SECTION27 SUBMISSION

Draft National Policy on HIV and TB

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I. INTRODUCTION

1. SECTION27 is a public interest law centre that uses and develops the law to advance human rights. As a law clinic, SECTION27 conducts research, advocacy and litigation to change the socio-economic conditions that undermine the exercise of fundamental rights. Our priority areas include the rights to basic education and access to healthcare services. In particular, we advocate for access to comprehensive HIV, STI and TB care, prevention, treatment and counselling and a healthy, safe educational environment for learners.

2. We are therefore encouraged by the Draft National Policy on HIV and TB ("**draft policy**") and welcome the opportunity to engage with the National Department of Basic Education ("**NDBE**") on the content of the draft policy.

3. Our submissions are focused on broad themes that run through the draft policy. We make submissions on the following aspects of the draft policy:

   3.1. Goals and guiding principles;

   3.2. Scope of application;

   3.3. Holistic and comprehensive HIV, TB and STI education for all learners;

   3.4. Access to care, treatment, counseling and support;

   3.5. Management of the policy response and implementation;

   3.6. Safe educational environment, reasonable accommodation and HIV, STI and TB-related learner absences; and

   3.7. Monitoring and evaluation.

II. GOALS AND GUIDING PRINCIPLES

4. Although the guiding principles of the draft policy make reference to a number of rights, including the right to basic education and components of the right to access to healthcare services, they do not adequately emphasise the centrality of these rights to the draft policy. In terms of section 7(2) of the Constitution the state has a positive obligation to "respect, protect, promote and fulfil" all of the rights in the Bill of Rights.[1] Compounding this general positive obligation, sections 27[2] and 29[3] of the Constitution entrench the rights to access to healthcare services and basic education respectively.

5. Section 27 requires the government to take "reasonable legislative and other measures" to progressively realize the right to access to healthcare services. Section 29 contains no such restriction and has therefore been interpreted by the Constitutional Court to be an "unqualified right" which is "immediately realizable": it therefore places an even more demanding positive obligation on the state.[4]

6. Education is well-understood to be a social determinant of health. Indeed, these two rights are mutually reinforcing. A learning environment in which learners are unnecessarily exposed to risk of HIV, TB and STI infection is one in which they will struggle to benefit from quality basic education which is the constitutional right of

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[1] s 7(2) of the Constitution states that: "The state must respect, protect, promote and fulfil the rights in the Bill of Rights."

[2] s 27 of the Constitution:

27. Health care, food, water and social security

> **(**1) Everyone has the right to have access to –
>
> > (a) health care services, including reproductive health care;
>
> …
>
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
>
> …"

[3] s 29 (1)(a) of the Constitution provides:

29. Education

> "(1) Everyone has the right-
>
> > (a) to a basic education, including adult basic education;
>
> …"

[4] *Juma Masjid and KZN Joint Liason Committee Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others* (CCT 29/10) [2011] ZACC 13; 2011 (8) BCLR 761 (CC) at para 37; *KwaZulu-Natal Joint Liaison Committee v MEC Department of Education, Kwazulu-Natal and Others* (CCT 60/12) [2013] ZACC 10; 2013 (6) BCLR 615 (CC); 2013 (4) SA 262 (CC) at para 89 per Froneman, see also para 38.

7. learners, as well as difficulties in concentrating during class. Effective access to health care services is therefore also a prerequisite to accessing quality basic education.

8. In addition, quality education will lead to good health outcomes, and healthy learners who benefit more from quality basic education are necessary for the achievement of a healthier South Africa.

9. We submit that as access to quality healthcare services is a prerequisite for access to quality basic education, learners' rights to have access to healthcare services form part of the "unqualified" right to basic education and are therefore, in this environment, "immediately realizable".[5] In addition to these strong claims to the state's immediate attention, in terms of section 237 of the Constitution, "all constitutional obligations must be performed diligently and without delay".[6]

10. This is the approach taken by National Strategic Plan on HIV, STIs and TB 2012-2016 ("**NSP**"), with which the policy must be consistent. The NSP lists "increasing protection for human rights and promoting access to justice" as one of its four key strategic objectives[7] and "takes as a starting point the constitutional recognition that access to healthcare and other social services … is itself a right enshrined in the Constitution".[8]

11. In this constitutional context, it is crucial that the full realisation of the rights to basic education and access to healthcare services in particular are explicitly and clearly placed at the forefront of the policy. These rights require a policy of this nature to be put in place and implemented effectively and expeditiously. We submit, therefore, that the policy should focus not only on the protection of these

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[5] For more on the meaning of these phrases the SECTION27 submission on the draft Norms and Standards dated October 2013, accessible at www.section27.org.za.
[6] Section 237 of the Constitution reads:
237. Diligent performance of obligations.
"All constitutional obligations must be performed diligently and without delay."
[7] National Strategic Plan on HIV, STIs and TB 2012-2016 ("**NSP**") at 12.
[8] Id at 53.

rights from interference but should be geared towards ensuring that they are fully enjoyed. It is our submission that improving existing outcomes and ensuring quality health and educational outcomes should be the core focus of this policy.

III. SCOPE OF APPLICATION OF THE POLICY

Infrastructural requirements for the successful implementation of the policy: the importance of Minimum Norms and Standards

12. The implementation and success of the policy will rely significantly on the existence and suitability of school infrastructure for its implementation. However, school infrastructure does not and should not form part of the draft policy. It is therefore crucial to the success of the policy that appropriate Regulations Relating to National Uniform Minimum Norms and Standards for Public School Infrastructure ("**Norms and Standards**"), envisaged by section 5A of the South African Schools Act 84 of 1996, that take into account the infrastructural capacity required for the implementation of the draft policy are promulgated.[9] The draft Norms and Standards released for public comment on 12 September 2013 make no reference to either the draft policy or the infrastructural capacity that will be needed to allow schools to "act as inclusive centres of learning, care and support in which school health teams will provide a comprehensive range of services."[10] It is essential that these important services are taken into account in finalizing a set of national uniform minimum norms and standards for school infrastructure.
13. The importance of appropriate infrastructure for the implementation of the policy is evident from the following examples:
    13.1. Although the prescribed teacher to learner ratio in ordinary public schools is 1:40 in primary schools and 1:35 in secondary schools, many of our client schools in Limpopo have as many as 100 learners per class. In s ome

[9] At the time of writing these submissions, Regulations Relating to Minimum Uniform Norms and Standards for Public School Infrastructure have published for comment under GN 932 at p 3 of Government Gazette No. 36837 dated 12 September 2013.
[10] Draft Policy at p 3.

schools, classes of up to 140 learners sit on the floor during their lessons. It is difficult to envisage effective measures for infection control – particularly in the case of TB – where there is such severe overcrowding in class.

13.2. The sanitation facilities at schools throughout South Africa, and particularly in Limpopo, the Eastern Cape and Mpumalanga, are unhygienic, unsafe, and unfit for use by learners. Learners forced to use these facilities, or to relieve themselves in the bushes as an alternative, are exposed to health risks including diarrheal disease, intestinal worms and other infections. Inadequate sanitation is also linked to a compromised ability to manage HIV.

13.3. Many schools do not have enough classrooms for ordinary lessons to be conducted, and administration spaces for the staff and school principal. In this context it is unlikely that there will be space that can be dedicated to the implementation of the draft policy. This will have a particularly severe impact on confidentiality, and the willingness of learners to seek out the services offered to them in terms of the draft policy. This practical obstacle must be addressed urgently before the policy may be effectively implemented.

14. Appropriate school infrastructure is crucial for the successful implementation of the policy. We note that in the draft Norms and Standards, provincial education departments are afforded ten years to implement certain "priority" norms and standards, and seventeen years to implement the remaining norms and standards. Given the clear link between appropriate infrastructure and the policy, a delay in implementation of the Norms and Standards will necessarily cause a delay in the implementation of the draft policy. This will have a negative impact on the health and education of learners across South African schools. Since a policy on HIV, TB and STIs is constitutionally required in order to improve the healthcare and educational outcomes for learners in schools and is urgently needed, this seriously

calls into question the appropriateness and constitutionality of the lengthy timeframes set by the draft Norms and Standards for their implementation.[11] We submit that these lengthy timeframes violate the government's duty perform its constitutional obligations "diligently and without delay".[12]

The overly-broad scope of the draft policy: toward a learner-focused policy

15. The goals set by the draft policy show admirable ambition on the part of the NDBE to combat the HIV and TB epidemics in the school environment. In addition to mainstreaming the NDBE's response to HIV and TB, the policy aims to: increase knowledge of HIV and TB; improve access to HIV prevention, diagnosis, treatment and care and support services; reduce the incidence of HIV and TB; increase learner retention; and create a safe and protective educational environment and improving system efficiency quality and output.[13]

16. These are all important goals and desirable aims not only for learners but for educators, administrators, support staff, officials and indeed society at large. However, focus on the importance of learner's access to healthcare services in particular is a constitutional necessity. In terms of section 28 of the Constitution, learners, as children, have an explicit right to "basic healthcare services" and their "best interests" are to be regarded as of "paramount importance" in all matters concerning them.[14] The Integrated School Health Policy ("**ISHP**") produced by the NDBE and the national department of Health ("**NDoH**") explicitly acknowledges the importance of a children's rights approach and focus[15] and therefore explicitly sets "all children and youth, regardless of age, who attend learning sites" as its "primary

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[11] See SECTION27's Submissions on the draft Norms and Standards dated October 2013, accessible at www.section27.org.za.

[12] Section 237 of the Constitution, above n 6.

[13] Draft Policy at p 2.

[14] Section 28 of the Constitution provides in relevant part:

28. Children.

"(1) Every child has the right-

…

(b) to basic nutrition, shelter, basic health care services and social services;

…

(2) A child's best interests are of paramount importance in every matter concerning the child."

[15] ISHP at, for example, pp 6 and 10.

target group" though acknowledging that the "school community" will benefit from its implementation.[16]

17. It is our submission that the differential manner in which the TB and HIV epidemics and STIs impact learners as children makes it even more desirable in the specific context of the policy to focus on the impact of the HIV and TB epidemics and STIs on learners exclusively. This is also where, in the draft policy's language, it enjoys a true "comparative advantage".[17] The breadth of the draft policy's aims further cautions against the inclusion of an overly-broad group of persons to which the policy applies. It is a concern that in an attempt to create a single policy for all persons involved in the educational environment the focus will be removed from where it is ought to be: improving educational and health outcomes of learners. We therefore submit that the NDBE should contemplate excluding the following from the ambit of the policy:

    17.1. **Workplace Issues:** The implementation of a TB and HIV policy pertaining to government employees requires input from a variety of stakeholders, including unions and other government departments including the Department of Labour. In our view, this requires the development of a separate policy. The NSP specifically requires that "all workplace wellness programmes should address HIV, STIs and TB in an integrated manner and aligned with national standards."[18] It must therefore be ensured that there is no conflict between this policy and relevant labour legislation,[19] codes of good practice in terms of these pieces of legislation[20] and any other existing Department of Labour HIV or TB policy for government and/or other

[16] Id at p 11-12.
[17] Draft Policy at p3 which notes that the NDBE acknowledges the "comparative advantage of the schooling sector to prevent new HIV, STI and TB infections and reduce the impact of HIV, STI and TB disease through education of learners…".
[18] NSP at 44.
[19] Including for example the Labour Relations Act 66 of 1995; the Basic Conditions of Employment Act 75 of 1977; the Employment Equity Act 55 of 1998; and the Occupational Health and Safety Act 85 of 1993. Such a policy would also have to consider the national standards set by the South African Bureau of Standards in SANS 16001:2013.
[20] See http://www.labour.gov.za/DOL/legislation for Codes of Good Practice relating to Labour Relations, Basic Conditions of Employment, Employment Equity and Occupational Health and Safety.

employees. This is particularly true of the section of the policy relating to sexual harassment.[21] Policy creation on employment-related issues requires an appreciation of different factors for a differing context and target group. As teacher and other labour unions are important stakeholders in the context of any policy attempting to regulate the behaviour and working conditions of government and other employees in the learning environment,[22] consultation with them is crucial for the success of any policy regarding employee wellness and workplace issues more generally. This process, whilst necessary, may well delay the implementation of the policy as it pertains to learners which, as the ISHP acknowledges and we have argued, is urgently needed. We therefore submit that the policy should exclude educators, administrators, support staff and officials, all of whom are employed by the provincial education departments, and focus solely on learners.

17.2. **Research Agenda:** We welcome and support the NDBE's explicit support for "evidence-based"[23] interventions and responses to the dual epidemics of HIV and TB. Indeed, rational policy is constitutionally required by the principle of legality which is deeply embedded in the Constitution through the entrenchment of the rule of law.[24] However, we submit that the inclusion of a research agenda within the scope of this policy will distract from the core objects of the draft policy discussed above. The NDBE simply lacks the capacity and expertise to "co-ordinate all related HIV and TB

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[21] See particularly the Code of Good Practice on Handling Sexual Harassment Cases issued in terms of the Labour Relations Act 75 of 1997 accessible at http://www.labour.gov.za/DOL/legislation/codes-of-good-ractise/labour-relations/code-of-good-practice-on-handling-sexual-harassment-cases.

[22] See ISHP at pp 8 and 16.

[23] Draft Policy, Guiding Principles at p 3.

[24] Section 1(d) of the Constitution reads:

1. Republic of South Africa.

> The Republic of South Africa is one, sovereign, democratic state founded on the following values:
>
> …
>
> (c) Supremacy of the constitution and the rule of law.
>
> …"

See Hoexter, C *Administrative Law in South Africa* 2ed (2012) at 121-3 on the principle of legality as a component of the rule of law generally and *Democratic Alliance v President of South Africa and Others* (CCT 122/11) [2012] ZACC 24; 2012 (12) BCLR 1297 (CC); 2013 (1) SA 248 (CC) at para 12 for a recent affirmation and detailing of rationality as a requirement in terms of the principle of legality.

research in the Basic Education Sector".[25] It is therefore submitted that the policy should encourage research conducted by other departments and research agencies with specialized expertise. These entities will certainly need the support, collaboration and co-operation of the NDBE to undertake the continuous research required for an evidence-based approach. However, it is submitted that giving the NDBE the responsibility for coordination of this research increases the scope of the policy unnecessarily beyond where the NDBE's comparative advantage lies to the detriment of its expeditious implementation.

The omission of STIs from the scope of the draft policy

18. Finally, there appears to be one relevant omission from the scope of the draft policy. It is our submission that the policy should be a policy on HIV, TB and STI's. The guiding principles of the draft policy explicitly acknowledge the "comparative advantage of the schooling sector to prevent new HIV, ***STI*** and TB infections and reduce the impact of HIV, STI and TB disease through education of learners…".[26] Furthermore, the NDBE's integrated strategy is titled "Integrated Strategy on HIV, STIs and TB",[27] an explicit acknowledgment of the interconnection between HIV, STIs and TB consistent with the approach taken by the NSP which the draft policy aspires to be "in accordance with" and to "take into consideration".[28] We therefore submit that the policy should be explicitly titled and consistently detailed as a policy combatting HIV, STIs and TB.

[25] Draft Policy, Research Agenda at p 16.
[26] Draft Policy, Guiding Principles at p 3. Emphasis added.
[27] Department of Basic Education *Integrated Strategy on HIV, STIs and TB 2012-2016*.
[28] Id.

IV. HOLISTIC AND COMPREHENSIVE HIV, TB AND STI EDUCATION FOR ALL LEARNERS

The inter-connectedness of sex-related issues: sex, sexuality, sexual orientation and gender

19. The NSP requires the roll out of "comprehensive education on sexuality, reproductive health and reproductive rights … in all schools".[29] Given the interconnectedness of sex, sexuality, sexual orientation and gender ("**sex-related issues**")[30] and the direct bearing that each of these has on particularly the transmission of HIV and STIs, it is submitted this "comprehensive education" requires that the draft policy explicitly adopt a holistic approach to HIV, TB and STI education that includes all of these sex-related issues. Furthermore this comprehensive education should be made available to all learners.

20. The draft policy lists "gender sensitivity and responsiveness" as a guiding principle.[31] It acknowledges that HIV and TB may affect women and men differently for biological, sociological, cultural and economic reasons and that it is important that the "application of all aspects of this policy will be sensitive and responsive" to these differing needs.[32] Despite this general statement, which is to be applauded, it is submitted that gender sensitivity needs to be more clearly and directly infused within the policy itself. The draft policy appears largely to isolate and relegate gender to a specific heading for "gender issues".[33] This is contrary to the statement in the guiding principles and has the regrettable effect of suggesting that gender issues are separable from the core issues in the policy – namely HIV, STIs and TB. It is our submission that this is an ill-advised approach; the policy must do more than

[29]NSP at p 41: "Comprehensive education on sexuality, reproductive health and reproductive rights, inclusive of life skills education, will be provided in all schools through the curriculum and co-curricular activities, to build skills, increase knowledge and shift attitudes, change harmful social norms and risky behaviour, and promote human rights values."
[30] The phrase is used purely as shorthand to describe sex, sexuality, sexual orientation and gender as a composite group of issues. These issues do not encompass all possible sex-related issues and are just the most important examples in the context of this submission.
[31] Id at p 4.
[32] Id.
[33] Id at p 9.

pay lip service to gender issues, which should be deeply infused explicitly within its provisions.

21. Furthermore, in some instances the draft policy refers to education or information on sexuality but does not specify that this includes information on sexual orientation. This is a crucial omission in the context of: a) the stigma that exists against lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQI) people; b) the difficulty of acknowledging, embracing and understanding one's sexual orientation in the South African schooling environment; c) the particular vulnerability of many LGBTQI people to the transmission of HIV and STIs; and d) the importance that every single child understands gender and sexual orientation norms and is equipped and empowered to deviate from them personally or understand and respect other's deviations from these norms.

22. There are at least three places in the draft policy at which the failure to specify the need to educate learners "about gender roles [and] the influence of power in male-female relationships"[34] and other sex-related issues such as sexuality and sexual orientation is particularly problematic:

22.1. **Curriculum development:** The draft policy emphasizes the teaching of life skills "including issues of sexuality".[35] We submit that because of the centrality of the curriculum to the achievement of the aims of the policy more specificity is required. The policy should therefore explicitly mandate that the development of the curriculum should engage with gender and sexual orientation in particular in addition to "issues of sexuality".[36] The curriculum itself should also confront the issues of sexual violence and sexual abuse and be sensitive to the particular requirements of and issues affecting learners with special needs, including, for example, the need for

[34] Draft Policy, Gender Issues p 9.
[35] Id, Curriculum Development p 6.
[36] Id.

access to all materials in braille and large print for blind and partially-sighted learners respectively.

22.2. **Information on Sexual and Reproductive Health Services:** The draft policy contemplates making "accurate and comprehensive information and materials on HIV and TB in the context of Sexual and Reproductive Health Services … available and accessible to all learners", but fails to make any mention of gender, sexuality or sexual orientation in this regard.[37] It is also fails to mention the provision of information on sexual violence and abuse, as is required by the NSP.[38] Learners require knowledge about sexual violence in particular in order to enable them to seek access to the medical, educational, emotional and psychological support they require, including post-exposure prophylaxis (which the NSP states "must be available at all healthcare sites"),[39] morning after pills and appropriate counseling. It is submitted that it should be clarified that these materials will deal specifically with issues of gender, sexual orientation, sexuality and sexual violence as they bear direct relevance to the transmission of HIV, STIs and TB.

22.3. The same is true of the "Information and Awareness" section in the "Treatment, Care, and Counseling and Support" section.[40]

23. Openness about sexual activity, sexual orientation, gender, sexuality and sexual violence in the learning environment is essential to combatting cultural, religious and other societal stigma that often surrounds sex in South Africa. Children may not seek out information and support that they require to practice safe sex and to

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[37] Id, Information, Awareness and Access p 6.

[38] NSP at p 45:

> "Campaigns targeting adults and children are needed to raise awareness of sexual abuse and exploitation, educate communities about their obligations and procedures for reporting and the importance of immediate reporting in order to ensure access to services, to gather the necessary forensic evidence, and to address the stigma associated with sexual abuse, which may prevent disclosure and hence inhibit access to services."

[39] Id.

[40] Id, Information and Awareness p 8.

avoid the transmission of HIV and other STIs if sex remains a taboo. The Constitutional Court recently acknowledged the "awkwardness and embarrassment children often feel when discussing sex with adults".[41] Emphasising the importance of making "safe environments within which [children] can discuss their sexual experiences" available to children the Court noted that laws should not discourage children from seeking guidance and support.[42] We therefore submit that the contents of the laudable information and awareness programmes and suggested curriculum developments contemplated by the draft policy ought to make it clear that education on sex-related issues must be accessible, holistic and free of value judgments.

Confusing and vague terminology: mystifying sex and the need for educators to be provided with clear guidance

24. It is therefore of further concern that the draft policy employs confusing and vague terminology which seems to mystify sex and leave educators without clear guidance as to what to teach about it. The following are illustrative examples:

    24.1. **"Sexually active" and "sexual intercourse" as prerequisites for education and treatment:** The draft policy makes reference to "learners who are sexually active or who have experienced sexual intercourse" indicating that these learners "should be counseled on sexual and reproductive health".[43] It is not clear what precisely the terms "sexually active" or "sexual intercourse" mean in this context. This assumes that it is possible to gauge which learners are or are not "sexually active" and that only this set of learners is entitled to counseling on sexual and reproductive health. It is submitted that the policy should clarify that counseling services should be made available and accessible and encouraged for all learners, not only those who are "sexually active" or who have had "sexual intercourse".

[41] *The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35 at para 45.
[42] Id.
[43] Draft Policy, Voluntary Counselling, Screening and Testing p 7.

Failure to do so conflicts with the prevention peg and guiding principle 4.2 of the draft policy on "access to counselling, treatment, care and support".[44] It also fails to acknowledge that not all sexual intercourse or sexual activity occurs by choice. We deal with this in more detail below.

24.2. **"Age appropriate Life Skills":** The draft policy makes reference to "***Age-appropriate*** Life Skills, including issues of sexuality, reproductive health, relationships and responsibilities, focusing on HIV and TB prevention in particular" as a part of the curriculum development required by it.[45] We submit that if the policy retains this terminology, it must provide more clarity on the meaning of "age appropriate" to provide greater guidance to schools and educators. Our submission, that education on all of these sex-related issues is needed by learners of all ages, is supported by other NDBE policies, reports and relevant legislation:

24.2.1. <u>NDBE Pregnancy Policy:</u> The NDBE's *Measures for the Prevention and Management of Learner Pregnancy Policy* ("pregnancy policy") acknowledges that the Life Skills programme which runs from Grade R to Grade 12 "deals with topics that affect ***every learner***…" and goes on to list "human sexuality", "teenage pregnancy, including contributory factors, consequences and prevention", "sexually transmitted diseases" and "sexual abuse, including the 'touch continuum', gender-based violence, incest and rape".[46] The pregnancy policy continues to acknowledge that "while some of these topics are difficult to teach, because of the sensitive nature of the issues addressed, it is important that suitable educators are prepared to do so, and equipped to deal with any issues that affect learners."[47]

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[44] Draft Policy, Guiding principle, 4.2 at p4 and Prevention Objective at p 5.
[45] Draft Policy, Curriculum Development p 7.
[46] National Department of Basic Education, *Measures for the Prevention and Management of Learner Pregnancy Policy*, 2007 p 3, para 12. Emphasis added.
[47] Id at p 3, para 13.

24.2.2. NDBE Annual Survey: The NDBE's 2009/2010 Report on the Annual Survey of Ordinary Schools ("**report**") clearly indicates that pregnancy – and therefore, by necessary implication, sex and the full complement of sex-related issues – affects most if not all learners, regardless of age. The report presents pregnancy statistics for learners between grades 3 and grade 12, recording 109 pregnant girls in grade 3, 107 in grade 4, 297 in grade 5 and 45276 pregnant girls overall between grades 3 and 12 in 2009.[48] The report also indicates considerable increases in the number of pregnancies in grades 3, 4 and 5 despite recording decreases in pregnancy prevalence in all other grades and overall between 2008 and 2009.[49] The increased prevalence of pregnancies in lower grades suggests that, if anything, education on sex and sex-related issues is quickly becoming more "appropriate" and necessary at lower ages.

24.2.3. The Children's Act: Section 130 (2) of the Children's Act 38 of 2005 empowers a child over 12 years old or a child under the age of 12 who is of "sufficient maturity to understand the benefits, risks and social implications" of an HIV test to consent to be tested. Firstly, this is a legislative acknowledgment of the capacity of 12 year old children to consent to HIV tests. This means that *before* the age of 12 years it would be very beneficial for children to understand the full implications and context of an HIV test, which in turn requires an understanding of HIV, sex, sexuality, gender, sexual orientation and all related issues. Secondly, a holistic education on "sex-related" issues will contribute significantly to the ability of a child below 12 years of age to be "sufficiently mature" to understand the implications of an HIV test. Thirdly, the Children's Act itself requires

[48] National Department of Basic Education, *Report on the 2009/2010 Annual Survey of Ordinary Schools*, 2012, at p 29.
[49] Id.

appropriate counseling for children before and after HIV testing.[50] There is no reason why this type of education through counseling, which is aimed at allowing the child to understand the HIV test and will require an explanation of a full range of "sex-related" issues, should only begin at the late stage of immediately prior to an HIV test.

24.2.4. Sexual Violence: The policy must confront the harsh reality of sexual violence against children, particularly within the education context. The South African Council for Educators ("**SACE**") has recently noted an increase in the number of reported cases of sexual abuse by teachers against learners.[51] Between 1 April 2012 and 31 March 2013 alone SACE received 104 complaints against teachers (nearly 20% of all complaints received) relating to "sexual misconduct, including rape".[52] As alarming as this statistic is, SECTION27's work on sexual violence in schools has led us to believe that many cases are not reported, with the result that many teachers rape and sexually assault learners with impunity. All too often children are physically forced or otherwise coerced into sex, either by their teachers or by their fellow learners in schools, or outside the school environment by relatives or community members. This can and does happen to both male and female learners of all ages, in all types of schools. The policy should not proceed on the assumption that this is not the case and therefore that it is only learners who are "sexually active" by choice who require critical education on sex-related issues. Indeed, education on sex-related issues may empower learners who are raped or sexually assaulted to negotiate, for example, the use of a condom, to mitigate the risk of HIV, STIs or pregnancy.[53] This type of information may also work to erode the stigma associated with rape and sexual assault, encouraging learners

[50] Children's Act 38 of 2005 s 132.
[51] South African Council for Educators 2012/2013 Annual Report at p 27.
[52] Id at p 28.
[53] See below at Section V, para 27-30.

to report cases of sexual violence and to seek the support that they need to deal with the trauma. An increase in reports of cases of sexual violence may also ensure its future prevention, where appropriate steps are taken to address it.

25. It has been recorded that 4.5% of learners have had sexual intercourse before the age of 15[54] and statistics in the NDBE Pregnancy Policy indicate that a significant number of learners are having sexual intercourse as early as grade 3.[55] The NSP notes 39% of girls between 15 and 19 have been pregnant and that 1 in 5 pregnant adolescents is HIV positive.[56] It is therefore clear that, as learners of all ages are affected by HIV, STIs and TB, the policy should emphatically endorse education that is free of value judgments on these HIV, STIs and TB and inextricably linked issues of sex, sexuality, sexual orientation, gender and sexual violence in all grades and throughout the redeveloped curriculum. We submit that there is no good reason why children should have to wait until they have already engaged in sexual activity or intercourse to be exposed to this empowering education.

26. Finally, referring to expert evidence in its recent decision striking down provisions that criminalised consensual sexual intercourse between minors, the Constitutional Court recently noted that "[children between the ages of 12 and 16] ordinarily engage in some form of sexual activity, ranging from kissing to masturbation to intercourse" and that exploration of this type is at least "potentially healthy".[57] We emphasise that talking to learners about sex is not purposed at encouraging them to engage in any and all sexual activity. Rather, it is an acknowledgement of the fact that many learners do engage in such activity, which is at least "potentially healthy"

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[54] HSRC study quoted at page 13 of the Summary Version of the NDBE Integrated Strategy on HIV STIs and TB which accompanies the draft policy.

[55] Pregnancy policy as cited above

[56] NSP at 41:

> "Special attention must be given to the issue of teenage pregnancy (planned and unplanned) with pregnancy-prevention education provided to young men and young women. Thirty-nine per cent of 15- to 19-year-old girls in South Africa have been pregnant at least once and 49% of adolescent mothers are pregnant again within the subsequent 24 months. One in five pregnant adolescents is HIV-positive. In addition, the annual risk of TB infection in this age group is high, and TB incidence peaks in adolescents and youths."

[57] *Teddy Bear Clinic* at para 44-45.

if it is entered into with the necessary guidance and support which will allow them to make informed, safe and healthy decisions. This is the primary purpose of the provision of holistic HIV, TB and STI education which includes comprehensive information on all sex-related issues.

V. ACCESS TO TREATMENT, CARE, COUNSELLING AND SUPPORT

The right to access to condoms at schools

27. The right to have access to healthcare services requires the government to take reasonable positive steps to prevent the transmission of HIV and STIs. Similarly to a plan that does not include access to nevirapine for the prevention of mother-to-child transmission of HIV,[58] a plan which fails to provide access to condoms, particularly to vulnerable populations such as children will fall foul of this constitutional standard as it would not only clearly be unreasonable but patently irrational. It is widely accepted that condom usage significantly decreases the risk of the transmission of HIV and STIs. Therefore, a policy which fails to provide access to condoms is a means which is not "rationally related to the purpose" at which the draft policy is aimed and therefore falls short of the requirements of the rule of law.[59] To curb the transmission of HIV and STIs at schools, the policy is constitutionally required to make provision for easy, discreet access to condoms on school premises for learners.

28. In addition to being a violation of the constitutional right to have access to healthcare services, a failure to make condoms available to learners would also be irrational because of its inconsistency with the NSP. The NSP is rightly emphatic in its position on condom distribution. It applauds the increase in male and female condom distribution nationally,[60] and lists "the provision of both male and female

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[58] *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).
[59] *Pharmaceutical Manufacturers Association of South Africa and Another: In re Ex Parte President of the Republic of South Africa and Others* (CCT31/99) [2000] ZACC 1; 2000 (2) SA 674; 2000 (3) BCLR 241 (25 February 2000) at para 25.
[60] NSP at p 8.

condom distribution" as a sub-objective for HIV, STI and TB prevention.[61] It sets tangible goals for increased condom usage amongst men and women between 15 and 24 years old, aiming to increase male condom usage from 40% (2008) to 100% in 2016. It seeks to achieve this, in part, by increasing male condom distribution from 492 million (2010/11) to 1 billion (2016) and increasing female condom distribution from 5.1 million (2010/11) to 25 million (2016).[62] The NSP also lists increased consistent condom use among "key populations" as a recommended action to counter behavioural and social determinants of the HIV epidemic.[63] In order to achieve this significantly increased distribution and usage amongst key populations the NSP contemplates the distribution of condoms at "non-traditional outlets" including schools during the NSP timeframe, though acknowledging that condom distribution in schools is "not current DBE policy".[64]

29. Finally, educating learners about the importance of condom use but then failing to ensure that they have access to condoms would render the "information and awareness" measures taken by the draft policy superfluous, thereby compounding its irrationality.

30. We submit that the draft policy does not sufficiently guarantee easy, discreet access to condoms on school premises for all learners. It provides no information about how often, where, when and how many condoms are to be distributed. The policy should specify requirements and guidelines for how condom distribution is to be undertaken nationwide and make a strong statement about the importance of access to condoms for learners. Although some flexibility is always desirable, condom distribution is far too central to the success of the policy to leave wide discretion to policy implementers about whether, and if so, how often, where, when and how many condoms are to be distributed on school premises. Furthermore, as will be discussed below[65] although consultation with SGBs is

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[61] Id at p14.
[62] Id at p 46.
[63] Id at p 23.
[64] Id at p 41 and particular FN 23 which reads "Condoms in schools is not current DBE policy, but this will be explored during the NSP timeframe"
[65] See para 41.2 below.

generally important, SGBs should not be the gatekeepers for compliance with national requirements and guidelines for condom distribution.

Comprehensive package of care

31. It is important that the draft policy include a clear indication of the package of care that school health teams will be expected to provide. It is our submission that for the policy to be effective, a comprehensive package of care should be detailed in the policy. All health services that can practicably be provided by these health teams at schools should be. This will ensure consistency with the ISHP, which anticipates "that the package of on-site services will be expanded over time".[66] In addition to access to HIV, TB and STI treatments and services, the policy should, for example, clearly indicate that the Sexual Reproductive Health Services (SRHS) provided will include the health teams being capacitated to deal with incidences of sexual violence, including, at a minimum, by providing post-exposure prophylaxis, morning after pills and appropriate counseling. This must be coupled with accessible and efficient procedures to report and address cases of sexual violence in schools and to ensure that learners receive the support they require.

Referrals

32. Although there will be circumstances where it is ethically or practically necessary for school health teams to make referrals to clinics and hospitals, the policy should not rely on referrals for the implementation of its core features. To do so will significantly reduce its effectiveness.

33. The draft policy acknowledges the "comparative advantage of the schooling sector to prevent new HIV, STI and TB infections" through education and "access to

[66] Id.

treatment, care and support programmes".[67] It envisions that "schools will be utilised as centres for enhancing access of young people to services for sexual and reproductive health, including HIV, as well as services for TB."[68] It proceeds to state that "schools will become health promoting institutions and act as inclusive centres of learning, care and support in which school health teams will provide a comprehensive range of services, including a range of referrals for the treatment of HIV and TB."[69] Despite these acknowledgements and repeated reference to the ISHP, the draft policy neglects the importance of one key strategy employed by the ISHP to achieve school health policy objectives: "provision of an essential package of health services ***in schools***"[70] which will "be expanded over time".[71]

34. The formation of school health teams that are equipped to provide a comprehensive package of care as envisioned and detailed in the ISHP,[72] will, if properly executed make a package of quality prevention and treatment services easily accessible to learners and will help prevent the spread and reduce the impact of HIV, TB and STIs in schools.[73] This is important, not only because of the "comparative advantage" schools hold because of their location and proximity to learners, but also as a result of the difficulty that many learners have in accessing quality healthcare services outside of schools.

35. As is implicitly acknowledged by the ISHP,[74] many learners lack access to transport and live far away from clinics and hospitals, which they struggle to access. Furthermore, part of the advantage of allowing learners an easy and accessible at-school platform to access healthcare services is to eliminate the disincentive to accessing these services created by perceived or real stigma associated with accessing treatment for HIV, TB, STIs and other sexual and reproductive health related issues.

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[67] Draft Policy, p 3.
[68] Id.
[69] Id.
[70] Integrated School Health Policy, 2011 at p 11. Emphasis added.
[71] Id at 15.
[72] Id at p 13 to 15.
[73] Id.
[74] Id. See for example pp15 and16.

36. Additionally, the healthcare services available at public clinics and hospitals, particularly in rural areas, are often of a low quality, a fact which is well known to learners. It is common for patients to have to wait for long periods of time before being attended to and stockouts of essential medications including HIV and TB treatment are widely reported.[75] All of these factors considerably increase the monetary and time costs of attending public healthcare facilities. Moreover, learners are aware that they must diligently attend school during the bulk of clinic operating hours or provide an explanation for failing to do so.

37. It is therefore of concern that the draft policy whilst on the one hand acknowledging the importance of "school health teams" simultaneously seems, unrealistically, to frequently rely on referral mechanisms for its success at a wide range and large number of external health care facilities.[76]

38. We submit that the draft policy's success will be dramatically decreased if it is reliant on referrals to healthcare institutions such as clinics and hospitals for its implementation. It is therefore crucial that schools become the "health promoting institutions and act as inclusive centres of learning, care and support in which

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[75] See http://stockouts.org and a "Emergency Intervention at Mthatha Depot" (2013) authored by the Treatment Action Campain, the Rural Health Advocacy Project, Medicins Sans Frontieres and SECTION27 accessible at http://www.section27.org.za/wp-content/uploads/2013/01/Report-Emergency-Intervention-at-Mthatha-Depot-Jan-2013_Final-.pdf.

[76] The following are some examples of the extensive reliance on referral mechanisms in the draft policy:

- Section 5.1.5.2 which notes that where services on sexual and reproductive health cannot be provided by a professional nurse in a manner that protects the privacy and confidentiality of learners then "learners must be referred to health facility to receive the services".
- Section 5.1.5.7 and 5.1.5.8 suggest that local clinics may be employed to conduct "contact investigations" and determine whether such contact investigations are necessary.
- Section 5.1.8.4 reads that "learners, educators, support staff and officials must return once they have been declared non-infectious by a professional healthcare provider or clinic".
- Sections 5.2.2.1 and 5.2.2.2 note that "school and education workplaces" will provide comprehensive guidance by utilizing "school-based support teams, counsellors and trained educators… but will provide referrals to clinics or other medical or social service professionals where necessary".
- Section 5.2.3.1 states that school health teams will provide "referrals for treatment of HIV and TB".
- Section 5.2.4.4 indicates that "the length of absence due to treatment for TB may vary depending on individual circumstance and must be regulated and confirmed by a professional health provider clinic".
- Section 5.2.6 which is specifically headed "Referral and Strategic Partnerships" provides for a wide range of referral services.
- Section 5.5.5 on Employee Wellness allows for "counselling, treatment and psycho-social support for employees living with HIV and/or TB through referral to appropriate services".

school health teams" provide a comprehensive package of services that the policy itself and the ISHP envision.[77]

39. Finally, although the policy should aim to minimize the need for referrals by equipping school health teams to provide a comprehensive package of care, the fact that referrals will sometimes be necessary makes school health team co-ordination with the DoH for the implementation of the policy crucial. As the ISHP notes "where learners are identified as requiring health and other services that cannot be provided on-site through routine school health services, mechanisms must be in place for ensuring that learners access these services".[78] It must be ensured that school health teams communicate with the DoH, and particularly local healthcare providers such as clinics and hospitals, continuously and effectively to ensure that the barriers to access to healthcare services discussed above do not obstruct the success of the policy.

VI. MANAGEMENT OF POLICY RESPONSE

40. Basic education and healthcare are both concurrent national and provincial competences.[79] The NDBE, The National Department of Health ("**NDoH**") and the nine provincial departments of education and health will all therefore have significant roles to play in the implementation of the policy. The Constitution requires this co-ordination of actions[80] to be "effective, transparent, accountable and coherent"[81] and in keeping with the principles of co-operative governance.[82]

41. As a national policy, the draft policy must give the policy's implementers, which will primarily be the nine provincial departments of education in co-ordination with the nine provincial departments of health, School Governing Bodies ("**SGBs**") and other

[77] Draft Policy, Guiding Principles, p 3.
[78] ISHP at p 15-16.
[79] Constitution of the Republic of South Africa, Schedule 4.
[80] Constitution of the Republic of South Africa, Chapter and specifically s 41 (iv).
[81] Id at s 41(c).
[82] Id.

"affected units at national, provincial, district and school levels",[83] some latitude within which to implement the policy. However, it is important that the policy set out some clear responsibilities and chains of accountability. This is crucial for both the successful implementation of the policy and the ability of the NDBE and the HEDCOM Sub-Committee to perform their monitoring and evaluation responsibilities set out in the draft policy. It must be borne in mind that the policy will require national co-ordination, guidance and facilitation to ensure its consistent implementation in schools throughout South Africa. What follow are submissions with regard to the roles and responsibilities of various governmental and other entities in terms of the draft policy:

41.1. **Curriculum Development:** The draft policy sets out a variety of core elements that will be incorporated into the Life Skills curriculum and other "co-curricula" and "evidence-based learning modules".[84] It is our submission that the policy should indicate that all curriculum development in terms of the draft policy will be the primary responsibility of the NDBE. Although the assistance, comments and recommendations of the NDoH, the Department of Social Development, the nine provincial departments of education, SGBs, civil society organisations and other relevant stakeholders is to be encouraged, ultimately curriculum development requires national coordination and facilitation to ensure a streamlined, effective system that accomplishes the draft policy's important aims.

41.2. **School Governing Bodies:** Although not mentioned specifically in the "Roles and Responsibilities" or "Strategic Partnerships" sections of the draft policy, the draft policy specifically allocates certain responsibilities to SGBs. The South African Schools Act 84 of 1996 "makes clear that public schools are run by a partnership involving SGBs (which represent the interests of parents and learners as well as the broader community within

[83] Draft Policy, Roles and Responsibilities p 15.
[84] Draft Policy, Curriculum Development, p 7.

which the school is located)…”.[85] Unfortunately, in practice, for a variety of reasons, SGBs do not always serve this purpose. On the one hand, our work on education has exposed us to SGBs that do not have the capacity to take important decisions in the best interests of the community, and require much support and development to allow them to operate effectively. On the other hand, we are often met with conservative SGBs that abuse their power and take decisions which are not in the best interests of the learners and the broader community. Given these significant challenges, we submit that it is both impractical and inappropriate for SGBs to a) "guide" discussions on behalf of school communities which appear to be prerequisites for condom distribution and b) make provision of SRHS dependent on "consultation" with SGBs. Conferring unfettered power on SGBs to act as gatekeepers to access to basic healthcare services that are in the interests of learners and central to their rights to health and education is therefore inappropriate. The draft policy is therefore of concern in the following respects:

41.2.1. Section 5.1.2.3 empowers SGBs to act as a gatekeeper for access to condoms for learners, stating that "access to condoms for learners will be guided by discussions with the school community led by the SGB concerned". Since condom-usage is one of the most effective measures that can be taken by learners to prevent the spread of HIV and STIs, easy, discreet access to condoms is a critical component of any successful HIV prevention policy.[86] We submit that there is no need for SGB discretion or input in this regard and it is the NDBE's responsibility to insist on standardized requirements for condom distribution in schools. If SGBs are empowered to create barriers to access to condoms, or relied on to take a

[85] *Head of Department, Department of Education, Free State Province v Welkom High School and Another; Head of Department, Department of Education, Free State Province v Harmony High School and Another* [Welkom] (CCT 103/12) [2013] ZACC 25; 2013 (9) BCLR 989 (CC) at para 36.
[86] See above at Section V, paras 27-30.

positive decision allowing access to condoms, it would undermine the "prevention" objective of the draft policy.[87]

41.2.2. Section 5.1.5.2 of the policy empowers SGBs to act as gatekeepers for the provision of SRHS by stating that "provision of SRHS to learners in senior and FET phases ***will only take place after consultation*** with the school community represented by the School Governing Body".[88] As SGBs around the country operate at various levels of efficiency, the provision of SRHS which is a crucial component of the draft policy cannot be made contingent on their approval. There are several other more particular problems with sections 5.1.5.1 and 5.1.5.2:

41.2.2.1. Firstly, it is not clear why although "in the short-term" section 5.1.5.1 does not require SGB approval; the long-term provision of these services requires such approval.[89]

41.2.2.2. Secondly, it is not apparent why although "in the short-term" section 5.1.5.1 includes within its ambit "intermediate learners, where required", presumably in the long-term in terms of 5.1.1.2, such intermediate learners are excluded from the provision of SRHS entirely.

41.2.2.3. Finally, it is not apparent why the proviso of "where required" in section 5.1.5.1 applies to intermediate learners. As we have argued

[87] Draft Policy, Prevention Policy Objective, 5.1.1 at p 5.
[88] Compare Draft Policy, 5.1.5.1 with 5.1.5.2, p 6. Emphasis added.
[89] 5.1.1.2

above, education, counseling, screening, testing and any other SRHS services should be made equally and easily available to all learners.

41.3. **HEDCOM Sub-Committee:** Although the creation of a HEDCOM Sub-Committee tasked with "aligning, delivering and coordinating policy, operational activities, budgetary policies, staffing and other norms and standards between the NDBE and the nine Provincial Departments of Education" is invaluable in ensuring that the draft policy achieves its aims,[90] it should be ensured that HEDCOM Sub-Committee is structured and equipped so that it has the capacity to operate efficiently and effectively. In light of this we submit that:

41.3.1. The make up of the HEDCOM Sub-Committee needs to be clarified within the draft policy. This committee should be kept as small as possible whilst retaining involvement of important stakeholders. One notable omission from the committee is a representative from the South African National AIDS Council which has a significant role in coordinating monitoring and advancing the NSP. The HEDCOM Sub-Committee would also benefit from the inclusion of a civil society representative with an expertise on the right to basic education and healthcare services.

41.3.2. It is not clear why there is a need for a National Basic Education Sector HIV and TB Co-ordination Committee[91] in addition to the HEDCOM-Subcommittee. On the face of the draft policy, the mandate of this committee appears to overlap to the extent that one of these committees is redundant. If this is correct, this additional committee is unnecessary and will only create an extra level of bureaucracy and therefore decrease the efficiency and

[90] Draft Policy, Structural Arrangements, p 14.
[91] 5.6.33

effectiveness of the HEDCOM Sub-committee. If both of these committees are retained in the final policy, the policy itself should spell out their different roles in some detail.

41.4. **Field Guides:** The draft policy suggests that "Field Guides for the application and use of this Policy will be developed".[92] Timeframes should be placed on the fulfillment of this requirement, as the successful publication and circulation of these field guides will be essential to the streamlined implementation of the policy. It is also submitted that policy should specifically indicate these Field Guides are to be developed by the NDBE, which is best positioned to produce streamlined, coherent field guides.

VII. MONITORING AND EVALUTION AND COSTING

Monitoring and Evaluation

42. We acknowledge that both the Integrated Strategy on HIV, STIs and TB and the NSP contain timeframes and goals. We submit, however that the policy itself should contain core measurable goals and timeframes for the achievement of these goals. Core, specific goals for this particular policy should be incorporated within the policy itself so as to allow for the measurement of the performance of schools, provincial departments of education and health, SGBs and the HEDCOM Sub-Committee in ensuring that the policy is effectively and efficiently implemented.

Costing, budgeting and the Constitution

43. As discussed above, the Constitution obliges the government to take positive steps to realise the rights to basic education and access to healthcare services. The Constitutional Court has acknowledged that planning and policy aimed at the realisation of rights and, more particularly socio-economic rights, will have

[92] Draft Policy, Management and Co-ordination, p 14.

budgetary implications and therefore elicit budgetary duties on the part of the state.[93] We submit that without costing there can be no budgeting and a plan that cannot be adequately budgeted is unlikely to be capable of effective and timeous implementation, if at all. Such a plan is therefore unlikely to meet the constitutional requirement of being capable of reasonable implementation.[94]

44. The NSP includes a chapter on costing and financing.[95] Despite being a considerable improvement on the costing of the 2007-2011 NSP,[96] the 2012-2016 NSP still fails, for example, to cost for Monitoring and Evaluation at all.[97]In addition, although the Integrated Strategy on HIV, STIs and TB notes that "one of the first tasks to be undertaken following the approval of this strategy is to cost the full implementation of all of its components", it does not itself contain any costing exercise. It is in this context that the draft policy's failure to include a costing exercise must be analysed.

45. We submit that, in this context, it is particularly important that the policy itself project detailed estimates for the costing of each section to ensure that budgeting, and in turn the policy's reasonable and effective implementation, is possible. Particularly at the level of specificity of a National Department's policy, it is a constitutional requirement that a costing exercise is undertaken to ensure that it can be budgeted for and implemented. Without such a costing exercise the promises detailed in the draft policy and the rights to basic education and access to healthcare services which it seeks to realise "will have a hollow ring".[98]

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[93] See *City of Johannesburg Metropolitan Muncipality v Blue Moonlight Properties 39 (Pty) Ltd and Others* [2011] ZACC 33 at para 74.

[94] See *Government of the Republic of South Africa & Others v Grootboom* 2000 (11) BCLR 1169 at para 42. This is the requirement for a plan to realise the right to access to healthcare services. The government's requirement in terms of the "immediately realisable" right to basic education is in our submission, if anything, more onerous than the reasonableness standard detailed in Grootboom. See also Hassim, A "The Cost of Rights: is there a legal right to transparent and efficient budgeting?", SECTION27 Review April 2010-December 2011, pp 45-53

[95] NSP, Chapter 8.

[96] HIV & AIDS and STI National Strategic Plan 2007-2011, which is the predecessor to the current 2012-2016 NSP.

[97]See the 2012-2016 NSP at 77 which explains "finally, while appropriate costing for and budgeting of M&E is essential, there are currently no data available for these costs." Hassim, A op cit at p 53.

[98] *Soobramoney v Minister of Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 at para 8.

VIII. SAFE EDUCATIONAL ENVIRONMENT, REASONABLE ACCOMODATION AND HIV, STI AND TB-RELATED LEARNER ABSENCES

The right of all learners to a safe healthy educational environment: the duration of TB isolation

46. Some temporary absences from school will be required if the policy is to ensure a safe healthy educational environment in which the spread of TB and other diseases is not more of a risk than it needs to be. Whilst learners have the right to return to school as soon as they are sufficiently healthy and no longer reasonably considered contagious, other learners have the right not to be unnecessarily exposed to infection as result of learners with contagious conditions returning to school prematurely.

47. It is therefore of concern that the draft policy contemplates the return of learners being treated for TB to school prior to the end of the ordinary periods of isolation recommended by medical experts. Although the draft policy makes it clear that return to the educational environment should only occur after a person is "declared non-infectious" the specification that this is "normally after a period of 72 hours from the onset of treatment" though this period can "rise up to 10 days in the case of complications" is of serious concern.[99] Although it is crucial for the policy to remain flexible and to take individual circumstances into account, evidence from clinical trials suggests a recommended respiratory isolation ranges between 7 and 25 days, depending on clinical indicators such as suspicion of drug resistance and pre-treatment sputum smear grade.[100] We therefore submit that this section should be reconsidered and regularly revisited in light of recommendations made by medical experts on ordinary periods of isolation. We further submit that the section should be revisited regularly to take account of new

[99] Draft Policy, Safe Educational Environment, 5.1.8, p 8.
[100] Ritchie et al, *New Recommendations for duration of respiratory isolation based on time to detect Mycobacterium tuberculosis in liquid Culture*, Eur Respir J 2007 Vol 30 Number 3 501, at 505. See in particular Table 4.

research and evidence in this area, and to ensure that the appropriate balance is struck between the rights of all learners involved

The reasonable accommodation of learner's needs during temporary absences

48. The policy correctly acknowledges the importance of temporary absences for learners with TB who remain contagious and therefore pose the risk of spreading the disease.[101] The draft policy also appropriately requires the "reasonable accommodation" of learners living with HIV and/or TB and particularly requires that schools remain "flexible in implementing learning arrangements for learners unable to attend on a regular basis due to their need for treatment, care, counseling and support linked to HIV and TB".[102] We submit, however, that the policy itself ought to provide more clarity for those implementing it in this regard so that that no learner is unnecessarily deprived of access to their right to basic education as a result of HIV, STIs and TB. We submit that, although in each particular set of circumstances a child's parent(s) or guardian(s) should be encouraged to consult with the school principal and their child's teachers in this regard, the policy should specify that at a minimum it is a learner's right that:

48.1. All learners who are absent from school because of HIV, STIs and TB are given access to textbooks, and learning materials that they will need to keep up with their regular school work;

48.2. All learners who must endure prolonged absences because of HIV, STIs and TB are given access to materials that are tailor-made for the purpose of learners teaching themselves outside of classrooms;

48.3. All learners who must endure prolonged absences because of HIV, STIs and TB are at a minimum provided with a contact teacher at their school who

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[101] Draft Policy, Reasonable Accommodation, 5.2.4, p 9.
[102] Draft Policy, Reasonable Accommodation, 5.2.4, p 9.

they can contact with questions about the learning material with which they have been provided;

48.4. As far as is practicable for prolonged absences, an alternative arrangement is made that ensures that learners have access to a teacher or tutor; and

48.5. All learners who must endure prolonged absences because of HIV, STIs and TB are provided with a catch-up programme, created by their school, which must involve a reasonable effort on the part of the school to ensure that the learner catches up with work that they have missed out on or did not properly understand during their absence.

IX. CONCLUSION

49. We reiterate our support for the NDBE's efforts to develop and implement a national policy on HIV, TB and STIs and congratulate the NDBE on the completion of the draft policy. We thank the NDBE for inviting comment on the draft policy and look forward to working together with the NDBE in finalizing and implementing the policy.

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