impaired by HIV.

Learners should receive education about HIV/AIDS in the context of life skills education. HIV/AIDS education should not be presented as an isolated learning content. The purpose of education about HIV/AIDS is to prevent HIV infection and to allay excessive

fears of the epidemic. Education should ensure that learners acquire the age-appropriate knowledge and skills they will need to adopt and maintain behaviour that will minimise the risk of infection. Education will include information on the sexual transmission of HIV and the dangers of drug abuse, which will be offered in a scientific manner. In the elementary classes, education about HIV/AIDS should be provided by the regular educator, while in secondary grades the guidance counsellor would ideally be the appropriate educator. Because of the sensitive nature of the learning content, the educator selected to offer this education should be specifically trained, should feel at ease with the content and should be a role-model with whom learners easily identify.

In accordance with the constitutional guarantees of the right to a basic and further education, the right not to be unfairly discriminated against, the right to freedom of access to information, the right to freedom of conscience and the right to privacy, the following policy shall constitute national policy.

### **Definitions**

1. In this policy any word or expression to which a meaning has been assigned in the South African Schools Act, 1996 (Act No. 84 of 1996), shall have that meaning.

### **Admission and testing**

2. (1) No learner will be denied admission or continued attendance at school on account of his or her HIV status or perceived HIV status.
- (2) The testing of learners for HIV as a prerequisite for admission or continued attendance is prohibited.

### **No unfair discrimination**

3. (1) No learner with HIV may be unfairly discriminated against.

(2) Any special measures in respect of learners with HIV must be medically indicated or in the learner's best interests.

### **Disclosure**

4. (1) A child is entitled to the same rights in respect of the protection of his or her privacy as an adult and such rights are limited to the same extent.

(2) Although disclosure to the school principal is probably not legally enforceable (in view of the fact that the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 have never been applied and will probably shortly be replaced by new Regulations), it may generally be in the best interests of the learner with HIV (for example that special needs may be met) if the principal or other care giver is informed of his or her condition either by his or her parents or guardians or by the learner him- or herself (if the learner is above the age of 14 years).

(3) The principal or other person to whom this information was divulged, may not inform anyone else of the condition of the learner with HIV except with the informed written consent of the learner (above the age of 14 years), or his or her parent(s) or guardian. Disclosure otherwise is justified only if statutory or other legal authorisation exists therefor.

(4) Schools must inform all parents of the incidence of infectious diseases (meaning common childhood diseases) in the school, and of all inoculation programmes that are implemented at the school.

### **Attendance**

5. (1) The needs of learners with HIV or learners affected by it shall as far as is reasonably practicable be accommodated within the school environment.

(2) Learners with HIV are expected to attend classes in accordance with statutory requirements for as long as they are able to function effectively. They have to supply written reasons for any absence.

(3) Academic work should be made available for personal study at home, and parents should be allowed to educate learners with HIV when they become incapacitated through illness, or if they pose a medically recognised health risk to others (for instance if such a learner has a serious secondary infection which cannot be treated and could be transmitted to other persons in the course of day to day contact).

(4) Learners with HIV who develop HIV-related behavioural problems or neurological damage could, if necessary, be accommodated within alternative structures in the same institution.

### **Education on HIV/AIDS**

**6.** (1) A continuing HIV/AIDS education programme will be implemented at all schools for all learners, educators and other members of staff. Parents and guardians will be informed about all HIV/AIDS education, the learning content and methodology to be used. They should be invited to participate and should be made aware of their role as sexuality educators at home. Other major role-players in the community (for example religious and traditional leaders) should be acknowledged and informed about the HIV/AIDS education offered in schools.

(2) Age-appropriate education on HIV/AIDS will form a part of the curriculum and will be integrated in the life skills education programme for primary and secondary school learners. The education programme will be aimed at giving information on the reality of HIV, AIDS and STD (sexually transmitted diseases) in South Africa and at developing the life skills necessary for the prevention of STD, HIV infection and teenage pregnancy. The information will be given in an accurate and scientific manner.

(3) Learners will be encouraged to make use of health care and counselling facilities including reproductive health care.

(4) A culture of non-discrimination towards people with HIV will be cultivated. Learners will be taught how to behave towards and live with a person with HIV. Social norms against drugs, sexual abuse and violence will be promoted.

### **Universal precautions**

7. (1) All schools will implement universal precautions to further minimise the negligible risk of transmission of all blood-borne pathogens, including HIV, in the educational setting. **All** blood, open wounds, breaks in the skin, grazes and infected skin lesions, as well as all body fluids, should be treated as potentially infectious.

(2) All schools will have available at least two first aid kits each of which contains two large and two medium pairs of disposable latex gloves, two large and two medium pairs of rubber household 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 cardio-pulmonary resuscitation mouth piece or a similar device with which mouth-to-mouth resuscitation could be applied without any contact being made with blood or other body fluids. In addition, each educator should preferably have a pair of rubber household gloves in his or her classroom.

(3) The contents of the first aid kits will be regularly checked and used items should be replaced immediately.

(4) The kits will be stored in one or more selected (class) rooms in the school.

(5) All bleeding wounds should be treated and cleaned while wearing latex gloves, and should be covered well with a dressing or plaster. However, emergency treatment should not be delayed because gloves are not available. Bleeding can be managed by compression with material that will absorb the blood, for example, a towel. People who have skin lesions should not attempt to give first aid when no latex gloves are available.

- (6) If blood has contaminated a surface, that surface should be cleaned with a fresh clean bleach solution and the person responsible for this should wear latex gloves. Other body fluids (such as urine, vomit or diarrhoea) should be cleaned up in similar fashion.
- (7) Blood-contaminated material should be sealed in a plastic bag and incinerated or sent to a disposal firm.
- (8) Skin exposed accidentally to blood should be cleaned promptly with water and disinfectant.
- (9) All personnel should be trained on the correct procedure to be followed and on the appropriate use of the various devices contained in the first aid kit. Learners, especially in primary school, should not handle emergencies such as the nosebleeds of friends, on their own.
- (10) If there is a biting or scratching incident where the skin is broken, the wound should be squeezed gently to make it bleed, and should then be washed thoroughly with warm water and disinfectant, and covered with a waterproof plaster. The injured person should be given an anti-tetanus injection.
- (11) (a) No learner should participate in contact sport, such as rugby or boxing, with an open wound or infected skin lesion.
- (b) If bleeding occurs during such a contact sport, the player should be taken off the field and should be appropriately treated.
- (c) Bleeding should be controlled, wounds or lesions should be cleaned with warm water and disinfectant, an antiseptic applied and the wound covered with a non-porous dressing. Only then may the player resume playing and only for as long as the dressing remains effective.
- (d) All change rooms or locker rooms should have a fully equipped first aid kit.

**School level policies**

**8.** (1) Governing bodies of schools may adopt an HIV/AIDS policy to give operational effect to the national policy. Such school level policy will reflect the needs, ethos and values of the school and the community. The national policy constitutes a set of basic principles from which the governing bodies of schools may not deviate. In the absence of a school level policy the national policy applies.

(2) It is strongly recommended that each school should establish its own Health Advisory Committee as a committee of the governing body. This committee will consist of members of the academic and administrative staff, representatives of the parents and guardians and a medical doctor or a public health officer.

(3) This committee should be set up and chaired by the principal. The committee should modify and/or approve the school's policy on HIV/AIDS and review it from time to time, especially if new scientific knowledge about HIV becomes available. This committee should advise the governing body on health care matters in the HIV/AIDS field.

**Where policy may be obtained**

**9.** This policy may be obtained from The Director-General, Department of Education, Private Bag X895, Pretoria, 0001.

## 5 COMMENTS ON DISCUSSION PAPER 73

### A) **CONSULTATION WITH INTERESTED PARTIES**

5.1 Discussion Paper 73 was distributed to more than 1 237 identified parties during August 1997. These include persons and bodies concerned with HIV/AIDS and children's issues; non-governmental organisations concerned with human rights and HIV/AIDS issues; Heads of Provincial Education Departments; provincial ministers responsible for education and for health; representatives of the organised educators' profession; educational institutions; selected school principals from the different provinces; the medical and health professions; women's organisations; relevant research institutions and government departments; and the South African legal fraternity.

5.2 The Department of Education, which assisted in developing the Discussion Paper and the draft national policy, was formally approached for comment and for assistance to ensure that the Commission's preliminary recommendations reach as many stakeholders as possible. This was done especially with the view to ensure liaison with the Heads of Provincial Education Departments and the Council of Education Ministers.

5.3 The release of the Discussion Paper was advertised in the **Government Gazette** and by way of a media statement. A further 44 copies of the paper were subsequently distributed.

5.4 The closing date for comment was 30 September 1997, extended to 15 October 1997. Comments received after the extended date were also taken into account.

5.5 Written comments were received from 66 respondents. These consisted mostly of persons and bodies concerned with children's issues. Comments include those received from the Departments of Education, Health, and Welfare; welfare organisations concerned with children's issues; the health, medical and educators' professions; organisations active in the fields of human rights and HIV/AIDS; three provincial

education departments; school principals; educational institutions; health departments of local authorities; non-governmental organisations concerned with HIV/AIDS and human rights issues; and research institutions. Some of the comments reflect the views of interest groups of considerable extent while other represent the views of private individuals, researchers or small organisations. Significant and extensive comments were, for instance, received from the Religious AIDS Programme and the youth organisations and religious communities affiliated to and in support of the Programme.

5.6 School principals and parents of learners with HIV were included in the consultation process.

5.6.1 Discussion Paper 73 and the draft policy were distributed to 387 identified school principals of various types of schools in the different provinces. The Paper was also submitted for comment to 44 educational institutions (universities and educators' training facilities). Although only two school principals and five university faculties of education responded formally to the Discussion Paper, 23 of the 66 persons and bodies responding to the Discussion Paper are directly involved in education and training of learners or educators. Prof Christa van Wyk (project committee member who assisted the Commission in compiling this interim report) took part in a discussion with school principals where the proposed policy was debated.<sup>397</sup> Issues raised by these principals (referred to as Greater Pretoria school principals) are included in the overview of comments below.

5.6.2 Parents of learners with HIV were reached through the National Association of People Living with AIDS (NAPWA). The Association's comments were informed by parents of learners with HIV as well as parents with HIV who have school going children. NAPWA's comments are integrated in the discussion below.

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<sup>397</sup> Life Skills and HIV/AIDS Training Session of 20 school principals from Atteridgeville, Laudium, Pretoria West and Pretoria Central presented by the Gauteng Education Department on 17 October 1997.

5.7 A list of respondents is attached as ANNEXURE A.

**B) COMMENT ON THE NECESSITY OF ENACTING A NATIONAL POLICY ON HIV/AIDS IN SCHOOLS**

5.8 In general, the comments reflect overwhelming and unanimous support - many without any reserve - for the necessity of a national policy on HIV/AIDS in schools.

5.8.1 Sixty-five of the 66 commentators expressly recognised the need for enacting a national policy on HIV/AIDS for schools.<sup>398</sup> (The Gauteng Education and Training Council raised specific concerns with regard to the proposed policy without expressing itself either in favour of or against it.) Some commentators suggested extension of the application of the policy to tertiary and pre-school institutions while many felt that it should also apply to school hostels.

5.8.2 Many commentators lauded the Commission for its initiative in taking a step long overdue, and for its thorough research in setting out the background to the policy and formulating its contents.

5.8.3 The vast majority of commentators positively expressed their motivation for supporting the proposal: they saw it as an important step forward;<sup>399</sup> as a rational and fair foundation on which to build;<sup>400</sup> and as succeeding admirably by catering for the needs of both the individual and the school community.<sup>401</sup>

398 These include the comments of the Medical Association of South Africa (MASA); the South African Paediatric Association; the Medical Officers of Health or City Health Departments of Bloemfontein, Durban, and Cape Town; various branches of the South African National Council for Child and Family Welfare; school principals; education/health/medical departments of the Universities of Rhodes, Natal, Port Elizabeth, Western Cape, Cape Town and Durban-Westville; the National Professional Teachers' Organisation of South Africa (NAPTOSA); relevant government departments (i.e. the Departments of Education, of Health and of Welfare); and parents of learners with HIV (commenting through NAPWA).

399 Eg the comments numbered 12.

400 Eg the comments numbered 16.

401 Eg the comments numbered 34.

NAPWA commented that the parents of learners with HIV who were interviewed expressed strong support for the concept of and need for a national policy on HIV/AIDS for schools. The consensus among these parents was that a national policy is necessary to create a uniform set of guidelines to help prevent discrimination directed at learners with HIV.

5.8.4 It is significant that the Joint United Nations Programme on HIV/AIDS (UNAIDS) Intercountry Team for Eastern and Southern Africa offered overwhelmingly supportive comments in the following terms:

This is the best policy on AIDS and school(s) in the world to date ... both on non-discrimination and on (the) right to education ... it is so good that such an advanced policy comes from Africa ... you can be proud that this document will set a high standard and an example for many other countries in the world ... let's make sure the policy becomes law of the land soon!<sup>402</sup>

5.9 With the exception of two commentators, commentators were also in broad agreement with the contents of the policy. Various commentators offered detailed suggestions for further refining the policy while some raised specific concerns. The suggestions and concerns relate mostly to practical matters. These latter comments reflect recurring concerns and suggestions. The concerns and suggestions emphasised by different commentators are recorded below.

5.9.1 Two commentators found the proposed policy to be unacceptable and unrealistic. Prof M J Bondesio, Dean of the Faculty of Education at the University of Pretoria, and the South African Foundation for Education and Training (SAFET) expressed the view that the policy is flawed in that it fails to achieve a correct balance between the fundamental rights of those free from HIV and those with HIV in that it generally overemphasises the rights of the latter

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402 In a country like Rumania, for instance, which has the largest number of children with HIV in Europe, there are still no policy guidelines given by the Ministers of Education or Health relating to the admission of children with HIV to schools. Medical files, which are held by the district doctor, are on enrollment to school passed on to the school where they are not kept confidential. School staff still discriminate against children with HIV (AIDSScan December 1997 11).

group. They also felt that the policy was poorly drafted and that it contained incorrect and misleading statements. They further questioned the authority of the Minister of Education to make policy on the matter of HIV/AIDS since, according to them, section 3 of the Education Policy Act is not absolutely clear in this regard.

5.10 The government departments which are stakeholders in the debate regarding a national policy for HIV/AIDS in schools are in strong support of the proposed national policy.

5.10.1 According to the Department of Education's comments the Heads of Education Committee approved of the proposals in Discussion Paper 73. The Council of Education Ministers on 24 November 1997 approved the preliminary recommendations as set out in the Discussion Paper.<sup>403</sup>

5.10.2 The Department of Health submitted comments in strong support of the policy and its contents. It also offered suggestions for refining the policy and adding to the background information. However, the Department regarded these as "relatively minor amendments". The Department's suggestions are included below. The Director of the Department's National AIDS Programme expressly suggested that any proposed amendments be subjected to the same consultative process which resulted in the development of the Discussion Paper.

5.10.3 The Department of Welfare welcomed the initiative taken and saw a national policy as a necessity which should also apply to school hostels. The Department referred the Commission to the **United Nations Convention on the Rights of the Child (1989)** which emphasises the interests of the child above all other considerations.

5.11 Parents of learners with HIV consulted by NAPWA strongly felt that a national

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403 Departmental letter of 23 January 1998.

policy must be adopted and implemented urgently as the lack thereof has contributed to the current unacceptable situation. They stressed that the Nkosi Johnson incident is illustrative of the confusion and lack of guidance created by the absence of a policy. NAPWA further recorded that discussions with staff and parents at the school attended by Nkosi Johnson reflect a view that if a national policy had been in place, the unfortunate situation would not have occurred. It was also suggested by the Co-operative for Research and Education (CORE) and Ms Tania Vergnani of the Department of Educational Psychology of the University of the Western Cape that the consultation process be hastened so as to enable implementation of the policy as soon as possible. The National Professional Teachers' Organisation of South Africa (NAPTOSA) would like to see HIV/AIDS education to be implemented at all schools as soon as possible. The Afrikaanse Christelike Vrouevereniging (ACVV) on the other hand suggested that any HIV/AIDS policy be evaluated first in terms of a pilot project launched at a number of representative schools before it is implemented nationally.

**C) CONCERNS, AND SUGGESTIONS FOR AMENDMENT, REFINEMENT OR EXTENSION OF THE PROPOSED NATIONAL POLICY ON HIV/AIDS IN SCHOOLS**

5.12 Concerns were expressed and suggestions offered on the principles enunciated in the policy in general, the specific terms of the policy, implementation of the policy and additional matters to be included in the policy. Many commentators also responded to the Commission's expressed invitation to comment on the suitability of the proposed policy for school hostels. Recurrent concerns related to a lack of clarity on whether the policy would also be applicable to other educational institutions (for instance pre-school and tertiary institutions, reformatories, and schools of industry and schools for the handicapped); the protection of "healthy learners"<sup>404</sup> and their rights; and the practical implementation of the policy. Concerns and suggestions are recorded in more detail below.

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404 See fn 405 below.

\* **General comments on the principles enunciated in the policy**

+ *Idealistic nature of the policy and current "abnormal circumstances"*

5.13 The Catholic Institute of Education commented on the rather idealistic nature of the proposed policy in that it does not give any real attention to what schools can actually cope with. It observed that the ability of schools to cope will vary considerably, depending upon the training and experience of staff, their material and financial resources, the soundness of their administration, the background of the learners accommodated, the educator/learner ratio and overall morale of a specific school. The Institute concluded that any given school may be able to cope with a few infected learners, but be overwhelmed if the numbers become too great.

5.14 Several commentators referred to the "abnormal" circumstances under which many of our schools currently operate and requested that these should be acknowledged.

5.14.1 The Catholic Institute of Education and Greater Pretoria school principals drew attention to the caveat that the transmission of HIV "under normal circumstances" in the school environment is highly unlikely. It questions the "normality" of the circumstances under which many of our schools are presently functioning with strikes by educators and boycotts by learners, and a widespread breakdown of discipline and unacceptable behaviour by educators. In such abnormal circumstances a higher degree of sexual activity among learners (and with educators) is more likely, which enhances the danger of infection. Prof Bondesio supports this view and adds that phenomena such as child abuse, sexual relations between educators and learners, and violence would increase the risk of infection substantially. He argues that these factors would increase the numbers of learners with HIV which would in turn increase the risk of infection. These comments are supported by SAFET.

5.14.2 The AIDS Consortium stressed the need (with high levels of sexual abuse between educators and learners, and among learners in schools and hostels) for schools to be developing an ethos that is tolerant of sexual orientation and intolerant of sexual abuse and discrimination.

+ *"AIDS exceptionalism"*

5.15 The Department of Community Health of the Faculty of Medicine, University of Natal suggested that the policy should not be aimed only at learners with HIV, but rather at learners with viral diseases. The Department felt that the inclusion of "socially acceptable" diseases in the policy such as Hepatitis B and C, which require similar universal precautions, may promote the acceptability of the policy in the school environment. The City Health Department, Durban supported this and suggested that even if Hepatitis B is not included in the policy itself (for fear of confusion), prominent reference highlighting the similarities between Hepatitis B and HIV/AIDS should be included in the preface to the policy. The ACVV strongly felt that the same criteria should be applicable to both HIV/AIDS and tuberculosis.

5.16 Stressing the need for a relationship of trust within a school environment, NAPTOSA observed that many homes share with the school cases of terminal illness in the family and asked why AIDS should be different in this respect. This view was shared by the Gauteng Education and Training Council. The District Surgeons Society pointed out that HIV/AIDS is no different from similarly fatal diseases and that the school system could be brought to a standstill if other fatal diseases are given the same focus or special treatment as HIV/AIDS.

5.17 Prof Bondesio and SAFET strongly felt that the proposed policy in general overemphasises the rights of learners with HIV.

5.18 Applying the argument of AIDS exceptionalism to the terms of the proposed policy, Dr Martie Lane of the Department of Education observed that the requirement in

clause 5(2) of the policy that learners with HIV should supply written reasons for any absence, creates the impression that they alone should supply reasons for absence (while learners absent with other diseases should in practice also supply reasons). The Department of Health endorsed this.

- 5.19 With regard to AIDS education the Newlands Education Support Centre suggests that a general culture of non-discrimination towards all people - regardless of race, colour, sexual preference, gender and religion - should be encouraged by an education programme rather than focussing exclusively on HIV/AIDS. The South African National Council on Alcoholism and Drug Dependence likewise favoured an integrated approach to various health and social issues and submitted that an HIV/AIDS education programme should be "one among others" (referring to, for instance, programmes on drug abuse, smoking, alcohol, teen pregnancy and mental health) and should not be singled out as the only issue. The Council is of the opinion that this will ensure a more balanced acceptability of the introduction of HIV/AIDS education.

+ ***Rights of learners without HIV ("healthy learners"<sup>405</sup>)***

5.20 Several commentators<sup>406</sup> shared the opinion that the rights of learners without HIV should be protected. They emphasised that the policy should aim at a clear balance between the rights of learners with HIV and those without HIV.

5.20.1 The Department of Educational Psychology, University of Port Elizabeth expressed the opinion that non-discrimination is not the primary issue at stake. According to this respondent it is crucial to also consider how "healthy learners" can be protected against HIV in future. The Catholic Institute of Education and the Gauteng Education and Training Council share this view. The Institute stated that the policy lacks an approach from the point of view of "healthy learners", the school principal, and staff. It further emphasised that the policy is silent on the obligations of learners with HIV and their parents or guardians towards the school and other learners.

5.20.2 The Rector of St Mary's Diocesan School for Girls, Pretoria thought it essential that the rights of "healthy learners" be protected on an equal basis to the rights of those with HIV. The policy should therefore aim at establishing and maintaining the delicate balance between the rights of these two groups. The South African National Council for Child and Family Welfare and the Johannesburg Institute of Social Services agreed with this.

5.20.3 Prof Bondesio and SAFET are of the opinion that the proposed policy is flawed in that it fails to achieve the correct balance between the rights of "healthy learners" and those with HIV. They submitted that the negligibility of the risk of transmission in the school environment should be balanced with the seriousness and increase of the risk in view of the phenomena of child abuse, sexual relations between educators and learners and violence which plague a significant number

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405 Many respondents to Discussion Paper 73 used the term "healthy learners" to refer to learners without HIV. In this Chapter the term is used to reflect these comments.

406 See eg the comments numbered 7, 12, 17, 19, 23, 25, 26, 31, 32, 34, 53, 56 and 63.

of schools in South Africa at present. The Gauteng Education and Training Council's comments implied that should it be shown that the risk of HIV transmission in the school environment is not negligible (as is accepted in the proposed policy), the policy would not be adequate. Prof Bondesio and SAFET further submit that only certain constitutional rights are emphasised in the policy (the right to a basic education, the right not to be unfairly discriminated against, the right to freedom of access to information, the right to freedom of conscience and the right to privacy) while other rights (which would ensure a balance in also protecting the healthy school population) are absent. In the latter regard they refer to the right to bodily and psychological integrity, the right to an environment that is not harmful to health and well-being and the right to freedom of association. They conclude that an unreasonable emphasis is placed on the rights of those with HIV and that the policy falls foul of section 4(a) of the National Education Policy Act which requires that policy be directed towards the fundamental rights of "every person".

5.20.4 Mr S S Gerber, Principal of the Rosenhof High School (a school of industry) emphasised the position of the government acting in the place of the parent in such schools (where sexual activity may occur) and the rights of the healthy should be protected. The Religious AIDS Programme stressed the responsibility of learners with HIV towards healthy people and referred to the possibility of claims resulting from negligence where "healthy learners" are exposed to HIV. The Association of Professional Teachers (an affiliate of NAPTOSA) commented that the proposed policy did not appear to give enough protection to "healthy learners", educators and support staff who will be in daily contact with learners with HIV. The Association enquired about the liability of parents or guardians and principals in the case of non-disclosure of AIDS-related information or lack of protective action in instances where "healthy learners" or educators are infected with HIV. The Child, Family and Community Care Centre of Durban emphasises that the proposed policy is silent on the issue of individuals becoming infected in the school environment despite all precautions. The Dutch Reformed Ministry of Caring stressed the need for clarity in the policy on the

responsibility of parents or guardians if their sexually active children expose others to HIV in an irresponsible or even intentional way. The Gauteng Education and Training Council likewise required clarity on legal responsibility in the case of educators or learners becoming infected in the course of duty or through activities related to the school (for instance, an injury where blood flows, a sexual act, or hospital treatment following an accident at school).

5.20.5 School principals from Greater Pretoria questioned how learners who are sexually active could be dealt with in the school environment. They asked clarification on the role of the school principal as protector of the rights of "healthy learners".

5.20.6 The City of Cape Town Medical Officer of Health stated that learners and staff with pulmonary tuberculosis have to be aware of the potential risk they pose for learners without HIV in the instance of non-compliance with treatment for tuberculosis.

5.20.7 The Western Cape Education Department has already implemented an AIDS policy which requires that the learner with HIV and his or her physician must "devise preventive and safety measures to protect healthy persons, but also meet the needs of the learners with HIV". This policy further stresses that "care must be taken that all the procedures are medically, ethically, educationally and legally sound".

**\* Comments on the terms of the proposed policy**

5.21 Many commentators offered specific suggestions for reformulation of the proposed clauses. Several suggestions pertaining to clarification of terms were incorporated in the revised policy attached as ANNEXURE B.

+ *Preamble*

- 5.22 The Department of Health suggested that a brief description of the natural course of HIV disease in children, in addition to what is already provided for, should be included in the policy. NAPWA supported this, especially with regard to the impact of HIV infection on physical growth and mental development in learners. the Department of Health further submitted that the statement referring to haemophiliacs and recipients of infected blood should be balanced against the fact that in South Africa Factor XII is heat treated and blood for transfusions is as safe as it is possible for it to be, and that these are thus insignificant sources of HIV infection.
- 5.23 The Western Cape ATICC suggested that reference also be made in the preamble to learners at risk of contracting HIV through child abuse and rape given the high rates of sexual abuse in our country.
- 5.24 The South African National Council for Child and Family Welfare requested clarity on what are considered to be the special needs of learners with HIV and how these differ from those of other learners.
- 5.25 The Department of Health proposed that guidelines and/or protocols should be provided on what constitutes a "medically recognised risk" owing to secondary infections and the appropriate measures that may be required to be taken in order to prevent arbitrary decisions in this regard. The North West Province Department of Education supported this.

+ ***Admission and testing (Clause 2)***

5.26 All parents of children with HIV consulted by NAPWA were opposed to the testing of learners as a prerequisite for admission to school, not only on the grounds that the practice is discriminatory, but also because they believe that testing for HIV should be voluntary and at the request of the individual concerned. They stressed that where certain schools have directed learners to service organisations for HIV testing (as a prerequisite for admission) in the past, this has caused great distress and anxiety. The Department of Health suggested that clause 2(2) should make HIV testing inadmissible for whatever reason (for instance before granting scholarships to learners).

5.27 The South African National Council for Child and Family Welfare submitted that even though HIV testing should not be a prerequisite for admission to schools, a medical report for admission to school should be a prerequisite at all levels. This should apply also to learners with HIV.

+ ***No unfair discrimination (Clause 3)***

5.28 The Institute for Human Rights Education stressed the need to cultivate a culture of non-discrimination and suggested that clause 3(2) should provide for education of the school community on how to relate to learners and educators with HIV.

5.29 The North West Department of Education suggested that the criteria of "fairness" be removed throughout the policy. The Department of Health supported this in specifically requesting that the word "unfairly" be removed in the provision that no learner with HIV may be "unfairly" discriminated against (clause 3(1)).

5.30 Parents of learners with HIV commenting through NAPWA supported the inclusion of clause 3(4) which requires schools to inform all parents of the incidence of infectious diseases in the school and of all inoculation programmes. They requested that special attention must be given to inoculation programmes, especially where the

inoculation involves live vaccines, which could be potentially dangerous for HIV positive recipients.

+ *Disclosure of AIDS-related information (Clause 4)*

5.31 A predominant number of respondents submitted that HIV status of learners should be disclosed in some or other way.<sup>407</sup>

5.31.1 The Catholic Institute of Education expressed the opinion that the view recorded in the text of the Discussion Paper that the legal and ethical duty of confidentiality is not absolute and that disclosure can be justified if it would be in the overriding public interest, seems to be in contradiction with clause 4 of the proposed policy. According to the Institute it appears that "healthy learners" and parents may have a constitutional right to know if a person at the school has HIV in terms of "healthy learners'" fundamental right to life. The Institute suggested that something stronger should be added to clause 4 on the *duty* of parents or guardians (or the learner above the age of 14) to inform the school principal and other care givers if their child has HIV.

5.31.2 The Rector of St Mary's Diocesan School for Girls, Pretoria submitted that the policy should insist on disclosure on a **need to know** basis to ensure special treatment for the learner with HIV and adequate protection for the "healthy learner". Although not expressly favouring disclosure, the Department of Health also suggested that the policy refer to the concept of "need to know" in the context of disclosure.

5.31.3 Most parents of learners with HIV consulted by NAPWA would be supportive of disclosing the learner's HIV status to both the school principal and the learner's (class)educator, or of them being aware of the learner's HIV status.

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<sup>407</sup> See eg the comments numbered 6, 7, 12, 14, 15, 19, 25, 34, 37, 38, 49, 50 and 66.

These parents felt that in addition to the principal being informed (by either the parents or the learner) they would in most instances prefer to also inform the class educator - particularly in the junior grades where learners generally have one assigned class educator. It was felt that the class educator is better placed to support and monitor learners than the school principal.

#### Reasons in support of disclosure

5.32 The main reasons forwarded for disclosure of AIDS-related information in comments, are: the need to confirm the relationship of openness and trust within the school; proper regulation of contact sport; promotion of a better understanding of and support of learners with HIV; and protection of the "healthy learner". A number of commentators also referred to the need for clarity with regard to liability in the event of HIV transmission.

5.32.1 The Rhodes University Education Department stated that principals and educators need to be trusted and treated as professionals. It would be impossible for professionals to act professionally if they are not in possession of crucial information. NAPTOSA agreed that a relationship of trust with the school is necessary. The Association emphasised that many homes share with the school cases of terminal illness in the family and asks why AIDS should be any different. They suggested that disclosure be encouraged.

5.32.2 The Association of Professional Teachers also advocates a relationship of openness and trust, especially with regard to the proper regulation of contact sport. The Association maintains that if a principal excluded a learner with HIV from contact sport and is unable to supply reasons for such action, it will lead to speculation on the part of educators and learners and that such speculation could be harmful for the learner with HIV as well as his family. The Gauteng Education and Training Council supported this view. The Council added that ultimately the truth will come out. NAPTOSA observed that information regarding a learner's HIV status will become common knowledge when he or she becomes

incapacitated. The Organisation asks what effect this would have on parents, educators and others who had contact with the learner but were unaware of his or her condition.

5.32.3 The Gauteng Education and Training Council stated that any illness (including HIV) influences a learner's school performance, his or her general happiness and development. Awareness of this problem allows the school to offer the learner support and understanding. NAPWA shared this view. The District Surgeons Society felt that it is important that learners with HIV be protected against common viral infections as they are more susceptible to these than healthy people and stated that this could only be done if such learners' HIV status was known.

5.32.4 The Principal of Rosenhof High School highlighted the problems regarding confidentiality of AIDS-related information in schools of industry. Many of the learners at these schools are sexually active. These activities pose a danger of transmission of HIV and cannot be controlled due to shortage of staff. In these schools the state is in the place of the parent and the question of liability in respect of HIV transmission arises. The Gauteng Education and Training Council is of the opinion that where information is not disclosed, neither the educator, nor the school, the principal or the governing body can be held responsible for cases of transmission of HIV in the school environment.

#### Who should be informed?

5.33 The Catholic Institute of Education contends that it may be in the best interest of the learner if those dealing regularly and closely with a learner, and in large measure responsible for his or her personal growth, are informed on a **need to know** basis about anything crucial to that individual's life and growth.

5.33.1 The South African National Council for Child and Family Welfare submitted that it should be *compulsory* for parents to inform the **school principal**

in order to ensure the protection of "healthy learners". The Johannesburg Institute of Social Services and school principals from Greater Pretoria agreed with this. The South African National Council for Child and Family Welfare stressed that the need for disclosure would be even more paramount in the case of hostels and suggested that the **hostel superintendent** should also be informed. The Rhodes University Education Department is strongly in favour that either **principals or other "care givers"** should as a matter of course be informed of HIV/AIDS cases in their schools. The AIDS Legal Network however required clarity on the term "care giver". Prof Bondesio and SAFET were also concerned about the lack of clarity of this term.

- 5.33.2 The Gauteng Education and Training Council stated that an **educator**, as the person who spends most of the day with a learner with HIV, surely has a right to know that the learner has the potential to pass the infection on to him or herself or other learners. The Council was of the opinion that the parents of other learners would insist that the educator has this information. The Stilfontein Child Welfare Society suggests that the principal or **class educator** should be informed. The AIDS Law Project, although supporting the encouragement of *voluntary* disclosure, questions the emphasis being placed on the role of the principal. This organisation suggests emphasis to be placed instead on HIV-related information being disclosed to the class educator in view of the personal relationship and contact between this person and the learner with HIV, and in view of the fact that the class educator knows the exact whereabouts of each learner on a daily basis. The Department of Health also questions the need for the principal (as opposed to the class educator who is the first level of contact, and a possible carer) to be informed. Parents of learners with HIV who commented through NAPWA also expressed support for disclosing HIV status of learners to the class educator in addition to the principal.

- 5.33.3 In view of the increasing democratisation of education and participation of parent **governing bodies**, the Dental Association of South Africa submitted that governing bodies should be given "equivalent right of disclosure to

information".<sup>408</sup>

5.33.4 The Gauteng Education and Training Council is in fact of the opinion that the **entire staff** must be allowed access to this information. NAPTOSA maintained that ideally the **school** should be informed of learners who have HIV.

5.33.5 The Rector of St Mary's Diocesan School for Girls, Pretoria suggests that the "relevant authorities" to whom HIV-related information should be disclosed are the school principal, **matron or school nurse**, and **guidance teacher**. The Department of Education, Mpumalanga suggested that "relevant authorities" could include **counsellors** and **sports masters** so that learners with HIV could be fully supported and "healthy learners" protected.

#### Reasons for not favouring disclosure

5.34 A substantial minority of respondents do not support the encouragement of disclosure of HIV-related information as provided for in clause 4(2).

5.34.1 The AIDS Legal Network believes that the policy should provide in clear terms that no learner may be compelled to disclose his or her HIV status - either to the school principal or other care givers - without his or her consent or that of his or her parent or guardian if below the age of 14.

5.34.2 The Western Cape AIDS and Life Skills Forum emphasised the current climate of discrimination in relation to HIV/AIDS within SA which may not be conducive to disclosure and requested that this be recognised within the policy. The Forum suggested that this could be done by providing that each learner with HIV, or his or her parent or guardian, might want to consider the level of knowledge and prevailing attitudes of the specific principal or care giver in relation to HIV/AIDS, and determine whether their disclosure would receive

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<sup>408</sup> Presumably this meant that HIV-related information should also be disclosed to such bodies.

positive support.

5.34.3 The Western Cape ATICC is of the opinion that disclosure to a principal may not be in the best interests of a learner as principals' level of knowledge and attitudes may vary. The AIDS Legal Network and the Western Cape AIDS and Lifeskills Forum agreed with this.

5.34.4 The AIDS Legal Network added that with an educator/learner ratio of about 1 to 70 it would be impossible to meet any special needs of individual learners with HIV (which would be the main reason for disclosure).

5.34.5 The Cotlands Baby Sanctuary for Abandoned and Abused Kids queried whether disclosure would generally be in the best interests of a learner with HIV - especially if universal precautions are adhered to.

The role of an enabling environment as an alternative to compulsory disclosure

5.35 The City of Bloemfontein Medical Officer of Health stressed that a supportive and enabling environment could encourage voluntary disclosure of HIV status by infected learners themselves. The AIDS Consortium agreed with this and suggested replacing the present provision encouraging disclosure to the school principal with a recommendation to develop an enabling environment in schools which would support voluntary disclosure.

Consent to disclose

5.36 The Catholic Institute of Education remarked that the possibility of divulging information only with written consent is likely to be too slow in the case of accident or emergency.

5.37 As regards the age of consent, the Kleinmond Child and Family Welfare Society doubted whether 14-year-old learners would be able to handle the matter themselves and

suggested that parents or guardians give the necessary consent up to the age of 16 years. The Cotlands Baby Sanctuary for Abandoned and Abused Kids shared this view.

Protection of confidentiality

5.38 The Department of Community Health, Faculty of Medicine at the University of Natal requested that the consequences of unauthorised disclosure be clarified in the policy (suggestably in clause 4(3)) so that the privacy of learners is recognised as paramount. The Department of Health likewise expressed concern about the protection of confidentiality in instances where information is indeed disclosed.

5.38.1 The Faculty of Education at the University of Durban-Westville expressed the opinion that educators should be trained to respect their position of trust and support.

5.38.2 The Gauteng Education and Training Council suggested that to maintain confidentiality SACE should have a system to take action against any educator who abuses the disclosure of HIV-related information.

5.38.3 Both the Western Cape ATICC and the Western Cape AIDS and Lifeskills Forum further suggested that clause 4(3) be expanded to expressly provide that a school principal to whom information has been disclosed may not inform other education department officials of the HIV status of learners.

Disclosure and public health

5.39 Various commentators expressed concern about the lack of clarity of clause 4(4) which provides that schools must inform all parents of the incidence of infectious diseases in the school and of all inoculation programmes that are implemented at the school.

5.39.1 The Western Cape ATICC, the South African Paediatric Association and the Dental Association of South Africa commented on the vagueness of the term "infectious diseases" and expressed the fear that it could be understood to include

HIV infection. According to the ATICC this could lead to schools experiencing unnecessary problems regarding disclosure of AIDS-related information.

5.39.2 The Western Cape ATICC however supported the proposal that parents and guardians be informed about inoculation programmes that will be implemented at the school. This would allow parents or guardians of learners with HIV to make the necessary arrangements with the principal or care giver to exclude the learner with HIV from the inoculation programme if it is not considered beneficial to such individual. The District Surgeons Society observed that a normal school going child has about six to nine episodes of a viral infection per year for the first twelve years of his or her life, not counting measles, mumps and chickenpox. They felt that it therefore seems important that learners with HIV should be protected against these infections as they are more susceptible to infection than healthy people, especially in a crowded environment like schools.

+ *School attendance by learners with HIV/AIDS (Clause 5)*

5.40 Dr Martie Lane of the Department of Education observed that the requirement in clause 5(2) that learners with HIV should supply written reasons for any absence creates the impression that they alone should supply reasons for absence (while learners absent with other diseases should in practice also supply reasons). The Department of Health and the South African Paediatric Society endorsed this view.

5.41 The MEC for Education and Cultural Affairs, Western Cape emphasised the fact that children of school-going age have the right to basic education. In view of this, learners should be supported in the learning process and provision is consequently made for home education in the Western Cape Education Department's interim AIDS Policy. This concept was supported by the Bloemfontein Medical Officer of Health who suggested that curricula should be written in such a way that learners with HIV could do self study at home if they are too ill to attend school. The District Surgeons Society submitted that supportive education by computer can secure a continued education on

the same level - even when a learner is being hospitalized.

5.42 Several respondents<sup>409</sup> strongly questioned the viability of providing that learners with HIV who develop HIV-related behavioural problems or neurological damage, could be accommodated "within alternative structures in the same institution" (clause 5(4) of the proposed policy).

5.42.1 Prof Bondesio and SAFET commented on the vague terms used in the policy which provides that learners with HIV-related behavioural problems "could, if necessary" be accommodated in alternative structures. The South African National Council for Child and Family Welfare likewise requested clarity on when a learner with HIV would be regarded as a health risk and who would determine this. The Cotlands Baby Sanctuary for Abandoned and Abused Kids also raised this concern. The Catholic Institute of Education expressed concern on whether behavioural problems would only become apparent when it may be too late. The Department of Health suggested that guidelines and protocols are needed to ensure that arbitrary decisions and actions are not taken with regard to whether a learner with HIV is a health risk.

5.42.2 The Bloemfontein City Medical Officer of Health asked for clarity on what "alternative structures" would be in view of current overcrowding and shortage of school buildings in most of the schools in our country; whether these structures would be stigma-free and whether there would be alternatives should learners with HIV not want to be accommodated in this way.

5.42.3 The Department of Community Health at the Faculty of Medicine, University of Natal added that the present high educator/learner ratio would influence the viability of the proposed provision. Prof Bondesio and SAFET also question the silence of the policy on how ordinary schools are supposed to deal with this daunting task in practice in view of the lack of space and human resources in most schools. The Newlands Education Support Centre agreed and

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409 See eg the comments numbered 9, 21, 22, 25, 29, 43, 56, 59 and 63.

stated that in practice there would be little likelihood of less affluent schools having the personnel to provide support in alternative structures. The Centre suggested that hospital schools be looked at as an alternative proposition.

5.42.4 The Catholic Institute of Education requested clarity as to who will finance accommodation within alternative structures. The District Surgeons Society stated that special measures needed to accommodate learners with HIV should not place an additional financial burden on schools and local communities. Financial and other assistance should be forthcoming from provincial or central government in respect of each learner with HIV being thus accommodated. Dr Martie Lane of the Department of Education submitted that lack of funds would render it impossible to supply all institutions with alternative structures. Providing for alternative accommodation "within the education system" would be more realistic and attainable. The Department of Health echoed these concerns and suggested that it rather be provided that learners with HIV/AIDS-related behavioural problems be accommodated in alternative structures "which are conducive to effective learning".

5.43 The Department of Education, Province of the North West observed that "healthy learners" should also be taken into account. The Department seems to favour accommodating learners with behavioural problems in separate institutions.

+ *Education on HIV/AIDS (Clause 6)*

#### The role of parents

5.44 Commentators' major concern with regard to HIV/AIDS education was that parents should not merely be informed about such education but should actually be consulted on the contents of what is relayed to their children.

5.44.1 The Religious AIDS Programme expressed strong concern about the

proposed formulation of the policy namely that parents and guardians will be "informed" about all HIV/AIDS education as opposed to being consulted. Although the Programme agreed that parents should be informed, it was concerned that the role of parents in sexuality and life-skills education should not be underestimated. It is therefore proposed that the policy ensure that consultations (on the content and methodology of an HIV/AIDS Education Programme) with parents and other important role-players in the community should take place as opposed to mere information-giving sessions. Moreover, the Programme suggests that each school should have the right to compile its own sexuality and lifestyles curriculum in consultation with parents and other role players from the community as well as with student leaders. The Department of Education of the North West Province suggested that traditional healers be included in the role players to be informed of HIV education being offered in schools. The Department of Environmental Affairs, the Dutch Reformed Ministry of Caring and the South African National Council for Child and Family Welfare agreed that parents should not be merely informed but be directly involved and included in the education programme. The Council also saw a need for parents to be informed of the credentials of the experts who will present HIV/AIDS education.

5.44.2 Dames Aktueel, while stressing the important role of parents, expressed concern that learners could be exposed to information at an age before they are psychologically ready for it. The respondent requested that the policy provide for parents to be directly involved, for instance, in the decision at which school level learners should be confronted with information on the use of condoms.

5.44.3 Prof Bondesio and SAFET noted that no reference was made to governing bodies of schools, associations of governing bodies and other bodies representing the interests of parents in respect of HIV education. They also observed that the position of other role players in the community in respect of HIV education is not defined clearly enough in the proposed policy.

Content of HIV/AIDS education

5.45 Several commentators offered suggestions on the content of an education programme on HIV/AIDS.

5.45.1 The South African National Council on Alcoholism and Drug Dependence expressed itself in favour of an integrated approach in which HIV education forms part of a balanced curriculum together with other issues such as drugs, alcohol, smoking, sexuality and mental health issues. Prof Hobdel suggested reformulating clause 6(4) to include the promotion of positive health behaviour and social norms against alcohol abuse. Prof Bondesio and SAFET however warned against referring to drugs, sexual abuse and violence in the same policy (as in the proposed clause 6(4)) since, according to them, this would strengthen popular notions that HIV/AIDS is somehow generally linked to immoral and antisocial behaviour.

5.45.2 The Catholic Institute of Education mentioned the need for an education programme on HIV/AIDS to be complemented by guidance on the meaning and value of life, health and sickness, relatedness and loneliness, and dying and death. NAPWA and the Religious AIDS Programme supported this. NAPWA submitted that such information would help prepare learners for the loss of friends and family members to AIDS and would ensure better coping skills. In this context the Religious AIDS Programme submitted that core values and the institutions of marriage and family should be promoted by educators.

5.45.3 The City of Cape Town Medical Officer of Health suggested that values and ethics of specific communities should be taken into account. Dames Aktueel also emphasised that the cultural differences in background and community values should be respected and considered in presenting HIV/AIDS education. The South African National Council for Child and Family Welfare supported this view.

5.45.4 The Newlands Education Support Centre stressed that issues related to

general lifeskills should be included in an education programme on HIV/AIDS. These would include issues such as decision making, assertiveness, building self-esteem, and understanding and controlling emotions.

- 5.45.5 Several commentators stressed the need for the cultivation of a non-discriminatory climate with regard to HIV/AIDS. The Department of Environmental Affairs emphasised the importance of proper education on the integration of persons with HIV into society. The North West Province Department of Education requested that appropriate positive attitudes towards the epidemic and persons with HIV/AIDS be promoted. The Institute for Human Rights Education stressed the need for education on how to relate to persons with HIV. The Institute insists that the responsibility not to discriminate should be expressly referred to in the policy itself. The Western Cape Education Department already expressly encourages supportiveness towards persons with HIV and discourages prejudice and stereotyping in its AIDS policy.
- 5.45.6 Ms Catherine Matthews on behalf of the Medical Research Council and the Department of Community Health, University of Cape Town, suggested that education should focus on gender roles, and should attempt to strengthen young women's ability to prevent becoming infected. The Catholic Institute of Education also favoured gender education since it saw a direct connection between the spread of AIDS and the low status of women in African societies.
- 5.45.7 The Stilfontein Child and Welfare Society requests that an HIV/AIDS education programme include information on the physical as well as the emotional treatment of the infection. The City of Cape Town Medical Officer of Health stated that the formation of support groups for learners with HIV should be encouraged in AIDS education. Funding should be made available to develop and encourage this process.
- 5.45.8 NAPWA suggested that, given the high levels of sexual abuse in South Africa, part of the curriculum should explore sexual abuse and the possibility of HIV transmission in this context. The Western Cape AIDS and Life Skills

Programme believes that educators and facilitators should not only be able to provide information on HIV/AIDS but also to give support and guidance in relation to sexual violence, sexual abuse and rape.

5.45.9 The City of Durban Health Department suggested that any HIV/AIDS education programme should include appropriate information regarding the use of universal precautions and protective measures, (for instance, learners are to be trained to manage their own bleeding or injuries). The Department of Environmental Affairs expressed the opinion that basic first aid principles, including how to deal with bleeding, should be part of a life skills curriculum from a very early age (preferably grade 1) and that this should be reinforced on a yearly basis until it is part of the child's basis knowledge.

5.45.10 The South African Paediatric Association stressed that the policy should provide for an HIV education programme to have a uniformly standardised content, provided or accepted by the Department of Health's Directorate: HIV/AIDS and STDs in order to ensure proper control over what is actually taught. The Department of Environmental Affairs supported this and suggested that the exact teaching content of the programme should be stipulated by the Departments of Health and Education.

#### Educating staff

5.46 The Early Learning Resource Unit requested that compulsory education on HIV/AIDS should also be aimed at staff and educators.

5.46.1 The Tongaat District's Child and Family Welfare Society and Community Centre stressed the urgency of ongoing and compulsory training for educators and requested that the policy should provide accordingly. The Faculty of Education of the University of Durban Westville supported the proposal for such training which should include skills necessary to handle learners with HIV and to support and prepare learners who wish to be tested for HIV.

5.46.2 The South African National Council for Child and Family Welfare is in favour of HIV/AIDS education on condition that the information will be given by experts in the AIDS field and/or by specially trained educational staff. The City of Durban Health Department stressed that HIV/AIDS information should be given in an accurate manner, in clear language and in understandable terms. The Newlands Education Support Centre stressed the importance of the posts of guidance councillors to be filled by trained personnel. The Rhodes University Education Department however strongly advocated that all educators need to have the capacity to make some contribution towards HIV/AIDS education as many schools do not have guidance councillors.

5.47 The Department of Environmental Affairs raised the question as to who would be responsible for training educators to empower them to relay information regarding HIV/AIDS. The Department stated that the policy lacks any information on the training of educators.

5.48 The Gauteng Education and Training Council raised the question whether an educator may decline to teach this content.

#### Educating parents

5.49 The Rector of St Mary's Diocesan School for Girls, Pretoria stated that one cannot simply ignore the perceptions and fears of society in respect of HIV/AIDS - however unfounded. He suggested that the implementation of the policy be preceded by a very strong educational programme to address these perceptions and fears.

5.49.1 The Religious AIDS Programme suggested that the proposed policy encourage voluntary parental education on HIV/AIDS and that such programme should precede the implementation of any sexuality and lifestyles education offered to learners. The Department of Environmental Affairs supported educating parents and saw this as an opportunity to allay community fears pro-

actively. The City of Bloemfontein Medical Officer of Health and the South African Paediatric Association agreed with this. The Association stated that where AIDS information and education are to be a compulsory part of the curriculum of primary school learners, it is absolutely essential that the school management bodies be obliged to make adequate factual information available to the parent communities of such schools since it is the adult community that is suffering from ignorance, which leads to prejudice and stigmatisation. In addition, at the junior primary stage, parents are likely to be at least as influential in educating their children as the educators, and consequently they need appropriate guidance and information:

Parents should not only know of the fact that HIV education is being provided but also be given access to adequate factual information themselves. In this way the Education Department could easily reach much larger groups of people than the Health Department, and also attempt to reinforce at home what is being taught at school.

- 5.49.2           The Faculty of Education of the University of Durban-Westville agreed that the onus is on the authorities to see to it that communities are educated - to allay fears and improve understanding of the disease. This was supported by the South African National Council for Child and Family Welfare. The Department of Health also agreed with these sentiments, suggesting that information on HIV/AIDS could be given through parent-educator organisations:

A great deal of prejudice and discrimination does not come from children but from ill-informed parents who then incite children to practise discrimination.

- 5.49.3           Mrs Prozesky suggested that all parents should receive information about the general policy of schools and more specifically about the precautions taken at each school to prevent the spread of HIV.

HIV/AIDS education to be compulsory?

5.50 The Gauteng Education and Training Council raised the question whether parental authority should be a prerequisite for teaching sensitive material regarding transmission of HIV.

5.50.1 The Klipriver Women's Institute and the Faculty of Education of the University of Durban-Westville stated that parents should not be allowed to withdraw their children from HIV/AIDS education and that such a programme should be made part of the compulsory curriculum. The AIDS Legal Network, the AIDS Law Project and the Johannesburg Institute of Social Services agreed with this. The AIDS Law Project maintained that should parents be allowed to remove their children from these important lessons, the basic education of a child will be hampered in the sense that HIV/AIDS as a health issue will seldom be addressed. The AIDS Legal Network added that an HIV education programme should be examinable otherwise it will never be taken seriously. The Mpumalanga Education Department supported these views.

5.50.2 The South African National Council for Child and Family Welfare expressed the contrary opinion that parents should retain the right to decide whether or not they want their children to take part in HIV/AIDS education.

5.50.3 The Religious AIDS Programme suggested that factual information regarding HIV/AIDS be compulsory but that parents retain their authority to decide what core values be taught to their children as those promoted in the school environment may be contradictory to values supported by parents. Although the AIDS Legal Network is in favour of compulsory AIDS education, it suggested developing a core curriculum which would allow parents and guardians to determine the learning content and methodology.

5.51 The City of Durban Health Department emphasised that the policy must anticipate and cure potential detrimental effects of educators' value systems on the content or effectiveness of AIDS education.

Need for a multi-disciplinary approach

5.52 The City of Durban Medical Officer of Health queried whether other organisations could assist with developing and implementing educational programmes.

5.52.1 The Family and Marriage Society of South Africa stated that it is equipped to assist with relaying information, training and education either directly or in training trainers for this purpose.

5.52.2 The ACVV is of the opinion that social organisations can play an indispensable role in educating communities on HIV/AIDS. Social workers know their communities and are already intensively involved in empowerment actions. It should therefore be recognised that they form an important part of the multi-disciplinary team at clinics and health forums. The ACVV requested that social workers be expressly identified as role players in the proposed policy.

5.52.3 The AIDS Law Project and the Department of Health supported a multi-disciplinary approach in implementing the proposed policy. The Project suggested that the assistance of ATICC counsellors be utilised. It observed that people from service organisations will perhaps be more suitable to relay information to learners who may feel threatened or who may feel uncomfortable with asking their guidance counsellor certain questions. The Department of Health stated that where visiting school health nurses are available (especially in urban areas) these nurses should become part of the education programme.

5.53 The North West Department of Education requested that a comprehensive school health service be established within the Department of Education to address HIV/AIDS issues in schools.

Evaluation of an HIV/AIDS education programme

5.54 The City of Durban Medical Officer of Health raised the question as to how the

efficacy of an HIV education programme would be evaluated. He questioned whether attitudes can in fact be dealt with effectively.

+ ***Universal precautions (Clause 7)***

- 5.55 Although the vast majority of respondents strongly approved of the principle of universal precautions in schools to prevent the transmission of HIV, many commentators<sup>410</sup> regarded the proposed policy as inadequate mainly because it was not supported by provisions regarding training; responsibility for implementation, upkeep and monitoring in practice; and improvisation in the case of lack of resources.

Need to define universal precautions

- 5.56 The Department of Health suggested that any information on universal precautions or infection control should be preceded by a definition of universal precautions, namely that in situations of potential exposure to HIV all persons should be considered as potentially infected and all blood and body fluids treated as such.

Financial implications

- 5.57 Several commentators stressed the financial implications of implementation and adherence to universal precautions and doubted whether their successful implementation would be attainable in our country.

- 5.57.1 The Department of Community Health, Faculty of Medicine at the University of Natal observed that the implementation of universal precautions is likely to be difficult with the current financial constraints affecting the Department of Education. A study done by the respondents indicated that many schools in Kwa Zulu-Natal have no first-aid facilities whatsoever. Many

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410 See eg the comments numbered 1, 2, 3, 5, 9, 15, 19, 20, 21, 24, 25, 26, 27, 34, 41, 54 and 56.

schools in this region also lack water. The Catholic Institute of Education likewise questioned whether many schools are in a position to implement the universal precautions proposed. The Institute observed that while for some schools it might not be a great problem, schools with dilapidated buildings may not even have a place where first aid kits can be kept safe; poorer schools would not be able to afford everything proposed; and sufficient staff would not always be available to attend to every cut, scratch or wound. The Gauteng Education and Training Council shared the concern in respect of the financing of universal precautions.

5.58 The Department of Environmental Affairs stressed that resources would be necessary for implementation of the policy and emphasised that with basics like electricity, phones and running water lacking in many schools in South Africa, items like first aid kits and other precautionary activities may not be a priority if it is not enforced by regular checking.

5.59 The Dental Association of South Africa expressed reservations about the necessary resources being available for the maintenance and replacement of first aid kits. Having regard to student population in public schools, the Association submitted that it would be preferable for all classrooms to have a first aid kit and that these kits should not be limited to two per school as proposed in the policy.

5.60 CORE stated that due to lack of facilities many urban and rural schools will be unable to adhere to the specific provisions proposed. Provisions on universal precautions should rather be prescribed in terms of general principles.

5.61 Contrary to these concerns the City of Durban Health Department stressed that universal precautions are mainly *basic* precautions to prevent the transmission of infections when dealing with blood or bodily fluids, and requested that the proposed policy should mandate the application of these precautions. The Department further noted that the precautions are neither time consuming nor significantly expensive. It requested that the proposed policy should be practical, feasible, sustainable, and

enforceable.

- 5.62 The Catholic Institute of Education stated that if the government enacts a national policy, it should also ensure that schools are in a position to implement it. The South African National Council on Alcoholism and Drug Dependence suggests that in instances where schools cannot finance implementation of the policy itself, financial arrangements should be allowed for (presumably through government assistance). The District Surgeons Society also submitted that the financial burden implicit in accommodating learners with HIV should not have to be borne by the relevant school and local community. Financial and other help should be given by provincial or central government for each child with HIV accommodated in a school.

#### Implementation

- 5.63 Some commentators stressed the need for a specific person or body to be made responsible for the implementation of universal precautions in general and the upkeep of first aid kits.

- 5.63.1 S G Abrahams was concerned that unless a person is designated in each and every school to supervise the implementation of universal precautions, a budget and funding for the replacement of consumable items are provided, and a quarterly report to the Department of Education by each and every school is submitted, the policy runs the risk of being a dead letter in some schools. Mr Abrahams suggested that a working plan should be formulated and attached as a schedule to the proposed policy. The working plan should contain details on the practical implementation of universal precautions. He also suggests that such a plan be devised with the assistance of the people who would in practice be called upon to implement the policy.

- 5.63.2 The Department of Environmental Affairs shared this concern:

Either the provincial or the national Departments of Education

will have to assume responsibility for ensuring that (precautionary measures) are in place in each and every school both in the form of first aid equipment, as well as trained staff. This could be done by an audit of all schools on an annual or business and industry-annual basis, and should be open to the public for their information, as part of the community education programme. If an audit is to be done on a regular basis, the policy should spell out who the responsible party is, when it should be done, and what should be audited. This will at the same time provide a measure for the success in implementing the policy.

5.63.3 CORE advised that the policy should be disseminated through the school governing bodies on an annual basis rather than centrally through the Department of Education.

5.64 The City of Bloemfontein Medical Officer of Health requested clarity on who would enforce and monitor the implementation of and adherence to universal precautions during contact sport.

5.64.1 The Gauteng Education and Training Council, the ACVV, Prof Bondesio and SAFET were equally concerned about adherence to universal precautions in contact sport and regarded the proposed procedure for contact sport as impractical, unrealistic and even "pathetic" (the latter in the case of SAFET). These commentators raised the following questions: Who should check learners for open wounds or infected skin lesions before they participate in contact sport? Who would be responsible for cleaning up surfaces contaminated by blood? Is covering a bleeding wound with a dressing, as proposed, realistic in view of the real danger of such dressing becoming unsettled by the learner during his or her further participating? The Council, Prof Bondesio and SAFET also raised the question of legal responsibility after a sporting event if a learner participated with open wounds or infected skin lesions and HIV was transmitted: Who will be legally responsible - the principal or the sports coach? The Council stressed that allowing learners with HIV to participate in contact sport increases the possibility of HIV transmission and concluded that the proposed precautions in respect of contact sport are inadequate.

5.64.2 Prof Hobdel suggested that clause 7(11) include directions on cleaning blood contaminated scissors and the Department of Health suggested that in the sporting context, soiled clothes should be changed before the player is allowed back on the field.

5.65 The Gauteng Education and Training Council however stressed that injuries to learners at school can take place at any time during the course of the day and not only during contact sport. This being the case, it would be necessary to regulate all physical contact (play, classroom situations and all sport and excursions) that learners with HIV have with others. The Council observed that the important issues raised in comments on the Commission 's Working Paper 58, namely that "proper regulation of contact sport had to take place", that "more consideration had to be given to children at risk of exposure to blood in play situations and contact sport and that the protection of the HIV negative child was necessary", and that "a child with HIV should be prohibited from taking part in contact sport" as recorded in paragraph 1.13 of Discussion Paper 73 appear not be reflected in the proposed policy. The Association of Professional Teachers supported this view.

5.65.1 Along the same lines the Catholic Institute of Education suggested that the policy should expressly provide that a first aid kit with rubber gloves should not only be available at *every* sporting event but should also be carried by the playground supervisor. The City of Durban Health Department also advised that first aid kits be available on the playground where bleeding accidents are more likely to happen. The Department of Health added that it should be provided that first aid kits be available and accessible at all times, also during breaks and whenever learners are present at school. The AIDS Legal Network recommended that first aid kits also be kept in school busses or vehicles during school outings or sports tours.

5.66 The Gauteng Education and Training Council raised concerns about the fact that protection in the form of universal precautions appears to be provided for only at the

point where there is a very real danger of transmission of HIV: "More attention should be given to the prior protection of other learners, educators and support staff".

5.67 The Early Learning Resource Unit requested that the policy should include some suggestions on improvisation for dealing with blood (for instance the use of undamaged plastic bags to protect hands in the absence of latex gloves). The City of Durban Health Department shared this view and suggested that the policy should clearly describe universal precautions for practical application and should include specific recommendations. The Gauteng Education and Training Council also pointed out that "strict adherence" to universal precautions (as in the preamble to the proposed policy and in clause 7(1)) would not always be possible in emergency situations and that the prescribed precautions may not be available in the case of an accident off school premises, for instance.

5.68 NAPTOSA suggested that to ensure proper implementation, specific rules and procedures should be prepared as an instruction manual for schools. The Organisation also suggested that regular feedback on the implementation of the policy be requested in order to monitor success and to initiate amendments where needed. NEWTO suggested that an evaluation board should monitor whether the national policy has been effectively implemented and see to it that school level policies do not deviate from the national policy.

### Training

5.69 Some commentators identified fear, ignorance and misunderstanding as factors which may stand in the way of implementing the proposed policy. They refer in this regard to the need for proper training which will enable schools to implement the policy and to provide HIV education.

5.69.1 The Department of Environmental Affairs and Tourism refers to the lack of express provisions in the policy regarding the training of educators while the Dental Association of South Africa suggests that the implementation of the

proposed policy should be preceded by an intensive training campaign. The Mpumalanga Education Department suggested that pre-service and in-service teacher training should include training on universal precautions.

5.69.2 The AIDS Legal Network recommended that learners should also be trained on the use on universal precautions so as to enable them to handle emergencies if necessary.

5.69.3 The Durban City Health Department appealed that educators, staff members and learners should all be given appropriate information regarding the use of universal precautions. It suggested that learners should, for instance, be trained to manage their own bleeding or injuries.

5.69.4 The Catholic Institute of Education stated that with the expected increase of numbers of very young children with HIV, young children need to be given more guidelines on dealing with cuts and scrapes at school than is presently provided for in clause 11(9). The Institute further observed that it might not be in anyone's interest to cause a non-bleeding wound to bleed (as is prescribed with regard to biting or scratching incidents in clause 11(10)).

5.69.5 On the question of whom should provide the training, the South African National Council on Alcoholism and Drug Dependance recommended that the Department of Education should ensure basic training for all educators on the issues covered by the policy. More specific programmes and training could then be arranged for identified educators to ensure an updated and ongoing process.

+ *School level policies (Clause 8)*

5.70 NAPWA supported the provision for school level policies. The Association indicated that parents of learners with HIV felt that such policies would create an

opportunity to involve all sectors of the school community in debate and that as such it would be a forum for HIV/AIDS education and information distribution.

5.71 As regards the establishment of a health advisory committee, the Department of Community Health of the Faculty of Medicine, University of Natal expressed concern that, particularly in rural areas, there may be few personnel with the requisite skills to convey relevant information to the principal and the Governing Body. The Medical Officer of Health of the City of Cape Town also stressed the need for proper training of the proposed health advisory committee.

5.72 The Medical Officer of Health of the City of Cape Town questioned the need for the health advisory committee to be chaired by the principal. The Religious AIDS Programme, the AIDS Law Project, Prof Bondesio, SAFET and the Dutch Reformed Ministry of Caring shared this view. The Religious AIDS Programme would prefer the committee to be chaired by a person with knowledge on HIV/AIDS, and only where such a person is not available, by the principal. In the AIDS Law Project's experience the main source of discrimination and unfair treatment in schools is often the principal. It therefore felt that undue emphasis should not be placed on the role of the principal in setting up committees and formulating particular policies.

\* **Suggestions in respect of additional matters**

5.73 According to certain respondents the following matters need also to be addressed (or to be addressed more clearly) in the proposed policy or through some other mechanism.

+ *Extension of policy to other institutions, educators and administrative staff*

5.74 Several respondents requested that the proposed policy be applicable also to other institutions where children are gathered in groups, as well as to educators and administrative staff.

Pre-schoolers and day-care centres

5.75 The Early Learning Resource Unit's main criticism of the proposed policy was that no reference is made to children between birth and nine years of age. The Unit submitted that it is of importance to include pre-school children in HIV information and education. Support for this suggestion was found in the statement in par 3.18.1 of Discussion Paper 73 that the window of opportunity in Africa (with respect to HIV education) is said to refer to children under nine years of age. The Unit further observed that most childcare facilities are unsubsidised by either the Department of Education or the Department of Welfare and proposed that the policy should apply to all schools and facilities where young children are cared for - not just the registered ones. The Cotlands Baby Sanctuary for Abandoned and Abused Kids supported extension of the policy to cover crèches while the City of Bloemfontein Medical Officer of Health submitted that day care mothers should be included in HIV education.

5.76 However, some respondents did not share this view in that they found the policy to be unsuitable for very young children.

5.76.1 Comments by the ACVV implied that the proposed policy would not be suitable for pre-primary schools and care centres for pre-school children as these children are not physically or emotionally able to protect themselves against transmission of HIV. They would for instance indiscriminately assist another child who bleeds rather than adhere to precautionary guidelines.

5.76.2 Mrs M Prozesky stated that although many of the aspects mentioned in Discussion Paper 73 are relevant to the pre-primary situation, the solutions or

suggestions proposed in both the Discussion Paper and the policy are not. According to the respondent the reason for this is that teaching staff work very much more closely with younger children on a physical level than is the case in primary and other schools. Moreover, younger children themselves are more exposed to viruses and diseases because of their close proximity during play. Mrs Prozesky's comments supported those of the ACVV in so far as she mentioned that young children (who often have open wounds and nosebleeds) react impulsively when faced with these kinds of situations and touch blood and wounds in their effort to help. She added that education on HIV in the pre-primary stage is limited to the basic rule "don't touch because of germs" which young children tend to forget during stressful situations.

#### Tertiary institutions

5.77 The City of Bloemfontein Medical Officer of Health observed that HIV education at tertiary institutions should form part of any intervention strategy. NEWTO also strongly supports extension of the policy to tertiary institutions.

5.78 The Western Cape AIDS and Life Skills Forum suggested that educators' training institutions, technikons, and universities be encouraged by the Law Commission to develop HIV/AIDS policies similar to the proposed policy.

5.79 The Western Cape Department of Education pointed out that it already has an HIV/AIDS Policy in place. The policy has broadly the same ambit and content of the proposed national policy. It is applicable to schools as well as colleges and it applies in the absence of a national policy.

#### School hostels

5.80 Comment was specifically invited in Discussion Paper 73 on whether the proposed policy should also apply to school hostels, and if so, whether additional measures are necessary.

- 5.80.1           The vast majority of respondents commenting on this, felt that a policy is needed. However, commentators were not unanimous on the terms of such policy. Some felt that the proposed national policy is appropriate and adequate for hostels;<sup>411</sup> others stressed the necessity for additional or stronger measures, or different measures more appropriate to the residential situation as the latter may create a greater risk for HIV transmission - especially among sexually active learners.<sup>412</sup>
- 5.80.2           Many commentators also stressed the need for an HIV/AIDS policy that would be applicable to other residential situations where children are housed.
- 5.81             Several commentators expressed themselves in favour of a **uniform policy** to be applicable in respect of all institutions that care for children gathered together in groups.
- 5.81.1           The South African National Council for Child and Family Welfare suggested that the best option would be for one policy to cover all institutions that care for children gathered together in groups (hostels, reform schools, schools of industry, crèches and children's homes). The Gauteng Education and Training Council shared this view and added special schools, hospitals and clinics to this list.
- 5.81.2           The Western Cape AIDS and Life Skills Forum suggested that the proposed policy should apply to hostels, schools of industry and reformatories as the underlying principles would be appropriate and adequate. The Forum further suggested that a schedule should be added to the policy which clearly refers to the various learning institutions which will be covered by the national policy since health care workers, parents and educators are not familiar with the

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411     Eg comments numbered 9, 16, 18, 24, 42, 46, 49 and 53.

412     Eg comments numbered 13, 15, 28, 41, 57 and 59.

various categories of schools falling under the authority of the Department of Education. The Western Cape ATICC supported this view.

- 5.81.3 The Bloemfontein ATICC also supported the need for a uniform and universal policy, basing its view on the fact that schools frequently take learners on tours where all learners would be in a residential situation similar to that in hostels. The ATICC submitted that different sets of rules relating to HIV would confuse learners.
- 5.81.4 Parents of children with HIV responding through NAPWA felt that as hostels are integral to the school environment the national policy should apply to hostels. They were of the view that if additional policy measures should be required, these could be included in a school level policy.
- 5.82 Some respondents strongly felt that **added precautions are needed** with regard to the hostel setting.
- 5.82.1 The Dental Association of South Africa submitted that the proposed policy should not apply to hostels as added precautions and special measures are needed. The Association believes that the risk of transmission of HIV in hostels is greater and that governing bodies should therefore be given the right to make decisions in this regard. Parents could also be given a greater participating role in taking policy decisions regarding hostels. CORE suggested that the controlling structures in respect of hostels should elaborate or add policy measures as may be necessary or appropriate.
- 5.82.2 The Vryheid Child and Family Welfare Society expressed the opinion that strict measures should be implemented in the hostel situation in order to protect both learners with HIV and "healthy learners".
- 5.82.3 The AIDS Law Project submitted that a specific and more developed policy has to be compiled for hostels in that the conditions in school hostels, as

opposed to day schools, are different.

- 5.82.4           The City Health Department of Durban is strongly of the opinion that additional policy measures should be applicable in respect of hostels since older learners in hostels may be sexually active. The Department suggests that a measure to reduce the risk of HIV transmission may be to separate older and younger learners and to provide condoms. The AIDS Consortium supported the provision of condoms for sexually active learners as part of additional policy measures which may be needed in respect of hostels. The AIDS Legal Network recommended that a policy for hostels should include provision for access to condoms unless measures are taken to prevent sexual intercourse between learners in the hostel setting.
- 5.82.5           The Witbank Child Welfare Society stated that all learners resident in hostels should be tested for HIV as a prerequisite for admission to any hostel in view of the fact that sexually active learners are accommodated in hostels. The Society stressed that universal precautions should be applicable in hostels in view of the heightened risk of HIV transmission.
- 5.82.6           The Tongaat and Districts Child and Family Welfare Society and Community Centre suggests that adequate training which focusses on prevention and infection control, should become compulsory for caregivers in the hostel situation. This view was supported by the South African Paediatric Association which stressed that staff training and education are vital for unbiased and nonjudgmental care and for ensuring that hostels are adequately equipped for universal precautionary wound management.
- 5.83             The Department of Welfare stated that the basic principles enunciated in article 3 of the **United Nations Convention on the Rights of the Child (1989)** could be used as a guideline on the question whether additional policy measure for hostels are necessary. According to the Department the article emphasises the child's best interest above all other considerations - political, social, religious or otherwise. It further requires that a child be treated as an individual whose particular needs and circumstances must be

considered and that a child's developmental needs, as well as basic needs and security, should be provided for.<sup>413</sup>

#### Institutions for the physically and mentally handicapped

5.84 A few respondents representing different interests especially enquired as to the suitability of the proposed policy for institutions for physically and mentally handicapped children, or expressed a need for a suitable policy to be developed for these institutions.

5.85 The North West Department of Education enquired as to the availability of a policy for institutions for mentally and physically handicapped children while the Triangle Project expressed a need for a policy to be developed in respect of special schools such as reform schools, schools of industry and centres for the handicapped. The Western Cape AIDS and Life Skills Forum also requested that the proposed policy should make provision for the needs of learners with mental handicaps.

5.86 School principals from Greater Pretoria were concerned about the accommodation of handicapped learners with special problems in the educational setting.

#### Independent schools

5.87 The South African National Council for Child and Family Welfare raised the question whether the proposed policy would also apply to private (independent) schools, and if not, requested as to how the education system will protect learners in independent schools from HIV-related discrimination. The Catholic Institute of Education observed that although the policy is clear on the fact that HIV testing may not be done on learners in public schools it is very unclear whether this also applies in respect of independent schools.

5.88 The Gauteng Education and Training Council suggested that the same policy

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413 See fn 191 above for more detail.

applies to public and independent schools. Parents of children with HIV commenting through NAPWA strongly supported a national policy on HIV/AIDS in schools being applicable to all schools, both public and private (independent), as pupils within both systems should be afforded the same protection.

All institutions of learning

5.89 The City of Cape Town Medical Officer of Health submitted that, despite the arguments given in Discussion Paper 73 as to why application of the policy is limited to schools, it should be applicable to "all institutions of learning". The respondent argued that the same problems facing "schools" as contemplated in the policy will also be experienced by, for instance, independent schools, technikons, and universities: all these institutions require policies on how to deal with HIV/AIDS. He noted that already a significant number of young adults are HIV positive.

5.90 The Gauteng Education and Training Council as well as the Department of Health supported this view. The Council added that state as well as private institutions, hostels and schools for learners with special education needs (for instance hospital schools, clinics and remedial schools) should be covered by the policy.

Youth organisations and day care centres

5.91 The City of Durban Medical Officer of Health believed that the policy should be promoted as recommended practice to youth organisations (for instance, Boy Scouts and Girl Guides), sports clubs and youth groups.

5.92 The Cotlands Baby Sanctuary for Abandoned and Abused Kids enquired as to how other children's facilities, for instance day centres and children's institutions, will be affected by the policy.

Educators and administrative staff at schools

5.93 The Western Cape AIDS and Life Skills Forum believes that it would be a critical omission to exclude school staff with HIV from the policy. The Forum remarked that no indication or motivation was given in Discussion Paper 73 as to why this did not receive attention. The Forum argued that in developing issues in relation to learners with HIV, one cannot omit the identical or similar issues that need to be addressed in relation to educators and administrative staff with HIV who share the same environment with learners. It is proposed that a policy for school staff be included in the national policy on HIV/AIDS for schools.

5.94 The Department of Health, the Durban City Medical Officer of Health, the Institute for Human Rights Education and the Western Cape ATICC supported this view.

5.94.1 The Institute for Human Rights Education felt that it is equally important for educators and administrative staff with HIV to adhere to the same policy proposed for learners in order to ensure the safety of all at school.

5.94.2 The Western Cape ATICC recorded that they have been requested to intervene on more than one occasion in situations where educators with HIV have been unfairly discriminated against and have experienced breaches of confidentiality by education officials in relation to HIV. Intervention in such cases was made extremely difficult in the absence of a clear and rational policy. The ATICC believes that the omission of staff in the policy is a major shortcoming and that this will not assist in the development of non-discriminatory and rational responses to staff with HIV.

5.95 Although the AIDS Legal Network accepted that the proposed policy will deal primarily with learners and not educators, they suggested that a preceding paragraph be added to the policy which highlights this more clearly, and that mention should nevertheless be made in such paragraph that discrimination against educators with HIV cannot be condoned.

+ *Condoms*

- 5.96 The Bloemfontein ATICC felt that learners in hostels should have access to or be supplied with condoms. The AIDS Legal Network supported this unless measures are taken to prevent sexual intercourse between learners in hostels.
- 5.96.1 The AIDS Consortium noted the possibility of increased sexual activity among learners who are older than the norm for their grade and submits that if sexually active learners do not have access to condoms, they are prevented from protecting themselves against HIV transmission - this would be particularly pertinent in hostels. The Consortium stressed that an education programme on HIV/AIDS will only be taken seriously if the form of protection which is advocated is available at the school itself.
- 5.97 The Western Cape AIDS and Lifeskills Forum recommended that learners should, within an AIDS education programme, be provided with information on where condoms are available and accessible.
- 5.98 NAPWA felt that education on HIV/AIDS should examine and explore the use of condoms to prevent HIV and STD transmission. Ms Catherine Matthews, on behalf of the Medical Research Council and the Department of Community Health, University of Cape Town supported this.
- 5.99 The Western Cape ATTIC, although realising the controversy of the issue, suggested that even if the policy does not expressly provide for condom distribution, the policy should provide for governing bodies to discuss the issue. The Department of Health suggested that, in view of the sensitivity of the issue, the governing body should at least be able to decide whether condoms should be provided in the school environment. Such decision should be based on the current knowledge of options for protection and the expressed needs of learners. NAPWA also acknowledged the controversy involved in condom supply to learners: The supply of condoms to secondary schools was seen by some of the respondents commenting through NAPWA as an integral and essential component of an education programme on HIV/AIDS while others felt that learners should rather be made aware of local sources of supply.

5.100 In contrast to the above comments, Prof Bondesio and SAFET fears that the proposed policy supports sexual promiscuity or sexually deviant behaviour by providing in clause 6(3) thereof for education regarding reproductive health care - which they fear may refer to the distribution of condoms. They observe that this provision may be repugnant to many parents who still believe that the condom is not the ultimate answer to AIDS and that its use is indicative of a life-style which may have extremely negative consequences.

+ ***Refusal to study with a learner with HIV***

5.101 The Western Cape ATICC stressed the importance of a policy dealing with the refusal to study with someone who has HIV. The ATICC states that such situations are likely to arise in educational settings, are usually extremely emotive and are likely to be poorly managed without guidelines for decision making. The Western Cape AIDS and Life Skills Forum supported this submission. The ATICC suggests that a clause on this issue be included in the proposed policy to the following effect:

The refusal of students to study with fellow students with HIV or AIDS is a potentially emotive situation and shall be preempted by providing accurate and understandable information to them and their parents. If, despite all attempts to educate them, students still refuse to study with infected individuals, the objectors should be transferred to other classes.

In the event of student and parental emotions becoming unmanageable, outside experts should be called in. However, at no point should concessions be made which would result in unconstitutional discrimination against the HIV infected individual(s).

+ ***Coercive measures***

5.102 The Department of the Premier, North West Province perceived the policy as lacking coercive measures with regard to the protection of the rights of learners with HIV. The Department wondered what would compel an educator who knows that a

learner has HIV, to treat such learner equally with his or her fellow learners.

5.102.1 The Child, Family and Community Care Centre of Durban suggested that disciplinary codes of educators be modified to deal with HIV-related discrimination and prejudice against learners with HIV and with breach of confidentiality. The Cotlands Baby Sanctuary for Abandoned and Abused Kids shared this view.

5.103 On the other hand some commentators were concerned about the lack of coercive measures which would ensure the protection of "healthy learners". The Religious AIDS Programme suggested that a school should have the right to refuse a learner schooling privileges (i.e. the right to attend that particular school) if such learner through irresponsible or negligent behaviour, unnecessarily exposes other learners to HIV. In this regard the Programme stressed the need for guidelines on expulsion from school. The Dutch Reformed Ministry of Caring supported this view.

+ *Access to health care*

5.104 The AIDS Legal Network requested that the proposed policy should deal with the question of accessibility of health care and counselling facilities to learners. The Network stated that most public facilities are not accessible to learners since they are not open after school hours. For schools that do not have counsellors, access to outside counsellors is therefore not guaranteed. It recommended that schools should negotiate specific times with local clinics in order that learners would have access to their facilities.

5.105 The Western Cape AIDS and Life Skills Forum saw special urgency in stronger links being secured between the Departments of Education and Health, and that these Departments should take co-responsibility for providing an environment that promotes the physical, mental and spiritual health of learners. It is suggested that this principle should be expressly enunciated in the proposed policy and that specific reference should be made to the need for the development of mechanisms that will ensure that the Health

and Education Departments work in collaboration to secure the well-being of learners.

5.105.1 The Mpumalanga Education Department submitted that for purposes of implementing universal precautions all schools should have clinics and school nurses where possible.

5.105.2 The City of Durban Medical Officer of Health suggested that the possibility of certain needs of learners being met by outside organisations should be considered. For instance, hospitals can meet more serious medical needs while AIDS service organisations can meet counselling needs.

+ *Need for facilities for terminally ill learners with HIV/AIDS*

5.106 The Faculty of Education, University of Durban Westville suggested that there should be (government?) centres where learners with HIV can be housed - especially those rejected by their families and friends. The Faculty stressed the financial difficulties experienced by private centres of this nature, as well as the need for centres to care for the ill where poor families cannot afford hospices and medical care for the terminally ill.

5.106.1 The Kleinmond Child and Family Welfare Society supported this proposal. The Society pointed out that children's homes often do not have the facilities for educating sick children, nor the financial means to cover the considerable medical expenses involved in caring for children with HIV once they become ill.

## 6 EVALUATION AND RECOMMENDATION

6.1 In evaluating the comments on Discussion Paper 73 with a view to formulating recommendations and a policy for HIV/AIDS in schools, the Commission's aim was to protect the rights of all children in the school environment.

6.2 The Commission attempted to address all significant concerns (as expressed by commentators on Discussion Paper 73 and recorded in Chapter 5 above) either by accounting for it in the information supplied in Chapters 2, 3 and 6 of this interim report or by adapting the proposed national policy. As indicated above<sup>414</sup> several suggestions from respondents pertaining to clarification of the terms of the policy were incorporated in the revised policy attached as ANNEXURE B. Some adaptations speak for themselves and are not discussed below. The discussion below is limited to the main concerns expressed and to additions or limitations which may need explanation.

### A) **THE NECESSITY OF ENACTING A NATIONAL POLICY ON HIV/AIDS IN SCHOOLS AND THE BROAD PRINCIPLES ON WHICH SUCH A POLICY SHOULD BE BASED**

6.3 The fact that the overwhelming majority of commentators strongly supported the principle of enacting a national policy on HIV/AIDS for schools, clearly confirms the need for such a policy.

6.3.1 However, a number of concerns were raised with regard to the broad principles on which the policy should be based. It was submitted that the Commission should acknowledge and take into account the following factors:

\* **An HIV/AIDS policy for schools will have to operate against the background of a**

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414 Par 5.21 above.

**wide variety of social circumstances, including current "abnormal" circumstances**

6.4 The comments in general reflected quite clearly that any policy on HIV/AIDS for schools will have to be formulated in such a way that it provides for a wide variety of circumstances and be capable of execution under the divergent social circumstances in South African society.

6.4.1 The variety of circumstances includes differences between school communities regarding social and religious norms, moral judgements on sexuality education, levels of affluence, availability of resources, and levels of HIV infection. The increasing incidence of abandoned and orphaned children posed specific problems.<sup>415</sup>

6.4.2 The "abnormal circumstances" referred to include lack of discipline, and increasing prevalence of physical and sexual abuse and violence between learners and between educators and learners.

6.4.3 Formulating a single policy suitable for ordinary public schools, independent schools, hostels, public schools for learners with special education needs (such as schools of industry and reform schools) and single-sex or mixed schools further complicates the task.

6.4.4 In this regard the Catholic Institute of Education remarked that the proposed policy did not give any real attention to what schools can actually cope with in view of their different abilities with relation to training and experience of staff, material and financial resources, soundness of administration, background of learners, educator-learner ratio and overall morale. The Institute stressed that the numbers of learners with HIV will also play a significant role in a school's ability to cope with the epidemic: any given school may be able to cope with a few learners with HIV, but be overwhelmed if the numbers become too great -

then education of "healthy learners" could suffer. The Newlands Education Support Centre shared this view and especially stressed the different capabilities of more and less affluent schools.

6.5 The Commission endeavoured to cater for this need by developing broad guidelines in accordance with the constitutional principles, education law and international standards. It is recommended that these guidelines, in the form of a national policy, should apply uniformly throughout the country. In view of the variety of circumstances emphasised above and of the fact that the Schools Act stresses the importance of parent empowerment and involvement in the education of their children,<sup>416</sup> the national policy provides that the governing body of a school may, in addition to the national policy, adopt an HIV/AIDS policy at school level to give operational effect to the national policy within an individual school community.<sup>417</sup> The purpose of this is to provide a mechanism to express the special needs of individual schools and their communities within the framework of the national policy's minimum standards and norms. Moreover, by providing for the establishment, where feasible, of a Health Advisory Committee to assist the governing body in its task, broader community participation is encouraged.<sup>418</sup> This is particularly recommended in order to ensure that the needs of an individual community are accounted for. Furthermore, the national policy has now been adapted to provide for its regular review and adaptation if necessitated by changed circumstances (for instance a scientifically established change in the risk of transmission of HIV).<sup>419</sup>

\* **HIV/AIDS should not receive special treatment ("AIDS exceptionalism")**

6.6 Some commentators expressed the view that HIV/AIDS should not be singled out for special mention in a national policy and submitted that other diseases (for instance viral diseases such as Hepatitis B requiring similar protection by way of universal

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416 Par 3.43.1 above.  
 417 Clause 12.  
 418 Clause 13.  
 419 Clause 15.

precautions) or other health or social issues (for instance drug and alcohol abuse and teenage pregnancy) should be addressed in the same policy.<sup>420</sup>

6.6.1 The policy could probably also be applicable to learners with similar conditions (i.e. those that are transmitted by blood and/or sexual contact in the school environment). It was however resolved not to address similar conditions in the same policy. The scale of the AIDS epidemic is singular and the Commission is of the view that the stigma and discrimination associated with it are such that special measures are required.

6.6.2 No research was conducted on the additional social issues mentioned. These issues also fall outside the Commission's research mandate. The Commission moreover endorses the view of Prof Bondesio who, in his comments on Discussion Paper 73, implies that to include reference to socially "unacceptable" behaviour within the same policy, may contribute to the further stigmatisation of and discrimination against learners with HIV.<sup>421</sup>

**\* The rights of learners without HIV should receive equal protection to those of learners with HIV and the responsibilities of learners with HIV should be emphasised**

6.7 The Commission's premise is that learners with HIV are to be accommodated in schools to the extent that their infection does not expose others to significant risks that cannot be eliminated by ordinary measures or reasonable adaptations. Universal precautionary measures are ordinary measures that will effectively eliminate the risk of HIV transmission in the school environment. They are basic measures that need not be expensive. On top of that, learners should be educated that they may not expose others to their blood or body fluids.

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420 Par 5.15 et seq above.

421 Cf par 5.45.1 above.

- 6.7.1            However, the Commission acknowledges concerns that were raised (for instance by the Catholic Institute for Education, Prof Bondesio and SAFET), that it fails to achieve the correct balance between the rights of "healthy learners" and those with HIV.<sup>422</sup>
- 6.8                As indicated in par 3.39 et seq above, all rights are inherently subject to corresponding duties. The Commission therefore considers that the premise set out in par 6.7 above is sound, subject to the following: In instances where learners with HIV present a medically recognised significant health risk to others (for instance because of secondary infections that cannot be treated, or aggressive behaviour<sup>423</sup>) which cannot be excluded by reasonable precautions, discrimination on the ground of the danger presented would be rational and fair. This viewpoint would be in accordance with that of the US Centers for Disease Control, which as far back as 1985 developed guidelines with regard to school attendance of learners with HIV. These guidelines *inter alia* provide that children with HIV must attend school, except those who, because of neurological problems, do not have control over their body fluids or who are inclined to bite, or who have open wounds which cannot be covered.<sup>424</sup>
- 6.9                The Commission is of the opinion that the Code of Conduct to be drawn up by every public school will constitute an ideal vehicle for dealing with behaviour which may create risk of HIV transmission.<sup>425</sup> The Code is in fact designed to anticipate and thus minimise the risk of such behaviour leading to transmission. Relevant behaviour could include sexual abuse, aggressive behaviour, and behaviour related to intravenous drug abuse.<sup>426</sup> According to the Schools Act, behaviour which may constitute serious misconduct and the disciplinary proceedings to be followed in such cases must be

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422            Par 5.20 et seq above.

423            Cf Van Wyk (Unpublished) 12; Treatment for HIV infection with some medicines could present side effects which could lead to aggressive behaviour (McNary-Keith 1995 **Journal of Law and Education** 69, 78).

424            Van Wyk (Unpublished) 13.

425            See par 3.43 above for more detail on the Code of Conduct as provided for in the Schools Act.

426            Cf par 2.21 above.

determined by notice in the **Government Gazette**.<sup>427</sup> It is submitted that behaviour which may create risk of HIV transmission could well constitute serious misconduct.

6.9.1 The Department of Education is currently compiling Guidelines for the Consideration of Governing Bodies in Adopting a Code of Conduct for Learners.<sup>428</sup> The following principles are *inter alia* included in a recent draft of the Guidelines: The Code of Conduct must suit the development of the learners and be appropriate to the school level - the language used must be easily understandable to make the content accessible.<sup>429</sup> Although the Code must contain a set of moral values, norms and principles which the school community should uphold, the Code is enforceable only against learners.<sup>430</sup> The need for commitment and acceptance of responsibility by other partners in education, alongside the state's obligation to make education available and accessible, should be referred to.<sup>431</sup> The Code should be directed towards a culture of mutual respect and the establishment of tolerance, and should prescribe behaviour that respects the rights of learners and educators.<sup>432</sup> As regards control and discipline of learners, it should be noted that educators have the same rights as parents to control and discipline learners during school attendance - which includes attendance at school functions, excursions or school related activities.<sup>433</sup> Learners' rights to human dignity, privacy, and freedom of expression (which would include the right to "seek, hear and read") should be confirmed.<sup>434</sup> The Guidelines propose that in cases of suspension and expulsion,

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427 Sec 9(3).

428 According to the 2 March Draft of the Guidelines the proposals have been compiled by the Department of Education and reflect discussion documents received from the provincial departments of education. The draft has been made available to stakeholder organisations of learners, governing bodies, provincial departments of education and unions of educators for comment and discussion. As required by section 8(3) of the Schools Act, the Minister of Education will consult the Council of Education Ministers before publishing the final guidelines for governing bodies in the **GG (Guidelines for the Consideration of Governing Bodies in Adopting a Code of Conduct for Learners)**.

429 **Guidelines for the Consideration of Governing Bodies in Adopting a Code of Conduct for Learners** par 1.8.

430 Ibid par 1.9.

431 Ibid par 2.2.

432 Ibid par 2.3 and 3.3.

433 Ibid par 3.7.

434 Ibid par 4.3 and 4.5.

placement in an alternative school environment (for instance, reassignment to another class or a special school for learners with behavioural disorders) or correctional education under supervision after school hours are options which could be considered in conjunction with a school psychologist or social worker. In this context it is stressed that the governing body may suspend a learner as a punitive measure if due process has been followed.<sup>435</sup> It is finally proposed in the draft Guidelines that serious misconduct (which may include offences according to the law) must be investigated by the police and referred to the court if necessary.<sup>436</sup>

6.9.2 According to media reports in October 1997 a draft document regarding misconduct and disciplinary procedures to be followed has been developed by the Gauteng Education Department. In terms of this draft a distinction is made between misconduct (for instance copying of work while writing a class test), serious misconduct (for instance possession of pornography and drugs) and criminal conduct (for instance rape and murder).<sup>437</sup> It is further proposed in the draft document that serious misconduct should be investigated by the governing body of the school involved as well as the relevant Provincial Department of Education and that learners who are found guilty of criminal conduct should receive psychological treatment and therapy, but that they could also be permanently expelled.<sup>438</sup>

6.9.3 In terms of our common law exposure of someone to HIV would under certain circumstances constitute a crime. Transmitting HIV intentionally could

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435 Ibid par 4.7(c). (According to the Schools Act [sec 8 and 9 - as confirmed in the proposed Guidelines par 13.1-13.4] due process will include the principal informing parents in writing of any proposed action after hearing the evidence of the learner; the principal arranging for a fair hearing by a number of members of and designated by the governing body; and the disciplinary committee so appointed conducting the hearing in accordance with the provincial regulations laid down by the MEC. In the case of very young learners special arrangements must be made. Parents or guardians could represent learners.)

436 **Guidelines for the Consideration of Governing Bodies in Adopting a Code of Conduct for Learners** par 14.

437 **Beeld** 15 October 1997 4.

438 Ibid.

constitute assault. Civil liability could also ensue as a result of exposure to HIV.<sup>439</sup> The possibility of strict liability of the state is provided for in the Schools Act in instances of damage or loss caused as a result of any act or omission in connection with any educational activity conducted by a public school.<sup>440</sup> The state may be held responsible where adequate precautionary measures are not taken and a safe school environment is consequently not established. (Liability will generally not result from the school principal being unaware of a learner's HIV status.) In accordance with the Gauteng draft document on misconduct referred to in the previous paragraph, a Code of Conduct could for instance distinguish between misconduct, serious misconduct and criminal acts in the context of HIV/AIDS. The Code could further provide for measures to be taken against learners who misbehave. They may for instance, in terms of the Schools Act, be dealt with by way of suspension or expulsion as provided for in section 9. It should however be noted that if a learner who is subject to compulsory school attendance in terms of section 3(1) of the Act, is expelled from a public school, the Head of Department must make an alternative arrangement for his or her placement at another public school. Learners with severe behavioural problems could therefore be placed at a public school for learners with special education needs.<sup>441</sup> Schools for learners with special education needs include clinic schools which cater for the needs of learners with behavioural deviations.

- 6.10 The proposed national policy has been adapted to reflect a balance between the rights of both learners with HIV and learners without HIV by expressly referring to the duties of learners with HIV and the responsibilities of their parents and legal guardians;<sup>442</sup> by identifying the Code of Conduct of a school as the ideal mechanism through which to address behaviour which may create risk of HIV transmission;<sup>443</sup> and by revising the provisions with regard to universal precautions to effectively exclude the risk of

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439 See also par 3.31 et seq above.

440 The Schools Act sec 60(1).

441 Cf the Schools Act sec 12(3).

442 Clause 10.

443 Clause 10.2.

transmission of HIV in the normal school environment, especially with regard to sport participation.<sup>444</sup>

**B) THE NEED FOR BROADER APPLICATION OF THE POLICY**

6.11 As indicated in the previous Chapter, many respondents drew attention to a need for application of the same policy, or a similar policy, to institutions within the educational context (other than schools) where the same problems with regard to HIV/AIDS would present themselves. These include centres for pre-school children and

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444 Clauses 7 and 8.

day care, institutions for tertiary education, and residential institutions. It was also proposed that the policy should cover the position of educators and school staff with HIV.

\* **Pre-schoolers and day care centres (very young children)**

6.12 The Commission acknowledges the comment of experts working with pre-school children that although the principles set out in the national policy are relevant to very young children, the solutions and suggestions proposed in the policy are, on a practical level, unsuitable for such children.<sup>445</sup> The reason advanced for this is that very young children are neither physically nor emotionally able to protect themselves against transmission of HIV. It was for instance mentioned that they would indiscriminately assist another child who bleeds rather than adhere to precautionary guidelines. It is also doubtful whether HIV/AIDS education would be meaningful or appropriate at pre-school level.

6.13 The Commission therefore confirms its view that the chief focus of the national policy should be children of school going age (which will include learners from pre-primary<sup>446</sup> school to secondary school - i e from grade zero to grade 12). If the Commission's recommendations are adopted by the Department of Education, the proposed policy will be enunciated under national legislation. As such it will signal a clear governmental commitment against unfair discrimination with respect to HIV/AIDS which persons and bodies involved with the care of very young children would not be able to ignore. The policy would also be publicly available and accessible and could constitute a broad model on which public and private entities could base similar policies more suitable for situations where very young children are cared for and educated.

\* **Tertiary institutions**

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445 Cf par 5.76 et seq above.

446 Dr N Louw during informal discussions with Prof C van Wyk (project committee member) and the researcher on 24 February 1998, stressed that children in the pre-primary stage should not be underestimated: They have the ability to understand that they are not to touch blood (see also fn 46).

6.14 The Commission has sympathy with respondents stressing the need for a similar policy at tertiary level,<sup>447</sup> but has to confirm its preliminary view that its recommendations will be applicable only to schools as defined in the Schools Act.<sup>448</sup>

6.14.1 The Policy Act will have to be used as a statutory vehicle to promulgate the proposed national policy. As pointed out in Chapters 3 and 4 above, neither this Act nor the Schools Act apply to university or technikon education.<sup>449</sup>

6.14.2 Specific protection is afforded "children" by our Constitution, and also by the **United Nations Convention on the Rights of the Child (1989)**<sup>450</sup> dealing with the rights of the child (on which certain of the principles enunciated in the policy are based). In both these instruments "children" are defined as persons under the age of 18 years.<sup>451</sup>

6.14.3 Although the broad constitutional principles (for instance non-discrimination, respect for privacy, freedom of association and access to information) would be applicable to persons attending tertiary institutions, it is also clear that the majority of provisions in the proposed national policy (for example those relating to compulsory school attendance, alternative provision for compulsory education in certain instances and the possibility of school level policies to be developed by [relatively small] individual school communities) would either be inapplicable to or ill-suited for persons above the age of 18 years and the much broader and bigger university and technikon communities. The problems inherent in establishing a suitable policy with regard to the wide variety of circumstances existing within our school communities alone was noted earlier.<sup>452</sup> In view of this the Commission is of opinion that it would be wellnigh impossible to address primary, secondary as well as tertiary institutions in a

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447 Cf par 5.77 et seq above.

448 See par 3.16 and 3.17 as well as fn 201, 202 and 196 in this regard.

449 Par 3.51.4 and 4.5.

450 See fn 191.

451 Cf par 3.16, 3.17, 3.37, 4.5 and fn 191 above.

452 Par 6.4 et seq above.

single policy.

6.15 As stated above with regard to pre-schoolers or very young children, the proposed national policy will, should it be promulgated, in any event be accessible and any institution would be free to adopt it.

\* **Residential institutions**

+ *Hostels*

6.16 The project committee in Discussion Paper 73 invited specific comment on whether the proposed policy should also apply to school hostels.<sup>453</sup> This was done on the assumption that hostels are not included in the definition of "schools" contained in the Schools Act.<sup>454</sup>

6.16.1 The vast majority of commentators who responded to the invitation felt that an HIV/AIDS policy was needed in respect of school hostels. Strong arguments were presented in favour of applying the same policy in schools and hostels. On the other hand, some commentators argued that additional measures were needed in view of what was considered to be a high risk situation.

6.16.2 In discussions with representatives of the Department of Education since publication of Discussion Paper 73,<sup>455</sup> it was indicated that in the Department's view the definition of "school" indeed includes hostels.<sup>456</sup> The Department furthermore expressed the view that the proposed national policy would be suitable for hostels and other situations (for instance school excursions or tours)

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453 Cf par 4.11 and 4.13 above.

454 Par 3.15.2 of **SALC Discussion Paper 73**. Cf also par 4.11 above.

455 See fn 46 above.

456 The Department based their conclusion on the provisions of sec 12(3) read with the definition of "school" in sec 1(xix) of the Schools Act.

where learners are gathered together. In view of this, the Commission accepts that the proposed policy will also apply to school hostels.

6.17 In spite of the concerns expressed by several respondents that stronger measures, especially with regard to disclosure of HIV-related information, were necessary in the residential situation in order to ensure the safety of learners without HIV, the Commission is of the opinion that the compulsory disclosure of HIV-related information in the residential situation will not alleviate the problem. As stated above, knowledge of HIV status cannot ensure an HIV-free environment because of the window period and the nature of HIV antibody testing.<sup>457</sup> Genuine voluntary disclosure of HIV status (for instance to care givers such as the matron or hostel superintendent) should be welcomed.<sup>458</sup> Strict adherence to universal precautionary measures is essential in the residential environment. Furthermore, where special provisions are required - for instance to ensure stricter supervision of hostel boarders - the proposed national policy is in general wide enough to enable the governing body to make provision for the specific needs of an individual school community with regard to hostels through the mechanism of a school level policy.

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<sup>457</sup> Cf par 2.41-2.45 above.

<sup>458</sup> Refer also to par 6.54 below where disclosure of HIV-related information is evaluated in general.

+ *Institutions for learners with special education needs (including institutions for mentally and physically disabled learners)*

6.18 Some commentators emphasised the need for a similar policy in respect of institutions for physically and mentally handicapped children, while others expressed concern about HIV-related problems in schools for learners with special education needs (such as reform schools and schools of industry).<sup>459</sup>

6.19 In a recent report of the Department of Education on special needs and support services in education and training in South Africa (**Special Needs Report 1997**)<sup>460</sup> it is stated that specialised education is currently organised in various ways and within a variety of settings which include both ordinary and specialised schools. The latter include specialised schools for learners who are blind, autistic, etc (i e physically disabled);<sup>461</sup> residential institutions for severe and profound types of "special needs" (which may be relevant in the context of HIV/AIDS and could serve the needs of AIDS orphans);<sup>462</sup> schools of industry, reform schools and places of safety for learners who have found themselves in trouble with the law or are in need of protection;<sup>463</sup> schools for mentally disabled children;<sup>464</sup> schools for children with behaviour deviations (clinic schools);<sup>465</sup> and hospital schools.<sup>466</sup> It would also include hostels for the residential accommodation of learners in these schools.<sup>467</sup>

6.19.1 The **Special Needs Report 1997**, furthermore, in analysing "barriers to learning and development", identifies certain socio-economic factors which place

459 Cf par 5.84 et seq above.

460 "Quality Education for All: Overcoming Barriers to Learning and Development" Report of the National Commission on Special Needs in Education and Training (NCSNET) and the National Committee for Education Support Services (NCESS): Department of Education, Pretoria 28 November 1997.

461 **Special Needs Report** 30.

462 Ibid.

463 Ibid.

464 Information supplied by Dr N Louw, Member of the National Task Team: Life Skills and HIV/AIDS Education Programme of the Department of Education and the Department of Health on 24 February 1998.

465 Ibid.

466 Ibid.

467 The Schools Act sec 12(2) and (3).

learners "at risk". The Report expressly acknowledges that HIV/AIDS has placed and will continue to place a large number of learners at risk. The Report states that the epidemic will affect not only those learners who have HIV, or are AIDS ill, but also those whose parents have died or who are chronically ill from the disease (AIDS orphans).<sup>468</sup>

6.20 According to the definition of "public school" in the Schools Act, a public school may include an ordinary public school or a public school for learners with special education needs.<sup>469</sup> Section 12(4) of the Act states that *where reasonable and practicable* education must be provided for learners with special education needs at ordinary public schools. In other instances education for such learners may be provided at schools for learners with special education needs. In terms of section 12(4) the relevant support services for such learners must also be provided. The Policy Act provides that the Minister of Education shall determine national policy in respect of the education system, and the Act includes in its definition of "education institution", "specialised education". It follows that the proposed policy will also be applicable to schools for learners with special education needs.

6.21 The Commission is of the opinion that although the broad guidelines included in the policy would be suitable for schools for children with special education needs, the policy would have to be further developed by the governing body at school level in order to provide adequately for the specific circumstances and needs prevailing at an individual school. It stands to reason that where children with special needs are gathered together in the school or residential situation, specific needs may arise with regard to HIV/AIDS, and the school principal or other responsible persons may feel an added responsibility for the safety and protection of learners without HIV. The right to life and the right to an environment that is not harmful to health or well-being of learners without HIV will, in circumstances where learners without HIV are endangered by promiscuous sexual behaviour and sexual assault, weigh heavier than the rights of children with HIV. A

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468 **Special Needs Report 1997** 34.  
469 Sec 1(xviii) read with sec 12.

suitable HIV/AIDS school level policy could under these circumstances be developed within the framework of the national policy.

6.22 This approach is supported by section 24 of the Schools Act which provides that the following categories of persons *must* be represented on a governing body of a public school for children with special education needs: parents of learners at the school; educators at the school; members of staff at the school who are not educators; learners attending the eighth grade or higher, if reasonably practicable; representatives of organisations of parents of learners with special education needs; representatives of organisations of disabled persons; and experts in appropriate fields of special needs education. Also in the instance of an ordinary public school providing education to learners with special education needs, the governing body must, where practically possible, co-opt a person or persons with expertise regarding the special education needs of such learners.<sup>470</sup>

6.22.1 The critical role which parents need to play in the education and development of learners with special education needs, parent empowerment and training programmes for parents are also emphasised in the **Special Needs Report 1997**.<sup>471</sup> The Report furthermore stresses the need for an integrated approach to be followed with regard to learners who experience barriers to learning and development, including troubled young people, within a systems perspective. It is suggested that medical practitioners, school health nurses, therapists, community-based rehabilitation workers, social workers and professionals from other disciplines should assist in providing a specific service to these learners.<sup>472</sup> This approach is supportive of the Commission's proposals that experts from the school community (in the form of a Health Advisory Committee) should participate in formulating a school level policy within the framework of constitutional principles.<sup>473</sup>

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470 The Schools Act sec 23(5).

471 **Special Needs Report 1997** 47.

472 Ibid 46.

473 Cf clause 13 of the proposed national policy.

6.23 The Commission is thus of the opinion that satisfactory provision exists, both in the form of existing legal provisions and in the envisaged possibility of a school level policy, in respect of schools for children with special education needs to be able to cope with HIV/AIDS.

\* **Independent Schools**

6.24 Some commentators observed that the position of independent schools has not been clearly addressed - neither in Discussion Paper 73 nor in the proposed national policy included for comment in the Discussion Paper.<sup>474</sup>

6.25 The legal position with regard to independent schools has now been set out in Chapter 3 of this interim report.<sup>475</sup> Broadly speaking it amounts to the following:

6.25.1 Independent schools may not unfairly discriminate against learners with HIV. Although such schools are not expressly prohibited from requiring a negative HIV test result as a prerequisite for admission, the use of the test result as the sole criterion for denying admission would probably amount to unfair and irrational discrimination.<sup>476</sup>

6.25.2 Independent schools have a right to freedom of association and to promote their own religion, culture and values although they may not discriminate on the ground of race.<sup>477</sup> Such schools do not have any statutory duty to provide education.<sup>478</sup> They must respect the right to privacy although they may be obliged to provide information which is required for the protection

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<sup>474</sup> Cf par 5.87 et seq above.

<sup>475</sup> Par 3.58 et seq. See also par 3.12, 3.16.1, 3.17.2, 3.27, 3.34.2 and 3.41.

<sup>476</sup> Par 3.12 above.

<sup>477</sup> The 1996 Constitution sec 18 and the Policy Act sec 4(a)(vii).

<sup>478</sup> Cf par 3.16 et seq.

of a person's rights.<sup>479</sup>

6.25.3 It was submitted above<sup>480</sup> that the definition of "education institution" in the Policy Act is wide enough also to include independent schools. This would mean that a national policy determined, published and implemented in accordance with this Act, would apply also to independent schools. The same enforcement mechanisms discussed above, and for which the Act makes specific provision, would apply.<sup>481</sup> However, the Educator's Employment Act (providing for the discharge of an educator on account of misconduct - which includes contravening or failing to comply with any provision of any law relating to education) does not apply to educators employed in independent schools. Nor would the direct enforcement offered by the Code of Conduct adopted by SACE be applicable without further ado to educators in independent schools.<sup>482</sup> The Code of Conduct does not compel educators in independent schools to register. Educators in independent schools who do not register of their own accord are therefore not bound by the Code of Conduct and could accordingly not be subjected to the disciplinary powers of SACE should they ignore the rights of learners. It has however been pointed out in Chapter 3 above that the Code is likely to carry moral authority even in the case of such educators.<sup>483</sup>

6.26 In view of the fact that compliance with the proposed national policy cannot otherwise be ensured in the case of independent schools, the Commission is of the opinion that compliance with the policy should in terms of section 46(2) of the Schools Act be determined as a ground on which registration of independent schools may be granted.<sup>484</sup> As with other institutions not directly covered, the policy will be accessible should it be promulgated, and independent schools would in any event also be free of their own accord to adopt it.

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479 Cf par 3.23, 3.32.2, 3.47.3 and 3.48 above.

480 Cf par 3.51.4 and 3.58 above.

481 Cf par 3.55 et seq above.

482 Par 3.57 above.

483 Ibid.

484 Cf fn 210 above.

\* **All institutions of learning**

6.27 As indicated in paragraph 5.89 et seq above, some commentators were in favour of a single policy (the proposed national policy) being applied to all institutions of learning (from institutions for very young children to tertiary institutions, hostels, and schools for learners with special education needs).

6.27.1 The Commission's response to requests in respect of each of these institutions is dealt with in par 6.12-6.23 above. In view of the motivation supplied in these paragraphs it is concluded that a single policy covering all of these institutions would not be feasible nor does legislative authority for this exist in all instances.<sup>485</sup> As pointed out, any institution would be free to develop suitable policies in respect of individual institutions along the broad guidelines of the proposed national policy for learners in public schools.

\* **Youth organisations and day care centres**

6.28 The Commission supports proposals by commentators that the policy should be promoted as recommended practice to youth organisations and day care centres. There is however no legislative authority to make the proposed policy statutorily applicable to such organisations and centres or to ensure its enforcement. The Commission once again stresses that any institution or organisation would be free to adopt the policy or its broad guidelines.

\* **Educators and administrative staff at schools**

6.29 Although the Commission appreciates that HIV-related problems could arise with respect to educators and administrative staff with HIV at school, it is of the view that the

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485 Cf par 6.14.1 above.

proposed policy is not suitable to deal with problems at employment level.

6.29.1 The Educators' Employment Act,<sup>486</sup> the Labour Relations Act 66 of 1995 and the Basic Conditions of Employment Act 75 of 1997 deal with the rights of educators as employees. The Labour Relations Act and the Basic Conditions of Employment Act will also cover the position of administrative staff at schools. In addition to this, proposals by the Commission to prohibit pre-employment HIV testing, except in narrowly defined circumstances, have been included in the Employment Equity Bill which has been released for comment by the Department of Labour in December 1997.<sup>487</sup> The Commission's First Interim Report on Aspects of the Law Relating to AIDS, 1997 dealt with universal work place infection control measures (universal precautions) which will also apply to educators and school personnel when implemented by the Department of Health.<sup>488</sup>

6.29.2 Furthermore, the education authorities and relevant professional bodies have already addressed the need for a national policy on HIV for educators. A first draft for a policy in this regard has become available in February 1998. The draft confirms principles of non-discrimination and addresses recruitment and continued employment; training, development and promotion of educators with HIV; ill-health, leave and performance; benefits; grievance and disciplinary procedures; refusal to work with an educator with HIV/AIDS; employer and employee responsibilities; HIV testing; confidentiality; colleagues' and management fears; and management, care and counselling of HIV/AIDS at work.<sup>489</sup>

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486 Proclamation 138 of 1994.

487 General Notice 1840 of 1997 in GG 18481 of 1 December 1997.

488 The National Assembly resolved on 18 September 1997 that the recommendations in the report should be implemented urgently by the government. The Department of Health indicated on 23 February 1998 that it is addressing the implementation.

489 **National Policy on HIV/AIDS for Educators.**

**C) ADDRESSING ADDITIONAL MATTERS IN THE PROPOSED POLICY****\* Multi-disciplinary approach**

6.30 The Commission acknowledges the need expressed by many commentators for a multi-disciplinary approach in dealing with HIV/AIDS in schools.<sup>490</sup>

6.31 The Commission is of the opinion that it would be meaningful to separate education on HIV/AIDS from support services regarding HIV/AIDS. In the Commission's view the primary responsibility of schools with regard to HIV is that of information and education. This responsibility should be supported by other disciplines: For instance matters such as accessibility of condoms, access to health care, counselling, prevention of sexually transmitted diseases and teenage pregnancy, and reproductive health care could successfully be dealt with by other disciplines in a supportive role. Schools do not usually have the professional medical staff available for such support services and the Department of Health could assist in this regard. To strengthen the Department of Health's involvement in preventing the spread of HIV at school level, a representative of the Department (for instance a nurse attached to a provincial hospital) could be co-opted on the Health Advisory Committee envisaged in Clause 13 of the proposed policy.

6.31.1 Commentators for instance mentioned the inaccessible hours of public health facilities.<sup>491</sup> In this regard it is recommended that the Department of Health should assist in making clinical services available during school hours or on the school premises after hours. In this way care could be taken of concerns of parents that schools should not encourage sexual promiscuity by promoting for instance condom use.

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490 Cf par 5.52 et seq.  
491 Par 5.104 et seq.

- 6.31.2 Furthermore, social service providers should be encouraged to provide support in preventing the spread of HIV.<sup>492</sup> The Family and Marriage Society of South Africa for instance indicated in their comments on Discussion Paper 73 that they are equipped to assist with relaying information, with training and education.<sup>493</sup> The ACVV also voiced a desire to be actively involved in supplying a supportive role to schools through social workers in their service.<sup>494</sup>
- 6.32 The Department of Welfare supports the multi-disciplinary approach. Commenting recently on its Draft Social Welfare Plan on HIV/AIDS the Department observed that "in view of the need for increased family support for people affected by HIV/AIDS a support/caring community based model should be urgently developed. Support programmes addressing the needs of especially, rural residents living with HIV/AIDS are vital".<sup>495</sup> The Draft Social Welfare Plan on HIV/AIDS expressly stresses the need to create partnerships within state structures and with civil society in order to deal with the HIV/AIDS epidemic.<sup>496</sup>
- \* **Condoms**
- 6.33 It is confirmed, from the contradictory viewpoints held by commentators, that any provisions in a national policy regarding supply of condoms to learners, or access to condoms, will be highly controversial. The Commission is thus of the view that express provision in this regard should not at this stage form part of the broad guidelines of a national policy on HIV/AIDS in schools.
- 6.34 As stated above, the Commission regards information and education on

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492 This multi-faceted approach was also advocated in the **Special Needs Report 1997** 71 et seq.

493 Par 5.52.1 above.

494 Par 5.52.2.

495 Correspondence received by the Secretary SALC from the Director Special Needs in the Department of Welfare on 14 January 1998 regarding the SALC's current investigation into the review of the Child Care Act.

496 Ibid.

HIV/AIDS as the main responsibility of schools.<sup>497</sup> Supply of condoms would more suitably fall within the ambit of a public health care initiative or HIV/AIDS prevention campaign by the Department of Health. The Commission is of the view that this could be an excellent example of a multi-disciplinary approach in preventing the spread of HIV among children of school going age.

6.35 However, the proposed national policy has been couched in wide enough terms to enable the governing body of a school to include provisions regarding condoms suitable to the specific school community, in a school level policy. The provisions in the Schools Act with regard to the compulsory composition of governing bodies (the principal, parents of learners, educators at the school, administrative staff members, and learners<sup>498</sup>) and the additional provisions in the proposed national policy regarding the establishment of a Health Advisory Committee<sup>499</sup> should ensure proper community-based decisions in this regard. The Commission holds the strong opinion that the controversy of the issue requires the intimate participation and final discretion of the parent community in any decision regarding supply of condoms.

\* **Refusal to study with a learner with HIV**

6.36 Certain respondents drew attention to problems that may arise where no clear or explicit guidelines exist with regard to the refusal to study with a learner with HIV.<sup>500</sup>

6.36.1 In view of the Commission's conclusion that compulsory disclosure of a learner's HIV status is probably not at present enforceable,<sup>501</sup> it is unlikely that this situation will be widespread. Should it however become known that a learner has HIV, and other learners refuse to study with him or her, it is recommended that such learners and their parents be counselled. If counselling

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497 Par 6.31 above.

498 The Schools Act sec 23 and 24.

499 Clause 13 of the proposed policy.

500 Cf par 5.101.

501 Par 3.47 above.

does not succeed in alleviating their fears, and the situation becomes unmanageable, the problem should be resolved by the principal and educators and if necessary, with the assistance of the governing body of the school. All learners' best interests and constitutional rights should be taken into account in finding a solution. The proposed policy has been adapted to include a suitable provision in this regard.<sup>502</sup>

\* **Facilities for terminally ill learners**

6.37 No statutory authority exists for the inclusion in the national policy of provisions regarding facilities for terminally ill learners as requested by some commentators.<sup>503</sup>

6.38 According to the **Special Needs Report 1997** referred to in par 6.19 above, the needs of the small percentage of learners who require high levels of support, should be accommodated in existing specialised learning contexts. In this regard it is to be noted that schools for learners with special education needs include hospital schools in which terminally ill learners could be accommodated. Where learners cannot be accommodated within a school, it is proposed in the Report that home- and community-based programmes should be provided.<sup>504</sup> The Schools Act also provides for the possibility that learners may receive education at home.<sup>505</sup>

\* **Proper regulation of contact sport**

6.39 Several commentators were concerned that the heightened risk of HIV transmission perceived to be inherent in contact sport was not adequately addressed in the policy proposed in Discussion Paper 73.<sup>506</sup>

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502 Clause 11 of the proposed policy.

503 Cf the requests of commentators referred to in par 5.106.

504 **Special Needs Report 1997** 156.

505 Sec 51(1).

506 Cf par 5.64 et seq.

6.40 In response to this the Commission took recourse to the National Department of Sport and Recreation's Draft Position Statement: HIV/AIDS in Sport which was issued in July 1997 in conjunction with the South Africa Sports Medicine Association and the Department of Health.

6.40.1 In the Draft Position Statement it is pointed out that there has been only one alleged report of HIV transmission during sport, and anecdotal reports of transmission following fist fights.<sup>507</sup> It is stressed that current scientific evidence suggests that there is an infinitesimally small risk of HIV transmission during the majority of sports and that there is no risk of transmission from saliva, sweat, tears, urine, respiratory droplets, hand shaking, swimming pool water, communal bath water, toilets, food or drinking water.<sup>508</sup>

6.40.2 The Statement indicates that the only risk of HIV transmission during sport is if the blood from an open bleeding wound of an infected participant mixes with the blood of an open wound of a non-infected participant. The seriousness of this risk depends on the seroprevalence of HIV in the sports participants; the risk of open bleeding wounds during sports participation; the risk of viral transfer when two bleeding wounds make contact; and the risk of two participants making contact.<sup>509</sup>

6.40.2.1 Some researchers regard specific contact sports as presenting a higher risk of HIV transmission. These include soccer, rugby, boxing and wrestling.<sup>510</sup> The South African Rugby and Football Union (SARFU) in a policy statement on HIV and rugby participation dated May 1996, in fact stated that "positive individuals should be discouraged

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507 **Draft Position Statement: HIV/AIDS in Sport 1997** 3. According to Hassan however, the alleged report from Italy - which concerned a case of possible HIV transmission between soccer players - was not shown to be conclusive (Hassan [Unpublished] 3).

508 **Draft Position Statement: HIV/AIDS in Sport 1997** 3.

509 Ibid.

510 Schweltnus (Unpublished) 2.

from participating in rugby despite the absence of any scientific evidence to suggest that asymptomatic HIV (positive) players are 'unfit' to play".<sup>511</sup> Undoubtedly, boxing by its very nature (repeated blows) is a unique sport and in South Africa, the United Kingdom and certain states in the US, mandatory HIV testing of professional boxers is, for instance, required.<sup>512</sup>

6.40.3 It is however stressed in the Draft Position Statement that the above observations regarding the low risk of transmission of HIV during sport participation hold true only if adequate wound management takes place at the sport field when a player sustains an open bleeding wound.<sup>513</sup>

6.41 The Commission is of the view that also in respect of sport, undue reliance should not be placed on the knowledge of a participant's HIV status.<sup>514</sup> It has been shown above that because of the window period HIV tests currently used cannot with 100% surety indicate at a specific point in time who is infected and who not.<sup>515</sup> Both the World Health Organisation and the International Olympic Committee hold the view that there is no medical or public health justification for testing or screening for HIV infection prior to participation in sports activities.<sup>516</sup> Routine HIV testing provides no guarantee and instead creates a false sense of security and may result in the greater likelihood of HIV transmission.<sup>517</sup>

6.41.1 In the Draft Position Statement referred to in the previous paragraphs, sport participants with HIV are advised to inform medical personnel of their condition if they sustain an open wound or skin lesion during sport so that these can be managed appropriately.

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511 As quoted in Hassan (Unpublished) 5.

512 Hassan (Unpublished) 11.

513 **Draft Position Statement: HIV/AIDS in Sport 1997** 3.

514 See also Hassan (Unpublished) 2 and 10.

515 Refer to par 2.42-2.45 above where the significance of the window period with regard to HIV testing is explained.

516 Hassan (Unpublished) 12, 17.

517 See also Hassan (Unpublished) 2-3.

6.41.2 Educating sport administrators and role players about HIV/AIDS and the risks and routes of HIV transmission, and strict compliance with universal precautions when providing medical attention in the case of bleeding as a result of injury can effectively exclude the risk of HIV transmission on the sports field.<sup>518</sup>

6.42 The Commission, in acknowledging the concerns expressed by commentators, adapted the proposed national policy by expressly including guidelines regarding sport participation.<sup>519</sup> These have been compiled in accordance with the National Department of Sport and Recreation's Draft Position Statement referred to above, although not all guidelines were adopted.

#### **D) ADAPTING THE TERMS OF THE POLICY**

6.43 The clauses referred to in the headings below correspond with the proposed policy as published for comment in Discussion Paper 73 and duplicated in Chapter 4 above. Comments in respect of broader application of the policy and additional matters to be included in the policy have been discussed in paragraph 6.11 to 6.42 above.

#### **\* Preamble**

6.44 Suggestions by commentators regarding additional information that should be included in a preamble to the policy<sup>520</sup> (for instance a brief description of the course of HIV in children, reference to sexual abuse as a way of transmission of HIV, and clarification of what constitutes a "medically recognised risk") have been catered for under "Premises" in the revised policy. The provisions under "Premises" contain the background against which the policy should be understood. If further information is needed, it is suggested that Chapter 2 (which deals with the course of HIV) and Chapter 3 (which

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518 Ibid.

519 Clause 8.

520 See par 5.22-5.25 above.

provides information on rights and duties in the school environment and balancing of rights) of this interim report could be made available to interested parties.

\* **Definitions (Clause 1)**

6.45 Some commentators submitted that the concept of "universal precautions" should be clearly defined in the national policy. This has been done in the definitions clause (clause 1.1). The concept was however further clarified under "Premises" (clause 2.6.1) and in the additional clause on a safe school environment (clause 7.1-7.12).

\* **Admission and testing (Clause 2)**

6.46 Some respondents to Discussion Paper 73 saw a need for HIV testing, especially of learners who are resident in school hostels, in order to protect learners without HIV. However, because of the window period and the nature of HIV testing discussed above,<sup>521</sup> an HIV-free school environment would not be guaranteed by requiring compulsory testing as a condition for admission to schools or hostels. Such approach could only lead to a false sense of security as it would not be possible to establish with certainty who is infected and who not. The most successful ways to prevent exposure to HIV in the normal school environment would be by constantly adhering to standard infection control procedures or precautionary measures aimed at the prevention of HIV transmission, and by ensuring that proper information regarding the transmission of HIV reaches the school population through a continuous education programme on HIV/AIDS.

6.47 The Commission is of the opinion that the proposed policy cannot, as requested by some commentators, prohibit HIV testing for whatever reason (for example the granting of bursaries). The policy is drafted within the ambit of a learner's right to a basic education as enunciated in the Schools Act and the 1996 Constitution. Furthermore,

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521 Par 2.41-2.45.

circumstances may conceivably arise which would justify HIV testing.<sup>522</sup>

6.48 The Commission is of the opinion that in general, information regarding the health of learners is offered on a voluntary basis by parents<sup>523</sup> and that this could be regarded as being in the learner's best interest (for example in the instance where parents supply the school with information regarding allergies suffered by their child). In a similar manner parents are free to offer information regarding their child's HIV infection. Consequently the South African National Council for Child and Family Welfare's submission in comments on Discussion Paper 73 (that even though HIV testing should not be a prerequisite for admission to schools, this information should be required in instances where parents supply the school with medical information regarding their child<sup>524</sup>) is not tenable.

\* **No unfair discrimination (Clause 3)**

6.49 Some commentators argued that by prohibiting *unfair* discrimination it is implied that a learner with HIV may be fairly discriminated against. This they found unacceptable and they therefore requested that the term "unfair" be deleted throughout the proposed policy.<sup>525</sup>

6.49.1 The Commission's view is that the language used is in accordance with the constitutional provision on equality in section 9(3) and (4) of the 1996 Constitution<sup>526</sup> as well as with corresponding provisions in the Schools Act<sup>527</sup> and the Policy Act.<sup>528</sup> These provisions indeed mean that in some instances it may be fair to treat a learner with HIV differently. Discrimination may for instance be fair

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522 Cf par 3.39 et seq above.

523 This was confirmed in discussions with representatives of the Department of Education on 24 February 1998. For more detail on these discussions see fn 46 above.

524 Cf par 5.27 above.

525 Cf par 5.29 above.

526 See par 3.11 et seq above for a full discussion of these provisions.

527 Sec 5(1).

528 Sec 4(a)(i).

and rational where learners with HIV present a significant risk to the life and limb of others which cannot be excluded by reasonable precautionary measures. The right to life and bodily integrity of the learner without HIV will in such cases outweigh the right to equality of the learner with HIV.<sup>529</sup>

6.49.2 Suggestions that a culture of non-discrimination should be established through education, is discussed in paragraph 6.65 below.

6.50 In response to NAPWA's emphasis in its comments on the necessity for parents of learners with HIV to be informed about all inoculation programmes, the original provision to this effect has been retained in the proposed national policy but has now been included under "Premises".<sup>530</sup>

\* **Disclosure (Clause 4)**

6.51 A significant number of respondents requested that disclosure of HIV status to some or other school staff member should be compulsory. The reasons for this view were that otherwise no relationship of trust between educators and learners would be possible; contact sport would not be properly regulated; and uncertainty with regard to possible liability in the case of transmission of HIV or exposure to HIV would ensue. Respondents suggested that the relevant person who should receive this information could be the school principal, the hostel superintendent, the class educator, governing bodies, the school matron or school nurse, the guidance teacher, or sports master. It was even suggested that the entire staff should be allowed access to HIV-related information.<sup>531</sup> Although not expressly endorsing the idea of compulsory disclosure, the Department of Health suggested that the "need-to-know" concept could be indicative of persons who may possibly be the relevant persons to be informed of the HIV status of a learner.<sup>532</sup>

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529 See par 3.44 et seq above.

530 See Clause 2.7 of the proposed national policy.

531 Par 5.31 et seq above.

532 Par 5.31.2 above.

According to this concept (which already enjoys wide recognition in the health care setting), and given the limited ways in which HIV can be transmitted, only those persons for whom AIDS-related information in regard to the care and treatment of children is indispensable, should be informed.<sup>533</sup> Such persons could, depending upon the circumstances in the school environment, include the school principal, class educator, guidance councillor, sports master or coach, hostel superintendent, matron or school nurse.<sup>534</sup>

6.52 Contrary to the above, other commentators were of the view that disclosure is unnecessary if universal precautions were applied in all instances of exposure to blood and body secretions, and if adequate information and education regarding the prevention of HIV transmission were given to all learners.<sup>535</sup> The consistent application of universal precautions implies that all persons are regarded as being potential carriers of HIV. Furthermore, it is accepted that the risk of transmission of HIV is effectively excluded by the application of universal precautionary measures. Commentators pointed out that these measures are of a basic nature and are in essence aimed at providing a barrier against blood contact.<sup>536</sup> It has moreover been stressed by experts from the Department of Education that young children can be effectively taught never to touch blood.<sup>537</sup> Consequently there is no need for HIV status to be divulged. This would be the case even in respect of sport contact and school excursions, school hostels and schools for learners with special education needs. In instances where learners are sexually active, the heads of relevant institutions should timeously take adequate measures.<sup>538</sup> A healthy and safe school environment will not be enhanced by disclosure of HIV status but by taking adequate precautionary measures. Furthermore, since an HIV-free environment cannot possibly be ensured because of the window period inherent in HIV antibody tests in

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533 Cameron *AIDS Bulletin* March 1993.

534 See the comments discussed in par 5.33 et seq above.

535 Cf par 5.34 et seq above.

536 Refer to the comments recorded in par 5.61 and 5.67. (The City of Durban Health Department pointed out in its comments that unsophisticated alternative measures may be used, eg plastic packets instead of latex gloves.)

537 Information supplied by Dr N Louw (member of the National Task Team: Life Skills and HIV/AIDS Education Programme) - see fn 46 above.

538 Eg by the segregation of children (according to age group and gender), disciplinary measures against sexually aggressive learners and adequate supervision where this is deemed to be necessary.

current use, a false sense of security could ensue.

6.53 Commentators were also concerned that HIV-related information will not be treated as confidential. In discussions with representatives of the Department of Education<sup>539</sup> these views were confirmed. In the Department's opinion disclosure of HIV status of learners would serve no meaningful purpose. The Department stressed that such information could only lead to increased discrimination against learners with HIV since the South African community has not yet developed a culture of non-discrimination and tolerance towards persons with HIV.

6.54 Although the legal position at present is not absolutely certain<sup>540</sup> and has since publication of Discussion Paper 73 not been clarified, the Commission confirms the view expressed in the Discussion Paper that disclosure of HIV status to a school is probably not legally enforceable. The Commission accepts the submission that universal precautions, information and education on HIV/AIDS and a Code of Conduct are better vehicles to bring about a safe school environment. Any learner with HIV (above the age of 14 years) or his or her parent would however be free to disclose voluntarily the learner's HIV status. The Commission is of the opinion that genuine, voluntary disclosure of the HIV status of learners should be welcomed. Voluntary disclosure of HIV status on a need-to-know basis could promote the development of an enabling environment, a culture of openness and of non-discrimination. This would imply that different "caretakers" could be informed depending on the nature of the institution (for instance the matron in the case of a school hostel or the resident school nurse at an independent school). The need-to-know concept could be expanded on by the governing body of a specific school through a school level

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539 See fn 46 above for detail.

540 The 1987 Regulations (in terms of which the parent or guardian of a child who attends a teaching institution as a pupil, and who, to the knowledge of the parent or guardian, suffers from AIDS or was in contact with any person suffering from AIDS, shall inform the principal of the teaching institution concerned immediately of such condition [reg 7(2)]) have, as far as could be ascertained never been applied to HIV or AIDS. Draft regulations intended to replace the 1987 Regulations were published for comment in 1993 but have since not been finalised or promulgated. For more detail see par 3.8 et seq above. The 1987 Regulations are also discussed in **SALC Working Paper 58** (par 3.164-3.165) and in **SALC First Interim Report on Aspects of the Law Relating to AIDS** (par 5.1-5.16).

policy on HIV/AIDS.<sup>541</sup>

6.55 The confidentiality of personal information regarding HIV status is already adequately protected by the law.<sup>542</sup> The legal position is confirmed by the Code of Conduct adopted by SACE.<sup>543</sup> It naturally follows that educators who disclose the HIV status of learners without legal justification could be held liable in terms of the law or could be subjected to the disciplinary measures and penalties of the SACE Code of Conduct.<sup>544</sup>

6.56 It should be noted however that breach of confidentiality may in certain instances be justified by the overriding public interest.<sup>545</sup> An overriding public interest may exist where learners without HIV have been exposed to the blood or body secretions of learners with HIV (for example where precautionary measures failed or could not be taken). In such instances it could be justified for the school principal, who knows the HIV status of a learner to whose blood or body secretions another learner was exposed, to divulge this information. It is recommended however that the procedure to be followed under these circumstances should accord with the guidelines of the Interim South African Medical and Dental Council.<sup>546</sup>

6.57 The proposed national policy accordingly provides for universal precautions, information and education on the prevention of HIV, voluntary disclosure of HIV-related

541 Requirements relating to membership of governing bodies of ordinary public schools and public schools for learners with special education needs in the Schools Act would ensure that adequate knowledge of the particular circumstances of a specific institution would be brought to bear on decisions in this regard. See also par 4.3.2 above.

542 Refer to par 3.20 et seq above.

543 By registering with SACE educators undertake, among other things, to respect the fundamental rights of learners, which include learners' right to privacy and confidentiality. See also par 3.57 above.

544 Complaints against educators may be investigated, a fine of up to R1 000 may be levied, and the educator's name struck from the register if he or she is found guilty of a breach of the Code. This would imply that such educator can no longer teach in a public school in South Africa. See also par 3.57 above.

545 See also par 3.32 et seq and 3.47 et seq above.

546 According to the **SAMDC Guidelines** the decision whether to divulge the information to other parties involved must be in consultation with the person with HIV (in the case of learners under the age of 14 years it would have to be in consultation with the parents of such learner). If the person's consent cannot be obtained, the person seeking consent should use his or her discretion whether or not to divulge the information to other parties involved. Such decision must be made with the greatest care, after explanation to the person with HIV (or his or her parent) and with acceptance of full responsibility at all times (Cf 5-6). Knowledge of a person's HIV status would be in the interest of the exposed learner and would enable him or her to use AZT or similar prophylaxis to prevent HIV transmission.

information and for the protection of confidentiality.<sup>547</sup>

\* **Attendance (Clause 5)**

6.58           Objections by commentators against the specific requirement that written reasons for absence have to be given in the case of learners with HIV<sup>548</sup> have been addressed by removing this requirement from the amended clause 5 of the proposed policy.

6.59           The Commission acknowledges the suggestions (as recorded in paragraph 5.41 above) that specific provision should be made for computerised home education. The Commission suggests that the Department of Education should investigate the proposal that supportive education by computer could secure continued education on the same level - even when a learner is being hospitalised.

6.60           Concerns about the lack of clarity regarding the accommodation of learners with HIV-related behavioural problems<sup>549</sup> have been addressed in the amended clause 5 of the policy. Representatives of the Department of Education<sup>550</sup> pointed out that existing structures within the "education system" (as opposed to the "same institution" proposed in Discussion Paper 73) could adequately cater for these needs. This is confirmed by the information in the **Special Needs Report 1997** referred to in paragraph 6.19 above. Clause 5 of the policy has been adapted accordingly.

6.61           The Commission is of the view that concerns raised regarding behavioural problems (i.e. that they would become apparent only when it may be too late<sup>551</sup>) could be adequately addressed in a school's Code of Conduct for learners. The Code should make it clear that certain conduct is unacceptable. This approach is in accordance with the draft Guidelines for the Consideration of Governing Bodies in Adopting a Code of Conduct for

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547           Clauses 7, 9 and 6 respectively.

548           Cf par 5.40 above.

549           Cf par 5.42 et seq above.

550           See fn 46 for detail of these discussions.

551           See par 5.42.1 above.

Learners issued by the Department of Education recently.<sup>552</sup> The Draft *inter alia* provides that a Code of Conduct must be displayed at the school and be given to each learner in the official language of teaching of the learner when he or she enrolls at a school. Learners must be informed of its contents, which must list the things learners may not do, or should do.<sup>553</sup>

\* **Education on HIV/AIDS (Clause 6)**

6.62 Although not examinable in the formal sense of the word,<sup>554</sup> HIV/AIDS education will form part of the compulsory curriculum for learners and will be included in the learning area "Life Orientation" of Curriculum 2005. Life Orientation is aimed at developing life skills and includes the building of self-esteem, survival skills and a healthy lifestyle. The values and attitudes necessary for a healthy and balanced lifestyle are demonstrated.<sup>555</sup> The fact that HIV/AIDS education will form part of the compulsory curriculum implies that parents will not be able to withdraw their child from such education.

6.63 The main concern expressed by commentators regarding HIV/AIDS education relates to the need for parents to be actively consulted and not only informed about the content of HIV/AIDS education.<sup>556</sup>

6.63.1 The Department of Education confirmed<sup>557</sup> that parents are never actively consulted on the contents of curricula. The role of parents in outcomes-based education (which is central to Curriculum 2005) is that "they are required to share the responsibility of the education of their children with the state. They are

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552 See par 6.9.1 above for more detail.

553 Par 3.4 of the **Guidelines for the Consideration of Governing Bodies in Adopting a Code of Conduct for Learners**.

554 The Department of Education indicated in discussions on 24 February 1998 that the teaching content would be evaluated on a continuous basis (see fn 46 for detail on these discussions).

555 **Curriculum 2005** 220 et seq.

556 Cf par 5.44 et seq above.

557 In discussions with representatives on 24 February 1998. See fn 46 for more detail.

encouraged to further their own education (a)nd ... to use any knowledge gained to build and develop their own community and country. The first step for most parents is to understand the new curriculum and get involved with the governing bodies of schools".<sup>558</sup> The Department pointed out in discussions<sup>559</sup> that HIV/AIDS education will relate to values as well as knowledge, and described the values imparted in the Life Skills Programme as being of a universally accepted nature. The Department mentioned that parents will be invited to guidance sessions where they will be informed about the contents of and methods used in the Life Skills Programme. In these sessions parents will be made aware of their role as primary sexuality educators and imparters of values.

6.63.2 Support is found for the Department of Education's view in the comments of the South African Paediatric Association, the Department of Health and the Department of Environmental Affairs.<sup>560</sup> These commentators stressed that the education programme should have a uniformly standardised content in order to ensure proper control over what is actually taught.

6.63.3 However, in view of the important role of parents and governing bodies in the education partnership as envisaged in the Schools Act, and the overwhelming support for parent participation reflected in comments on Discussion Paper 73, the Commission recommends that parents should be involved in HIV/AIDS education at school level. This would imply that parents should be informed of HIV/AIDS education programmes presented at the school and of universal precautionary measures adopted by the school to prevent the transmission of HIV. It also implies that they should be involved in the development of a school level policy on HIV (which may contain provisions regarding condom supply). The proposed national policy has been adapted to clearly reflect this intention.<sup>561</sup>

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558 **Curriculum 2005 - Lifelong Learning for the 21<sup>st</sup> Century** 27.

559 See fn 46 above.

560 See par 5.45.10 above.

561 See clauses 9.4, 12 (especially 12.4) and 13.

6.64 Several commentators also expressed a need for parental education on HIV/AIDS. As indicated in the previous paragraphs, the Department of Education in discussions confirmed that parents will be involved in guidance sessions. It is in fact already done as part of the implementation of the Life Skills Programme. As indicated, the adapted national policy also provides for some parent participation in the proposed clause 9.4. The Commission further supports the suggestion of the Department of Health that education of parents could be addressed through parent-educator organisations.<sup>562</sup> In addition, a school level policy on HIV/AIDS could probably provide for parent education according to the needs of a specific community.

6.65 The Commission included in the revised clause 9 (previously clause 6) of the proposed national policy several of the suggestions for a specific content of an HIV/AIDS education programme - for instance that it should contain information on basic first aid principles and on proper behaviour towards persons with HIV, and that it should cultivate a culture of non-discrimination.<sup>563</sup> The Commission is however of the opinion that specific needs of specific communities could be better addressed in a school level policy. The latter could, for instance, address gender education in view of the low status of women,<sup>564</sup> and the formation of support groups for learners with HIV.<sup>565</sup> It is further believed that a multi-disciplinary approach could take care of needs with regard to support and guidance in relation to sexual violence, sexual abuse and rape. Learners with needs in this regard should be referred to other disciplines or service organisations.<sup>566</sup>

6.66 The proposal by the South African National Council for Child and Family Welfare that HIV/AIDS education should be given by experts is not feasible.<sup>567</sup> The Department of Education indicated that *training* of educators would be done by experts.<sup>568</sup> However, the adapted national policy does provide for information on HIV/AIDS to be given in an

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562 Cf par 5.49.2.

563 Refer to the requests recorded in par 5.45 et seq above.

564 Refer to the comments recorded in par 5.45.6 above.

565 Cf par 5.45.7 above.

566 Cf par 5.45.8 above.

567 Cf par 5.46.2

568 In discussions with representatives of the Department on 24 February. See fn 46 above for more detail.

accurate and scientific manner.<sup>569</sup> Likewise training of all educators to contribute to HIV/AIDS education is probably not practically possible<sup>570</sup> although it has been set as an ideal under "Premises" in the adapted national policy.<sup>571</sup>

**\* Universal precautions (Clause 7)**

6.67 The provisions relating to a safe school environment have been completely redrafted and extensively adapted according to the strong concerns raised by various commentators as reflected in par 5.55 - 5.69.5 above.<sup>572</sup>

6.67.1 The adapted clause 7 now includes clear and specific directions with regard to universal precautionary measures as well as directions on alternative or less sophisticated measures (should resources or circumstances make traditional universal precautions inaccessible).<sup>573</sup> Provisions regarding the availability of first aid kits and the training of educators and learners in the application of precautionary measures have been included in the revised policy in response to concerns emphasising the need for express provision in this regard.<sup>574</sup>

6.67.2 An additional and separate clause on the prevention of HIV transmission during sport participation has been included in view of comments on the lack of information and the uncertainty in this regard.<sup>575</sup> In drafting this provision the Commission made use of the National Department of Sport and Recreation's Draft Position Statement: HIV/AIDS in Sport which was issued in July 1997 in conjunction with the South Africa Sports Medicine Association and the Department of Health. This has been discussed in more detail in paragraph 6.39 et seq above.

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569 Clause 9.3.  
 570 Cf par 5.46.2.  
 571 Clause 2.8.3.  
 572 See adapted clause 7.  
 573 See clause 7.3.  
 574 See clause 7.1.1-7.12.  
 575 See new clause 8.

6.67.3 In addition to the above, provisions setting out the duties of learners with HIV, responsibilities of parents and educators, and liability for damage caused in the context of HIV have been included in the revised national policy.<sup>576</sup> It has been expressly provided that the Code of Conduct adopted for learners of a school should include provisions regarding behaviour which may create risk of HIV transmission.<sup>577</sup>

6.67.4 The adaptations referred to in the previous paragraphs are further supported by additions to the background information and argumentation in Chapters 3 and 6 of this interim report. Rights and duties of learners, and criminal and civil liability for HIV transmission are discussed in view of the uncertainty reflected in comments in this regard. It is suggested that interested parties take recourse to this information if necessary.<sup>578</sup>

6.67.5 A new clause in the revised policy identifies those responsible for the practical implementation of universal precautionary measures.<sup>579</sup> The clause was drafted in accordance with the provisions of the Schools Act and is supported by background information supplied in Chapter 3.<sup>580</sup> It is accepted that the state, through the provincial structures, is responsible for creating a safe school environment and that funds for this will have to be made available.

**\* School level policies and Health Advisory Committee (Clause 8)**

6.68 The provision regarding school level policies and the establishment of a Health Advisory Committee has now been separated into two clauses.<sup>581</sup> The main concern of

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576 Clauses 10 and 14.4.  
 577 Clause 10.2.  
 578 See par 3.39-3.49 and 6.39-6.42.  
 579 See clause 14.  
 580 Par 3.52 et seq.  
 581 See clauses 12 and 13.

commentators, namely that the school principal should not necessarily chair the Health Advisory Committee<sup>582</sup> (as previously provided), has been addressed in that it is now provided that a person with knowledge in the field of health care should chair the committee.<sup>583</sup> The policy was also adapted in response to comment by the Department of Education during discussions<sup>584</sup> that not all schools will have access to the necessary community resources to establish a Health Advisory Committee and that this could be resolved by drawing on available expertise at provincial, regional or sub-regional level within the education and health systems.<sup>585</sup>

## **E) CONCLUSION**

6.69 Having evaluated the comments of persons and bodies responding to Discussion Paper 73, the Commission confirms its preliminary conclusion in Working Paper 58 and Discussion Paper 73 that a national policy for HIV/AIDS in schools is urgently required in order to protect learners with HIV from unfair discrimination in the school environment. However, such intervention will have to take into account the rights of all learners and should aim for a fair balance between the rights of learners with HIV and those without HIV.

**6.70 The Commission confirms its preliminary view that the policy should apply nationally, that it should prevail over any other policy instrument on HIV/AIDS in public schools,<sup>586</sup> and have children of school going age (including children in the pre-primary phase) as its chief focus. In view of the fact that compliance with the proposed policy cannot otherwise be ensured in the case of independent schools, the**

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582 Cf par 5.72 above.

583 Clause 13.2.2.

584 See fn 46 above.

585 See clause 13.1.

586 The Western Cape Department of Education has an HIV/AIDS policy in place (cf par 5.79 above). Sec 3(3) of the Policy Act empowers the Minister of Education to declare that a particular national policy should prevail over the whole or a part of any provincial law on education (which would include any policy). In such an instance the Minister should inform the provincial political heads of education accordingly and a specific declaration to this effect should be included in the policy instrument concerned (see also par 3.51 et seq above).

Commission concludes that Members of Executive Councils responsible for education should in terms of section 46(2) of the Schools Act determine compliance with the policy to be a condition on which registration of independent schools may be granted.<sup>587</sup>

**6.71** The Commission further confirms its view that the policy should set out broad guidelines in accordance with constitutional principles. In view of the wide variety of circumstances prevailing in South African schools and of the fact that the Schools Act stresses the importance of parent empowerment in the education of their children, a governing body of a school should be able to adopt an HIV/AIDS policy at school level to give operational effect to the national policy in an individual school community. The purpose of the school level policy would be to provide a mechanism to express the needs of individual schools and their communities, especially with regard to their ethos and values, within the framework of the national policy's minimum standards and norms.

**6.72** In view of the current legal position and the comments received on preliminary proposals in Discussion Paper 73, the Commission concludes that the proposed national policy should contain the following basic principles:

- \* Compulsory testing of learners as a prerequisite for admission to any school, or any unfair discriminatory treatment (for instance the refusal of continued school attendance on the basis of the HIV status of the learner), is not justified.
  
- \* However, it is recognised that special measures in respect of learners with HIV may be necessary. These must be fair and justifiable in the light of medical facts, school conditions and the best interests of learners with and without HIV.

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<sup>587</sup> See par 6.25 et seq as well as fn 210 above.

- \* **Learners' rights in respect of privacy are confirmed. Where HIV-related information is disclosed to a member of staff, the policy provides that, except where statutory or other legal authorisation exists, such information may be divulged only with the informed consent of the learner (above the age of 14 years) or in other cases with that of his or her parent or guardian.**
- \* **The needs of learners with HIV should, as far as is reasonably practicable, be accommodated within the school environment.**
- \* **Universal precautions should be implemented by all schools to exclude effectively the risk of transmission of HIV in the school environment. The policy contains specific provisions on participation in contact sport and contact play.**
- \* **All learners have a right to be educated on HIV/AIDS, sexuality and healthy lifestyles, in order to protect themselves against HIV infection. The policy recognises the need for the involvement - although limited - of parent communities in order to ensure that sexuality education will take into account the community ethos and values. The policy requires that information on HIV/AIDS be given in an accurate and scientific manner.**
- \* **All learners should respect the rights of other learners.**
- \* **Governing bodies should be able to adopt an HIV/AIDS policy at school level to give operational effect to the national policy. This would however have to take place within the framework set by the national policy.**

## **F) RECOMMENDATION**

**6.73** It is recommended that the Minister of Education should, in terms of section 3 of the National Education Policy Act 27 of 1996 determine the policy attached as

**ANNEXURE B to this interim report as national policy to be applied in respect of HIV/AIDS in public schools; and that Members of Executive Councils responsible for education should, in terms of section 46(2) of the Schools Act 84 of 1996, by notice in the Provincial Gazette, determine compliance with the proposed national policy to be a ground on which registration of independent schools may be granted.**

**ANNEXURE A**

**RESPONDENTS TO DISCUSSION PAPER 73 IN ORDER OF RECEIPT OF  
SUBMISSIONS**

- 1 Co-operative for Research and Education (CORE) (Phiroshaw Camay)
- 2 SG Abrahams
- 3 Early Learning Resource Unit (Ms Thinkam Pillay, Anti-Bias Project Co-ordinator)
- 4 South African Police Service (Director JA Du Plessis, Manager Organisational Health and Safety)
- 5 The Premier, North West Province (M Motsapi, Chief Director Legal Services and Policy Co-ordination)
- 6 Stilfontein Child and Family Welfare Society (Mrs TA Vos, Social Worker)
- 7 Rosenhof High School (SS Gerber, Principal)
- 8 Institute for Human Rights Education (Ms Heather Tuynsma, Project Manager)
- 9 City of Bloemfontein Medical Officer of Health (Dr A Hiemstra)
- 10 South African National Council for Child and Family Welfare (Ros Halkett, Resource Department)
- 11 Gauteng Department of Welfare and Population Development (Ms C Wagner, Acting Head of Office)
- 12 St Mary's Diocesan School for Girls, Pretoria (TJ Gordon, Rector)
- 13 Witbank Child Welfare Society (Mrs R Fourie, Social Worker)
- 14 Rhodes University Education Department (Dr H van der Mescht, Acting Deputy Dean of Education)
- 15 The Dental Association of South Africa (Dr JT Barnard, Executive Director)
- 16 Western Cape ATICC (Ms Sally Martindale-Tucker, Training Co-ordinator)
- 17 Mrs M Olckers, MEC Education and Cultural Affairs Western Cape Province
- 18 Klipriver Women's Institute, Ladysmith
- 19 Gauteng Education and Training Council
- 20 Afrikaanse Christelike Vrouevereniging Hoofbestuur (Mrs M Koornhof, Director)
- 21 Department of Community Health, Faculty of Medicine University of Natal
- 22 Dr Martie Lane (Chief Educational Specialist, Department of Education - commenting in her personal capacity)
- 23 Department of Educational Psychology University of Port Elizabeth (Dr MAJ Olivier, Acting Head of the Department)
- 24 AIDS Legal Network (ALN) and Lawyers for Human Rights
- 25 Catholic Institute of Education (Sr Brigid Rose Tiernan, Director)
- 26 HIV/AIDS Representative Elizabeth Donkin Hospital, Port Elizabeth (Sr S Botes)
- 27 City of Cape Town Medical Officer of Health (Dr Ashaf Grimwood)
- 28 Vryheid Child and Family Welfare Society (Mrs C Ellenberger, Social Worker)
- 29 Newlands Education Support Centre
- 30 Prof M Hobdel (Dean, Faculty of Dentistry University of the Western Cape)
- 31 Religious AIDS Programme (RAP) (Dr Nelda Swart, National Co-ordinator on behalf of 26 affiliated organisations and religious communities including Youth Alive Ministries; People of Destiny; Methodist Church Youth; The Evangelical Alliance; The Presbyterian Church of SA; Scripture Union of South Africa; Youth for Christ; Campus Crusade for Christ; Vineyard Youth; African Operation Whole; NG Kerk Jeug Kommissie; Full Gospel Church Youth; YWAM; Vision SA; CSV/CSA (Christian Student Association); Apostolic Faith Mission; Council of African Instituted Churches; Federal Council of African Indigenous Churches; Pan African Christian Women's Alliance; Harvest Network Youth; South African Council of Churches; SUCA; Acts Ministries; Interyouth; and Student Christian Movement)

- 32 Dames Aktueel (Dr Dione Prinsloo, President)
- 33 Western Cape AIDS and Lifeskills Forum (on behalf of NACOSA Western Cape; ATICC Western Cape; Zikhulule AIDS Project; Mamre Community Health Project; UCT Student HIV/AIDS Resistance Programme; SHAWCO, UCT; Litha Lomso Children and Youth Organisation; Health Education Services; Helderberg HIV Centre; and the Reproductive Health Directorate of the Provincial Administration of the Western Cape)
- 34 National Professional Teachers' Organisation of South Africa (Andrew Pyper, Executive Director)
- 35 Ms Catherine Mathews (on behalf of the Centre for Epidemiological Research, SA [CERSA] at the Medical Research Council and the Department of Community Health University of Cape Town)
- 36 Triangle Project
- 37 Department of Education, Mpumalanga Province (Mr FT Sithole Deputy Director General)
- 38 South African National Council for Child and Family Welfare, Empangeni Region (Ms Erna Steynberg, Professional Consultant)
- 39 Mrs M Prozesky (Principal, Kwa-Zulu Natal NCVV Pre-primary School)
- 40 Department of Minerals and Energy
- 41 Durban City Medical Officer of Health (Dr CA Pieterse)
- 42 Kleinmond Child and Family Welfare Society (Miss Dot Aves, Chairperson)
- 43 Department of Education, Province of the North West (Jana Venter)
- 44 Family and Marriage Society of South Africa (NE Mashigo, Advocacy and Development Manager and Dr A van Rensburg, National Director)
- 45 Department of Environmental Affairs and Tourism (Director-General)
- 46 Tongaat and Districts Child and Family Welfare Society and Community Centre (Kay Charles, Secretary)
- 47 Faculty of Education, University of Durban-Westville (Mr Henry Muribwathoho, lecturer and his B Ed students)
- 48 Ms Tania Vergnani, Department of Educational Psychology University of the Western Cape
- 49 Medical Association of South Africa (MASA) (Mr Braam Volschenk, Director Medical Ethics and Legal Affairs)
- 50 AIDS Law Project (ALP)
- 51 Department of Correctional Services (Ms KM Mabena, Deputy Director Medical Support Services)
- 52 NEWTO (Ms NN Gcanga)
- 53 Child, Family and Community Care Centre of Durban (Dr TD Chetty, President)
- 54 South African National Council on Alcoholism and Drug Dependence (Shamim Garda, National Executive Director)
- 55 Cotlands Baby Sanctuary for Abandoned and Abused Kids
- 56 University of Pretoria Faculty of Education (Prof MJ Bondesio)
- 57 AIDS Consortium (Ms Morna Cornell, Co-ordinator)
- 58 Department of Education (HEDCOM Secretariat)
- 59 Department of Health (Ms Rose Smart, Director HIV/AIDS and STDS; Dr Gonda Perez, Director Health Promotion and Communication; Dr ER Mhlanga, Director Maternal, Child and Women's Health; and Ms N Dladla, Director Nutrition)
- 60 South African National Council for Child and Family Welfare, Bloemfontein (MR

- Khalienyana, Regional Director)
- 61 Dutch Reformed Ministry of Caring (Ds SP Kloppers, Chairman of the Ministry of Caring Subcommittee on AIDS)
- 62 Department of Welfare (L Patel, Director-General)
- 63 South African Foundation for Education and Training (SAFET)
- 64 Joint United Nations Programme on HIV/AIDS (UNAIDS) Intercountry Team for Eastern and Southern Africa
- 65 Johannesburg Institute of Social Services (Ms Alida M Boshoff, Director)
- 66 National Association of People Living with HIV and AIDS (NAPWA) (Peter Busse, National Director)

**ANNEXURE B**

**DRAFT NATIONAL POLICY ON HIV/AIDS FOR LEARNERS IN PUBLIC  
SCHOOLS**

**NOTICE NO ... OF 1998**

**DEPARTMENT OF EDUCATION**

I, Sibusiso Mandlenkosi Emmanuel Bengu, Minister of Education, hereby give notice in terms of section 7 of the National Education Policy Act, 1996 (Act No. 27 of 1996) that, with the concurrence of the Minister of Finance, and after consultation with the Council of Education Ministers and the organised teaching profession, I have determined the following national policy in terms of section 3(3) and 3(4) of the said Act to be applied in respect of HIV/AIDS in public schools and to prevail over any provincial law or policy dealing with HIV/AIDS in public schools.

**NATIONAL POLICY ON HIV/AIDS FOR LEARNERS IN PUBLIC SCHOOLS**

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 policy shall constitute national policy.

## **1 DEFINITIONS**

- (1) In this policy any expression to which a meaning has been assigned in the South African Schools Act (Act No. 84 of 1996), shall have that meaning and, unless the context otherwise indicates -

"HIV" means the human immune deficiency virus;

"AIDS" means the acquired immune deficiency syndrome, that is the final phase of HIV infection; and

"Universal precautions" refers to the concept used world-wide 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 instructions concerning basic hygiene and the wearing of protective clothing such as rubber gloves.

## **2 PREMISES**

- (1) There are no known cases of the transmission of HIV in the school environment.
- (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 that these fluids can cause transmission of HIV.
- (3) Because of the increase in infection rates, learners with HIV will increasingly form part of the school population. More and more children who acquire HIV perinatally will, with better medical care, reach school going age and attend primary schools. Indications that young people are sexually active mean that increasing numbers of learners attending secondary schools might be infected.

Moreover, evidence suggests an increasing risk of HIV transmission related to sexual abuse of children in our country. Intravenous drug abuse may also become an increasingly important source of HIV transmission among learners. Although the possibility is remote, recipients of infected blood products (for instance haemophiliacs), may also be present at schools.

- (4) Because of the nature of HIV antibody testing and the window period it is impossible to know with absolute certainty who has HIV and who not. Even if mandatory testing for HIV were to form part of a school's admission requirements and if it were repeated at regular intervals, it would be impossible to know with certainty who is infected and who not, or to effectively exclude all learners with HIV. Testing for HIV and excluding those who test positive are therefore not considered meaningful ways in which to achieve an HIV-free school environment.
- (5) Compulsory disclosure of a learner's HIV status to school authorities is not advocated as this would serve no meaningful purpose. Any learner with HIV or his or her parent would however be free to disclose such information voluntarily. Genuine voluntary disclosure of a learner's HIV status 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.
- (6) Children with HIV 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. Their infection as such does not expose others to significant risks within the school environment that cannot be eliminated by ordinary measures or reasonable adaptations.
  - (a) The insignificant risk of transmission of HIV in the school environment 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 all persons should be considered as potentially infected and their blood and body fluids treated as such.

- (b) Strict adherence to universal precautions under all circumstances in the school environment is advised.
  - (c) Current scientific evidence suggests that the risk of HIV transmission during sport and play activities is also insignificant: There is no risk of transmission from saliva, sweat, tears, urine, respiratory droplets, hand shaking, swimming pool water, communal bath water, toilets, food or drinking water. The statement about the insignificant risk of transmission during sport and play activities, however holds true only if universal precautions are adhered to. Adequate wound management has to take place at the sport field when a player sustains an open bleeding wound. Boxing and rugby could probably be regarded as sports representing a higher risk of HIV transmission than other sports.
  - (d) 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 a safe school environment is linked to compulsory school attendance for learners and should be regarded as a sound investment in the future of South Africa.
- (7) The constitutional rights of all learners should be protected on an equal basis. If it is therefore ascertained that a learner poses a medically recognised significant health risk to others, appropriate measures may be taken. A medically recognised significant health risk in the context of HIV could include the presence of untreatable contagious (highly communicable) diseases, uncontrollable bleeding, unmanageable wounds, or sexual or aggressive behaviour which may create risk of HIV transmission. Furthermore, learners with infectious illnesses such as

measles, whooping cough and mumps should be kept from school to protect all other learners, and especially those whose immune systems may be impaired by HIV. Schools should inform parents of inoculation programmes and of their possible significance for the well-being of learners with HIV.

- (8) Learners should receive education about HIV/AIDS in the context of life skills education on an ongoing basis. HIV/AIDS education should not be presented as an isolated learning content. It should be presented in a scientific but understandable way.
  - (a) 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 instill non-discriminatory attitudes towards persons with HIV/AIDS. Education should ensure that learners acquire age-appropriate knowledge and skills in order that they may adopt and maintain behaviour that will protect them from HIV infection.
  - (b) In the elementary classes, education about HIV/AIDS should be provided by the regular educator, while in secondary grades the guidance counsellor would ideally be the appropriate educator. Because of the sensitive nature of the learning content, the educator selected to offer this education should be specifically trained, should feel at ease with the content and should be a role-model with whom learners easily identify.
  - (c) Ideally 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 in the context of HIV/AIDS.
- (9) 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

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 should preferably give operational effect to the national policy by developing and adopting an HIV/AIDS policy at school level which would reflect the needs, ethos and values of a specific school and its communities within the framework of the national policy.

### **3 NON-DISCRIMINATION AND EQUALITY WITH REGARD TO LEARNERS WITH HIV**

- (1) No learner with or perceived to have HIV or AIDS may be unfairly discriminated against.
- (2) Learners with HIV should be treated in a just, humane and life-affirming way.
- (3) Any special measures in respect of a learner with HIV should be fair and justifiable in the light of medical facts, school conditions and the best interests of the learner with HIV or those of other learners.

### **4 ADMISSION TO SCHOOL AND HIV TESTING**

- (1) No learner should be denied admission to or continued attendance at school on account of his or her HIV status or perceived HIV status.
- (2) There is no medical or scientific justification for routinely testing learners for evidence of HIV infection. The testing of learners for HIV as a prerequisite for admission to or continued attendance at school is prohibited.

## **5 SCHOOL ATTENDANCE BY LEARNERS WITH HIV**

- (1) The needs of learners with HIV with regard to their right to a basic education should as far as is reasonably practicable be accommodated within the school environment.
- (2) Learners with HIV are expected to attend classes in accordance with statutory requirements for as long as they are able to function effectively.
- (3) Academic work should be made available for study at home, and parents should be allowed to educate learners with HIV when they become incapacitated through illness, or if they pose a medically recognised significant health risk to others at school. Learners who cannot be accommodated in this way should be accommodated within the education system in residential institutions for learners with special education needs.
- (4) Learners with HIV who develop HIV-related behavioural problems or neurological damage should be accommodated within the education system in suitable institutions for learners with special education needs.

## **6 DISCLOSURE OF HIV-RELATED INFORMATION AND CONFIDENTIALITY**

- (1) No learner, or his or her parent, is compelled to disclose his or her HIV status to the school authorities.
- (2) Any learner with HIV (above the age of 14 years) or his or her parent is however free to disclose voluntarily the learner's HIV status. Genuine voluntary disclosure of HIV status should be welcomed. In the event of voluntary disclosure it may be in the best interests of a learner with HIV if a member of the school staff directly involved with the care of the learner with HIV is informed of his or her HIV status either by the learner's parent or by the learner him- or herself (if the learner is above the age of 14 years).

- (3) Any person to whom any information about the medical condition of a learner with HIV has been divulged shall keep this information confidential.
- (a) Disclosure to third parties may nevertheless be authorised by the informed consent of the learner (if the learner is above the age of 14 years), or his or her parent; or be justified by statutory or other legal authorisation.
  - (b) Unauthorised disclosure of HIV-related information could give rise to legal liability.

## **7 A SAFE SCHOOL ENVIRONMENT**

- (1) All schools should implement universal precautions to effectively eliminate the risk of transmission of all blood-borne pathogens, including HIV, in the school environment.
- (a) 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 and body fluids 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.
    - (i) Blood, especially in large spills such as from nose bleeds, should be handled with extreme caution.

- (ii) Skin exposed accidentally to blood should be cleaned promptly with water and disinfectant.
  - (iii) All bleeding wounds, sores, breaks in the skin, grazes and open skin lesions should ideally be cleaned immediately with a suitable antiseptic such as hypochlorite (for instance bleach or Milton), 2% gluteraldehyde (for instance Cidex), organic iodines, or 70% alcohol (for instance ethyl alcohol or isopropyl alcohol).
  - (iv) If there is a biting or scratching incident where the skin is broken, the wound should be washed thoroughly with running water and disinfectant.
  - (v) Blood splashes to the face (mucous membranes of eyes, nose or mouth) should be flushed with running water for at least three minutes.
- (b) All open wounds, sores, breaks in the skin, grazes and open skin lesions should be covered securely with a non-porous or waterproof dressing or plaster so that there is no risk of exposure to blood.
- (c) 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 so as to pour water over the area to be cleansed.
- (d) 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 to effectively exclude the risk

of HIV transmission. However, emergency treatment should not be delayed because gloves are not available. Bleeding can be managed by compression with material that will absorb the blood, for example a towel. However people who have skin lesions should not attempt to give first aid when no latex gloves are available.

- (e) If blood has contaminated a surface, that surface should be cleaned with a fresh clean bleach solution and the person responsible for this should wear latex gloves. Other body fluids and excretions which could be stained or contaminated with blood (for instance tears, saliva, mucus, phlegm, urine, vomit, faeces, and pus) should be cleaned up in similar fashion.
  - (f) Blood-contaminated material should be sealed in a plastic bag and incinerated or sent to an appropriate disposal firm.
  - (g) If instruments (for instance scissors) become contaminated with blood or other body fluids, they should be washed and placed in a strong bleach solution for at least one hour before drying and re-use.
- (2) All schools should ideally have available at least two first aid kits each of which contains the following -
- (a) two large and two medium pairs of disposable latex gloves;
  - (b) two large and two medium pairs of rubber household gloves for handling blood-soaked material in specific instances (for example when broken glass makes the use of latex gloves inappropriate);
  - (c) absorbent material;

- (d) waterproof plasters;
  - (e) disinfectant (such as hypochlorite);
  - (f) scissors;
  - (g) cotton wool;
  - (h) gauze tape;
  - (i) tissues;
  - (j) containers for water;
  - (k) 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.
- (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 these described in 7.2. Alternatives would, for example include the following -
- (a) unbroken plastic packets for use on hands where latex or rubber gloves are not available (these should be in supply indoors and outdoors);
  - (b) common household bleach for use as disinfectant, diluted one part to nine parts water (1:10 solution) made up as needed.
- (4) Each educator should preferably have a pair of rubber household gloves in his or her classroom.

- (5) Rubber household gloves should be available at every sport event and should also be carried by the playground supervisor.
- (6) First aid kits should be stored in one or more selected (class)rooms in the school and should be accessible at all times, also by the playground supervisor.
- (7) Used items should be dealt with as indicated in 7.1.6 and 7.1.7.
- (8) The contents of the first aid kits, or the availability of other suitable barriers, should be regularly checked by a designated school staff member and discarded items should be replaced immediately.
- (9) A fully equipped first aid kit should be available at all school events, outings and tours and should be kept on vehicles for the transport of learners to such events.
- (10) All educators and other staff, including sport coaches, should be given appropriate information and training on HIV transmission, the application of universal precautions, and the importance of adherence thereto.
- (11) All learners should be given appropriate information and training regarding the application of universal precautions.
  - (a) Learners should be trained to manage their own bleeding or injuries.
  - (b) Learners, especially those in pre-primary and primary school, 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 the nosebleeds, cuts and scrapes of friends, on their own. They should be taught to call the assistance of an educator or other staff member.

- (c) Learners should be taught that all open wounds, sores, breaks in the skin, grazes and open skin lesions on all persons should be covered with waterproof dressing or plasters at all times, not only when they occur in the school environment.
- (12) Parents of learners should be informed about the universal precautions that will be adhered to at a school.

## **8 PREVENTION OF HIV TRANSMISSION DURING PLAY AND SPORT**

- (1) The risk of HIV transmission as a result of contact play and contact sport is generally insignificant.
- (a) The risk increases where open wounds, sores, breaks in the skin, grazes, open skin lesions or mucous membranes of learners without HIV are exposed to infected blood.
  - (b) Certain contact sports (rugby and boxing) may represent an increased risk of HIV transmission.
- (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.
- (a) No learner may participate in contact play or contact sport with an open wound, sore, break in the skin, graze or open skin lesion.
  - (b) If bleeding occurs during contact play or contact sport, the player should be taken off the playground or sport field immediately and appropriately treated as described in 7.1.1 to 7.1.4. Only then may

the player resume playing and only for as long as any an open wound, sore, break in the skin, graze or open skin lesion remains securely covered.

- (c) Soiled clothes must be changed.
  
- (3) A fully equipped first aid kit should be available wherever contact play or contact sport takes place. A first aid kit should be kept on vehicles used for transport of learners to sport events, sport outings or sport tours.
  
- (4) Sport participants with HIV should seek medical counselling before considering participation in sport in order to assess risks to their own health as well as the risk of HIV transmission to other sport participants.
  
- (5) Staff members acting as sport administrators, managers and coaches should ensure the availability of first aid kits and the adherence to universal precautions in the event of bleeding during sport participation.
  
- (6) Staff members acting as sport administrators, managers and coaches have special opportunities for meaningful education of sport participants with respect to HIV/AIDS. They should encourage sport participants to seek medical counselling where appropriate.

## 9 EDUCATION ON HIV/AIDS

- (1) A continuing HIV/AIDS education programme should be implemented at all schools for all learners, educators and other staff.
- (2) Age-appropriate education on HIV/AIDS should form part of the compulsory curriculum for all learners and should be integrated in the life skills education programme for pre-primary, primary and secondary school learners. This should include the following -
  - (a) providing information on HIV/AIDS in South Africa and developing the life skills necessary for the prevention of these;
  - (b) inculcating from an early age onwards basic first aid principles, including how to deal with bleeding;
  - (c) emphasising the role of drugs, sexual abuse and violence in the transmission of HIV;
  - (d) encouraging learners 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;
  - (e) teaching learners how to behave towards persons with HIV;
  - (f) cultivating an enabling environment and a culture of non-discrimination towards persons with HIV;
  - (g) providing information on appropriate prevention and avoidance measures, including abstinence and the use of condoms.

- (3) Education and information regarding HIV/AIDS should be given in an accurate and scientific manner and in language and terms that are understandable.
- (4) Parents of learners should be informed about all HIV/AIDS education offered at the school, 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.

## **10 DUTIES AND RESPONSIBILITIES OF LEARNERS, PARENTS AND EDUCATORS**

- (1) All learners should respect the rights of other learners.
- (2) The Code of Conduct adopted for learners at a school should include provisions regarding the unacceptability of behaviour which may create risk of HIV transmission.
- (3) The ultimate responsibility for learners' behaviour rests with their parents. Parents of all learners -
  - (a) are expected to require learners to observe all school rules aimed at preventing behaviour which may create risk of HIV transmission;
  - (b) are encouraged to take an active interest in acquiring any information or knowledge on HIV/AIDS supplied by the school, and to attend meetings convened for them by the governing body.
- (4) It is recommended that a learner with HIV and his or her parent should consult

medical opinion to assess whether the learner poses a medically recognised significant health risk to others. If such a risk is established, the Health Advisory Committee or governing body should be informed.

- (5) Educators have a particular duty to ensure that the rights and dignity of all learners are respected and protected.

## **11 REFUSAL TO STUDY WITH A LEARNER WITH HIV**

- (1) Refusal to study with a learner with or perceived to have HIV should be preempted by providing accurate and understandable information on HIV/AIDS to all learners and their parents.
- (2) Learners who refuse to study with a fellow learner with or perceived to have HIV should be counselled.
- (3) The situation should be resolved by the principal and educators and, if necessary, with the assistance of the governing body of the school in accordance with the principles contained in this policy.

## **12 SCHOOL LEVEL POLICIES**

- (1) This national policy constitutes a set of basic principles.
- (2) The governing body of a school should preferably develop and adopt its own school level policy on HIV/AIDS to give operational effect to the national policy. The school level policy may however not deviate from the basic principles of the national policy.
- (3) Major role-players in the school community (for example religious and traditional leaders, traditional healers and representatives of the medical or health care

professions) should be involved in developing a school level policy on HIV/AIDS.

- (4) A school level policy on HIV/AIDS should reflect the needs, ethos and values of the specific school and its communities. The school level policy could, for instance, contain provisions regarding the supply of condoms by the school in accordance with the needs and values of the specific school and its communities.
- (5) In the absence of a school level policy on HIV/AIDS the national policy applies.

### **13 HEALTH ADVISORY COMMITTEE**

- (1) Where community resources make this possible, it is recommended that each school should establish its own Health Advisory Committee as a committee of the governing body. Where the establishment of such committee is not possible, the school may draw on expertise available at provincial, regional or sub-regional level within the education and health systems.
- (2) Where it is possible to establish a Health Advisory Committee, the Committee should -
  - (a) be set up by the governing body and should consist of school educators and other staff, representatives of the parents of learners at the school, representatives of the learners, and representatives from the medical or health care professions;
  - (b) elect its own chairperson who should preferably be a person with knowledge in the field of health care;
  - (c) advise the governing body on all HIV/AIDS-related matters and especially what is considered to be a medically recognised significant health risk in connection with HIV;

- (d) be responsible for developing, approving and adopting a school level policy on HIV/AIDS and review it from time to time, especially as new scientific knowledge about HIV becomes available; and
- (e) be consulted on the provisions relating to the prevention of HIV transmission in the Code of Conduct.

#### **14 IMPLEMENTATION**

- (1) The Member of the Executive Council shall be responsible for the implementation of this policy.
- (2) The principal, or the head of a hostel, shall be responsible for the practical implementation of this policy at school or residential level, and for maintaining an adequate standard of safety according to this policy.
- (3) It is recommended that a governing body 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 of adequate barriers (even in the form of less sophisticated material) to prevent contact with blood or body fluids.
- (4) Strict adherence to universal precautions under all circumstances (including play and sport 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.

#### **15 REGULAR REVIEW**

- (1) This policy should be reviewed regularly and should be adapted to changed

circumstances.

**16 APPLICATION**

- (1) This policy applies to learners in public<sup>588</sup> schools which enrol learners in one or more grades between grade zero and grade twelve.

**17 INTERPRETATION**

- (1) In all instances, this policy should be interpreted to ensure respect for the rights of learners with HIV as well as other learners.

**18 WHERE THIS POLICY MAY BE OBTAINED**

- (1) This policy may be obtained from The Director-General, Department of Education, Private Bag X895, Pretoria, 0001.

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588 According to sec 1, 12(2) and 12 (3) of the South African Schools Act 1996 (Act No. 84 of 1996) public schools include the following: ordinary public schools; public schools for learners with special education needs; and hostels for the residential accommodation of learners in these schools. According to information supplied by the Department of Education public schools for learners with special education needs include schools for physically disabled children; schools for mentally disabled children; schools for children with behavioural deviations (clinic schools); residential institutions for severe and profound types of "special needs"; hospital schools; and schools of industry, reform schools and places of safety for learners who have found themselves in trouble with the law or are in need of protection.