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SOUTH AFRICAN LAW COMMISSION

DISCUSSION PAPER 73

Project 85

ASPECTS OF THE LAW RELATING TO AIDS:

HIV/AIDS and Discrimination in Schools

CLOSING DATE FOR COMMENT: 30 September 1997

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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 P J J Olivier (Vice-Chairperson)

The Honourable Madam Justice Y Mokgoro

Adv J J Gauntlett SC

Mr P Mojapelo

Prof R T Nhlapo

Ms Z Seedat

The members of the Project Committee for this investigation are -

The Honourable Mr Justice E Cameron (Chairperson)

Mr Z Achmat

Dr P J Haasbroek

Ms M Makhalemele

Dr M J Matjila

Dr G J Mtshali

Prof R T Nhlapo (Full-time member of the Commission)

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

Ms L Seftel

Ms A E Strobe

Prof C W van Wyk

The Secretary is Mr W Henegan. The Commission's offices are on the 8th floor, 228 Visagie Street, Pretoria. Correspondence should be addressed to:

The Secretary
South African Law Commission
Private Bag X668
PRETORIA 0001

Telephone: (012)322-6440

Fax : (012)320-0936

E-mail : lawcom@salawcom.org.za

Website: www.law.wits.ac.za/salc/salc.html

ACKNOWLEDGEMENT

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The Commission is indebted to Prof Christa W Van Wyk (member of the project committee) who undertook additional research for this discussion paper.

PREFACE

This discussion paper (which reflects information accumulated up to the end of May 1997), has been prepared to elicit responses from key parties and to serve as a basis for the Commission's deliberations. Following an evaluation of the responses and any final deliberations on the matter the Commission may issue a report on this subject which will be submitted to the Minister of Justice for Tabling in Parliament. The views, conclusions and recommendations in this paper are accordingly not to be regarded as the Commission's final views. The paper is published in full so as to provide persons and bodies wishing to comment or to make suggestions relating to the reform of this particular branch of the law with sufficient background information to enable them to place focused submissions before the Commission.

For the convenience of the reader a summary of issues discussed and requests for comment appear on the next page.

The Commission will assume that respondents agree to the Commission quoting from or referring to comments and attributing comments to respondents, unless representations are marked confidential. Respondents should be aware that the Commission may in any event be required to release information contained in representations under the Constitution of the Republic of South Africa, Act 108 of 1996.

Respondents are requested to submit **written** comments, representations or requests to the Commission by **30 September 1997** at the address appearing on the previous page. The researcher will endeavour to assist you with particular difficulties you may have.

The researcher allocated to this project, who may be contacted for further information, is Mrs A-M Havenga. The project leader responsible for this project is the Honourable Mr Justice E Cameron.

SUMMARY

- 1 The risk of HIV transmission in schools, under normal circumstances, is negligible and there are also no known cases of transmission of HIV in the educational setting.
- 2 Nevertheless, HIV/AIDS will undoubtedly affect most schools.
 - 2.1 Amongst children, the most important route of HIV transmission by far is vertical (from mother to baby). Although the majority of infants with HIV in South Africa are unlikely to reach school going age, recent studies show that some infected children may remain symptom-free up to the age of seven years and will therefore reach school going age.
 - 2.2 Statistics also indicate that adolescents and young adults account for a disproportionate share of the increase in HIV infection in our country.
 - 2.3 Learners may be faced with the illness of their parents. 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 disrupt the learning process. The education authorities may be faced with a situation where orphans drop out of school because their guardians are unable or unwilling to pay for school requisites. 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 also be increasing discrimination because of stigma.
- 3 The Commission in 1995 in its Working Paper 58 made preliminary recommendations on HIV/AIDS in schools. These were based on the negligible risk of transmission of HIV in the school setting and the principle of non-discrimination enunciated in the 1993 interim Constitution.
 - 3.1 The Commission specifically concluded that HIV testing should not be a

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prerequisite for admission to schools or for continued school attendance; that a learner may not be barred from continued school attendance solely on the ground of his or her HIV infection; that confidentiality of AIDS related information should be maintained; that the education authorities should be compelled to provide AIDS information and education as part of the compulsory curriculum to primary and secondary school learners; and that the education authorities should establish a clear and comprehensive national policy regarding the management of learners with HIV in which these principles are embodied.

- 3.2 The Commission at the time emphasised the lack of a uniform national policy dealing with the issue of HIV/AIDS in schools.
- 4 The responses received to these preliminary recommendations were generally supportive. They reflected that a large measure of consensus on the need for, and contents of, a national policy on HIV/AIDS for schools exists.
- 5 The recent well-publicised crisis caused by the application 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 lack of a national education policy on this issue, underscore the lesson that the situation has not improved since 1995. This is despite the fact that the South African Schools Act was passed in 1996 which gives effect to both the spirit and letter of 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.
- 6 In view of the Commission's initial work on the matter, the project committee has, since the Nkosi Johnson incident, been engaged in informal discussions and liaison with the Department of Education to ascertain whether the Commission could be of assistance in advancing resolution of the matter. The present proposals and policy have been developed in a joint consultative process. They result from input and guidance from the Department. The Department will again be included in the committee's work when comment on this discussion paper is processed and final recommendations formulated.

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- 7 The project committee is of the view that recent experience suggests that a precisely directed and clearly targeted policy would create legal certainty and help prevent injustice to learners with HIV. It thus provisionally recommends the adoption of a national policy on HIV/AIDS in schools that will constitute a set of basic principles from which the governing bodies of schools may not deviate. Provision is made for the governing body, in addition, to adopt an HIV/AIDS school level policy to give operational effect to the national policy. The school level policy may reflect the needs, ethos and values of the specific school and community, though it may not deviate from the national policy's basic principles. In the absence of a school level policy the national policy will apply.
- 7.1 The proposed policy - which would apply to public as well as independent schools - includes the following principles:
- 7.1.1 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.
- 7.1.2 However, it is 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.
- 7.1.3 Learners' rights in respect of privacy are confirmed. Where AIDS related information is disclosed to the educational authorities, the policy provides 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.
- 7.1.4 The needs of learners with HIV should, as far as is reasonably practicable, be

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accommodated within the school environment.

7.1.5 All learners have a right to be educated on AIDS, sexuality and healthy lifestyles, in order to protect themselves against HIV infection. The policy recognises the need for consultations with parent communities in order to ensure that sexuality education will accord with the community ethos and values. The policy requires that information be given in an accurate and scientific manner.

7.1.6 Universal precautions should be implemented by all schools to further minimise the negligible risk of transmission of HIV in the educational setting. The policy contains specific provisions on participation in contact sports.

8 The draft policy is attached for comment. The project committee will especially welcome comment on whether the proposed national policy should also apply to school hostels, and if so, whether additional policy measures are necessary.

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NOTICE NO ... OF 1997

DEPARTMENT OF EDUCATION

PROPOSED NATIONAL POLICY ON HIV/AIDS FOR SCHOOLS

I,, 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 have 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 may 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.

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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 HIV 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 are subject to 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 minimise the risk of transmission of all blood-borne pathogens, including HIV, in the educational setting (in the case of HIV, this risk is negligible). **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 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.

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1 BACKGROUND

- 1.1 The South African Law Commission has been investigating aspects of the law relating to HIV/AIDS since 1993. The Commission was initially requested by the Director-General of the Department of Health to investigate all aspects of the law relating to HIV infection and AIDS with a view to possible legislation to discourage discrimination against people with HIV and/or AIDS. A project committee, which consisted of Mr J E Knoll and Mr G G Smit (members of the Commission), Ms Dawn Mokhobo and Prof C W van Wyk, was established during 1993 to assist with the investigation. Mr Knoll acted as Chairperson of the project committee and as project leader. Ms Mokhobo resigned as member of the committee in March 1995 and the appointment of the other three members expired in September 1995. The researcher was Mrs A-M Havenga.
- 1.2 Extensive research was done. Evidence was heard from interest groups and a discussion document (Working Paper 58 "Aspects of the Law relating to AIDS" - Project 85) was published by the Commission at the end of September 1995. In the Working Paper the Commission's basic preliminary conclusions and recommendations on possible law reform were set out. Interested parties were afforded the opportunity to comment. The Working Paper was distributed to 721 persons or bodies. A total of 49 comments were received.
- 1.3 The project committee was reconstituted during 1996, following the expiry of the previous committee's terms of appointment in 1995, and the appointment of a new representative Law Commission at the beginning of 1996. The members of the new committee are Mr Justice E Cameron (Chairperson), Mr Z Achmat, Ms M Makhalemele, Dr M J Matjila, Prof R T Nhlapo (full-time member of the Commission), Ms A E Strobe and Prof C W van Wyk. Dr G Mtshali joined the committee in January 1997 and Mr Justice P J J Olivier (Vice-Chairperson of the Commission) joined the committee in April 1997. Mr J W Botha resigned as member of the committee in February 1997. The researcher is Mrs A-M Havenga.

- 1.4 The new project committee's mandate is to assist in resolving the differences of opinion between interest groups resulting from Working Paper 58 and in developing a draft report for submission to the Minister of Justice reflecting constitutional principles.
- 1.5 The project committee is pursuing a consultative process in an attempt to resolve the differences and works from the basis of research reflected in Working Paper 58. It has adopted a working method of dealing with issues incrementally in an attempt to finalise them more swiftly.
- 1.6 In its first interim report¹ the project committee addressed matters which are largely uncontroversial and which commanded almost universal support. This 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 Conditions² (the 1987 Regulations); and a national policy on HIV testing and informed consent. The Commission has already adopted this interim report and it has been presented to the Minister of Justice for Tabling in Parliament.
- 1.7 The previous project committee did valuable research also in respect of HIV/AIDS in schools, which was reflected in Working Paper 58.³ It found that there were no uniform or sufficient measures or policy guidelines in this regard and that a real need for a uniform national policy regarding HIV/AIDS in schools existed.
- 1.8 Based on this research, the Commission came to the following conclusions in respect of HIV/AIDS in schools in Working Paper 58:⁴

1.8.1 The risk of HIV transmission in schools, under normal circumstances, is

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 research is reflected in par 3.163-3.179 of Working Paper 58.

4 Par 3.171 -3.179.

effectively excluded.⁵ There were at that time also no known cases of transmission of HIV in the school setting.⁶

1.8.2 In terms of the Constitution of the Republic of South Africa Act, 1993⁷ (the 1993 interim Constitution) every person had the right to basic education and to equal access to educational institutions, and unfair discrimination was prohibited.⁸

1.8.3 In the light of the negligible risk of transmission of HIV in the school setting, 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 learner) would be unjustified.

1.8.4 There would, however, be justification for withdrawing a learner from school in cases where he or she posed a significant health risk to others (for instance when such a learner 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.⁹

1.8.5 This approach was in accordance with the Commission's premise¹⁰ 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

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

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

7 Act 200 of 1993.

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

9 Sec 33 of the 1993 Constitution, 1996; cf also **AIDS The Legal Issues** 196-197 and **Someone at School has AIDS** 8-9.

10 Cf par 2.21 of Working Paper 58. A number of premises were accepted 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.

eliminated by ordinary measures or reasonable adaptations.¹¹

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

1.8.7 A call for the disclosure of AIDS related information¹² could, however, be justified only if its confidentiality was ensured, and if it was not used as the basis for discriminatory behaviour against learners with HIV

11 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 U S 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 pupil 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 [NYS Ct 1986]), 82, 86, 92; see also Jarvis et al 82-84). The ratio behind this was that since it was likely that there were other children with HIV attending school, but 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 infectious 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, are the main sources 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 U S, 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 U S 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 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 setting (cf Jarvis et al 88).

12 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 3.11 - 3.12 below.

infection.¹³ This information could also be of real value only if there were clear policy guidelines regarding the management of learners in respect of whom this kind of information had in fact been disclosed.

1.8.8 The Commission took cognisance of national policy guidelines which had been issued in this regard in the U S.¹⁴ They provide that with the consent of the infected child or his or her parent or guardian, additional persons could be notified (for instance the principal of the school concerned).¹⁵ 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 learner posed a “medically recognised risk”¹⁶ to healthy learners, whether such a learner 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

13 In the U S 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 U S 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 setting 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).

14 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).

15 Ibid.

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

this process.¹⁷

1.8.9 A learner with HIV would in many instances not be included under the definition of “handicapped child” in South African legislation¹⁸ which ensured the education of such children.¹⁹ It was also uncertain whether the 1993 interim Constitution,²⁰ would without more provide protection to persons with HIV infection against unfair discrimination on the basis of “disability”.²¹

1.8.10 In the light of this the Commission was of the opinion that legislation could be employed to regulate the right to equal access.

1.8.11 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.²² Early sexual activity and intravenous drug abuse by teenagers were recognised as important potential sources of HIV transmission.²³ In the light of this and of the general ignorance regarding HIV/AIDS²⁴ and the modes by which the virus is spread, especially among school children in South Africa,²⁵ the Commission was of the opinion that it was of cardinal importance that school going children

17 Ibid.

18 See fn 128 below.

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

20 Sec 8(2).

21 See par 2.17 of 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.

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

23 Jarvis et al 93.

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

25 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 STD's and AIDS (study quoted in **AIDSScan** June 1992 7).

receive information and education regarding HIV/AIDS and its prevention.

1.8.12 With regard to HIV/AIDS education in schools, a divergence of opinion among the then existing Education Departments on this issue was apparent²⁶ from evidence before the Commission.²⁷ The nature and extent of AIDS information to school children at that time varied between the supply of no information to full information.²⁸ 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.²⁹ The premises of

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

27 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).

28 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 shortages 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]).

29 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 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

the different sets of guidelines were, however, not uniform in all respects: some were still based on the 1987 Regulations as discussed in paragraph 3.11 to 3.12 below, and others were aimed at AIDS education only.³⁰ It was clear that, for various reasons, most children in South Africa did not receive such education.

1.8.13 The Commission was aware of the fact, and it had been confirmed in evidence,³¹ that HIV education was a controversial matter with 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.³²

1.8.14 The Commission concluded that a real need existed for a uniform national policy regarding HIV and AIDS in schools in which aspects such as continued school attendance, management of persons with HIV infection,

Lötz, 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**.

30 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]).

31 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.

32 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, and 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 U S 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).

confidentiality of AIDS related information, and HIV/AIDS education were addressed.

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

1.8.15.1 That legislation should confirm -

- * **that HIV testing may not be a prerequisite for admission to schools or for continued school attendance;**
- * **that a learner 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.**

1.8.15.2 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 learner be permitted to refuse in writing that the learner concerned attend such a programme.

1.8.15.3 That the education authorities establish a clear and comprehensive national policy regarding the management of learners 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 learners with HIV infection, the application of relevant universal precautions, and the supply of information and education on HIV/AIDS should be ensured.

1.9 Twenty four of the 49 comments received on Working Paper 58 as a whole included reference to HIV/AIDS in schools.

- 1.10 The following parties agreed with all the preliminary recommendations of the Commission on HIV infection and AIDS in schools: The Medical Association of South Africa, the Afrikaanse Handelsinstituut, and the City Health Department of the City of Cape Town.
- 1.11 The following respondents endorsed these recommendations in general: the Department of Education (although a different formulation of one of the recommendations was proposed); Mrs M E Olckers (Member of the Executive Committee [MEC] for Education and Cultural Affairs, Western Cape) on behalf of a committee of head office personnel at this Department; the Dutch Reformed Ministry of Caring (with the proviso that an infected learner should not pose a health risk to others and that his or her health condition should not permanently restrict his or her ability to attend classes or to work); the AIDS Legal Network (ALN) (with the proviso that there was no need for school authorities to be notified of a child's HIV infection); and the Department of Health (which endorsed the proposals submitted by the ALN).
- 1.12 Some 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 learners in previously white schools.
- 1.13 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. NACOSA (Western sub-province of Eastern Cape) submitted that proper regulation of contact sport had to take place; 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; 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 learners; the ALN and the Department of Health believed that proper regulation of contact sport had to take place, and that precautions had to be taken with all wounds, and not just with those of children known to be infected; the Association of Law Societies believed that a child with HIV

should be prohibited from taking part in contact sport; A B Bluhm (private citizen) proposed that a principal should have the authority to prohibit an infected learner from participation in sport, without making known his or her condition; I L Hay (human resources manager) believed that children and school staff should be protected from HIV infection through contact sport or through assisting an infected learner in an accident.

- 1.14 The following respondents generally supported the recommendations, but emphasised sexuality education and AIDS education. The Department of Community Health of the University of Cape Town welcomed the recommendation that authorities be obliged to provide sexuality education; 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 AIDS information and education in schools and suggested that sexuality education be made compulsory and examinable. Mrs M E Olckers supported the right of a parent/guardian to arrange that a learner 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 learner(s) concerned. R J Elliott (on behalf of Sappi Health Advisory Committee) in general agreed with the recommendations and with the need for a national education policy, 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. He also 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. 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. The Superintendent of the Sterkfontein Hospital proposed that principles of universal precautions (including the use of mechanical devices in mouth to mouth/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.

- 1.15 The following commentators were not supportive of the recommendations of the Commission: 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. Dr H G V Küstner (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 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.
- 1.16 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 (learners) 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.
- 1.17 The project committee concludes from the responses received to the Commission's 1995 recommendations that from a scientific, medical and legal viewpoint, this matter is relatively uncontroversial and that a large measure of consensus exists on the need for, and the contents of, a national policy on HIV/AIDS in schools.

- 1.18 The recent well-publicised crisis caused by the application 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,³³ underscore the lesson that the situation has not improved since 1995. This is despite the fact that the South African Schools Act³⁴ (the Schools Act) was passed in 1996, giving effect to both the spirit and letter of the Constitution of the Republic of South Africa, 1996³⁵ (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.³⁶
- 1.19 In view of the Commission's initial work on the matter, the project committee has, since the Nkosi Johnson incident, been engaged in informal 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.³⁷ It was confirmed that the Department of Education, with the Department of Health, is in the process of developing ways to deal with HIV/AIDS in schools and that the Department of Health favours the adoption of a national policy.³⁸ The project committee

33 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.

34 Act 84 of 1996.

35 Act 108 of 1996.

36 Cf the joint statement by Prof S M E Bengu, Minister of Education and Dr N D 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 ...".

37 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).

38 This was confirmed, on behalf of the Department of Education, by Dr T Coombes (Deputy Director-General, Department of Education) 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 in

consequently proceeded to draft a provisional discussion paper 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 discrimination in schools and in order to conclude the work of the Commission initiated by the 1995 proposals. The provisional paper was submitted to the Department of Education for comment. The present proposals and policy have been developed in a joint consultative process. They result from input and guidance received from the Department of Education.³⁹ By including this input, the project committee has attempted to be responsive to the needs of the Department and to the expertise at the Department's disposal. It is envisaged that senior officers of the Department will again be included in the committee's work at the stage when comments on this discussion paper are processed and final recommendations formulated.

- 1.20 If the Commission's 1995 recommendations as set out above and as now elaborated in the present discussion paper, command the continued support of relevant government departments, especially the Department of Education and the Department of Health, and of other significant interest groups, the project committee is of the view that it would be of major public benefit to proceed swiftly also on this matter.

the Department of Health and member of the project committee) at the project committee's meeting on 6 March 1997. Dr C C P Madiba (Chief Director: Education Systems, Training, and Co-ordination) indicated at a project committee meeting on 25 March 1997 that the Commission's consultation process will in fact greatly assist the Department of Education in formulating and finalising a national policy.

³⁹ 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 C C P Madiba, Chief Director: Education Systems, Training 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.

2 HIV and AIDS - WHAT ARE THEY?⁴⁰

- 2.1 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.⁴¹ 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 DNA⁴² (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 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 is not a specific 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 or certain cancers) that are described as “opportunistic” because they attack the body when immunity is low. AIDS

40 **This chapter consists mainly of edited extracts from 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.**

41 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.

42 DNA is the abbreviation for "deoxyribonucleic acid".

can therefore be defined as a syndrome of opportunistic diseases, infections and certain cancers that eventually cause a person's death.

- 2.2 Infection of a person with HIV does not in itself mean that the person is sick. A person with HIV infection can remain healthy for many years without showing any visible signs of the infection, and can lead a full and productive life.⁴³ At this stage the person does not have AIDS. It is said that a person has AIDS only when he or she becomes ill as a result of one or other opportunistic illness. AIDS is the final clinical stage of HIV infection.⁴⁴

* **Transmission of HIV**⁴⁵

- 2.3 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 infections⁴⁶).
- 2.4 HIV has been identified in blood, semen, vaginal discharge, mother's milk, the brain, bone-marrow, cerebrospinal fluid, urine, tears, foetal material and saliva. However, current scientific knowledge indicates that probably only blood, semen, vaginal discharge and mother's milk contain a sufficient concentration of the virus to be able to transmit HIV.
- 2.5 At present no scientific evidence exists that HIV can be transmitted in any other mode than the following:

43 See also par 2.11 below.

44 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).

45 See the sources referred to in fn 40 above.

46 Eg hepatitis B (Van Dyk 22).

- * by hetero- or homosexual intercourse;
- * by receipt of or exposure to the blood, blood products, seed or organs of a person who is infected with HIV;⁴⁷ and
- * by a mother with HIV to her foetus before birth, or to her baby during birth, or after birth by means of breast-feeding.

2.6 In order to infect a person, HIV must reach the bloodstream of that person. The virus can therefore not be spread by other forms of personal contact than those described in paragraph 2.5 above. HIV cannot be transmitted through daily social contact such as breathing, coughing, shaking hands, hugging or sharing toilets, food, water or utensils. Even if blood contact did take place, the chances of being infected are negligible. The incidence of infection 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 1 000.⁴⁸ 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 42 000.⁴⁹

2.7 HIV has a limited life span outside the human body and especially outside body fluids.⁵⁰ It can also be killed by almost any disinfectant.⁵¹

47 This can occur *inter alia* by the use of dirty or used syringes and/or needles for intravenous drugs. 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).

48 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 seroconversion after percutaneous exposure 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).

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

50 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).

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

- 2.8 Not every person who is exposed to HIV is infected with this virus. Similarly, it is possible that not every person who is infected with HIV eventually develops AIDS. Scientists are as yet uncertain of the precise facts in this regard and little is known about the proportion of HIV-positive people who may never show symptoms.⁵² 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.⁵³

* **Course of AIDS**⁵⁴

- 2.9 The course of AIDS is generally divided into four different stages: The acute or initial phase; the latent phase (or asymptomatic carrier 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

- 2.10 The initial phase begins very shortly after a person has been infected with HIV. Symptoms occur that are similar to those of flu (fever, night sweats, headaches, muscular pain, skin rashes and swollen glands). The initial phase continues until seroconversion occurs (when antibodies in the infected person's blood develop in an ineffective attempt to protect the body against HIV). This occurs on average six to twelve weeks after exposure (in exceptional cases even later). This period of time (before seroconversion

52 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).

53 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.

54 See the sources referred to in fn 40 above.

has occurred) is also known as the window period. Blood tests⁵⁵ that are generally used to determine whether a person has been infected with HIV cannot trace HIV itself, but react to the presence of the antibodies. The fact that antibodies are formed only after a period of time implies that blood tests that are conducted during the window period may deliver false negative results: where antibodies have not yet developed in the blood of the person concerned, the blood test will be negative in spite of the fact that the person has already been infected with HIV. During the window period an infected person is already infectious and can transmit the virus to other persons.

Second phase: Asymptomatic seropositivity

- 2.11 During this phase the infected person has HIV and antibodies have already developed, but he or she shows no symptoms of illness. However, the infected person's resistance is slowly but surely impaired until it is so low that opportunistic diseases start attacking the body in the third phase. This latent phase can continue for years while the infected person remains relatively healthy. In this phase also infected persons are often not aware that they are carriers of HIV and they can therefore unknowingly transmit the virus to others.

AIDS related symptoms

- 2.12 This phase (which has in the past often been referred to a AIDS-related complex [ARC]) can also continue for several years. Symptoms of the opportunistic diseases that cause death in the final phase occur during this phase. 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.

55 For more detail see par 2.17-2.21 below.

Final phase: Clinical AIDS

- 2.13 Only during this phase can it be said that a person has AIDS. Such a person's body is no longer capable of withstanding the opportunistic diseases, the symptoms of which were observed in the previous phase, and he or she usually dies within two years as a result of these diseases.⁵⁶ Diseases that generally occur are pneumonia, tuberculosis and Kaposi's sarcoma. Neurological and psychiatric disorders (known as AIDS dementia) may also occur.⁵⁷ The occurrence of these diseases, however, differs from continent to continent.⁵⁸ The most important opportunistic diseases in Africa are tuberculosis and chronic diarrhoea while a certain form of pneumonia (caused by *Pneumocystis carinii*) is responsible for the majority of mortalities among persons with AIDS in Europe and North America.⁵⁹
- 2.14 The course of AIDS varies from person to person. It has been stated above that the period prior to seroconversion can last on average from six to twelve weeks. The average duration of the latent period 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 infection will differ according to their general state of health, their living conditions and the specific opportunistic disease which develops.⁶⁰ In connection with the latter it is indicated that although the course of the disease follows the same pattern in developed and developing countries, the period between becoming infected and death is much shorter in developing countries.⁶¹ This can probably be ascribed to the prevalence of endemic diseases (for instance tuberculosis

56 Van Dyk 11; Carr **AIDS in Australia** 8.

57 Some writers point out that neurological manifestations may occur even in the earlier phases of the disease (see sources quoted by Van Wyk 22).

58 Volberding **AIDS: Principles, Practices and Politics** 103.

59 Hawkes & McAdam 1993 **Medicine International** 70-71; the information relating to the position in Africa was also confirmed by Dr Jacob Gayle in his evidence before the Commission on 15 April 1994.

60 Cf Van Wyk 23-24.

61 Hawkes & McAdam 1993 **Medicine International** 70.

and other parasitical infections) and to a lack of adequate medical treatment.⁶²

- 2.15 Not all persons with HIV infection go through all of the four phases mentioned above and some of them do not even show symptoms before they develop clinical AIDS (the final phase).
- 2.16 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.

* **Testing for HIV**⁶³

- 2.17 At present the most general manner in which the question as to whether a person is infected with HIV can be determined is by blood tests which are utilised to indicate the presence of HIV antibodies. Although available, blood tests to detect HIV itself in a person's blood are not at present generally utilised.⁶⁴
- 2.18 The blood tests that have been used throughout the world since 1985 to detect the presence of HIV antibodies in a person's blood are known as the ELISA (enzyme-linked immunosorbent assay) and the Western Blot test. The ELISA test is a very sensitive test which will react positively to nearly any infection in the body.⁶⁵ Because of the high degree of sensitivity of the ELISA test a single test can deliver a false HIV positive

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

63 See the sources referred to in fn 40 above. See also Levine & Bayer **AIDS an Epidemic of Ethical Puzzles** 21-22; **Confronting AIDS** 304-307; Moodie 1988 **SA Journal of Continuing Medical Education** 58-63.

64 Tests which detect HIV in the urine, and saliva, and the polymerase chain reaction technique (internationally known as the PCR) which detects the virus itself in the blood are also available, but are not in general use - the former due to its relative unreliability and the latter due to the fact that it is complicated, difficult to execute and thus impracticable (information supplied by Dr R Crookes of the SA Blood Transfusion Service on 6 June 1994; see also Van Dyk 12; Crofts **AIDS in Australia** 26-27).

65 Levine & Bayer **AIDS an Epidemic of Ethical Puzzles** 21-22; **Confronting AIDS** 305-306; Crofts **AIDS in Australia** 25-26; Van Dyk 12.

result. For this reason it is necessary to carry out a second, more specific test in order to confirm true HIV positivity.⁶⁶ The Western Blot test, which is such a more specific test, is traditionally used to confirm an initial positive test. However, the Western Blot is expensive⁶⁷ and can therefore not always be used in practice.⁶⁸ 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.⁶⁹

- 2.19 When a blood test to detect the presence of HIV antibodies is carried out, the result of the test can be available approximately 24 to 48 hours after taking the blood sample.⁷⁰
- 2.20 A positive HIV antibody test means that the person concerned is infected with HIV, will have the virus for the rest of his or her life and can infect other persons. The blood tests discussed above do not indicate the stage of infection which the person tested has reached. A negative HIV antibody test means that no antibodies against HIV have been traced in the blood of the person concerned. It could mean that the person is not infected, or is infected but is in the window period.⁷¹ To obtain a reliable result such a person will have to be tested for HIV again after a period of time.⁷² Recently developed viral load testing constitutes a sensitive indicator of viral activity in the blood of an individual with

66 Ibid.

67 The cost of a Western Blot test is approximately R200 while the cost of an ELISA test executed by a private body varies from R70 to R90 (evidence before the Commission by Prof A Heyns and Dr R Crookes of the SA Blood Transfusion Service on 7 February 1994).

68 Information supplied by Dr R Crookes of the SA Blood Transfusion Service on 6 June 1994, and in evidence before the Commission on 7 February 1994; see also Fleming & Martin 1993 **SAMJ** 685-687.

69 According to the WHO guidelines the prevalence of HIV infection 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 & Martin 1993 **SAMJ** 685-687).

70 Information supplied by Dr R Crookes of the SA Blood Transfusion Service on 6 June 1994.

71 Cf also par 2.10 above, which explains what the window period is.

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

HIV.⁷³ As this testing becomes more sophisticated it may assist as a diagnostic tool in accurately predicting the stage of infection and a person's future health status.

- 2.21 It is alleged that where the above-described 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 the cases in which the persons concerned are HIV infected.⁷⁴

* **Treatment**

- 2.22 There is at present no cure for HIV infection or AIDS and it seems unlikely that a cure will be developed in the near future. The best known drug for the treatment of persons with HIV infection and AIDS, is AZT (zidovudine).⁷⁵ 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.⁷⁶ In spite of its benefits AZT is highly toxic and because of its side-effects (like anaemia, headaches and nausea) some persons cannot be treated with it.⁷⁷ AZT treatment may possibly be only initially successful and its effectiveness may deteriorate in the course of treatment.⁷⁸ Moreover, cost of AZT

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

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

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

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

77 Penslar **AIDS an Epidemic of Ethical Puzzles** 174; Carr **AIDS in Australia** 9; see also Concôrde Coordinating Committee 1994 **The Lancet** 877; Havlir & Richman 1993 **Medicine International** 63; Tindall et al **AIDS in Australia** 218.

78 Plummer **AIDS in Australia** 82; Van Wyk 61; Havlir & Richman 1993 **Medicine International** 61-62; Carr **AIDS in Australia** 9.

treatment is very high.⁷⁹ In addition there are differences of opinion among scientists concerning the question as to whether AZT is of any real benefit during the long asymptomatic phase.⁸⁰ However recent development of protease inhibitor treatments appear to offer, for the first time, significant hope that viral advance may be contained. In addition, of course, symptomatic treatment for debilitating conditions affecting persons with AIDS is improving all the time. There is some hope that HIV/AIDS may eventually, for those who can afford treatment, become manageable in ways similar to diabetes, epilepsy, and heart disease.⁸¹

3

79 Van Wyk 60; Penslar **AIDS an Epidemic of Ethical Puzzles** 174-176. This was confirmed in evidence before the Commission on 4 February 1994 by a private medical practitioner who treats persons with HIV infection and AIDS and on 4 and 15 February 1994 by such persons themselves.

80 Tindall et al **AIDS in Australia** 218; Havlir & Richman 1993 **Medicine International** 62; Freedman **AIDS an Epidemic of Ethical Puzzles** 167; Concôrde Co-ordinating Committee 1994 **The Lancet** 871-879.

81 Cf Farnham 1994 **Public Health Reports** 312.

HIV/AIDS AND CHILDREN

* Incidence of HIV infection among children

- 3.1 The ways in which children can become infected with HIV are by vertical transmission (from mother to baby before or during birth or possibly after birth by way of breast feeding); receiving infected blood, blood products or organs; intravenous drug abuse, early sexual activities⁸² and sexual abuse.⁸³
- 3.2 Amongst children the most important route of HIV transmission by far is vertical transmission.⁸⁴ According to statistics available towards the end of 1995,⁸⁵ more than 73% of reported cases of clinical AIDS in South Africa were the result of heterosexual intercourse and transmission from mother to baby. Vertical transmission was at that time responsible for approximately 11% of the total number of AIDS cases⁸⁶ 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 U S, the situation in South Africa corresponding with that in other African countries.⁸⁷ It is accepted that vertical transmission increases at the rate at which heterosexual transmission of HIV increases.⁸⁸ Estimates based on the seventh national HIV survey carried out in South Africa at the end of 1996, are that 1,4 million women were infected with HIV at the end of 1996, and that 57 000 HIV-infected babies were born in 1996 (4% of the total of 1,34 million babies born during that year). The number of babies with HIV born since 1990 is estimated to be 156 000. It is further estimated that there will be about 90 000 new cases

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

83 Cf the response of the AIDS Legal Network to the Law Commission's Working Paper 58.

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

85 **Epi Comments** September 1995 218.

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

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

88 Berer & Ray 72. Women are physically more susceptible to infection during heterosexual intercourse than men (Arnott **Innes Labour Brief** June 1996 32).

of clinical AIDS in South Africa during 1997 and that 20 000 of those will be children born to mothers with HIV.⁸⁹

- 3.3 Recent national and international studies of HIV seroprevalence reveal that adolescent females are now being infected at increasing rates, and in some developing countries at rates higher than adults.⁹⁰ The seventh national HIV survey carried out in South Africa at the end of 1996, indicated that 14,07% of women who attended antenatal clinics in 1996 were infected with HIV.⁹¹ The 20-24 year group was the group most infected (17,52%), closely followed by the 25-29 year old group (15,21%) and the under twenty year old group (teenagers). Of teenagers attending antenatal clinics, 12,78% tested HIV positive, compared to 9,5% a year earlier. This figure reveals sexual activity and an increased risk of contracting HIV amongst children of secondary school age. Statistics indicate that adolescents and young adults account for a disproportionate share of the increase in HIV/AIDS infection in South Africa.⁹²
- 3.4 Intravenous drug abuse as a route of infection has received scant attention in South Africa. Of the 8 802 cases of clinical AIDS reported at October 1995, only 3 were a result of intravenous drug abuse.⁹³ This route should nevertheless be recognised as an important potential source of HIV transmission.
- 3.5 It is said that approximately 50% of babies born of mothers with HIV will test HIV

89 Commentary on the 7th National HIV Survey - Oct/Nov 1996 by Mr Peter Doyle of Metropolitan Life. An incubation period of eight to nine years on average is assumed for these estimates.

90 **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.

91 Compared to the infection rate of 10,44% of 1995, the infection rate increased by 35% in the course of 1996.

92 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).

93 **Epi Comments** September 1996 218.

positive at birth.⁹⁴ It is, however, uncertain whether a newborn baby will merely reflect his or her mother's HIV status or whether such a baby is itself 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 only then be established with certainty.⁹⁵ The polymerase chain reaction technique referred to above,⁹⁶ may be used to detect the virus itself in the blood of newborn babies. However, as indicated above, this test is not generally available. Scientific estimates of the percentage of births to mothers with HIV where HIV transmission occurs differ and estimates of 7%-39%,⁹⁷ 15%-40% (in respect of European and American studies),⁹⁸ and even as high as 60% (in respect of studies done in Africa)⁹⁹ have been recorded. The rate of transmission for South Africa is currently accepted to be around 30%.¹⁰⁰ 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.¹⁰¹

* **Course of AIDS in children**

3.6 As far as the course of the disease in children is concerned, symptoms appear in 80% of infected babies by approximately six months after birth.¹⁰² The earlier symptoms and

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

95 Ibid; Newell & Peckham *HIV Infection and Children in Need* 13; WHO AIDS Series 8 36-37; Gibb & Peckham 1993 **Medicine International** 65.

96 Cf fn 64. 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).

97 Newell & Peckham **HIV Infection and Children in Need** 14.

98 Ibid; McIntyre (Unpublished) 42.

99 McIntyre (Unpublished) 42.

100 See editorial **AIDSScan** October 1996 4, as well as the discussion of a study on the effect of breastfeeding on the vertical transmission of HIV in Soweto (**AIDSScan** October 1996 13). Doyle **Facing up to AIDS** 98 accepts a 35% mother-to-child infection rate.

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

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

disease appear, the more likely an infant is to die at a very young age. This is because its immune system is not fully developed and immunity to many diseases has not yet been acquired.¹⁰³ 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.¹⁰⁴ By the end of their first year of life 25%-33% of these children have already developed full-blown AIDS or have already died from some or other AIDS related infection.¹⁰⁵ Although progression of the disease in the remaining 66%-75% of children is slower,¹⁰⁶ some scientists estimate that the life-spans of most infected children are shorter than three or four years.¹⁰⁷ In South Africa the majority of infants with HIV are unlikely to reach school going age.¹⁰⁸ However, recent studies show that some infected children may remain symptom-free up to the age of seven years¹⁰⁹ and will therefore reach school going age. In other cases, despite the onset of symptomatic AIDS, children may survive to reach school going age.

- 3.7 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.¹¹⁰ 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,

103 Berer & Ray **Women and HIV/AIDS** 72.

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

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

106 Gibb & Peckham 1993 **Medicine International** 66; Newell & 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 & McIntyre 1992 **SAMJ** 90-94.

persistent diarrhoea and vomiting.¹¹¹ 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, perianal rash.¹¹² 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.¹¹³

* **Treatment**

3.8 HIV infection in children can be managed by anti-HIV drugs. These include zidovudine (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.¹¹⁴) Prophylactic treatment can be given 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. It has furthermore been suggested that infected children should receive all immunisations, with certain provisos.¹¹⁵

* **HIV infection and AIDS in schools**¹¹⁶

3.9 HIV/AIDS will undoubtedly affect most schools.¹¹⁷ Learners may be faced with the

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

112 **AIDSScan** June 1994 13.

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

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

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

116 See par 3.163 -3.170 of Working Paper 58.

illness of their parents. 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 disrupt the learning process. The education authorities may be faced with a situation where orphans drop out of school because their guardians are unable or unwilling to pay for school requisites. 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.

- 3.10 Prohibiting children with HIV from attending school, managing and educating children with HIV, confidentiality of AIDS related information, and the supplying of information and education regarding HIV/AIDS to learners, are the legal aspects which need discussion in connection with schools.
- 3.11 The 1987 Regulations contain far-reaching measures regarding “communicable diseases” in schools. Because AIDS is listed¹¹⁸ in the 1987 Regulations, certain coercive measures apply mandatorily to it.¹¹⁹
- 3.12 The 1987 Regulations have, as far as could be ascertained, never been applied in respect of schools.¹²⁰ They have been widely criticised¹²¹ and have in draft been revised. Draft

117 Cf the remarks of Kwitshana (Unpublished).

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

119 They 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)).

120 Cf also Van Wyk 449; Cameron & Swanson 1992 **SAJHR** 217.

121 A more detailed discussion followed in Chap 4 of Working Paper 58; see also par 5.4-5.9 of **SALC First**

Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions¹²² (the Draft Regulations) were published for comment in 1993 but had not been finalised by mid-1997. In the Draft Regulations AIDS is no longer a listed “communicable disease” with the result that the far-reaching provisions discussed above,¹²³ will apparently not be applicable in respect of AIDS in future. Also, the Draft Regulations explicitly prohibit a principal from refusing a pupil who is “a carrier” of HIV (or who is suspected of being “a carrier”), attendance at school on this ground only.¹²⁴ The first interim report of the Commission referred to in paragraph 1.6 above, recommended that the Draft Regulations be finalised and promulgated, subject to certain amendments.¹²⁵

- 3.13 Other legislation,¹²⁶ and regulations¹²⁷ 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” children.¹²⁸ The definition of “handicapped” child in the different Acts is of such a

Interim Report on Aspects of the Law Relating to AIDS.

- 122 Published under Notice 703 of 1993 in **GG** 15011 of 30 July 1993.
- 123 See fn 119 above.
- 124 The Draft Regulations, draft reg 7(4). See also **SALC First Interim Report on Aspects of the Law Relating to AIDS** par 5.2.
- 125 Which will remove the 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).
- 126 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).
- 127 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.)
- 128 Education and Training Act 90 of 1979, sec 1 and 5; Education Affairs Act 70 of 1988, sec 1 and 12(1)(d);

nature that a child with asymptomatic HIV infection is probably not included.¹²⁹ The medical model of “disability” has in any event been rejected in education circles as a basis on which to model children with HIV.¹³⁰

- 3.14 The 1996 Constitution¹³¹ provides for various rights which may compete in determining policy on HIV/AIDS in schools. These are the right to equality, the right to education, the right to privacy, the right of access to information, the right to procreative health care and the right to freedom of conscience and religion.
- 3.15 The 1996 Constitution provides that neither the state, nor any person,¹³² may unfairly discriminate directly or indirectly against anyone on one or more grounds, including disability. The 1996 Constitution therefore prohibits unfair discrimination not only vertically (between the state and its subjects) but also horizontally (between individuals and juristic persons).¹³³ 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 1996 Constitution also confirms that everyone has the right to a basic education (including adult basic education), and to further education, which the state must progressively make available.¹³⁴ In terms of

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).

- 129 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).
- 130 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 1997.
- 131 The new Constitution came into effect on 4 February 1997.
- 132 Sec 9(4) provides that national legislation must be enacted to prevent or prohibit unfair discrimination between private parties.
- 133 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). National legislation must be enacted to prevent or prohibit unfair discrimination”. 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”.
- 134 Sec 29(1).

section 28(2) “a child’s best interests are of paramount importance in every matter concerning the child” while in terms of section 28(3) a child means “a person under the age of 18 years”.

3.15.1 The Schools Act¹³⁵ (which applies to all school education in South Africa and thus covers both public and independent schools admitting learners between grades zero and twelve¹³⁶) confirms the constitutional prohibition on unfair discrimination and the right to a basic education. 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.

3.15.2 The Act provides that a public school¹³⁷ must admit learners¹³⁸ and serve their educational requirements without unfairly discriminating in any way.¹³⁹ Provinces have to provide public schools for the education of learners.¹⁴⁰ In terms of the Act “the provision of public schools” may include “the provision of hostels for the residential accommodation of learners”.¹⁴¹ The Act further provides for the administration, control and maintenance of school property, including school hostels.¹⁴² It would seem that these

135 See fn 34. This Act became operative on 1 January 1997.

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

137 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. 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). The governance of public schools vests in governing bodies (sec 16).

138 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.

139 Sec 5(1).

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

141 Sec 12(1) and (2).

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

stipulations of the Act (which all have a bearing on the provision and maintenance of physical facilities), do not expand the general definition of “school” (a public or an independent school which enrolls learners between grade zero and grade twelve)¹⁴³ to include also school hostels. (However, it is submitted that the underlying principles contained in the proposed school policy, such as the principle of non-discrimination, could also apply to any school hostel provided.)

3.15.3 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.¹⁴⁴ It is submitted that “any test” is wide enough to include tests for HIV, which would mean that no learner who applies for admission to a public school may be asked to undergo a test for HIV. HIV testing may therefore not be a prerequisite for admission to public schools. No such prohibition, however, exists with regard to independent schools.¹⁴⁵ It is nevertheless submitted that unfair discrimination against learners is prohibited in regard to the admission to, and the continued education in, all schools, including independent schools.

3.15.4 The Act provides for compulsory education (education from age seven up to the ninth grade or the age of fifteen).¹⁴⁶ The Act also provides for special

143 Sec 1(xix).

144 Sec 5(2).

145 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)). 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).

146 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

needs that learners may have. A learner may be totally, partially or conditionally exempted from compulsory school attendance if it is in the best interests of the learner.¹⁴⁷ Parents may also apply to the Head of an Education Department¹⁴⁸ 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 requirements of the curriculum at public schools and will be of a standard not inferior to education at public schools.¹⁴⁹

3.15.5 The National Education Policy Act¹⁵⁰ (the Policy Act) also enhances the constitutional right to basic and further education and the protection against unfair discrimination. It aims to provide for, *inter alia*, the determination and implementation of a national education policy by the Minister of Education.¹⁵¹

3.15.6 The Policy Act provides that national education policy has to be determined in accordance with the provisions of the 1996 Constitution and of the Act itself,¹⁵² and that in determining such national policy for education at education institutions,¹⁵³ the Minister shall take into account the competence of the provincial legislatures in terms of the 1996 Constitution¹⁵⁴ and the relevant provisions of any provincial law relating

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)).

147 Sec 4(1).

148 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).

149 Sec 51(1) and (2).

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

151 Sec 2, read with sec 1.

152 Sec 3(1).

153 "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).

to education.

3.15.7 In terms of the 1996 Constitution the national and provincial legislatures have concurrent legislative competence on education at all levels, excluding tertiary education.¹⁵⁵ 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.¹⁵⁶

3.15.8 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 a specific declaration in the policy instrument to that effect.¹⁵⁷

3.15.9 The Minister must determine national policy on matters such as financing and staffing,¹⁵⁸ and may determine national policy for *inter alia* development in education, compulsory school¹⁵⁹ education, the admission of students¹⁶⁰ to education institutions, curriculum frameworks, core syllabuses,

154 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.

155 Schedule 4 of the 1996 Constitution.

156 See sec 146 of the 1996 Constitution.

157 Sec 3(3) of the Policy Act.

158 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).

159 “School” means a pre-primary, primary or secondary school (sec 1 of the Policy Act).

160 “Student” means any person enrolled in an education institution (sec 1). For the meaning of “education institution”, see fn 153.

education programmes, and education support services (including health and welfare development and counselling).¹⁶¹ It is submitted that “education institution” includes independent schools.¹⁶²

3.15.10 The national policy 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.¹⁶³ South Africa on 16 June 1995 ratified the United Nations Convention on the Rights of the Child.¹⁶⁴ States Parties undertake *inter alia* to ensure children (under 18 years of age) such protection and care as is necessary for their well-being,¹⁶⁵ to ensure to the maximum extent possible the survival and development of children¹⁶⁶ and to ensure that children have access to information and material aimed at the promotion of *inter alia* their physical health.¹⁶⁷ The national policy has, in particular, to advance and protect the right of every person to be protected against unfair discrimination in education on any ground whatsoever, and to basic education and equal access to education institutions.¹⁶⁸ The 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.¹⁶⁹

3.16 The 1996 Constitution protects every person's right to privacy.¹⁷⁰

161 The Policy Act, sec 3(4).

162 See fn 153.

163 The Policy Act, sec 4(a).

164 The Convention was adopted by the United Nations General Assembly on 20 November 1989 and came into force on 2 September 1990.

165 The U N Convention, article 3(2).

166 Ibid, article 6(2).

167 Ibid, article 17.

168 The Policy Act, sec 4(a)(i)-(viii). The Act echoes the wording of the 1993 interim Constitution and will probably have to be brought into line with the provisions of the 1996 Constitution.

169 The Policy Act, sec 4(b) and (d).

170 Sec 14.

3.16.1 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.¹⁷¹ A doctor treating a child is bound by the same ethical and legal obligations of confidentiality which protect adults,¹⁷² and the SAMDC Guidelines do not distinguish between adults and children.¹⁷³

3.16.2 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 violation of a duty of confidentiality.¹⁷⁴ In general, disclosure can be justified if the individual gives his or her informed consent thereto; where legislation requires that the information be disclosed;¹⁷⁵ if a doctor is ordered by court to disclose the information; or if disclosure would be in the overriding public interest.¹⁷⁶ However, in view of the specific and limited modes by which HIV is transmitted, particular third parties whose interests may be affected, are sexual partners and persons (such as health care workers) who become exposed to the body fluid or blood of the infected person.¹⁷⁷

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

172 See par 3.47-3.57 of Working Paper 58. In these paragraphs the confidentiality of AIDS related information is discussed.

173 See par 3.54-3.56 of Working Paper 58 for quotations from the relevant SAMDC Guidelines in this regard. 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".

174 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.

175 Provided that this legislation conforms to the provisions of sec 36 of the 1996 Constitution.

176 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.

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

3.16.3 The HIV status of a child may, therefore, not be disclosed without justification, such as consent.¹⁷⁸ The consent will usually be given by the child's parent or guardian.¹⁷⁹ 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 any medical treatment of him- or herself or his or her child.¹⁸⁰ This would include an HIV test. 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.¹⁸¹ By analogy, a mother of 14 years and older, may consent to the disclosure of the HIV status of her baby to third parties.¹⁸² 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".¹⁸³

3.17 The 1996 Constitution also provides for everyone's right of access to information¹⁸⁴ held by the state as well as any information that is "held by another person and that is required for the exercise or protection of any rights".¹⁸⁵ Until such time as legislation is enacted to give effect to this right,¹⁸⁶ persons have the right of access only against the state and its organs: they have the right of access to all information held by the state or any of its

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

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

180 See sec 39(4)(b). (In the case of an operation this age limit is 18 years - sec 39(4)(a).)

181 The Child Care Act, sec 39(4)(b); see also Cameron **AIDS Bulletin** March 1993.

182 Cf the Child Care Act, sec 39(4)(b).

183 Neethling 259, 97-98 (our translation).

184 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.

185 Sec 32(1).

186 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, revised draft of May 1996, aims to give the public a right of access to information held by governmental and private bodies.

organs in any sphere of government in so far as that information is required for the exercise or protection of any of their rights.¹⁸⁷

3.17.1 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.¹⁸⁸

3.17.2 Parents, or learners themselves, could argue that the 1996 Constitution enables them to have access to state-held information on infected learners in public schools, the latter being conceived as "organs of state"¹⁸⁹ or that the Schools Act itself affords them access to such information in any school. Parents or learners would have to show that they need this information to protect a specific right.¹⁹⁰ The right need not be only a fundamental right¹⁹¹ (such as the healthy learner's fundamental right to life¹⁹² or to bodily integrity¹⁹³).

3.18 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

187 Sec 32(1) read with sec 23(2) of Schedule 6 - Transitional Arrangements.

188 Sec 59(1).

189 See **Baloro v University of Bophuthatswana** 1995 4 SA 197 (B) 235-246 in which Friedman J P 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 probably apply to public schools which are funded by the state (sec 34(1) of the Schools Act), and possibly even 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).

190 Cf sec 32(1) of the 1996 Constitution; see also sec 59(1) of the Schools Act.

191 **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).

192 The 1996 Constitution, sec 11.

193 Ibid, sec 12(2).

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,¹⁹⁴ that it would promote the constitutional right of access to (reproductive) health care¹⁹⁵ and that it would have a significant positive impact on public health.¹⁹⁶ Studies have shown that publicity about AIDS has resulted in beneficial change in the sexual practices of teenagers.¹⁹⁷

3.18.1 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.¹⁹⁸ 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,¹⁹⁹ and that schools do have the economic resources to implement such programmes without taking away money allocated for traditional core courses. It has been found that teacher-delivered curricula could favourably modify AIDS related knowledge and risk behaviour among learners.²⁰⁰ 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 safety precautions once they are already sexually

194 Ibid, sec 28(2).

195 Ibid, sec 27(1)(a).

196 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 picked up the information from friends (**AIDSScan** March/April 1995 8-9).

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

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

199 Cf Strode & Small **Rights** December 1995 29.

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

active. The message needs to reach them before they reach puberty.²⁰¹
The “window of opportunity” in Africa is said to refer to children under nine years of age.

3.19 The 1996 Constitution also provides that everyone has the right to freedom of conscience, religion, thought, belief and opinion.²⁰²

3.19.1 The Schools Act²⁰³ and the Policy Act²⁰⁴ reaffirm these rights.

3.19.2 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 sends the message that sexual activity is permissible as long as it is “safe”.

3.19.3 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

201 With regard to AIDS sex education, it has been recommended that teenagers should be told 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.

202 Sec 15(1).

203 See the preamble and sec 7 of the Act.

204 Sec 4(a)(i)-(viii) provides that a 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.

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.²⁰⁵ Proponents of parental rights maintain that the latter overrides the concern for public health.

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

EVALUATION

- 4.1 In the light of current scientific knowledge, and of the (competing) fundamental rights set out above, the project committee is of the view that the compulsory testing of learners as a prerequisite for admission to any school, or any unfair discriminatory treatment, is not justified. This includes, for instance, refusing admission to school or continued school attendance solely on the basis of the HIV positive status of the learner.
- 4.2 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 significant health risk to others (for instance where he or she 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 his or her health condition permanently restricts his or her ability to attend classes. 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.
- 4.3 Although disclosure to the school principal is probably not legally enforceable (in view of the fact that the 1987 Regulations have to our knowledge 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 or by the learner him- or herself (if the learner is above the age of 14 years). 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.²⁰⁶

²⁰⁶ 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

- 4.4 Such information would facilitate informed decisions regarding the management of learners with HIV infection. This will be possible only if the information is disclosed to school staff on a need to know basis, the information is not used as a ground for unfair discrimination against learners with HIV and the confidentiality of information is 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 a specific right. If universal precautions are adhered to in all circumstances, it would in any event be difficult to conceive of such a right which may be threatened by maintaining confidentiality.
- 4.5 Schools should be sensitised to HIV/AIDS and the need for universal precautions as the state may 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.²⁰⁷ 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.²⁰⁸
- 4.6 The project committee is further of the view that learners have a right to be educated on AIDS, sexuality and healthy lifestyles, 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. The committee however recognises the need for consultations with parent communities in an open

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 ...”.

207 Sec 60(1) of the Schools Act.

208 Ibid, sec 5(3).

manner to help allay any unfounded fears, improve understanding²⁰⁹ and above all, ensure that sexuality education will accord with the community ethos and values.²¹⁰ The information about AIDS should be designed to fit the developmental levels and background of learners.

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

210 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.

MOTIVATION FOR INTERVENTION

- 5.1 It may be argued that the existing constitutional and legislative inhibitions on unfair discrimination and the disclosure of confidential information in the educational setting are sufficient. This however, assumes extensive knowledge regarding HIV and the ability to apply this knowledge effectively. Recent experience suggests that a precisely directed and clearly targeted policy on these issues 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.
- 5.2 Furthermore, a clear national policy on a core curriculum on HIV/AIDS education and on universal precautions to prevent infection with HIV in the context of contact sport, will bring about much needed guidance on these issues.
- 5.3 In order to be effective, such a policy will require uniformity across the nation.²¹¹ It therefore needs to be embodied in a national statutory instrument. As pointed out earlier, the 1996 Constitution provides that in such an event, national legislation may prevail over any existing and conflicting provincial legislation.²¹²
- 5.4 From the discussion above it is clear that the Minister of Education may determine a national policy on HIV/AIDS for educational institutions, which would include both public and independent schools. The Policy Act further provides for the publication, implementation and monitoring of such a national policy.²¹³ The project committee is of the view that this should be done, as envisaged in the Policy Act, by regulation, after prescribed consultation with various bodies and the necessary publication have taken

211 See par 3.15.6-3.15.8 above.

212 Sec 146 of the 1996 Constitution.

213 Sec 3 deals with the determination of the policy, sec 4 deals with the directive principles that apply to such policy, sec 5 prescribes the consultations which must take place before the policy is determined, sec 7 deals with publication of the policy, and sec 8 deals with monitoring and evaluation of education and the compliance with national policy.

place.²¹⁴ The committee further considers that the policy should cover admission to schools, school attendance, universal protection measures, and education on general health and safe lifestyles, of which sexuality education is to form part. HIV/AIDS education would fit in comfortably with the curriculum on life skills or life orientation.

5.5 The project committee is of the view that the chief focus of the policy in question should be children under 18 years.²¹⁵ The policy 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. The definition of “education institution” in the Policy Act is too wide to be of use in defining the target group for such a policy. It includes, among other institutions, also distance and community education institutions. This Act, as well as the Schools Act, in any event does not apply to university and technikon education.

5.6 If the Minister of Education determines, publishes and implements such a national policy, every school will be governed by this policy. The governing body may then in addition adopt an HIV/AIDS policy to give operational effect to the national policy. 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.²¹⁶ A governing body also has to discharge functions as determined by the Minister of Education or the MEC.²¹⁷ The functions of the governing body of a school could therefore include the adoption of an HIV/AIDS policy for that school provided however that the policy does not infringe upon the norms and minimum standards of the curriculum prescribed by the Minister of Education.

214 Policy Act, sec 5, 6 and 7.

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

216 The governing bodies may further apply to be allocated other functions consistent with the Act and any applicable provincial law (see sec 20(1)(a) and sec 21(1)(e)).

217 Sec 20(2) of the Schools Act.

- 5.7 Apart from the composition of governing bodies as prescribed by the Schools Act,²¹⁸ a public health official, a medical doctor or health care worker and other community representatives may also usefully be co-opted.²¹⁹ They could also then serve on a Health Advisory Committee (a committee of the governing body) together with members of the academic and administrative staff, and representatives of the parents. This would ensure broad community participation in order that a school's HIV/AIDS education policy may be in keeping with the ethos and values of the school and the community.²²⁰ The Health Advisory Committee should also review the school's health care policy on HIV/AIDS (including universal precautions) from time to time, and should advise the governing body on this.
- 5.8 The national policy will thus constitute 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 will apply.
- 5.9 In the project committee's view 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, the 1996 Constitution expressly provide for the right to have access to "reproductive health care".²²¹ The policy therefore endeavours to reflect this general constitutional entitlement: If it is felt within a specific community that provision should be made for condom distribution, the governing body of a school may adopt a policy to this effect.
- 5.10 The policy focuses on the principle of non-discrimination and on learners. It therefore does not deal with issues concerning employment in education. Most of these aspects are

218 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.

219 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, but such co-opted member(s) will have no voting rights (sec 23(8)).

220 Cf **Morbidity and Mortality Weekly Report** 29 January 1988 2.

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

adequately dealt with in existing and pending legislation.²²² The South African Council for Educators is also at present attending to a policy for educators with HIV.²²³

- 5.11 The policy will furthermore not deal with other diseases, but will deal only with non-discrimination in the context of HIV/AIDS. The scale of the AIDS epidemic is singular and the stigma and discrimination associated with it are such that special measures are required.
- 5.12 The policy will not directly address the problems in the educational setting associated with HIV infection and intravenous drug abuse. This issue could possibly be dealt with in the code of conduct for learners to be developed by governing bodies.
- 5.13 Although all previous policy guidelines on HIV/AIDS sexuality education²²⁴ allowed parents to withdraw their children from such education sessions, the project committee is of the view that, in view of the singular urgency of the matter, this education should be made part of the compulsory curriculum.
- 5.14 On the assumption made above,²²⁵ that the definition of “schools” in the Schools Act does not in general include also school hostels, and in view of the fact that the Policy Act applies to institutions providing “education” as such, the project committee is further of the view that such a policy should apply in the first instance primarily to schools and not also to school hostels, although its underlying principles, such as the principle of non-discrimination, could clearly be applicable. The policy will therefore not directly address

222 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 Bill (Notice 718 of 1997 in **GG** 17945 of 18 April 1997) which may come into operation shortly. The South African Law Commission's Discussion Paper 72, containing preliminary proposals to prohibit pre-employment HIV testing except in narrowly defined circumstances, has been released for general information and comment on 11 June 1997. The Commission's First Interim Report on Aspects of the Law Relating to AIDS (cf par 1.6 above) dealt with universal work place infection control measures (universal precautions) which will also apply to educators and school personnel.

223 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.

224 Cf fn 28 above.

225 See par 3.15.2 above.

additional measures which may be necessary in respect of cohabitation of learners under residential circumstances in school hostels.

* **Enforcement of draft policy**

- 5.15 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.²²⁶ The Department prepares and publishes a report on the results of each investigation after providing an opportunity for the competent authority to comment.²²⁷ If this report indicates that the standards of education do not comply with the 1996 Constitution or with the 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 to be prepared by the provincial education department in consultation with the national Department of Education, and will be Tabled in Parliament.²²⁸
- 5.16 In addition, the Educators' Employment Act, 1994 provides for the discharge of an educator on account of incompetence or inability to perform the duties attached to his or her post,²²⁹ 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 his or her duties.²³⁰ Other action can include transfer to another post and even lowering of salary or rank or both.²³¹ It has to be borne in mind, however, that this Act does not apply to educators employed in

226 The Policy Act, sec 8(1) and (3).

227 Ibid, sec 8(5).

228 Ibid, sec 8(6) and (7).

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

230 Ibid, sec 12(1)(a) and (d).

231 Ibid, sec 19.

independent schools,²³² who constitute a small minority of educators in South Africa.²³³

5.17 Thirdly, a Code of Conduct was also adopted by the South African Council for Educators (SACE),²³⁴ and will eventually apply to educators registered with the SACE. It is envisaged that all educators²³⁵ (excluding educators in independent schools, independent colleges, universities and technikons²³⁶) will be registered with the SACE by the end of 1997.²³⁷ 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. The Code of Conduct will only gain legal status and become applicable once educators register. Complaints against educators may then be investigated and a fine of up to R1 000 may be levied and the educator's name struck from the register if an educator is found guilty of a breach of the Code - which means that he or she 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, (which include 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,²³⁸ to recognise that schools serve their communities, to accept their professional obligation towards the

232 See par 5.17 and fn 235 and 236 below.

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

234 The decision to establish the Council 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. The SACE was established as a statutory body in 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 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]).

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

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

237 **SACE Code of Conduct** mentions this cut-off date.

238 **SACE Code of Conduct, Registration Procedures, Disciplinary Mechanisms.**

education profession and to accept the disciplinary powers of the SACE. Although the Code will not be applicable to educators in independent schools (unless they registered of their own accord with SACE), the Code is likely to carry moral authority even in the case of such educators.

PRELIMINARY RECOMMENDATIONS

- 6.1 It is recommended that the Minister of Education should, in terms of the National Education Policy Act, 1996 adopt, publish and implement a national policy on HIV/AIDS.²³⁹ The Minister should state clearly that the policy applies nationally, and that it applies to public as well as independent schools.
- 6.2 In view of the above exposition, the national policy on HIV/AIDS for schools as set out below, is proposed.²⁴⁰ It sets out the basic principles which should apply throughout the country. This policy could then be adapted to the needs of various schools and their communities within the framework of its norms and minimum standards.
- 6.3 Comment is invited on these recommendations and on the contents of the proposed national policy as set out below.
- 6.4 The project committee will especially welcome comment on whether the proposed national policy should also apply to school hostels, and if so, whether additional policy measures are necessary.

239 The Policy Act, sec 6. Legislation on such a policy has to be introduced in Parliament, or in the case of regulations, be published in the **Gazette** after consultation as prescribed in the Act.

240 The guidelines set out in this policy took into account Crewe **Draft Policy Discussion Document for the Provision for Children with HIV or AIDS in Gauteng Schools** and the **Independent Schools' Council's AIDS Policy Document**.

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

I,, 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 have 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 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.