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Game over or back to the beginning..?

A reflection on nineteen years of legal and policy reform to prohibit HIV-related discrimination in South Africa

Ann Strode

The HIV epidemic has always been characterised by high levels of stigma and discrimination against persons infected or perceived to be infected with the virus.¹ The South African experience has been no different with initial legislative responses to HIV being discriminatory². This was to be expected given the perception that it was firstly, a disease of 'black people' who were already second class citizens. A member of parliament noted at the time 'the terrorists are now coming to us with a weapon more terrible than Marxism: AIDS'³. Secondly, a belief that it was a 'gay plague', with gay men being a group who were also

**Human rights
must be
non-negotiable...**

No matter what...
age, sex, gender,
sexual orientation, and/or HIV status

**Who have you
discriminated against lately?**



The AIDS Legal Network is a human rights organisation committed to the promotion, protection and realisation of fundamental rights and freedoms of people living with - and affected by - HIV and AIDS
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stigmatised and marginalised through the criminalisation of same-sex relationships. However, since 1994 the new government has committed itself to the outlawing of unfair discrimination against people living with HIV. Resultantly, a number of new laws and policies have been put in place to address unfair discrimination based on a person's HIV status.

INTRODUCTION

This article reflects on the legal framework for outlawing unfair discrimination. It submits that nineteen years into our emerging democracy is an opportune time to interrogate this commitment to non-discrimination and to ask, where have we come from? Where are we now? What have we achieved? What still needs to be done?

Editorial...

Continuing with the discourse on human rights challenges in the context of HIV, and the HIV response, this issue of the **ALQ** highlights some of the causes, forms and effects of stigma and discrimination.

Based on the recognition that stigma and discrimination persevere to impact as much on peoples' risks to HIV and related rights abuses, as on the 'success' and effectiveness of the HIV response, the various articles explore the extent to which different aspects of legal and social environments are indeed 'supportive and enabling'.

Reflecting on 19 years of legal and policy reform to prohibit HIV-related discrimination, **Ann Strode** raises the question of 'game over or back to the beginning'. The article highlights that despite 'considerable efforts' made to create a legal framework prohibiting unfair discrimination against people living with HIV, people continue to face 'multiple layers of discrimination' based on and in the context of HIV. Given this prevailing gap between rights and realities, she argues that we must 'move away' from creating frameworks to ensuring 'that it works for people', which requires a 'new' approach – 'an approach that cannot focus on the law alone'.

A growing knowledge and evidence base on HIV-related rights abuses is arguably a key element of ensuring effective responses to stigma and discrimination. Findings from a 2012 study on perceptions and experiences of HIV-related stigma and discrimination in the Northern Cape and North West are introduced by **Johanna Kehler**. She argues that the study not only reveals the multiple risks and effects of rights violations upon HIV status disclosure, as people 'fear to be known', but also underscores the great disconnect between communities' perceptions and peoples' experiences of HIV disclosure and its consequences. Moving towards creating an 'enabling', 'supportive' and 'safe' environment for HIV disclosure, the study clearly points to the dire need that 'we as people should change our attitudes and stop discriminating'.

The 'prejudices of others' are one of the well-recognised elements causing stigma and related rights abuses. Premised on the understanding that 'identities' are always based on the 'us' and 'them' logic, **Pierre de Vos** explores the 'oppressive and disciplining powers of

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WHERE HAVE WE COME FROM? THE RIGHT TO EQUALITY UNDER APARTHEID

Early reports of stigma and discrimination against people living with HIV related to HIV discrimination in families and communities, in the workplace (with many employers using pre-employment HIV testing and unfair dismissals to exclude persons living with HIV from working), in the healthcare sector (with denials of access to healthcare services), in education (denying children with HIV access to pre-schools), and in the insurance sector (where persons testing HIV positive were denied access to life insurance).⁴ However, for people living with HIV facing discrimination there were limited legal remedies, as there was no general

...equality provisions, which are broad enough to encompass discrimination based on a person's HIV status...

right to equality. Furthermore, for the most part, apartheid laws aimed at systemic discrimination, particularly on the grounds of race and gender⁵.

Given this context, it is not surprising that the apartheid government's initial responses to HIV were also premised on stigmatising and discriminatory concepts

Table 1: Discriminatory apartheid laws on HIV

LAW	PURPOSE	IMPACT
Regulations issued under the Aliens Control Act	Declare people living with HIV or AIDS as 'prohibited persons'	Immigration authorities given the power to detain, deport or subject any person suspected to be infected with HIV to a compulsory medical examination Used extensively to repatriate HIV positive foreign mine workers back to their home countries
Regulations on Communicable Diseases and Notifiable Conditions, 1987	Declared AIDS as a communicable disease	Enabled people living with AIDS to be removed from schools, placed in quarantine etc

...the post-apartheid's HIV response has always been premised on human rights principles, including the right to equality...

of people living with HIV. The government only passed two HIV specific pieces of legislation pre-1994 and both aimed at the active exclusion of people living with HIV from various spheres of life, such as the workplace and schools. These provisions were seen as valid mechanisms for keeping the community 'AIDS free'⁶.

essentialised identities. Pointing to the many forms in which *'identity'* has been, and continues to be, used to *'justify'* that people are *'unworthy'* of being shown respect, to *'silence critics'*, and to *'enforce conformity'*, he argues that the re-emergence of *'a virulent form of identity politics'* poses a *'serious threat'* to our democracy and freedoms.

Stigma and discrimination have long been recognised as barriers (and deterrents) to access to healthcare services, with evidence showing that stigma and discrimination determines the extent to which people are in the position to make informed choices whether or not and when to access services. Further elaborating on the effects of prejudices and stigma, **Alexandra Muller** looks at how a *'queer identity'* impacts on the access to *'appropriate'* healthcare for lesbian, gay, bisexual and transgender people. She emphasises that although transgender people and men who have sex with men are recognised as *'key populations'* in the NSP, *'little'* is done to ensure that healthcare workers' personal prejudices are not the defining factors for a patient's treatment. Calling for non-judgemental and *'queer-affirming'* healthcare, she argues that we need to *'challenge our own prejudices'*, so as to ensure that *'queer health issues'* are on everyone's agenda and the right to equality and non-discrimination truly expands to lesbian, gay, bisexual and transgender people.

The need to decriminalise sex work as a key element addressing

stigma and discrimination based on, and in the context of, HIV has been at the centre of the human rights discourse for a long time. Yet, sex work remains criminalised, thus not only perpetuating HIV risks and related rights abuses, but also maintaining limited access to healthcare services (and justice) for sex workers. The National Sex Work Programme, introduced by **Sally-Jean Shackleton**, is arguably a *'potential milestone'* towards ensuring both greater access to health services and *'sex work appropriate healthcare'*. Based on the recognition of sex workers' rights and the principle *'nothing about us, without us'*, sex worker ownership is central to the *'success'* of the programme.

Further elaborating on the *'impact'* of criminal law as it relates to the criminalisation of consensual sexual acts, **Pierre de Vos** raises the question as to whether or not it is in the best interest of children to criminalise consensual exploration between teenagers. Introducing the recent High Court ruling on the Sexual Offences Act, he argues that the current law provisions criminalising consensual sexual acts will not only turn children into *'criminals'* for *'exploring their sexual awakening'*, and discourage teenagers from *'seeking help'*, but also reinforce prevailing *'social stigmas and taboos around sexuality'* – which is neither in the best of children nor constitutional.

The importance and role of education in addressing HIV-related stigma and discrimination

is often cited as one of the *'effective'* responses. Similarly, *'proper'* sex education in schools is commonly seen as a key factor in the response to HIV. Discussing the legal and policy provisions, **Precious Acker** examines the *'quality'* and *'adequacy'* of sex education in schools. Exploring the *'pros'* and *'cons'* of the large amount of autonomy given to educators in the *'actual practice of this course'*, she argues that as long as sex education is *'given to anyone who fits in on the timetable'*, the quality of sex education will continue to rely on the individual *'efforts'* and *'disposition'* of the teacher who *'fits in'* – thus, continue to lack *'universality'* and assurance of *'quality'* sex education.

One of the recurring themes in all the articles is as much the persistent dichotomies between *'enabling'* legal environments and *'disabling'* social environments, as the ongoing call for action to *'move beyond commitments'*, to *'make rights work for people'*, to *'change our attitudes'*, and *'challenge our own prejudices'*. Thus, the *'real'* challenge now seems to be *'transforming'* the very same societal context *'nurturing'* and *'condoning'* prejudices and stigma against the *'other'*. Failing to do so, social environments will continue to override the progress made in creating enabling legal environments...

JOHANNA KEHLER

WHERE ARE WE NOW? THE RIGHT TO EQUALITY IN POST-APARTHEID SOUTH AFRICA

Allegations of discrimination against people living with HIV continued in the post-1994 period. For example, in the HIV/AIDS/STD Strategic Plan for South Africa: 2000 – 2005 it was noted that a key constraining factor in HIV responses was the

...continued high levels of discrimination and human rights abuses of people infected and affected with HIV/AIDS.⁷

However, legal redress now exists, as in the post-apartheid South Africa everyone has the right to equality⁸. Equality includes the right to equal protection from the law, equal access to all rights and freedoms, and the right to not be unfairly discriminated against⁹. Although the equality clause lists seventeen grounds on which there may not be unfair discrimination, HIV is not one of them. Nevertheless, the Constitutional Court has held that arbitrary discrimination against people living with HIV is unfair and violates Section 9 of the Constitution.¹⁰

People who are living with HIV constitute a minority. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination . As the present case

... testing of an employee to determine that employee's HIV status is prohibited, unless such testing is determined to be justifiable by the Labour Court...

...a well-established legal framework for prohibiting HIV-related discrimination in South Africa...

demonstrates, they have been denied employment because of their HIV status without regard to their ability to perform the duties of the position from which they have been excluded. ... The impact of discrimination on HIV-positive people is devastating.¹¹

Flowing from these constitutional principles the post-apartheid's HIV response has always been premised on human rights principles, including the right to equality. The government has also taken a number of legislative steps to specifically outlaw HIV-related discrimination. It has done this in two ways: firstly, through the introduction of HIV-specific laws and secondly, through more general equality provisions, which are broad enough to encompass discrimination based on a person's HIV status.

HIV specific laws which prohibit unfair discrimination on the grounds of HIV status

There is only one HIV specific law prohibiting unfair discrimination on the basis of a person's HIV status, this is the Employment Equity Act of 1998. This Act prohibits unfair discrimination in any employment policy or practice on various grounds, including an employee or job applicant's HIV status. Section 6 of the Act provides that

...no person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice.

This prevents employers from using HIV test results, or other knowledge of an employee's HIV status, in a discriminatory fashion; for example, excluding HIV positive job applicants, such as occurred in the *Hoffman v SAA* case¹². The Employment Equity Act provides further in Section 7(2) that testing of an employee to determine that employee's HIV status is prohibited, unless such testing is determined to be justifiable by the Labour Court. This expressly prevents employers from using the practice of discriminatory pre-employment HIV testing, which was previously practiced in a number of sectors including the military, the South African Police Services and on many mines¹³.

...given that the legal framework is protective, are further legal reforms still required?...

On 15 June 2012, the Minister of Labour supplemented these provisions by providing guidance on how to implement these principles in all workplaces through the publication of the Code of Good Practice on HIV/AIDs and the World of Work, which is attached to the Employment Equity Act. One of the objectives of the Code is to

*...eliminate unfair discrimination and stigma in the workplace based on real or perceived HIV status, including dealing with HIV testing, confidentiality and disclosure.*¹⁴

Furthermore, equality is a guiding principle underpinning the Code:

Elimination of unfair discrimination remains a key principle for protection of the rights of individuals. There must be no unfair discrimination against or stigmatisation of workers on the grounds of real or

Now more than ever

**Human rights should be at the centre
of the response to HIV and AIDS**

Because...

*The protection of human rights is
the way
to protect the public's health*

perceived HIV status. It is the responsibility of every worker and employer to eliminate unfair discrimination in the workplace.

...it may be imperfect,
but it is protective...

Non HIV-specific laws which prohibit unfair discrimination on grounds broad enough to protect people living with HIV

There are also non-HIV specific laws, which contain equality provisions in the key areas identified above and could be used to protect people living with HIV against unfair discrimination.

WHAT HAVE WE ACHIEVED? REVIEW OF THE EXTENT TO WHICH THE LAW HAS BEEN USED TO OUTLAW HIV-RELATED DISCRIMINATION IN SOUTH AFRICA

There is a well-established legal framework for prohibiting HIV-related discrimination in South Africa. Although there is only one expressed prohibition of HIV discrimination in the Employment Equity Act, the Promotion of Equality and

...the allegations of on-going discrimination relate to practices prohibited by law...

Table 2: Non-HIV specific laws which protect people living with HIV from unfair discrimination

LAW	PROVISIONS	IMPACT
Children's Act (No 38 of 2005)	<p>Section 6 – in all decisions affecting children they are unfairly discriminated against on the basis of amongst others a child's 'health status'</p> <p>Section 130 – no child may be tested for HIV unless it is in their best interests</p> <p>Section 133 – a child's HIV status may not be disclosed without consent from the child or their proxy consentor</p>	Ensures that children are not unfairly discriminated against due to their HIV status and protects children against discriminatory HIV testing, as well as disclosure of HIV status, which could result in discrimination
Medical Schemes Act (No 131 of 1998) and corresponding Regulation 1262 of 20 October 1999	Prohibits the unfair exclusion of a person from a medical scheme on the basis of his or her 'past or present state of health'	Ensures that people living with HIV are not arbitrarily excluded from medical aid schemes simply because they are HIV positive
Promotion of Equality and Prevention of Unfair Discrimination Act (No 4 of 2000)	Outlaws all forms of unfair discrimination	The Act does allow a person to bring an HIV-related complaint on the basis of 'any other ground' (i.e. an unlisted ground), and it is likely that a court would recognise HIV as an 'unlisted' ground for unfair discrimination

Prevention of Unfair Discrimination Act is broad enough to ensure that the right of people living with HIV to equality could be enforced. There are also general equality provisions in legislation, which result in protections for children and persons purchasing or accessing medical aids.

The strengths of the current framework is that the Promotion of Equality and the Prevention of Unfair Discrimination Act is very broad and applies to both the state and all persons. This means that it also protects persons not covered by the Employment Equity Act, such as members of the South African National Defence Force, the Secret Service, and the National Intelligence Agency. Furthermore, the Children’s Act attempts to address the underlying causes of discrimination through, for example, providing protections regarding the disclosure of HIV status and requiring an HIV test to be in the best interests of the child¹⁵.

WHAT STILL NEEDS TO BE DONE? ON-GOING ADVOCACY ISSUES

Given that the legal framework is generally protective, are further legal reforms still required? It is submitted that

Table 3: Discriminatory practices that have been outlawed by the protective legal framework

PRACTICE	OUTLAWED
Pre-employment HIV testing	Yes
Dismissals for being HIV positive	Yes
Denial of access to health care services	Yes
Exclusion from pre-schools and other public schools	Yes

...more reflection is required on the current status of the ‘game’..

there are no glaring gaps in the legal framework. This view is supported by the current National Strategic Plan on HIV/STIs and TB: 2012 – 2016 which appears to indicate that law reform in this area is not a priority, as it provides

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that there should be *interventions* to ensure (a) discrimination on the basis of HIV and TB is reduced; (b) monitoring mechanisms for tracking rights violations are put in place; (c) discrimination, especially in the workplace, is reduced; and (d) there is a reduction in the discriminatory access to social services¹⁶. It does not propose specific legal reforms to the framework on unfair discrimination.

Furthermore, Table 3 shows that many of the key discriminatory practices, described above, have in fact been outlawed during the last decade through either HIV-specific or non-specific laws.

If some of the discriminatory practices have been prohibited, what type of discrimination is still prevalent? It appears that firstly, many of the allegations of on-going discrimination relate to practices prohibited by law, such as women

...it appears that we must move away from building the framework to ensuring that it works for people living with HIV...

living with HIV being sterilised without their consent, simply because they are HIV positive¹⁷, or discriminatory dismissals¹⁸. In other words, the on-going discriminatory practices flow from a lack of enforcement of protective laws. This view was echoed by two South African civil society participants at the African Regional Dialogue on HIV and the Law who noted that :

Even 30 years into the disease stigma is very much alive, in families and communities. For example, using health care facilities such as dedicated clinics for HIV testing or ARVs, results in people living with HIV being marked and makes them stigmatised. It dehumanises people and this discourages them from accessing treatment – sending them to an early death.

[Civil Society Participant, South Africa]

Where laws exist there is no implementation of the law. The law which is meant to protect people living with HIV means nothing if it is not enforced by the very people who are meant to help those living with this virus.

[Civil Society Participant, South Africa]¹⁹

It is submitted that although considerable effort has been put into creating a legal framework to prohibit unfair discrimination against people living with HIV in South Africa, focusing future advocacy on refining the framework would be wasteful.

Secondly, it has been argued that, in the current era, people living with HIV frequently face multiple layers of discrimination.²⁰ Thus, laws focusing narrowly on outlawing HIV-related discrimination do not protect people living with HIV from other forms of discrimination, which may be related to, amongst others, their sexual identity, such as bisexuals, or their profession, such as sex workers, or their gender, such as women.²¹ South Africa's constitutional framework requires the outlawing of a wide range of forms of discrimination, thus protecting many previously marginalised groups. Nevertheless, more work may be needed examining whether discrimination is not being re-focused on other reasons; for seeing some people living with HIV as different, perhaps because they are refugees, gays or drug users. Reserach is needed, into whether these forms of discrimination are comprehensively prohibited by our legal framework.

...an approach that cannot focus on the law alone...

CONCLUSIONS

Sadly, it is not 'game over' on the issue of HIV-related discrimination, even though significant progress has been made in creating a framework that protects people living with HIV. It is argued that more reflection is required on the current status of the 'game'. Key questions to be raised include:

- Is the legal framework failing to stop discrimination? If so, why?
- Are laws being properly resourced and implemented?
- Is there access to remedial legal action? If not, what are the barriers for people living with HIV accessing justice?

- Does the law protect all vulnerable populations from unfair discrimination?
- Is the legal framework meeting its objectives? Should our focus shift more squarely to addressing the underlying causes of discrimination through programming?

...realise the wide range of factors that make people living with HIV susceptible to discrimination...

In conclusion, it is argued that in this next phase, we must move away from building the framework to ensuring that it works for people living with HIV – an approach that cannot focus on the law alone. We must also broaden our lens and realise the wide range of factors that make people living with HIV susceptible to discrimination, and ensure that laws protect all vulnerable groups. *Game on!*

FOOTNOTES:

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Ann Strode is a senior lecturer at the School of Law at the University of KwaZulu Natal. For more information and/or comments, please contact her on StrodeA@ukzn.ac.za.

The best thing for me, is to keep everything to myself...

Perceptions and experiences of HIV-related stigma and discrimination

Johanna Kehler



Stigma and discrimination are well-recognised as both causes and consequences of persistent HIV risks and vulnerabilities. It is also widely acknowledged that stigma and discrimination impact on the extent to which information, programmes and services are accessible and

beneficial to people at risk of, vulnerable to, and living with HIV.

There has also been growing commitment to address stigma and discrimination as an essential aspect of effective responses to HIV.

...we must account for and address social and legal environments that fail to protect people in the context of HIV and/or block effective HIV responses...¹

Evidence shows that despite efforts to address stigma and discrimination, stigma and discrimination persist to impact as much on peoples' risks to HIV and related rights abuses, as on the effectiveness of HIV responses. As such, stigma and discrimination continue to determine not only peoples' risks of HIV exposure and transmission, but also the extent to which people are in the position to make informed choices as to whether or not and when to access services.

Now more than ever

**Human rights should be at the centre
of the response to HIV and AIDS**

*Because...
Despite much rhetoric,
real action remains lacking*

...well aware of the risks associated
with HIV status disclosure...

Moreover, gendered inequalities, power relations, and patriarchal systems, as well as prevailing prejudices and exclusions, create social environments that further manifest prevailing levels of stigma and discrimination based on and in the context of HIV, despite the enabling legal environment promoting equality and non-discrimination.

Recognising the multiple causes, forms and effects of stigma and discrimination in the context of HIV, it

seems imperative to address and transform the very same societal norms and values, as well as prejudices that cause, manifest, perpetuate, and at times condone and justify, HIV-related stigma, discrimination and other violations of rights. Thus, for programmes and interventions to carry the potential to effectively address stigma and discrimination, it is crucial to '*better understand and address the factors that contribute to vulnerability to HIV and impede service access*'², which

...the fear of lack of confidentiality
and healthcare workers' attitudes...

...stigma and discrimination persist to be as much a consequence of, as a barrier to, HIV disclosure...

includes various causes, forms and effects of HIV-related stigma and discrimination.

It is within this context that the AIDS Legal Network (ALN), in collaboration with partner organisations, engaged in a study project intended to assess and document perceptions and experiences of stigma and discrimination based on and in the context of HIV, and to enhance the knowledge and evidence base on

HIV-related rights abuses. The data presented here forms part of a broader study which took place in five areas, namely Lethabong and Phatsima in the North West, and Beaconsfield, Galeshewe and Barkly West in the Northern Cape between May and October 2012.³

HIV STATUS DISCLOSURE

Responses reveal that communities are well aware of the risks associated with HIV status disclosure, and knowledgeable about the right to choose whether or not and when to disclose one's HIV positive status. Yet, the majority of community members participating in the study⁴ felt strongly that people need to disclose their HIV status, for reasons of 'support' from family and friends; and as HIV disclosure is 'better' for peoples' health and well-being, 'because if you talk about it you won't have stress and will live a healthy life'⁵.

...it is very important...you must disclose, so that you get that support from your household...⁶

Contrary to communities' perceptions of families and friends as a source of support and comfort for people living with HIV⁷, peoples' experiences of HIV disclosure are often linked to blame, insults, humiliation, rejection and abuse by family and friends, as well as partners' violent reactions.



...she is talking about my HIV status without my permission; she even tells people on the street...this is not right, because I didn't want people to know... sometimes, I am scared to go on the street fearing that people will start pointing fingers at me...⁸

These responses arguably underscore not only the great disconnect between communities' perceptions and peoples' experiences of HIV disclosure and its consequences, but also the societal pressure, expectations and responsibility placed on people to disclose their HIV positive status, despite the knowledge of the risks associated with such disclosure.

...detering people from accessing healthcare services...

The study exposed a similar disconnect between perceptions and experiences in relation to healthcare provision, in that community members believe that people living with HIV are '*treated well*' and '*supported*' in clinics and hospitals⁹, while people experience clinics and hospitals as '*unsafe*' and '*abusive*'. Talking about their experiences, people living with HIV recalled incidences of being ill-treated, shouted at, humiliated and abused, as well as incidences of healthcare workers refusing to assist them.

...you are so scared to fetch your medication, because you feel ashamed and embarrassed...¹⁰

For many people living with HIV, accessing healthcare services is often accompanied by the fear of lack of confidentiality and healthcare workers' attitudes, greatly impacting on both access and adherence to treatment, because '*our clinic doesn't treat people with respect or privacy*'¹¹.

...we fear to be known...people here would prefer going to private clinics or not going to clinics at all...¹

HIV STATUS DISCLOSURE CONSEQUENCES

The study also confirmed that stigma and discrimination persist to be as much a consequence of, as a barrier to, HIV disclosure. The fear of stigma and discrimination also affects decisions as to whether or not, when and to whom to disclose one's HIV positive status, because '*we are so afraid to disclose*'¹³ and '*once they know your status, they start to discriminate*'¹⁴.

...once people start to know my status they will never treat me like before...they will start reacting funny around me, judge me and gossip a lot about me... I'd rather keep it to myself...I won't say anything to anyone...¹⁵

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Responses clearly illustrate that communities are largely perceived to be ‘unsafe’ environments for people living with HIV, since ‘to be positive in this community is dangerous’¹⁶, and people will be ‘rejected’, ‘judged’ and ‘discriminated against’ by fellow community members as a result of their HIV positive status becoming known¹⁷.

*...the community here, they don't treat people right, if they are positive...they discriminate...*¹⁸

*...when people find out that you are HIV positive, they start to discriminate you and ignoring that you have rights too...*¹⁹

However, these levels of awareness of the risks associated with HIV status disclosure seem to have little impact on the perceived need for people living with HIV to disclose their HIV positive status, based on the belief that ‘not to disclose your status is wrong’²⁰.

High levels of HIV-related stigma, discrimination and other rights abuses also impact, amongst other, on peoples’ health seeking behaviour, including decisions

whether or not to access HIV testing services – thus deterring people from accessing healthcare services, whilst at the same time impeding the effectiveness of the national response to HIV.

*...I will not go to the clinic to get tested...we are too afraid of the world knowing and turning against us...*²¹

*...people are scared to go to the clinic; because they are scared the nurse will discuss their status or break their confidentiality...*²²

HIV NON-DISCLOSURE CONSEQUENCES

Although knowledgeable of everyone’s right to choose whether or not to disclose one’s HIV status, responses further suggest that people who choose not to disclose their HIV status are nevertheless assumed to take the responsibility for their partners’ HIV acquisition.²³ It is these beliefs that not only perpetuate the perceptions

...assumed to take the responsibility for their partners’ HIV acquisition...

that people who know of their HIV positive status are solely ‘*responsible*’ for the ‘*protection*’ of their partner (as compared to both partners being responsible for preventing the risk of HIV exposure and transmission), but also manifest the understanding that not disclosing one’s HIV positive status is thus ‘*wrong*’ and needs to be ‘*punished*’.

More specifically, more than a third of community members participating in the study felt strongly that people ‘*must be punished for infecting innocent people*’²⁴, because ‘*they are committing a crime by infecting their partners*’²⁵ – thus, they should be ‘*sued*’ and held ‘*legally responsible*’ for HIV transmission.

...they should have been honest...they destroyed a life...²⁶

...because he has lied about his status, so I think he should be sued, because he shamed my marriage...²⁷

Again, these responses clearly underscore that the knowledge of stigma, discrimination, violence

...perpetuating the assumed responsibility of people living with HIV to disclose their HIV status...

and other abuses subsequent to HIV status disclosure seems to have little effect on community members’ perceptions of the ‘*need*’ for, and ‘*rightfulness*’ of, HIV disclosure. At the same time, the need for HIV disclosure appears to be linked mostly to the perceived responsibility of people living with HIV to ‘*protect others*’; disregarding not only everyone’s right to choose whether or not, when and to whom to disclose one’s HIV status, but also everyone’s ‘*responsibility*’ to prevent the risk of HIV exposure and transmission.

...each person has the responsibility to protect themselves, you cannot blame anyone for something you took part in...²⁸

WHERE TO FORM HERE...

...we as people should change our attitudes and stop discriminating...²⁹

Responses clearly illustrate that although community members are aware and knowledgeable about the risks associated with HIV disclosure, they feel strongly that people living with HIV need to disclose their HIV status – thus implying that the perceived need for HIV status disclosure outweighs the knowledge of the risks associated with such disclosure.

The study also underscores that despite the knowledge of the right to choose whether or not to disclose one’s

HIV status, people who choose not to disclose their HIV positive status are likely to be subjected to stigma, discrimination, abuse and other rights violations based on their decision – thus further perpetuating the assumed responsibility of people living with HIV to disclose their HIV status and to ‘*protect others*’.

Although the data affords a general trend of community perceptions in these areas, responses also clearly point to the varying degrees of understanding between areas – thus emphasising the need for intensified awareness raising and capacity building.

...create enabling and supportive environments for all people to claim their rights and to have access to services...

According to communities, ‘*something needs to be done*’ to end the violence against people living with HIV. Communities specifically mentioned the need for ‘*awareness raising and education*’, as well as the need for people living with HIV to ‘*speak out*’, ‘*stand up for their rights*’, and ‘*take legal actions*’ against the perpetrators.

...they should stop the abuse and treat that person with respect...³⁰

And finally, the data seems to strongly suggest that in order to ensure the protection and advancement of rights of people living with HIV; the effectiveness of programmes aimed at addressing HIV-related stigma and discrimination; and to ensure enhanced access to rights and services free of fear of stigma, prejudice and violence, there is a great need to advocate for and create sustained change in the following areas:

- Enhance levels of awareness and understanding of the various causes, forms and layers, as well as effects, of stigma and discrimination based on and in the context of HIV
- Address and transform societal beliefs and prejudices manifesting, perpetuating and, to an extent, condoning discrimination against people living with HIV, so as to create enabling and supportive environments for all people to claim their rights and to have access to services
- Build capacity on the rights protections in the context of HIV, including the various mechanisms

for redress, among communities and service providers, so as to ensure both decreased levels of HIV-related rights violations and enhanced access to redress as and when peoples' rights have been violated

- Develop and implement stigma mitigation programmes that address the various causes, forms and effects of HIV-related stigma and discrimination, and truly respond to the realities and needs of people living with HIV

- Experiences of HIV-related rights abuses as collated through incident forms in Phatsima, North West.
- Man, 20s, Phatsima, North West.
- Woman, 20s, Barkly West, Northern Cape.
- Man, 20s, Lethabong, North West.
- Man, 40s, Beaconsfield, Northern Cape.
- More than half, 57% of all respondents believed that HIV status disclosure would have negative consequences at a community level.
- Woman, 20s, Galeshewe, Northern Cape.
- Woman, 20s, Phatsima, North West.
- Man, 40s, Galeshewe, Northern Cape.
- Man, 30s, Northern Cape.
- Man, 20s, Beaconsfield, Northern Cape.
- More than half of all respondents (57%) believed that the person living with HIV would be 'responsible' for their partner's HIV acquisition.
- Woman, 30s, Beaconsfield, Northern Cape.
- Woman, 20s, Galeshewe, Northern Cape.
- Woman, 20s, Barkly West, Northern Cape.
- Woman, 50s, Lethabong, North West.
- Woman, 20s, Beaconsfield, Northern Cape.
- Woman, 20s, Phatsima, North West.
- Man, 40s, Galeshewe, Northern Cape.

FOOTNOTES:

- This article is an edited version of the report presenting the research findings. See Kehler, J. 2012. *'We as people should change our attitudes': Perceptions and experiences of HIV-related stigma and discrimination in the Northern Cape and North West, South Africa.* AIDS Legal Network, Cape Town. [www.aln.org.za/downloads/Stigma%20and%20HIV%20Report.pdf]
- UNAIDS. 2010. Getting to Zero, 2011 – 2015 Strategy, p24.
- UNAIDS. 2012. Global Report, p81.
- In total, 2379 community members participated in the study by responding to a structured questionnaire. In addition, 130 incident forms were collated, capturing individuals' experiences of rights violations, as well as access to redress.
- Of all respondents, 72% believed that people need to disclose their HIV status.
- Woman, 40s, Barkly West, Northern Cape.
- Woman, 40s, Galeshewe, Northern Cape.
- Nearly half (44%) of all responded believed that family and friends are supportive.
- Experiences of HIV-related rights abuses as collated through incident forms in Lethabong, North West.
- Of all respondents, 68% believed that healthcare settings are supportive environments.
- Experiences of HIV-related rights abuses as collated through incident forms in Beaconsfield, Northern Cape.
- Woman, 60s, Barkly West, Northern Cape.

Johanna Kehler is the Director of the AIDS Legal Network (ALN). For more information and/or comments, please contact her on jkaln@mweb.co.za.

A virulent form of identity politics...

Why there are no authentic Africans, Afrikaners, women or homosexuals...¹

Pierre De Vos

The re-emergence of a virulent form of identity politics poses a serious threat to South Africa's democracy and the freedom of its citizens.

Wherever one turns, there are people who insist that

there is one authentic way to be African,

Afrikaans, Zulu, Xhosa, gay or lesbian, white,

black, heterosexual, Jewish, Christian, Muslim, or atheist and that, if one does not conform to one of these essentialist stereotypes, one is somehow unauthentic and fake, not worthy of being shown respect and of being taken seriously.

Identity is, thus, used to try and silence critics, to enforce conformity and obedience within the group and to banish those who refuse to perform their 'essential' identities from the policed group itself.

It's not about 'they' and 'them'

It's about US!!!

Who have you discriminated against lately?



The AIDS Legal Network is a human rights organisation committed to the promotion, protection and realisation of fundamental rights and freedoms of people living with - and affected by - HIV and AIDS
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Growing up as a white Afrikaans boy in the threatening shadows of apartheid, I was, of ten, told that certain beliefs and actions and certain people were 'volksvreemd' (alien to the 'Afrikaner nation'). Beyers Naude, Bram Fischer and Frederick van Zyl Slabbert were *volksvreemd*. Listening to Queen, The Rolling Stones and The Beatles were *volksvreemd* – unless one played their songs backwards to identify

the dangerous messages from the devil supposedly contained in them in order to confirm how *volksvreemd* these bands really were. Being an atheist or criticising National Party leaders, like BJ Vorster and PW Botha, were *volksvreemd*. Dancing on a Sunday and being a *moffie* were *volksvreemd*. Marrying an *Engelse meisie* or, god forbid, sleeping with somebody classified as 'Coloured' or 'African' was beyond *volksvreemd*. And, of course, opposing apartheid and supporting the struggle against it was definitely *volksvreemd*.

Some people were devastated when branded as *volksvreemd*. (Others rather revelled in being excommunicated from the very 'tribe' in charge of perfecting apartheid.) *Volksvreemdes* were often shunned by family and friends, ridiculed and shamed, told that they were not 'true' Afrikaners (whatever that might be). Their views could, therefore, be ignored, laughed at or branded as 'dangerous' or 'inauthentic'. At best, they would be pitied for having lost their way. At worst, they would be banished.

The Afrikaner establishment, thus, attempted to police the thoughts and behaviour of white Afrikaans speakers to ensure that not too many of us would become critical of the government or ask too many questions about the injustices of the world we lived in and from which we benefited socially and economically. We were told that there was only one 'right' way to think about our world and our place in it and one 'right' way to live, if we wanted to be viewed as authentic Afrikaners.

I was recently reminded of this oppressive past by several public statements. President Jacob Zuma

...identity is, thus, used to try and silence critics, to enforce conformity and obedience within the group...

...not worthy of being shown respect and of being taken seriously...

was reported as saying that black people should not keep dogs as pets, because it is 'un-African'. Then Gillian Schutte, in a widely read open letter, called on 'white people' to recognise that by jumping in on national debates 'that do not concern them' they are usurping a platform for 'authentic black voices'. And on 14 January 2013 ANC spokesperson Jackson Mthembu attacked Lindiwe Mazibuko for criticising President Jacob Zuma, who said that one's business will multiply if one donated money to the ANC by stating that Mazibuko is 'naïve when it comes to African traditions', which she cannot relate to. Mthembu said in a statement that

...it is our tradition as Africans that if someone gives you something, in return you thank him/her and wish them prosperity and abundance...

What all these comments may have in common, it seems to me, is that they accept that there is a 'right' way and a 'wrong' way to be African, and that those who are 'real' Africans are worthy of respect and to be listened to, while those who are not, can be ridiculed and dismissed as being un-African or need not be taken seriously. One either has an authentic black voice or one is inauthentically black (whatever that may mean). One is either a true African

(who likes people more than dogs, embraces a certain traditional culture and rewards those who look after you) or one is un-African and, therefore, lacks credibility, authenticity and any authority to be taken seriously.

Some commentators even imply that the authentic, 'truly African', identity ought to be strictly policed and that those who do not conform (because they have become 'too white', because they twang when they speak English, because they sleep with members of their own sex, because they have become too critical of their elders or the leaders of the ANC) must be expelled from the group and branded as 'coconuts' (sorry for having to use this offensive term), or race traitors.

Although I am referring to African identity, I could just as easily have used examples showing how the identities of women, gay men and lesbians, Afrikaners, or Jews are policed. A woman who does not like to cook for 'her man', or wears a miniskirt or is not monogamous is suddenly not a 'real' woman. A gay man who knows nothing about Judy Garland or does not support same-sex marriage is suddenly told that he is in denial about his sexuality. An Israeli who criticises the occupation of Palestine becomes a self-hating Jew. An

...the oppressive and disciplining power of essentialised identities...

Afrikaner who supports the ANC once again becomes a *volksvreemde verraaiër*.

By complaining about the oppressive and disciplining power of essentialised identities, I am not denying the

fact that there are sometimes strategic benefits to be had from pretending to belong to a more or less stable and fixed identity group. Claiming to belong to a marginalised identity group helps us to resist oppression and marginalisation and to challenge the economic and social dominance of the privileged group, whose inferior opposite we have been defined as.

That is why, for strategic reasons, some of us resist homophobic oppression by invoking our identities as gay men and lesbians – even as we know that there are a million ways to love and desire members of the same sex. Some of us insist that it is important to address the effects of past and on-going racial discrimination by pretending

Respect

**You have the right to get it
You have the duty to give it**

**Who have you
discriminated against – lately?**



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...claiming to belong to
a marginalised identity group
helps us to resist
oppression and marginalisation...

that there is an easily identifiable group called ‘*Africans*’, and that this category can be used to implement effective and necessary redress policies – even as we know that there are a million ways in which such ‘*Africans*’ can choose to live their lives.

Ironically racism thrives on the assumption that all people who are black (or all people who are white, for that matter) are exactly the same; that they have no individuality; and that people who belong to the despised race possess no personal attributes and characteristics not associable with their race. That is why the strategic use of identity categories will not be without its problems and dangers.

Given the fact that identities are always based on a ‘*them*’ and ‘*us*’ logic, and given that there is always a hierarchy of dichotomous identities (heterosexual versus homosexual; black versus white; male versus female) which allows members of the dominant identity group (whites; heterosexuals, males) to exploit their cultural, social and economic dominance and to benefit from it, this kind of exploitation and oppression will only end if we manage to destabilise or even destroy the logic of (and the

belief in) essentialist notions of identity categories, such as race or sex or sexual orientation. The paradox is that we need racial (and other) identity categories to resist racial (and other forms of oppression), even as we run the risk of thereby perpetuating the very system that we need to destabilise or even destroy.

The only way out, so it seems to me, is to challenge the notion that there is one authentic or true or inevitable way in which one is supposed to be African, to be gay and lesbian, to be white, to be a woman.

One should note that the only thing one really always has in common with all other members of any of the identity groups that one might associate with, is the shared experience of either the oppression and marginalisation caused by the prejudices of others or by the shared experience of benefiting from being seen as a member of a dominant identity group.

The rest is all drag.

FOOTNOTES:

1. An earlier version of this article has been published on 15 January 2013 on the Constitutionally Speaking blog. [<http://constitutionallyspeaking.co.za>]

Pierre de Vos is a constitutional law professor at the Department of Public Law at the University of Cape Town. For more information and/or comments, please contact him at Pierre.DeVos@uct.ac.za.

A call to action...

Healthcare for lesbian, gay, bisexual and transgender people

The South African Constitution guarantees access to healthcare for every citizen (Section 27). It also stipulates that no one may be discriminated against on the basis of their sexual orientation (Section 9). Sadly, these citizenship rights are all too often violated for people who identify as lesbian, gay, bisexual, transgender (LGBT) or queer.

Alexandra Muller

This article reviews the state of healthcare for lesbian, gay, bisexual, and transgender people in South Africa and examines relevant health policies. It highlights health issues, faced by lesbian, gay, bisexual, and transgender people, and argues for the inclusion of lesbian, gay, bisexual, and transgender health into health activists' demands.



as important in determining how a person is perceived in society, and which privileges they can access. It is thus important to look at how these identities intersect and play out in their totality.

In this article, I will focus on queer identity – sexual orientation and gender identity – in the understanding that these identities are shaped by all other identities as described.

Queer is an umbrella term and refers to people who are outside the mainstream, outside the norm as dictated by society. Being queer is only one of numerous identities that a person inhabits. It is often a powerful identity, because queer people are marginalised and oppressed. But peoples' racial and gender identities, bodily abledness etc. are just

HEALTHCARE NEEDS

Lesbian, gay, bisexual, and transgender people have specific health and healthcare needs in various fields from chronic disease risk, adult and adolescent mental health, unhealthy relationships (for example intimate partner violence), to sexually transmitted infections and

Definitions and terminology

HETEROSEXISM is the assumption or belief that everyone is and should be heterosexual and that other sexual orientations are unhealthy, unnatural and a threat.

HOMOPHOBIA is the irrational fear of, hatred against, or disgust towards homosexuals or homosexuality.

SEX is commonly understood as the classification of a person as male or female at birth, based on bodily characteristics such as chromosomes, hormones, internal reproductive organs, and genitalia.

GENDER is a socially constructed system of classification that ascribes qualities of masculinity and femininity to people. Gender characteristics can change over time and differ between cultures.

SEXUAL ORIENTATION describes whom you are intimately attracted to. People are attracted to members of the same sex, of the opposite sex, or both. Western society tends to think of sexual orientation as expressing itself in three forms: homosexual (gay or lesbian), heterosexual (sometimes referred to as 'straight') or bisexual (having both homosexual and heterosexual feelings). People also identify as queer (refusing to fit into any category) and asexual (not being sexually attracted to people).

HETEROSEXUAL PEOPLE are emotionally, physically and sexually attracted to people of the opposite sex.

HOMOSEXUAL PEOPLE are emotionally, physically and sexually attracted to people of the same sex.

LESBIAN women are emotionally, physically and sexually attracted to women.

GAY men are emotionally, physically and sexually attracted to men.

BISEXUAL PEOPLE are emotionally, physically and sexually attracted to people of both sexes.

GENDER IDENTITY is one's basic sense of being male or female or another gender. It usually, but not always, matches the sex based on the external genitalia present at birth.

TRANSGENDER describes a person whose gender identity is different from the sex assigned at birth. A transgender person may choose to adhere to the gender role with which that person identifies. A person who does not adhere to gender roles is called gender non-conforming. It is important to recognise that the gender binary (the view that they are either male or female) does not describe the identity of many people.

QUEER is an umbrella term to refer to all LGBT people, also a political statement, as well as a sexual orientation, which advocates breaking binary thinking and seeing both sexual orientation and gender identity as potentially fluid. In the past often used as a derogatory term for non-heterosexual people.

MEN WHO HAVE SEX WITH MEN (MSM) describes a sexual practice. MSM can identify as gay, bisexual, or straight.

WOMEN WHO HAVE SEX WITH WOMEN (WSW) describes a sexual practice. WSW can identify as lesbian, bisexual, or straight.

[Taken from: 'Understanding the Challenges facing Gay and Lesbian South Africans', available from OUT LGBT Pretoria, and 'Guidelines for primary care workers providing care for transgender patients', available from Gender Dynamix, Cape Town]

HIV infection¹. HIV, which originated in the early 1980s as so-called GRID^S – gay-related immune deficiency syndrome – often shows higher infection rates in gay men and transgender people. The focus of the HIV epidemic in African countries, including South Africa, is usually on women and children. This neglects the fact that lesbian, gay, bisexual, and transgender people are equally, if not more, at risk of contracting HIV. Various studies from South Africa provide evidence that HIV prevalence among men who have sex with men is higher than in the general population.²

However, our current HIV education does not acknowledge this at all. HIV counsellors assume that clients are straight, practice heterosexual sexual practices, and have partners of the opposite sex. Not only is this incorrect – between five to ten percent of all people identify as queer, and even more engage in same-sex activities – but it creates dangerous norms in HIV counselling and testing. It is a lost opportunity to provide adequate information about HIV prevention, and places an already marginalised group of people even more at risk.

...because they disproportionately experience discrimination, stigma, and violence, because of their queer identity...

...does little to address the challenge of continuous heteronormativity and homophobia in the health system...

Equally wrong and dangerous is the perception that lesbian women, and other women who have sex with women (WSW), are not at risk of contracting HIV. A recent study of women who have sex with women in South Africa, Namibia, Zimbabwe and Botswana found that HIV prevalence among women who have sex with women, as self-reported by study participants, was 9.6%³. HIV can be transmitted between two women who have sex through vaginal fluid or menstrual blood. Furthermore, many women who have sex with women also have sex with men: almost half of lesbian women reported to have had consensual heterosexual sex. Furthermore, lesbian women are at higher risk of experiencing sexual violence⁴, and this further increases their risk of contracting HIV⁵.

However, lesbian, gay, bisexual, and transgender people not only have special health needs when it comes to infectious diseases such as HIV. Research shows that lesbian, gay, bisexual, and transgender people experience higher rates of depression and suicide attempts than heterosexual

No turning tides without changing minds...

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patients who belong to sexual minorities experience healthcare as an unsafe space, mostly because of the attitudes of healthcare workers,

people⁶. This is not because their sexual orientation or gender identity predisposes them to mental health issues, but because they disproportionately experience discrimination, stigma, and violence, because of their queer identity.

HEALTHCARE ACCESS

Compared with heterosexual and non-transgender socio-economically matched peers, lesbian, gay, bisexual, and transgender individuals are more likely to face barriers accessing appropriate healthcare⁷. In our context of heteronormativity and patriarchy, women and sexual minorities are particularly vulnerable to ill-health. Many

including doctors. Recent reports from various South African contexts highlight that gay men, lesbian women and transgender people are discriminated against, insulted, and sometimes even refused healthcare, when accessing HIV services. Gay men can recount numerous experiences of healthcare workers telling them that being infected with HIV is God's punishment for them, and that they deserve getting a sexually transmitted disease, because they sleep around⁸. The experiences of stigma, discrimination and moral judgements, recollected by transgender people in a recent report of Gender Dynamix are typical of the barriers that lesbian, gay, bisexual, and transgender people face when accessing healthcare:

They [health care workers] look at me like I am an alien and call me istabane [Zulu derogatory term for gay] and want to know why I am like this.⁹

I tested [for HIV] and was not of the best as the person who pricked me urged me to change my life as being like I am is immoral she said.¹⁰

...health needs and risks of lesbian, gay, bisexual, transgender people do not find entry into the content of the existing teaching schedules...

As a result of these experiences, and because they fear further discrimination, many lesbian, gay, bisexual, and transgender people do not disclose their sexual orientation to their healthcare provider. There are a number of instances where this is detrimental to the healthcare that they can receive – counselling about the risks of contracting HIV, as highlighted earlier, is one example.

HEALTHCARE PROVISION

The 2012-2016 National Strategic Plan on HIV, TB and STIs recognises that transgender people and men who have sex with men are key populations for efforts of preventing and treating HIV. However, it does little to address the challenge of

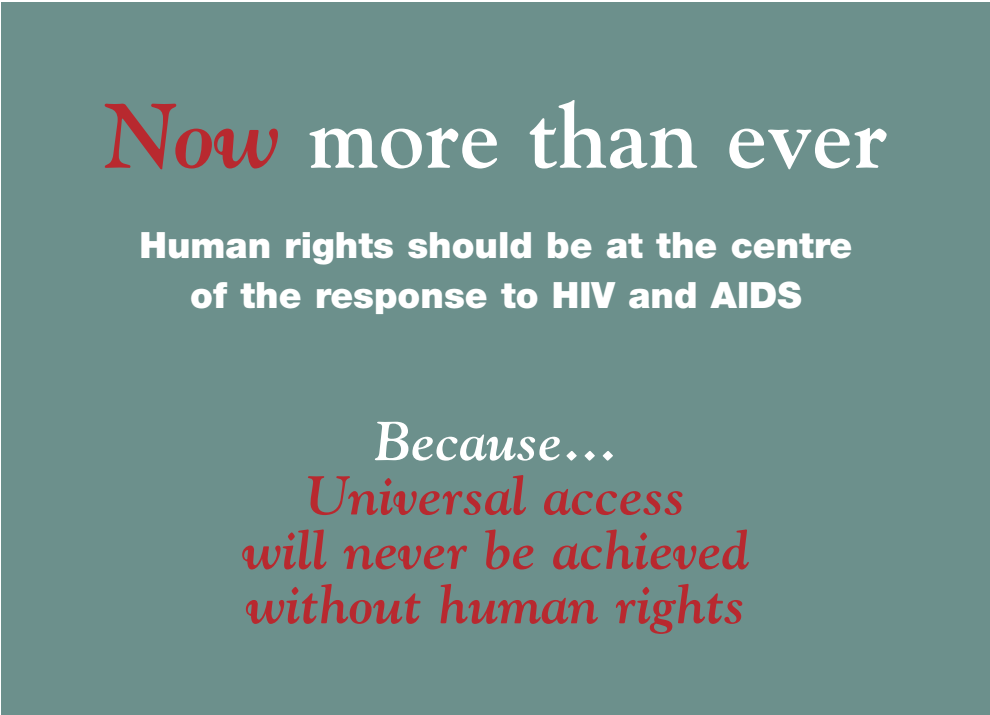


...health activists in civil society need to include queer health issues in their agendas...

...healthcare workers allow their personal prejudices to define the treatment that they give a patient who does not identify accordingly to their own value system...

continuous heteronormativity and homophobia in the health system in general, and in HIV services in particular. The new draft policy on sexual and reproductive health, under review by the Department of Health since May 2011, also recognises the existence and health needs of lesbian, gay, bisexual, and transgender people¹¹. These initiatives have to be applauded. However,

they will have little impact on the health of lesbian, gay, bisexual, and transgender people if not followed by adequate implementation. Healthcare workers, who are the gatekeepers to accessing the healthcare system, need to be willing and equipped to provide adequate, non-judgmental healthcare to people who identify as lesbian, gay, bisexual, transgender or queer.



Currently, healthcare workers – nurses, doctors, counsellors and community health workers – do not receive training on sexuality, sexual orientation, or lesbian, gay, bisexual, and transgender health. The curricula of our medical schools and nursing colleges do not address the moral attitudes of our future healthcare providers. Nor do they teach them how to provide HIV counselling to people who have sex with partners of the same sex, or transgender people. The health needs and risks of lesbian, gay, bisexual, and transgender people do not find entry into the content of the existing teaching schedules. It is thus understandable that healthcare workers are ill-equipped to deal with lesbian, gay, bisexual, and transgender patients. It is, however, not understandable that healthcare workers

allow their personal prejudices to define the treatment that they give a patient who does not identify accordingly to their own value system.

There are a few non-governmental organisations that provide non-judgmental, queer-affirming healthcare to lesbian, gay, bisexual, and transgender people¹². Some of these organisations also provide critically important sensitisation training to healthcare workers. Their work provides a rare safe space for lesbian, gay, bisexual, and transgender people who, for the most part, have had horrible experiences in the public health sector.

CALL TO ACTION...

It is unacceptable that the burden for providing healthcare to one of the most vulnerable groups is placed on civil

society organisations. Training on lesbian, gay, bisexual, and transgender health, including sensitisation training,

...address discrimination
within our own organisations,
and challenge our own prejudices
and those of our colleagues...

needs to be mandatory for all current and future healthcare workers. The Department of Health needs to commit to the declarations made in the NSP, and provide this training to all its employees (nurses, doctors, counsellors and community health workers). Medical schools and nursing colleges need to include lesbian, gay, bisexual, and transgender health into their curricula, and ensure that all graduates are skilled and willing to provide healthcare to lesbian, gay, bisexual, and transgender people.

Health activists in civil society need to include queer health issues in their agendas. We cannot leave it up to queer organisations to address the discrimination of lesbian, gay, bisexual, and transgender people. When reviewing and evaluating health policies and their implementation, we must analyse their impact on, and their provision for the health needs of lesbian, gay, bisexual, and transgender people.

But we must also address discrimination within our own organisations, and challenge our own prejudices and those of our colleagues. Only then are we working towards living in a society in which the constitutional equality framework also expands to lesbian, gay, bisexual and transgender people.

FOOTNOTES:

1. See Harcourt, J. 2006. 'Current issues in lesbian, gay, bisexual and transgender health'. In: *Journal of Homosexuality*, 51(1), DOI: 10.1300/J082v51n01_01.
2. Lane, T. et al. 2011. 'High HIV prevalence among men who have sex with men in Soweto, South Africa: Results from the Soweto Men's Study'. In: *AIDS Behavior*, 15, pp626-634.
3. See Sandfort TGM et al. 2013. 'Forced Sexual Experiences as Risk Factor for Self-Reported HIV Infection among Southern African Lesbian and Bisexual Women'. In: *PLoS ONE*, 8(1): e53552. doi:10.1371/journal.pone.0053552.
4. Often reported as so-called 'corrective rape' in the media, sexual violence particularly against black lesbian women has a high prevalence in South Africa.
5. See Sandfort TGM et al. 2013. 'Forced Sexual Experiences as Risk Factor for Self-Reported HIV Infection among Southern African Lesbian and Bisexual Women'. In: *PLoS ONE*, 8(1): e53552. doi:10.1371/journal.pone.0053552.
6. See King, M. et al. 2008. 'A systemic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people'. In: *BMC Psychiatry*, 2008, 8(70), doi:10.1186/1471-244X-8-70.
7. Gay and Lesbian Medical Association 2001.
8. Lane, T. et al. 2011. 'High HIV prevalence among men who have sex with men in Soweto, South Africa: Results from the Soweto Men's Study'. In: *AIDS Behavior*, 15, pp626-634.
9. Stevens, M. 2012. Transgender access to sexual health services in South Africa: A key informant report. Cape Town: Gender Dynamix.
10. *Ibid.*
11. SRHR: Fulfilling our commitments, Department of Health [www.agenda.org.za/wp-content/uploads/2012/09/SRHR-Fulfilling-our-Commitments.pdf].
12. Triangle Project in Cape Town, OUT in Pretoria, the Durban Lesbian and Gay Community & Health Centre, and a few ANOVA/Health 4 Men clinics.

Alexandra Muller is a postdoctoral research fellow at the Health and Human Rights Programme, School of Public Health and Family Medicine, University of Cape Town. For more information and/or comments, please contact her on alexandra.muller@uct.ac.za.

The National Sex Work Programme...

Towards universal services for sex workers in South Africa

The National Sex Work Programme (NSWP) is a potential milestone for improving access to health services and establishing sex work appropriate healthcare.

Sally-Jean Shackleton

HOW THE PLAN WAS DEVELOPED

Early in 2012, the Sex Work Sector started developing a Sex Work Sector Plan, with support from the UNFPA. The process involved a two-day meeting with sex workers and implementers to consult

them on what they thought

should be prioritised. This resulted in a first version of the Plan drafted by Marion Stevens, for the sector. In the mean-time, the South African National AIDS Council (SANAC) Secretariat recognised the importance of addressing sex work directly and offered support to the sector.

In August 2012, over 200 experts got together at a three-day symposium titled '*National Sex Work Symposium: Best Practice in HIV Prevention, Care and Treatment for*



Sex workers march in Cape Town to demand better treatment from Police, Cape Town 2012

Sex Workers in South Africa'. The Symposium was supported by SANAC and UNFPA, and was held in partnership with the National Department of Health and the Ministry of Women, Children and People with Disabilities. The programme of the symposium ensured the active participation of sex workers themselves as presenters. In the audience were sex worker peer educators, human rights advocates, nurses and healthcare practitioners, staff members of NGOs, researchers and policy makers. The symposium was addressed by the Deputy Minister of Police, and the

closing remarks were made by Dr Fareed Abdullah, CEO of SANAC who said:

I think this meeting is going to go down in history as a turning point in the work of the sex worker movement.

...increased vulnerability and obstacles in the way of accessing healthcare and justice...

The Symposium was another venue in which the Sex Work Plan was presented, and which elicited a number of inputs. SANAC began bringing together a small group of people as a technical working group, which began putting the finishing touches to the Sex Work Plan – which at this time, evolved into a national programme.

THE PLAN

Let's not have another meeting like this where we talk about what to do. I am tired of talking about many of these issues; we need to get on and do the work.

[Dr Yogan Pillay, Deputy Director General, NDoH at the National Symposium August 2012]

The National Sex Work Programme defines sex work as adult consensual sex in exchange for money or goods, either regularly or occasionally. It acknowledges that



Peer educators from SWEAT demonstrate the use of safer sex equipment at a taxi rank in Cape Town

sex workers are viewed very negatively by society, and this negative attitude is located in the context of the lower socio-economic status of women and other minority groups. This moral judgment, social stigma and discrimination result in the marginalisation, social exclusion and disempowerment of sex workers.

...moral judgment, social stigma and discrimination result in the marginalisation, social exclusion and disempowerment of sex workers...

Sex work takes place in every village, town and city in South Africa in a variety of settings (at truck stops, in shebeens, brothels and on the streets) and is criminalised in South African law. Both buying and selling sex is criminalised, as well as associated activities and living off the proceeds of sex work. The criminalisation of sex work, and contextual factors like poverty, result in increased

...sex workers are not victims
by virtue of being
sex workers...

vulnerability and obstacles in the way of accessing healthcare and justice. Sex workers in South Africa live and work in hostile environments, endure high levels of human rights abuses, and historically have not enjoyed the benefits of a responsive, non-discriminatory health system.

These elements contribute to the disproportionately high risk for HIV infection among sex workers – with prevalence rates of 60% versus 25% among non-sex working women (15 to 49 years old).¹ Additionally, limited access to enabling health environments prevent good health outcomes among sex workers living with HIV.²



Sex workers march in Cape Town to demand better treatment from Police, Cape Town 2012

THE PRINCIPLES

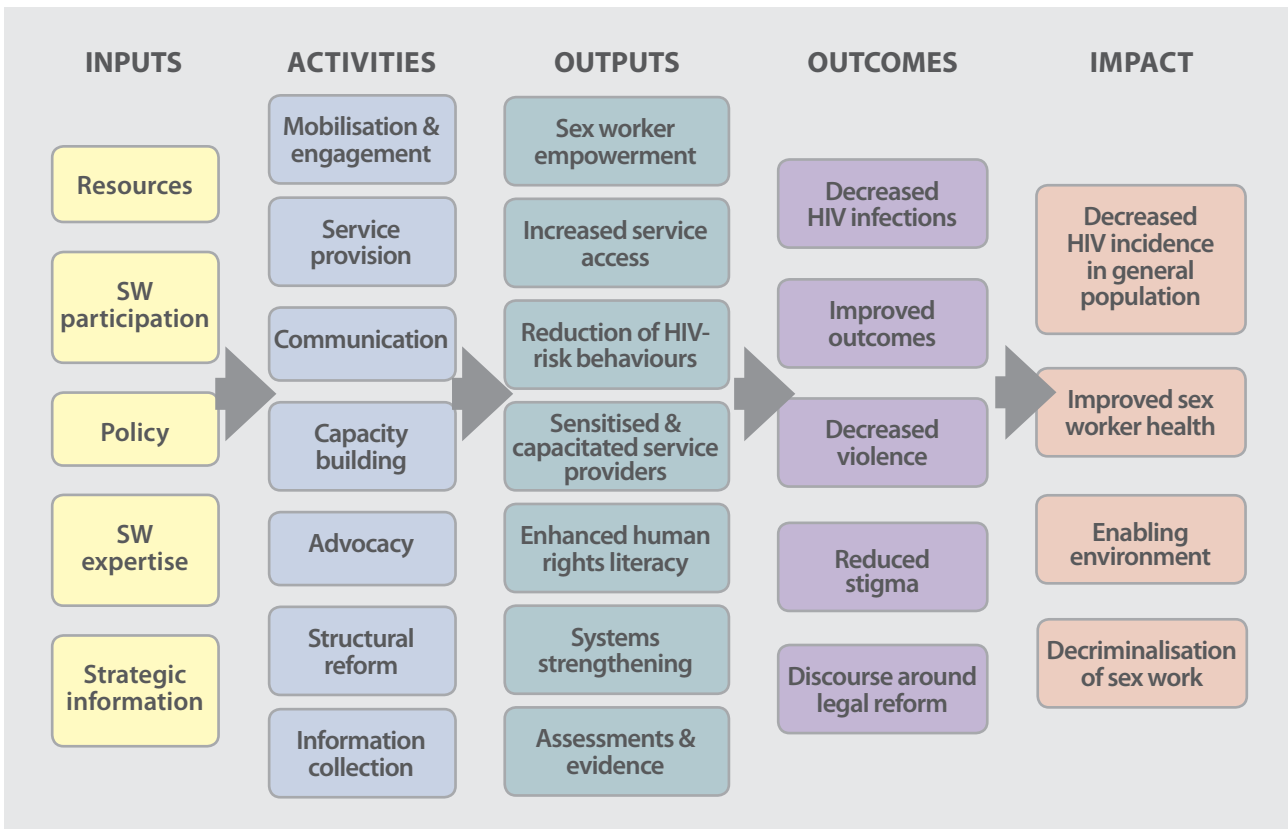
The National Sex Work Programme is informed by a number of important principles:

- Sex workers are equal citizens and have families
- Sex workers’ rights and dignity must be respected
- Sex workers are not victims by virtue of being sex workers
- Sex work is a livelihood option for those who engage in it
- Sex worker ownership: *‘nothing about us, without us’* is central

- Evidence-informed response is central
- Interventions should not do harm
- Collective sex worker engagement, mobilisation and empowerment are essential for success

...collective sex worker engagement, mobilisation and empowerment are essential for success...

The National Sex Work Programme is carefully designed so as to ensure that there is a logical thread running from its inputs to its impact:



The aims of the National Sex Work Programme are to:

- Increase coverage and access to comprehensive HIV, STI & TB services for sex workers, their partners and families
- Reduce violence and human rights abuses experienced by sex workers
- Create enabling health and related systems for the realisation of constitutional rights

2. Reduce sexual transmission of HIV among sex workers
3. Sustain sex workers' health and wellness
4. Strengthen the health system
5. Collect information and research to enable an effective HIV response

Its objectives are to:

1. Reduce social and structural barriers to HIV, STI & TB prevention, care and impact

Activities included in the plan are adapted to three contexts: metropolitan areas, where sex work happens in high concentrations and within an identifiable

CONTEXT ³	SERVICE DELIVERY MODEL ⁴	PACKAGE OF SERVICES
Metropolitan area	High concentration of sex workers Specialist sex worker clinics (NGO-government partnerships) e.g. Essen St clinic <ul style="list-style-type: none"> • extended hours • established networks • mobile services 	<ol style="list-style-type: none"> 1. Condoms and lubricants 2. Post-exposure prophylaxis (PEP) 3. STI/TB diagnosis and management 4. HIV, testing, treatment, care and support 5. Psychosocial services and risk reduction 6. Referral for substance abuse 7. Reproductive and sexual health 8. IEC materials 9. Safe spaces and peer-led mobilisation
Sex worker 'hot spots'	Sex-worker focused services (NGO or government provided) e.g., truck stops <ul style="list-style-type: none"> • Includes sex worker clients • Includes mobile services 	<ol style="list-style-type: none"> 1. Services described above (1 to 9) 2. Services for sex worker partners (1 to 5, 9) 3. Mobile services (1 to 4, 9)
Other areas	HTA clinics Sex-worker friendly services (NGO or government provided)	Outreach work and primary healthcare package, provided in a sensitised manner



*Dudu Dlamini, Sisonke Organiser,
addressing sex workers with a poem*

geographical area; sex worker 'hot-spots', where sex workers are concentrated around a truck stop for instance; and other areas, where sex work happens in smaller numbers.

Central to the delivery of services is peer education programmes where peers are current or former sex

workers, and where sex workers are central to the planning, implementation and evaluation of services.

...interventions should not
do harm...

NEXT STEPS

The National Sex Work Plan needs the support of all SANAC Sectors. It needs to be approved by Plenary and thereafter costed. It is crucial that funding is allocated to its implementation.

FOOTNOTES:

1. Baral, S. et. al. 2012. 'Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis'. In: *Lancet*, 12(7), pp538-549.
2. SACEMA. 2010. Modes of Transmission Study. Report. Stellenbosch.
3. Context assessed through location mapping and needs assessment, defined by sex worker concentration.
4. Peer led outreach, education, linkage to services and support provided in all contexts.

*Sally-Jean Shackleton is the Director at SWEAT.
For more information and/or to get involved,
please contact her on sallys@sweat.org.za.*

...collect information
and research to enable
an effective HIV response...

In the best interest of children...?

Why the criminalisation of consensual sexual exploration between teenagers is unconstitutional...¹

Pierre De Vos

Is it in the best interest of children to turn up to 80% of them into potential criminals? Is it constitutionally acceptable for teachers, principals and parents to abdicate their responsibility to educate children about sexual matters by potentially criminalising all forms of kissing, cuddling, touching and other forms of sexual exploration between children, despite the fact that such behaviour are ordinarily associated with the normal physical and emotional development of children? Thankfully, Judge Pierre Rabie of the North Gauteng High Court in January 2013 ruled that it would not. Predictably, the sexual perverts and prudes who see sex as something dirty, disgusting and corrupting are up in arms. This is why they are wrong.

The High Court was asked, among others, to consider the constitutional validity of Section 15 and 16 of the Sexual Offences Act. These sections prohibit 12 to 15 year old adolescents from engaging in voluntary and consensual

**Stigma + social norms
= HIV risk**

not 'wrong' choices

**Who have you
discriminated against lately?**



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conduct with one another that would include anything from kissing, holding hands and light petting, to oral sex and other forms of sexual intimacy, including sexual intercourse, if there is more than a two year age gap between them. If a child of 15 kisses a child of 13 both commit an offence. However, if a child of 17 kisses a child of 15 only the 17 year old can be prosecuted. The Act, therefore, provides an incentive for children younger than 16 to engage in sexual activities with people older than 16.

The Act also states that when a child deceives an accused into believing that he or she is already 16, then the older child or adult will not be guilty of an offence. This means that when a girl pretends to be 16 (but is, in fact, 15) and has sex with a 16 year old boy (or kisses that boy), neither of them could be prosecuted. However, if the same 15 year old girl has sex with (or kisses) a 15 year old boy, both could be prosecuted because the exception does not apply to children younger than 16.

...it reinforces the social stigmas and taboos around sexuality...

The Act further places a legal duty on any person who has knowledge that any of these sexual offences have been committed against a child must report such knowledge immediately to a police official and failure to do so constitutes an offence for which the person is liable on conviction to a fine or to imprisonment for a period not exceeding five years. This means that where a 15 year old boy informs his mother that he has kissed a 17 year old girl, his mother will potentially become a criminal if she does not report her child to the police.

...this will discourage adolescents from seeking help with respect to their sexuality...

The Act bestows a discretion on the National Prosecuting Authority (NPA) to decide on whether to prosecute the children, but requires the NPA to prosecute both parties involved in the sexual activity if they are both younger than 16, regardless the circumstances. However, the Act does not provide any guidelines for how this discretion should be exercised, meaning that the enforcement of these criminal prohibitions will necessarily be selective and arbitrary.

According to statistics submitted to court between 39% and 80% of adolescents surveyed in Cape Town and Polokwane had engaged in kissing; between 25.8% and 33.8% had engaged in heavy petting; and between 15% and 26.8% had engaged in vaginal sex. The reality is that most adolescents experiment with their sexuality and this is recognised by our law.

Thus, in order to protect adolescents against HIV infection and pregnancy, Section 134 of the Children's Act prohibits any person from selling condoms to a child over the age of 12 and requires the provision of condoms

...it may discourage rape survivors from reporting the rape...

...behaviour that is mutually consensual, wanted, desired, non-violent, safe (in terms of using methods to minimise risks of STI transmission and pregnancy), and for which the individual feels emotionally and physically ready.

to all children over the age of 12 on request where such condoms are provided or distributed free of charge. Contraceptives, other than condoms, may be provided to a child on request by the child and without the consent of the parent or caregiver of the child if the child is at least 12 years of age. The Choice on Termination of Pregnancy Act further provides that ‘no consent other than that of the pregnant woman shall be required for the termination of a pregnancy’, meaning that any 13 year old is entitled to terminate her pregnancy without knowledge or consent of her parents or caregivers.

Different children will obviously be ready for different forms of sexual exploration at different stages of their lives. The best possible way to help children deal with their sexual development in a healthy manner is to ensure that they seek out advice and help from appropriate individuals.

The expert evidence submitted to the court indicated that

If one criminalises consensual sexual acts, this will discourage adolescents from seeking help with respect to their sexuality, because they may then be prosecuted for such behaviour, and because it reinforces the social stigmas and taboos around sexuality. Because the Act silences and isolates adolescents regarding their sexual exploration, it makes unhealthy behaviour and poor developmental outcomes more likely and does not advance

...given their developmental stage and their developmental tasks, it is not unusual or necessarily unhealthy and harmful for adolescents to engage in sexual behaviours as they begin to learn about their sexuality and become more mature in several life domains.

...the problem with these provisions is that it treats children not as individual social beings...

Experts defined ‘healthy’ sexual behaviour as

the best interests of children as required by Section 28(2) of the Constitution. As the court pointed out:

This would also increase the likelihood that adolescents will engage in risky behaviour by making it impossible for caregivers to provide advice, counselling and support on issues regarding the child's sexuality. Such caregivers would obviously also, from their side, be reluctant to enquire too much and would thus be inhibited in their actions, and actually be prevented from performing their duties as they are supposed to do. The existence of the offences also increases the risk that children will experience unhealthy sexual contact, by

teaching them that consensual, developmentally normative sexual behaviour is wrong and deserves to be punished

...the risk of turning many children into criminals for no other reason than that they explored healthy sexual behaviour...

There is an even bigger problem with the impugned provisions: it may discourage rape survivors from reporting the rape. Because it would be far easier for the NPA to

Now more than ever

**Human rights should be at the centre
of the response to HIV and AIDS**

Because...

*AIDS poses unique challenges
and requires exceptional responses*

prove consensual sex occurred between the minor and an adult, than it would be to prove that rape occurred; hence, there is a danger that the NPA will tend towards pursuing a charge of consensual sex. Where the alleged rapist is under 16 years old, the victim of the possible rape must her/himself also be charged with contravening Section 15. It would then be for her to prove that the sex was non-consensual, and thus, avoid conviction under Section 15. Failing this, she would be convicted.

...a relief to some parents who believe the criminal law should do their parenting for them...

The problem with these provisions is that it treats children not as individual social beings. Instead, in an attempt to impose a narrow, moralistic view of sexuality not in line with the lived experience of children, it runs the risk of turning many children into criminals for no other reason than that they explored healthy sexual behaviour as part of their normal development as human beings. To emphasise this point, the High Court quotes from the Constitutional Court judgment in *S v M (Centre for Child Law as Amicus Curiae)* where the purpose of the children's rights guaranteed in Section 28 of the Constitution is described as follows:

Individually and collectively all children have the right to express themselves as independent social beings, to have their own laughter as well as sorrow, to play, imagine and explore in their own way, to themselves get to understand their bodies, minds and emotions, and above all to learn as they grow how they should conduct themselves and make choices in the wide social and moral world of adulthood.

As with all High Court orders declaring invalid legislative provisions, the order of invalidity will not come into effect until it is confirmed by the Constitutional Court. For the time being, it thus remains a criminal offence for a 15 year old to kiss or hold hands with a 13 year old, which might come as a relief to some parents who believe the criminal law should do their parenting for them, but is not in the best interests of children exploring their sexual awakening in a normal and healthy manner.

FOOTNOTES:

1. An earlier version of this article has been published on 17 January 2013 on the Constitutionally Speaking blog. [<http://constitutionallyspeaking.co.za>]

Pierre de Vos is a constitutional law professor at the Department of Public Law at the University of Cape Town. For more information and/or comments, please contact him at Pierre.DeVos@uct.ac.za.

Given to anyone who fits in on the time table... Sex education in schools

Precious Acker

There is a high risk factor of HIV infection for the age group of 10 to 19 years old in South Africa. The

HIV prevalence in this age group increased from 21% in 2007 to 23% in 2010¹. As HIV continued to increase for the youth population in South Africa, Life Orientation was introduced as a compulsory subject in South African schools starting in 2002.

In an effort to make a difference and adequately address the high risk of HIV exposure and transmission to the youth of South Africa, the Department of Education seeks to provide opportunities to the youth by implementing sex education programmes within the curriculum to educate school children with the knowledge and skills they need to make informed and healthy choices, including, but not limited to, HIV prevention and information about the disease. The *Life Orientation* programme has become one of the educational responses to the HIV pandemic in South Africa, and is viewed as effective for addressing the HIV pandemic and reducing other health outcomes for learners².

We need to move
beyond commitments...

www.aln.org.za



The aim of this article is to examine what is 'proper' sex education in South Africa and how is the message interpreted in the classroom.

WHAT IS SEX EDUCATION?

In South Africa, sex education is a required subject for learners in conjunction with *Life Orientation* courses. *Life Orientation* is a required course starting in grade R through to grade 12. In the *Revised National Curriculum Statement Grades R-9*, the Department of Education describes that *Life Orientation* learning area

...guides and prepares learners for life and its possibilities, specifically for meaningful and successful living in a rapidly changing and transforming society.³

Life Orientation is central to the holistic development of learners. It addresses skills, knowledge and values for the personal, social, intellectual, emotional and physical growth of learners, and is concerned with the ways in

which these facets are interrelated. *Life Orientation* covers five learning areas⁴:

- Health promotion
- Social development
- Personal development
- Physical development and movement
- Orientation to the world of work

Life Orientation is divided into four phases: foundation phase (Grade R-3), intermediate phase (Grade 4-6), senior phase (Grade 7-9) and general phase (Grade 10-12). For example, children in Grade R-3 are expected to explain the right to say 'no' to sexual abuse, and describe ways in which to do so, and understand basic personal hygiene. Older children in Grades 4-6 need to know how to explain causes of communicable diseases (including HIV) and available cures, and evaluate prevention strategies, in relation to community norms and values, as well as identify different forms of abuse and suggest strategies to deal with them. The senior phase, grades 7-9, introduces learners to personal decision-making skills. Students should know how to describe strategies for living with diseases, including HIV, and also describe a healthy lifestyle in their own personal situation, as a way to prevent disease. Grade 10-12 students are equipped to explain changes associated with growing towards adulthood, and describe values and strategies to make responsible decisions regarding sexuality and lifestyle choices in order to optimise personal potential. Students should also know how to investigate

...responsible decisions regarding sexuality and lifestyle choices in order to optimise personal potential...

the extent to which unequal power relations between the sexes are constructed, and how they influence overall health and well-being, and apply this understanding to work, cultural and social contexts. The programme is designed to enable students to be informed, responsible and participating citizens by providing access to a holistic curriculum that addresses educational and societal fundamentals.

Life Orientation is a fact-based curriculum with an outcome-based education focus⁵. The outcome-based focus encompasses a learner-centred and activity-based approach, which allows students to have a more active learning experience by encouraging students to have discussions, critically evaluate and problem solve, and develop community building through group projects. Outcome-based focus curriculum is an important aspect of the *Life Orientation* learning areas, as it aims to effectively transmit knowledge to all learning types.

I have the right to protect myself...
and be safe...

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...designed to enable students to be informed, responsible and participating citizens...

IS EVERYONE REQUIRED TO RECEIVE SEX EDUCATION?

The right to education is a fundamental human right and enshrined in South African law. Section 29 of the Constitution guarantees that everyone has the right to education, basic education and further education; that no citizen should be discriminated against in relation to race, age, socio-economic status, or language; and that education should be accessible and available for all.⁶

(1) Everyone has the right

(a) To a basic education, including adult basic education; and

(b) To further education, which the state, through reasonable measures, must make progressively available and accessible.

(2) Everyone has the right to receive education in the official language or languages of their choice in public educational institutions where that education is reasonably practicable. In order to ensure the effective access to, and implementation of, this right,

...no specific law requiring sex education to be compulsory...

the state must consider all reasonable educational alternatives, including single medium institutions, taking into account:

(a) Equity;

(b) Practicability; and

(c) The need to redress the results of past racially discriminatory laws and practices.

(3) Everyone has the right to establish and maintain, at their own expense, independent educational institutions that

(a) Do not discriminate on the basis of race;

(b) Are registered with the state; and

(c) Maintain standards that are not inferior to standards at comparable public educational institutions.

(4) Subsection (3) does not preclude state subsidies for independent educational institutions.

South Africa attempts to strengthen the right to education by implementing compulsory attendance for all children. The South African Schools Act Chapter 2 Section 3 states that learners are required to attend school for eight years, from the age of seven until fifteen or Grades 1 through to 9, whichever comes first⁷. However, Chapter 2 Section 4 also states that ‘a Head of Department may exempt a learner from compulsory attendance’ demonstrating that there are exceptions for not attending compulsory school. The South African Schools Act further outlines that ‘school fees may be determined and charged a fee at public school’, although no learner may be refused admission to a public school, reiterating the non-discriminatory practice of socio-economic status. Although

the South African Schools Acts aims to *promote inclusivity and access to education to all students*, the Act contradicts itself with the implementation of fees in public schools, and the option for some to be exempt from compulsory attendance illustrating exclusivity in practice.

...to effectively ensure that learners apply their knowledge gained...

Neither the Bill of Rights nor the South African Schools Act has clauses recognising compulsory sex education (or *Life Orientation*) as a requirement for all students. Although sex education is defined in *The National Curriculum Statement*, there is no specific law requiring sex education to be compulsory.

Those in opposition of the *Life Orientation* course have concerns of the legality of this course and non-parental consent. Although the South African Schools Act does not have a clause that addresses parents' role with regards to sex and sex education, it is their human right to freedom of conscience, religion, thought, and belief to raise their concerns. This right is also strengthened in the South African Schools Acts that states in Chapter 2 Section 7:

*Subject to the Constitution and any applicable provincial law, religious observances may be conducted at a public school under rules issued by the governing body if such observances are conducted on an equitable basis and attendance at them by learners and members of staff is free and voluntary.*⁸

Parents, who because of religious concerns, object to the *Life Orientation* course seem to challenge not only the legality of the subject being compulsory, but also the manner in which the subject is presented. In any challenge brought forward as to whether or not sex education should be part of the school curriculum, parents would have to demonstrate how this subject violates their freedom to religious beliefs. Parents' right to challenge the '*required*' *Life Orientation* (including sex education) course seems to also pose the ultimate question of whether or not, and to what extent, parents have the right to challenge (and change) the curriculum in public schools.

...the quality of sex education is heavily dependent on teachers...

HOW IS SEX EDUCATION IMPLEMENTED?

Sex Education is introduced through the *Life Orientation* learning area courses. The implementation of this course is divided into three phases: subject framework, work schedule, and lesson plans. It is recommended that the teachers of a subject at a school, or cluster of schools, first put together a broad subject outline; secondly teachers of the same grade must develop a work schedule to draw from the content and context identified for their grade in the Subject Framework; and lastly teachers should design a lesson plan using the grade-specific work schedule as the starting point.⁹

This plan is contingent upon the success of the teacher's work schedule, which indicates the sequence in which the content and context will be presented for the subject in that particular grade. The work schedules are documents that outline the course content, assessments, and importantly, teaching for the 32-36 week span. It is important to fulfil the work schedules in order to effectively ensure that learners apply their knowledge gained. It is teachers' goal to promote team work and hold each other accountable for upholding the general standards.¹⁰

WHAT IS THE QUALITY OF SEX EDUCATION?

The quality of sex education is heavily dependent on teachers. The level of quality is dependent on the teacher's training, teacher's implementation of the curriculum, and teacher's assessment of the learners.

Life Orientation teachers are trained by departmental

...referring to schools' actions towards the course as less important and less organised...

...teachers do not possess the skills to effectively implement the full programme...

in-service workshop training sessions, or sessions at Higher Education Institutions offered by the Department of Education¹¹

through Further Education and Training (FET). Although the National Curriculum Statement visualises *Life Orientation* teachers who are qualified, competent, dedicated and caring, they must also fulfil the Norms and Standards for Educators' seven roles requirement. One of the seven role requirements is that all educators:

Will be well-grounded in the knowledge, skills, values, principles, methods, and procedures relevant to the discipline, subject, learning

area, phase of study, or professional or occupational practice. The educator will know about different approaches to teaching and learning (and, where appropriate, research and management), and how these may be used in ways, which are appropriate to the learners and the context. The educator will have a well-developed understanding of the knowledge appropriate to the specialism.¹²

“Rights are not free”

They have responsibilities

While you have the right to be treated the same as everyone else - You also have the duty to treat the next person equally

Who have you discriminated against lately?



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The National Curriculum does not explicitly state what the teacher requirements are with regards to specialisation, neither what presents the success of the training, nor if a completed certificate of the training is required to teach.

Research argues that teachers are not qualified to teach *Life Orientation* courses, because of the lack of specialisation, and questions whether or not teachers are equipped to teach these

...teacher's generic disposition
affects the outcomes of
teachers' individual implementation
of sex education...

courses effectively. Research examining the implementation of *Life Orientation* in schools in the Western Cape showed evidence of a shortage of *Life Orientation* teachers and a large percentage of unqualified teachers, which ultimately had implications for the growth and development of learners. One of the *Life Orientation* teachers commented that 'a full syllabus does not allow the incumbent teacher sufficient time to do physical training'¹³, arguing that the National Curriculum Guidelines are not enough in practice. She continues commenting that 'unqualified persons find it difficult to implement a programme for assessment'¹⁴, and that less focus is given to *Life Orientation* as a separate subject, because *Life Orientation* 'is given to anyone who fits in on the timetable'¹⁵.

The teacher comments express concerns for the lack of attention schools give to the *Life Orientation* course, referring

to schools' actions towards the course as less important and less organised. This also illustrates that teachers do not possess the skills to effectively implement the full programme. Earlier research suggests that *Life Orientation* should be intensively skilled-based to provide interactive teaching to carry out the programme.¹⁶ Because the teacher's skills impacts on the outcome of the programme and its success, teachers should be adequately trained.

The teacher's role in the implementation of *Life Orientation* and sex education is critical in understanding the practicality of the subject. The National Curriculum Statement Learning Programme Guidelines argues that

...the key to successful teaching in *Life Orientation* relies heavily on the teaching approach chosen by the teacher.¹⁷

Although teachers collectively decide on a work schedule and lesson plan guidelines, individual teachers are given autonomy in the actual practice of the course. The guideline continues by stating that

...the choice of assessment strategies is a subjective one, unique to each teacher, grade and school and depends on the teacher's professional judgment.¹⁸

The direction of the programme success being based on the teacher's professional judgment is, however, based on the assumption that every teacher implements the full programme; that every teacher is fully committed; and that every teacher approaches and presents the curriculum unbiased. In light of this large amount of autonomy to what extent can teachers be held

accountable for barriers to the successful implementation of the programme? Research argues that a teacher's generic disposition affects the outcomes of teachers' individual implementation of sex education, which suggests that 'self-selection or screening procedures should include the dimension of student-centeredness, responsibility, and controllability'.¹⁹

...a lack of universality in the course presentation and in the targeted outcomes the course should achieve...

Ultimately, the quality of sex education relies on teachers' efforts. Whether it is a measurement of teacher training effectiveness, or teachers' accountability in relation to autonomy, teachers have the responsibility (and pressure) of implementing a successful sex education programme.

CONCLUSION

With the teachers given considerable amount of responsibility and autonomy in respect of implementation of the *Life Orientation* programme, in practice, approach and pedagogy vary considerably²⁰, illustrating a lack of universality in the course presentation and in the targeted outcomes the course should achieve. The question of effectiveness realises in the quality a particular teacher put forth in the course, which also is not universally defined. Because the National Curriculum does

not define exactly what skills a *Life Orientation* teacher should possess, individual assumptions will continue to be the leading indicator of who is a successful teacher.

In reality, the quality of sex education will continue to vary based on the individual teacher presenting the course, until such time that *Life Orientation* and sex education at schools are given the required attention to ensure quality and *proper* sex education for learners.

FOOTNOTES:

1. See The South African Department of Health Study, 2010. [www.avert.org]
2. Francis, DA. 2011. 'Sexuality Education in South Africa: Wedged within a triad of contradictory values'. In: *Journal of Psychology in Africa*, 21.2, pp317-22.
3. Department of Education. May 2000. Revised National Curriculum Statement Grades R-9 (Schools) Life Orientation. [www.education.gov.za]
4. *Ibid.*
5. *Ibid.*
6. Section 29 of the Constitution of the Republic of South Africa, Act 108 of 1996.
7. South African Schools Act (No 84 of 1996), Chapter 2, Section 3.
8. *Ibid*, Chapter 2, Section 7.
9. Department of Education. January 2008. National Curriculum Statement Learning Programme Guidelines.
10. *Ibid.*
11. Van Deventer, K. 2009. 'Perspectives of Teachers on the Implementation of Life Orientation in Grades R-11 from Selected Western Cape Schools'. In: *South African Journal of Education*, 29.1, pp127-45.
12. See Explanatory Notes to the Norms and Standards for Educators [www.education.gov.za/LinkClick.aspx?fileticket=RrtRelvj7AY%3D&tabid=335&mid=971].
13. Van Deventer, pp139-140.
14. Van Deventer, p140.
15. *Ibid.*
16. Shamagonam, J. et al. 2006. 'The Impact of an HIV and AIDS Life Skills Program on Secondary School Students in KwaZulu-Natal, South Africa' in: *AIDS Education and Prevention*, 18.4, p281-94.
17. National Curriculum Statement Learning Programme Guidelines.
18. *Ibid.*
19. Mathews, CH. Et al. 2006. 'Factors Associated with Teachers' Implementation of HIV/AIDS Education in Secondary Schools in Cape Town, South Africa'. In: *AIDS Care*, 18.4, pp388-97.
20. Francis, p317.

Precious Acker is an intern at the AIDS Legal Network (ALN). For more information and/or comments, please contact her at pbacker89@gmail.com.

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is critical
for the protection of human rights**

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*The protection of human rights
is the way
to protect the public's health*

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of the response to HIV and AIDS**

Because...

*Human rights are practical, and
they work*

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Editor & Photographer: Johanna Kehler (*jkaln@mweb.co.za*) • **DTP Design:** Melissa Smith (*melissas1@telkomsa.net*) • **Printing:** FA Print
Tel: +27 21 447 8435 • Fax: +27 21 447 9946 • E-mail: *alnapt@aln.org.za* • Website: *www.aln.org.za*