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AIDS in schools: a human rights perspective on parameters for sexuality education

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This article is set against the background of a sustained HIV/AIDS epidemic affecting the South African population, including the education sector. It explores the education sector's responses to the epidemic in the area of sexuality education for learners. It is submitted that lifeskills education — the main medium for imparting sexuality education — is an essential instrument in the armamentarium against HIV/AIDS. However, lifeskills education is not value-free. The values that underpin lifeskills education are libertarian in orientation. They cherish diversity, and do not sit easily with a sectarian view of life. The success of lifeskills education will depend, in part, on striking an acceptable balance between the duty of the school to impart the knowledge and skills essential for development and survival, the evolving capacity of the learner, and parental authority. In the final analysis, the impetus is towards a sexuality education in which the core values of human dignity, liberty and equality are protected and promoted in accordance with the imperatives of the Constitution.

VIGS in skole: parameters vir die seksualiteitsopvoeding vanuit 'n menseregteperspektief

Hierdie artikel is geskryf teen die agtergrond van 'n volgehoue MIV/VIGS-epidemie met volskaalse effek op al die sektore in die Suid-Afrikaanse samelewing, insluitende die onderwys. Die reaksie van die onderwyssektor op die epidemie is op die gebied van seksualiteitopvoeding vir leerders ondersoek. Die vertrekpunt is dat onderrig van lewensvaardighede — die hoofmedium waardeur seksualiteitsopvoeding gegee word — 'n essensiële instrument is in die bewapening teen MIV/VIGS. Opvoeding in lewensvaardighede het egter 'n prys nie, aangesien die waardes wat lewensvaardighede onderlê libertyns van aard is. Hoewel diversiteit dus gekoester word, word ongemak met 'n sektariese uitkyk op die lewe bespeur. Die sukses van onderrig in lewensvaardighede sal deels daarvan afhang om 'n aanvaarbare balans te vind tussen die plig van skole om kennis en vaardighede oor te dra (wat essensieel is vir ontwikkeling en oorlewing), die vormende kapasiteit van die leerder, asook die outoriteit van die ouer. Uit die finale analise blyk dit dat die noodsaaklikheid van seksualiteitsopvoeding in ooreenstemming met die Grondwet is waarin die kernwaardes van menslike waardigheid, gelykheid en vryheid beskerm en bevorder moet word.

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HIV/AIDS,[1] teenage pregnancies, sexual abuse, alcohol abuse and drug abuse are the main social afflictions that have led to the implementation of lifeskills education in schools. HIV/AIDS has certainly provided the strongest impetus in recent years (cf Adler & Qulo 1999: 307; Dept of Health 1999a: 5; Save the Children 2002a: 44-51). The reasons for the ascendancy of HIV/AIDS are not hard to find. It has become the biggest single contributor to morbidity and mortality in South Africa (Medical Research Council 2001: 6). Children, and perforce learners, are particularly vulnerable to HIV/AIDS. As part of a preventative strategy, there is an urgent need to provide children not only with information, but also with the necessary skills for survival and development in the midst of a devastating epidemic.

South Africa has a particularly high prevalence of HIV/AIDS. With the exception of India, it is the country with the highest number of PLWAs or people living with HIV/AIDS (UNAIDS 2000: 9). Close to five million people were living with HIV/AIDS in South Africa at the end of 2001 (Kenyon *et al* 2001: 162; Dept of Health 2002). Every day, about 1500 people become infected with HIV in South Africa. Over half of these new infections occur in young people (Dickson-Tetteh 1999: 396). A significant proportion of PLWAs are children. Of the 4.2 million people infected with HIV/AIDS at the end of 1999, it is estimated that 95 000 were children aged 0-14 years (Grimwood *et al* 2000: 289). A fifteen-year-old has a 70% lifetime risk of HIV/AIDS-related death (Grimwood *et al* 2000: 290). Teenage girls are particularly at risk (UNAIDS 2000: 11).

The vulnerability of children to HIV/AIDS results from a number of interacting factors. For the most part, children are dependent. They are socio-economically disadvantaged. They are more likely than adults to lack the information and/or skills that are essential for preventing, or avoiding the risk of HIV/AIDS. Equally, they are less able than adults to access health information and health services (Heunis 2000: 56) Children are more susceptible to peer pressure and less able to protect themselves from rape and sexual abuse or to negotiate safer sex. It is not insignificant that the fastest growth of HIV/

1 Acronyms for Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome respectively.

AIDS in recent years has occurred among the youth. The stigma and discrimination surrounding HIV/AIDS accentuate the vulnerability of children (Save the Children 2002b: 4).

While the preponderance of infections that occur in children under the age of 12 result from mother-to-child transmission, there is also a significant proportion of infections from rape, sexual abuse and sexual exploitation (Grimwood *et al* 2000). In the case of older children, especially, uncoerced sexual intercourse accounts for much of the HIV prevalence. The available evidence indicates that a significant proportion of children become sexually active at a relatively early age (Dickson-Tetteh & Ladha 2000; Abt Associates 2001: 23). For many children, sexual debut occurs in their mid-teens. More than 50% of teenagers are still at school when they have their first child (Van Rensburg *et al* 2002: 20). Moreover, though sexually active children are generally aware of HIV/AIDS, they lack skills to avoid contracting it. Of the four million cases of sexually transmitted infections that occur each year in South Africa, it is estimated that 50% occur in adolescents and young adults (Dickson-Tetteh & Ladha 1999: 396). The gap between knowledge and the adoption of safe sexual behaviour is crucial. While a significant proportion of young people engage in sexual intercourse with multiple partners, condom use is comparatively low. Generally, adolescents, particularly those with little or no education, have a poor understanding of the reproductive function and of sexuality (Dickson-Tetteh 2000: 397).

This article is therefore set against the background of a sustained epidemic that has transcended all population groups, including learners at school. It explores the education sector's responses to HIV/AIDS in the form of sexuality education for learners. It submits that lifeskills education — currently the main vehicle for imparting sexuality education to learners — is an essential instrument in the armamentarium against HIV/AIDS. However, lifeskills education is not value-free and is apt to engender controversy, especially among those of a conservative moral persuasion. The values that underpin lifeskills education in South Africa are decidedly libertarian in orientation, not least on account of the imperatives of the Constitution, and such values do not sit easily with a sectarian view of life.

1. The role of schools in the strategy to combat HIV/AIDS

The education sector is an integral part of the Partnership Against AIDS (Dept of Health 1999a: 3). In 1998, as part of the acknowledgement that South Africa's strategy to combat HIV/AIDS had for a long time been overly unisectoral and centred in the Department of Health rather than a multisectoral strategy involving community mobilisation, the then Deputy President Mbeki said in a television broadcast:

> The power to defeat the spread of HIV/AIDS lies in our partnership as youth, women and men, as business people, as workers, as religious leaders, as parents, *as teachers, as students*, as healers, as farmers and farm workers, as the unemployed and the professionals, as the rich and the poor, all of us [my italics, CN].

There is a general consensus that the education sector is favourably placed to play a crucial role in checking new infections among children and young people in general (Save the Children 2002a: 45-6; ABT Associates 2001: 31-4). By virtue of being a young and captive population, learners can be made the focus of intervention programmes. They are in the process of learning sexual behaviour and are more likely to be receptive to adopting safer sexual mores and practices than adults who already have settled sexual habits. If an entire generation of children can be protected from HIV/AIDS, then the tide of the epidemic will have been stemmed.

The central role of the education sector in combating HIV/AIDS is underscored in the national strategy to combat HIV/AIDS — the HIV/AIDS Strategic Plan for South Africa 2000-2005 (the Strategic Plan) (Dept of Health 2000a). This Plan has carved out a role for the education sector. One of its primary goals is to reduce the number of new infections, especially among the youth. As part of its objective of promoting improved health-seeking behaviour and adopting safer sex practices, the Department of Education is specifically charged with incorporating HIV/AIDS training into lifeskills education in all primary and secondary schools (Dept of Health 2000a: 14).

Even more pertinently, the national Department of Education has adopted a policy aimed specifically at addressing HIV/AIDS in

schools and other institutions of learning — the National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions of 1999 (the National Policy) (Dept of Education 1999). The aims and objectives of the National Policy are encapsulated in its Preamble which says (Dept of Education 1999: 4):

> Because the Ministry of Education acknowledges the seriousness of the HIV/AIDS epidemic, and international and local evidence suggests that there is a great deal that can be done to influence the course of the epidemic, the Ministry is committed to minimise [*sic*] the social, economic and developmental consequences of HIV/AIDS to the education system, all learners, students and educators, and to provide [*sic*] leadership to implement an HIV/AIDS policy. This policy seeks to contribute towards promoting effective prevention and care within the context of the public education system.

The National Policy was adopted in 1999 following the recommendations of the South African Law Commission (1998). In its Third Interim Report on Aspects of Law Relating to AIDS, the Commission recommended the promulgation of a national policy on HIV/AIDS in schools with a view to protecting the human rights of learners living with HIV/AIDS, as well as ensuring that the school environment is safe and healthy for every learner and educator. The National Policy has in essence implemented the recommendations of the Law Commission in that it addresses two aspects — the protection of human rights and the prevention of the spread of HIV. These objectives are in part to be achieved through the provision of HIV/AIDS education. The National Policy provides that "a continuing lifeskills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members". Learners, students, and educators must be taught human rights in order to ensure that the human rights and dignity of everyone are respected. On the prevention side, learners must be taught about universal precautions so as to minimise any chance of HIV's being transmitted in the school environment. Equally significantly, they must also be given sexuality education as part of their ongoing lifeskills education, in order to ensure their survival and development.

According to the National policy, it is incumbent upon individual schools to develop and implement programmes on HIV/AIDS. Within the parameters of the Schools Act of 1996 and the Further Education and Training Act of 1998, as well as any applicable provincial legislation, the school governing body or the council of an institution may develop and implement its own HIV/AIDS policy. In developing such a policy, schools must be guided by provincial education policy on HIV/AIDS, which in turn is guided by national policy. All major stakeholders, including religious and traditional leaders, representatives of the medical or health care professions and traditional healers, should be involved in the development and implementation of the policy and an operational plan on HIV/AIDS. Ultimately, each school should have a programme in place enabling it to carry out HIV/AIDS education programmes for staff, learners, parents and communities.

1.1 The place of human rights in schools

Imparting knowledge skills relating to the protection of human rights in general raises little controversy, not least because, in post-apartheid South Africa, human rights are inscribed in the Constitution,[2] which is the supreme law.[3] The South African Constitution has drawn significantly on contemporary international human rights jurisprudence. It is faithful to the premise of universal rights and freedoms proclaimed by international human rights instruments such as the Universal Declaration of Human Rights of 1948, which serves as a common standard of achievement for all peoples and all nations.

Its Preamble clearly states that the Constitution is aimed at establishing a society based on "democratic values, social justice and fundamental human rights". The substantive provisions of the Constitution, especially those of the Bill of Rights, reiterate its human rights premises. Legislation governing schools, including the South African Schools Act,[4] which is intended to provide uniform system of orga-

2 Constitution of the Republic of South Africa Act No 108 of 1996 (the Final Constitution) which superseded the Constitution of the Republic of South Africa Act No 200 of 1993 (the Interim Constitution).

3 Section 2 of the Constitution.

4 Act No 84 of 1996.

nisation, democratic governance and funding for schools, and the National Education Policy Act of 1996,[5] which provides for the determination of national policy for education, is unpinned by the human rights values in the Constitution. For instance, section 4 of the National Education Policy Act provides that the directive principles of national education policy should be directed toward the advancement and protection of the fundamental rights of every person as guaranteed in the Bill of Rights and in terms of international conventions ratified by Parliament. In this regard it is significant to note that Parliament has ratified the Convention on the Rights of the Child (CRC), thus signalling its intention that the CRC be treated as part of domestic law.

The CRC is an international treaty that focuses specifically on protecting the human rights and interests of children.[6] It recognises that because of their physical and mental immaturity, children need special safeguards and care, including legal protection.[7] At the same time, it recognises that regardless of dependence upon parents or guardians, children possess rights. It recognises children as persons with "evolving capacities".[8] In any matter concerning a child, the child's best interests are the paramount consideration.[9]

In the context of HIV/AIDS and sexuality education, the following general provisions of the CRC are particularly pertinent:

- the child's right to equality;[10]
- the child's right to express his/her own views if capable of forming them and the duty to accord due weight to those views according to the age and maturity of the child;[11]
- the freedom to seek and impart information;[12]
- the freedom of thought, conscience and religion;[13]

5 Act No 27 of 1996.
6 Under the CRC children are persons under 18 years of age (Article) 1.
7 Preamble to the CRC.
8 Article 5.
9 Article 3.
10 Article 2.
11 Article 12.
12 Article 13.
13 Article 14.

- the duty of the state to promote dissemination of, and access to information;[14]
- the right to health, and[15]
- the right to education.[16]

The Constitution complements rather than detracts from provisions of the CRC. Thus, it is not in doubt whether schools should subscribe to human rights values. The challenge has been in the implementation of such values, especially in areas such as sexuality education, which raise delicate questions, not least because sexuality education impacts on the moral and religious sensibilities of educators, learners and parents. For this reason, the National Policy accords the individual school discretion in respect of the provision of mandatory sexuality education. The National Policy has also left to the discretion of the individual school, whether condoms should be made accessible and, if so, under what circumstances.

The challenge lies in developing a paradigm for imparting sexuality education in a manner that accommodates all the main stakeholders. Educators must be allowed to equip learners with the knowledge and skills required to avoid HIV/AIDS. Children must be allowed to receive information and acquire skills commensurate with their intelligence and maturity level. At the same time, sexuality education must be alive to the moral and religious sensibilities of children and their parents. As the next section will elaborate, this accommodation should be achieved by rendering sexuality education in a context that seeks to equip the learner with lifeskills rather than initiating him or her into early sexual activity.

2. The essence of lifeskills and sexuality education

Lifeskills education is intended to equip learners with the knowledge and skills required to negotiate all situations in life positively and effectively. In the Department of Education's Life Skills and Education Programme: Teacher's Resource Guide, the concept of lifeskills is explained in the following way (Dept of Health 1999a: 72):

14 Article 17.
15 Article 24.
16 Article 29.

> Life skills are essential for successful living and learning. Life skills are a large range of coping abilities people need to be able to function effectively in everyday lives. As we develop skills, we should be able to deal with challenges and problems better and even prevent some problems occurring. Life skills make life easier. The more we practice these skills the greater our abilities become to live successfully and do the best we can. When life skills are achieved, capacity building (the growth and development of people) becomes a reality. Through life skills, people also become empowered.

At a broad level of generality, lifeskills include all skills relevant to all areas of life, including all learning in school, not merely about HIV/AIDS (Rooth 1999). According to Nelson-Jones (1993: 9), lifeskills are ultimately intended to assist people in making "personally responsible choices" to maximise their happiness and fulfilment. The concept is a positive, empowering one which, if successfully inculcated, should enable people to acquire a repertoire of skills in accordance with their developmental tasks and the specific problems and challenges that they face (Nelson-Jones 1993: 10).

In the context of schools, lifeskills education is premised on the belief that the skills for coping with undermining and oppressive situations are not acquired naturally by all children in the course of growing up. Rather, such skills should be taught and practised in class as part of outcomes-based education (Dept of Health 1999a: 64-95). Lifeskills education represents an acknowledgement that children form a vulnerable group and that their vulnerability increases when they are denied the information and skills vital to their survival and development. Girls are more vulnerable than boys because of the prevalence of gender inequality in South Africa. It is girls who bear the burden of teenage pregnancy. In South Africa, 35% of girls under 19 are pregnant (Dept of Health 1998). Girls are also more vulnerable to HIV than boys (Van Rensburg *et al* 2002). Girls are often given no choice about having sex. Poverty, the patriarchal tradition and a general ignorance about sexuality and reproductive rights renders girls vulnerable to unplanned pregnancies and HIV/AIDS (Van Rensburg *et al* 2002). Lifeskills education is empowering and has a role to play in at least mitigating these factors.

Lifeskills education forms part of Life Orientation — one of the eight learning areas in the new curriculum (Dept of Health 1999b:

19).[17] Curriculum 2005 promotes outcomes-based education (Edwards & Louw 1998), which represents a new way of learning and teaching in South African schools. Life Orientation is seen as central to the holistic development of learners. It is intended to nurture not only intellectual growth, but also physical, personal, social, spiritual and emotional growth in the context of a society aspiring towards the values of freedom, democracy, stability, a good quality of life for everyone, and a prosperous economy (Dept of Health 1999a: 22). In this way, Life Orientation underscores the values promoted by the Constitution, including the advancement of human rights and liberties.

Clearly, if lifeskills education is to be efficacious, it must respond to real-life situations. Discrete problems such as drug abuse, rape, sexual exploitation, teenage pregnancy and HIV/AIDS require discrete components within the framework of lifeskills. The intensity of the HIV/AIDS epidemic, in particulary, has given sexuality education special significance and urgency. At the same time, sexuality education engenders controversy when parents, educators and governing bodies seek to ascertain and negotiate the legitimate parameters of engaging learners in sexuality education. Some educators and many parents fear that rather than providing the child with the relevant knowledge and skills required for healthy sexuality, lifeskills will paradoxically rob the child of its innocence and entice it into early sexual activity (Heunis *et al* 2000: 55). It does not help to reassure parents that sexuality education should not be confused with sex education, which is generally associated with value-free, permissive sexual mores. It is thus important to emphasise that the Department of Education draws a distinction between sex education and sexuality education.

Sex education is information about the raw biological facts of being male or female, as well as concerning the act of sexual intercourse. It is devoid of values and norms (Dept of Health 1999b: 69). Sex education is not about teaching the skills essential for developing caring, considerate relationships. Sexuality education, on the other

17 The other seven are: language, literacy and communication; arts and culture; technology; economic and management sciences; natural sciences; human and social sciences; mathematical literacy, mathematics and mathematical sciences.

hand, offers far more than mere information about biological sex characteristics. It is also about the values and skills essential to achieving sexual health and developing caring, considerate relationships (Dept of Health 1999b: 69-70). Sexuality education is about acquiring the necessary skills to make responsible, informed choices about sexual and reproductive matters. According to the Department of Education, sexuality education is not a single event, but a lifelong learning process that starts at birth and is complemented at school as part of one's passage through life. In that learning process, information is acquired and attitudes, beliefs, and values concerning identity, relationships and intimacy are formed. Sexuality education includes the topics of sexual development, reproductive health, body image and gender roles (Dept of Health 1999b: 66).

In terms of aims and objectives, sexuality education draws on the values that underpin lifeskills education in general, but has a particular application to sexuality. The specific aims and objectives of sexuality education involve the following outcomes (Dept of Health 1999b: 70):

- enhancing self-esteem and self-awareness;
- seeing sexuality as a natural and positive part of life;
- acquiring accurate information;
- developing skills needed to make informed, responsible decisions, including those relating to sexual relationships;
- exploring various values and attitudes in order to help each learner develop his/her own moral framework;
- acting in accordance with own values;
- understanding, tolerating, and respecting different sexual needs, orientations and values;
- behaving responsibly and in a caring, respectful way in all relationships;
- protecting oneself from exploitation, and not exploiting others;
- communicating and expressing one's needs and feelings, and
- using health services and being able to access the information one needs.

From the above outcomes, it is apparent that empowerment is a key outcome of Life Orientation. This means that the learner must not simply possess knowledge. Ultimately, he or she must also develop survival and coping skills. The reason why HIV has taken root so strongly is not so much a lack of awareness about unsafe behaviour but that many people are not sufficiently empowered to translate that knowledge into practice. The World Health Organisation's review of programmes on reproductive and sexual health for adolescents has shown that lifeskills education is essential for responsible, safe sexual behaviour. Where such education is of good quality, it helps delay sexual debut (UNAIDS 1998; Heunis *et al* 2000: 55-6).

The question of what discrete sexual values should be taught is a particularly sensitive issue. Learners need to be given guidance about right or wrong. At the same time, lifeskills education is underpinned by a liberal premise. To give sexuality education in a liberal context might appear to be licensing or encouraging permissiveness. Equally, moralistic, judgmental views run the risk of stigmatising those whose sexual mores are unconventional, such as gay men and lesbian women, thus encouraging unfair discrimination. A balance must therefore be struck between distinguishing right from wrong in areas where the choices are stark — such as unambiguously condemning violence, sexual abuse and rape — and allowing tolerance and diversity in areas where society does not have a moral consensus — such as premarital sex, abortion, contraception and homosexuality. After all, lifeskills education recognises heterogeneity and teaches respect for other people's values. The guiding values underlying what is taught should ultimately be a respect for freedom and human dignity, and the advancement of human rights as prescribed by the Constitution.

It appears, however, that some of the guidance on sexuality education that has been given to teachers by the Department of Education is contradictory and in some cases overly judgmental. On the one hand, the Department appears to recognise diversity in sexual mores. On the other hand, it attempts to be prescriptive in respect of certain values. For example, while professing adherence to the Bill of Rights of the Constitution and recognition of homosexuality as a different and acceptable form of sexuality, the Department of Education says that the issue of sexuality education is often sensitive and con-

troversial and should be handled by a teacher with special qualities, who, *inter alia*, has a "healthy heterosexual orientation" (Dept of Health 1999b: 79). It is submitted that this approach contradicts the ethos of lifeskills education. It is apt to send confusing messages to educators. Such a bias towards a heterosexual norm does not sit well with a jurisprudence that unambiguously recognises the right to sexual orientation not only as part of the right to privacy, but perhaps even more significantly, as part of the right to equality and human dignity (De Waal 2001: 216-7; Devenish 1999: 59-61). In *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*,[18] the Constitutional Court held quite categorically that religious or moral views on the wrongness of homosexuality, however sincerely held, cannot outweigh the Constitution's dictates in respect of discrimination on the grounds of sexual orientation. In that case, the Court held that the common law crime of sodomy constituted unfair discrimination under the Constitution. It is important to ensure that sexuality education is not confined to the heterosexual norm to the exclusion of other sexual identities (Ngwena 2002).

It is important to note that there is no uniform standard on sexuality education. Sexuality education is age-specific (Dept of Health 1999a: 81-2). Learners fall into three general phases — the junior primary phase, the senior primary phase, and the secondary phase. The junior primary phase is for children of roughly 6 to 8 years. This group is at a foundational phase and is still discovering and learning about values. Because of their extreme youth, the Department of Education emphasises that no formal sexuality education should be given, with the only exception being in respect of lessons on the prevention of sexual abuse.

The senior primary phase covers children aged roughly 9 to 11 years. This group falls into the pre-pubescent stage of development. There is an awareness of the differences between the sexes but generally very little sexual development. Lessons should teach the stages of human development rather than sexual development or relationships with members of their own and the opposite sex. Sexual abuse and AIDS should also be covered but in a general fashion, as a way of allaying anxieties and warning against unsafe behaviour. Because

18 1999 (1) SA 6 (CC).

girls usually develop faster than boys and some start menstruation early, a discussion on menstruation with girls in this age group is recommended.

The secondary phase is for learners at the adolescent stage (±12-18 years). All themes relating to sexuality education, including puberty, adolescence, heterosexuality, homosexuality, family planning, teenage pregnancy and abortion, should be discussed. In respect of sensitive topics, it is recommended that boys and girls be taught separately, not least because this encourages learners to ask questions without undue embarrassment.

To accommodate the age differentials of learners, the Department of Education, in conjunction with the Department of Health, has prepared lifeskills teacher guidance manuals tailored to the needs of each grade.

3. Negotiating the boundaries between educators' autonomy, the evolving capacities of the learner and parental authority

It is true that sexuality education, when given in the context of lifeskills education, might appear to impinge on the legitimate rights and responsibilities of parents to give moral guidance to their children. After all, parents are the primary care-givers. Educators might seem to be usurping the prerogative of parents or contradicting the moral and religious teachings of parents if they start discussing HIV/AIDS and sexuality. However, while parents do have the primary responsibility for equipping young people to respond more healthily and positively to HIV/AIDS, they have not succeeded on their own in imparting to children the kind of information, as well the type and range of skills that are essential for building a successful armoury against the epidemic. Most young people learn about HIV/AIDS from the mass media, and the majority learn about sex from friends (Save the Children 2002a: 20). For the majority of families in South Africa, talking about sexuality remains taboo. Religious leaders and churches have not fared any better. On account of cultural conservatism and religious moralism, respectively, parents and churches have both remained largely silent in respect of educating children and

young people about sexuality, reproductive health and relationships. Consequently, the task of equipping children against the epidemic has shifted from the home to the school as well as to other social institutions such as youth centres (Heunis 1999; Heunis *et al* 2000).

The Committee on the Rights of the Child, the body charged with monitoring compliance with the CRC, has observed that children do not often receive from social institutions such as the home the educative information required to protect them from a number of health risks, including HIV/AIDS. This is what the Committee said in respect of Armenia in connection with the right to health under the Convention (Committee on the Rights of the Child 2000):

> With regard to adolescent health, the Committee is concerned at the high and increasing rate of teenage pregnancies, and the consequent abortions among girls under 18, especially illegal abortions; the rise of STDs, and the spread of HIV. Although parents play the most important role in this regard, nevertheless cultural attitudes, and lack of personal knowledge and communication skills on the part of parents are barriers to accurate reproductive health information and counselling.
>
> The Committee recommends that the State party undertake a comprehensive study on the nature and extent of adolescent health problems, to be used as a basis for formulating adolescent health policies. In the light of article 24, the Committee recommends that adolescents have access to and be provided with reproductive health education and child-friendly counselling and rehabilitation services.

While the views of parents on sexuality education should be established and every effort made to accommodate their wishes and aspirations as the primary care-givers, they should not be given the power of veto. From the standpoint of international human rights jurisprudence, parental authority is not an absolute right (Cook & Dickens 2000: 15-6). Parents are best regarded not so much as bearers of legal rights *vis-à-vis* their children, but as bearers of responsibilities. Any rights that parents have *vis-à-vis* their children are for the purposes of facilitating the discharge of parental duties (Ngwena 1996: 141-3). It is thus incumbent upon parents to regard children not as infants under their absolute authority, but rather as persons with evolving capacities, as indeed is recognised by the CRC.[19]

19 Article 5.

In respect of adolescents, in particular, lifeskills education must take cognisance of the fact that such learners are moving from childhood towards physical, psychological and social maturity. Adolescence is a phase of curiosity and experimentation (Maart 2000: 145). It provides a key opportunity for inculcating lifeskills. In the area of sexuality, many adolescent children are capable of expressing their own views and preferences if they have sufficient information and education (Cook & Dickens 2000: 17). The CRC requires that their views and preferences be given due weight according to their age and maturity. Depending on the physical and intellectual development of a child, it may be appropriate or even mandatory to involve him or her in decision-making about his or her own health (Cook & Dickens 2000: 17). Parents are not entitled to exclusive authority over the moral guidance given to their children. Other legitimate social institutions, in particular schools, also exercise legitimate authority over children, not least because they are under a positive legal obligation to provide children with the necessary knowledge and skills for survival and development.

Cook & Dickens (2000: 18) are correct in observing that when the state routinely aligns itself with parental interests, it may fail to give due regard to the evolving capacities of adolescents. While parental authority must be respected, it must, according to article 5 of the Convention on the Rights of the Child, be exerted in a manner consistent with the evolving capacities of the child (Detrick 1999: 115-24). Deferring to parental authority as a matter of course may discount the wishes of adolescents. While schools may feel inhibited about conducting sexuality education for fear of affronting parental sensibilities, children will be the major losers since the belief that parents will educate children about sexuality in their homes is frequently unwarranted. Regardless of dependence on parents or guardians, children possess constitutional rights. In the light of the magnitude of the HIV/AIDS epidemic, providing sexuality education in schools should be seen as an integral part of complying with the right to health care services, as well as with the right to life and to education. The Constitution provides unambiguously that the child's best interests are of paramount importance in every matter concerning a child. The interests of learners will be ill served if schools keep them

insulated from the knowledge and skills required to avoid a life-threatening disease (Tarantola & Gruskin 1998).

The solution is not to avoid talking about sexuality, but rather to ensure that the curriculum is conveyed in an objective, critical and pluralistic manner. The aim should not be to indoctrinate or to convey disrespect for parental religious and philosophical convictions. Rather it must be to impart the information essential for the protection and health of learners in the knowledge that parents, religious leaders and healthcare practitioners may lack the capacity or inclination to discuss sexuality and sexual matters. Moreover, sexuality education should be rendered in an environment that accommodates conscientious objection. Conscientious objectors should be allowed, for example, to refuse to participate in a class where there is an explicit display or demonstration of condoms. Conscientious objection should not, however, be exercised in a manner that would deny the learner the opportunity to acquire the information and skills necessary for survival and development. The magnitude of the HIV/AIDS in South Africa is such that protecting the health and lives of learners should take precedence over moralism, religious or otherwise. Thus the case for compulsory sexuality education is justified by the magnitude and the life-threatening nature of the epidemic.

The Department of Education is aware that parents are often suspicious and even hostile towards sexuality education. To allay parental concerns, it has recommended that schools should familiarise parents and other interest groups with the content of sexuality education lessons. In this connection the Department of Health has, for example, produced Ubungani: a Parent Guide for Life Skills, Sexuality and HIV/AIDS Education (Dept of Health 2000b). Such an approach fosters dialogue and trust rather than confrontation and suspicion between parents and schools.

4. Conclusion

The implementation of lifeskills education has been underway since 1997 (Save the Children 2002a:45). Teachers are being trained to facilitate such education. Vast quantities of materials tailored to the needs of teachers, learners and parents have been produced and dis-

tributed throughout the country. However, the efficacy of current lifeskills education will only become known once the various provinces have carried out independent evaluations of their programmes. In the meantime, however, tentative evidence suggests that despite the increasing numbers of trained teachers, lifeskills education has yet to be fully and successfully implemented. A number of factors beset its operation (Adler & Qulo 1999: 307; Save the Children 2002a: 46). Moral conservatism and discomfiture with sexuality education on the part of educators have been identified as barriers to effective lifeskills education (Adler & Qulo 1999: 307). The onus is on the Department of Education and on individual schools to overcome the obstacles and make a meaningful contribution to combating HIV/AIDS. It may well be that sexuality-based lifeskills courses need to be mainstreamed if they are to have any discernable impact on the epidemic.

The success of lifeskills education will depend, in part, on striking an acceptable balance between the duty of the school to impart the knowledge and skills essential for development and survival, the evolving capacity of the learner, and parental authority. In any event, on account of the Constitution, the impetus is towards an education in which the core values of human dignity, equality and liberty are protected and promoted. In the face of the current HIV/AIDS epidemic it is essential that schools take seriously the challenge of imparting human rights knowledge and skills.

If successfully implemented, Life Orientation should enhance the practice of positive values, attitudes, behaviour and skills both by the learner and in the community. It should also succeed in complementing the transformation of society in the interests of promoting the human rights culture inscribed in the Constitution. The core values of freedom, human dignity and the advancement of human rights, as promoted by the Constitution, must be the implicit benchmarks informing Life Orientation in respect of HIV/AIDS.

Bibliography

ABT ASSOCIATES

2001. *Impending catastrophe revisited: an update on the HIV/AIDS epidemic in South Africa*. Johannesburg: LoveLife.

ADLER G & QULO

1999. HIV/AIDS and STDs. *South African Health Review*. Durban: Health Systems Trust: 301-14.

COMMITTEE ON THE RIGHTS OF THE CHILD

2000. Concluding observations of the Committee on the Rights of the Child: Armenia 24/02/2000, CRC/C/15/Add.119, paras 38-39. Stanchieri *et al* 2000: 178.

COOK R & B M DICKENS

2000. Recognizing adolescents' 'evolving capacities' to exercise choice in reproductive health care. *International Journal of Gynaecology & Obstetrics* 70: 13-21.

DE WAAL J, I CURRIE & G ERASMUS

2001. *The Bill of Rights handbook*. Lansdowne: Juta.

DEPARTMENT OF EDUCATION

1999. *National policy on HIV/AIDS, for learners and educators in public schools, and students and educators in further education and training institutions*. Pretoria: Department of Education.

DEPARTMENT OF HEALTH

1998. *South African demographic health survey*. Pretoria: Department of Health.

1999a. *Lifeskills and HIV/AIDS education programme. Teacher's resource manual Grade 1-7*. Pretoria: Department of Health.

1999b. *Lions-quest. Lifeskills and HIV/AIDS education programme. Teacher's resource guide Grades 8 & 9*. Pretoria: Department of Health.

2000a. *HIV/AIDS STD strategic plan for South Africa*. Pretoria: Department of Health.

2000b. *Ubungani: a parental guide for lifeskills, sexuality and HIV/AIDS education*. Pretoria: Department of Education.

2002. *National HIV and syphilis sero-prevalence survey of women attending public antenatal clinics in South Africa 2001*. Pretoria: Department of Health.

DETRICK S

1999. *A commentary on the United Nations Convention on the Rights of the Child*. The Hague: Marthinus Nijhoff.

DEVENISH G E

1999. *A commentary on the South Africa Bill of Rights*. Durban: Butterworths.

DICKSON-TETTEH K & S LADHA
2000. Youth health. *South African Health Review* 2000. Durban: Health Systems Trust: 393-409.

EDWARDS D N & C D LOUW
1998. *Outcomes-based sexuality education*. Pretoria: Kagiso.

FLOYD L
1997. HIV/AIDS. *South African Health Review* 1997. Durban: Health Systems Trust: 187-202.

FRANSMAN D & V KASNER
1995. *Lovelife facilitator's manual*. Cape Town: Old Mutual, Edutech.

GRIMWOOD A, M CREWE & D BETTERIDGE
2000. HIV/AIDS — current issues. *South African Health Review* 2000. Durban: Health Systems Trust: 287-99.

HEUNIS C
1999. *Combating HIV/AIDS amongst youth in South Africa: a youth multi-function centre for Thabong/Welkom in the Free State Province*. Bloemfontein: Centre for Health Systems Research & Development.

HEUNIS C, H C J VAN RENSBURG & C NGWENA
2000. A 'Youth Multi-function Centre' in the Free State: an alternative to clinic-based HIV/AIDS prevention and care. *Curationis* 23(4): 54-62.

KEIGHTLY R (ed)
1996. *Children's rights*. Kenwyn: Juta.

KENYON C, M HEYWOOD M & S CONWAY
2001. Mainstreaming HIV/AIDS: progress and challenges. *South African Health Review*. Durban: Health Systems Trust: 161-83.

MAART B
2000. Risky business: issues affecting adolescent sexual health in South Africa. *Development Update* 3(2): 144-59.

MEDICAL RESEARCH COUNCIL
2001. *The impact of HIV/AIDS on adult mortality in South Africa*. Cape Town: Medical Research Council.

NELSON-JONES R
1993. *Lifeskills helping*. Pacific Grover, California: Brooks/Cole Publishing Company.

NGWENA C
1996. Health care decision-making and the competent minor. *Acta Juridica* 1996: 132-47 (reproduced in Keightly (ed) 1996: 132-47).

2002. Sexuality rights as human rights in Southern Africa with particular reference to South Africa. *South African Public Law* 17(1): 1-21.

ROOTH E
1999. *Introduction of lifeskills. Hands-on approaches to lifeskills education*. Cape Town: Via Afrika.

SAVE THE CHILDREN
2002a. *Pathways to action*. Pretoria: Save the Children.

2002b. *The role of stigma and discrimination in increasing the vulnerability of children and youth infected and affected by HIV/AIDS*. Pretoria: Save the Children.

SOUTH AFRICAN LAW COMMISSION
1998. Third interim report on aspects of the law relating to AIDS: HIV/AIDS and discrimination in schools. Pretoria: South African Law Commission.

STANCHIERI J, I MERALI & R J COOK
2000. *The application of human rights to reproductive and sexual health: a compilation of the work of international human rights treaty bodies*. Ottawa: Action Canada for Population Development.

TARANTOLA D & S GRUSKIN
1998. Children confronting HIV/AIDS: charting the confluence of rights and health. *Health and Human Rights* 3(1): 60-86.

UNAIDS
1998. Word AIDS Campaign with young people. <http://www.unaids.org.highband/events/wad/1998/force.html>

2000. *UNAIDS report on the global HIV/AIDS epidemic*. Geneva: UNAIDS.

VAN RENSBURG H C J, L FRIEDMAN, C NGWENA, A PELSER, F STEYN, F BOOYSEN & E ADENDORFF
2002. *Strengthening local government and civic responses to the HIV/AIDS epidemic in South Africa*. Bloemfontein: Centre for Health Systems Research & Development.