# NSP REVIEW

Engaging with South Africa's National Strategic Plan for HIV, STIs and TB | Edition 6 | May 2013 – June 2013

A publication of the Treatment Action Campaign and SECTION27

## HELPING TEENS FIGHT HIV

How we fail the young: No justice for abused learners

What's really happening? Sexual behaviour and HIV risk in South African youth

Integrated School Health Programme in focus: Expert analysis of SA's health plan for schools

Upping the competition: South Africa's ARV tender unpacked

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*Photo by Roulé le Roux*

This is the sixth issue of NSP Review. We aim to provide quality analysis and monitoring of the implementation of the current NSP. It is our hope that this publication will increase awareness of, and critical engagement with the NSP. We will try to keep it relevant with evidence from new research and feedback from the various district offices of the Treatment Action Campaign as well as organisations with which we work closely. Our vision is a vibrant, evidence-based publication that will help all stakeholders drive a more successful response to HIV, STIs and TB. We encourage you to get in touch with us should you want to contribute to future editions of NSP Review. You can e-mail the editor at nsp@tac.org.za.

## NSP Review is online at www.nspreview.org


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# EDITORIAL

## Set bold targets to reduce new HIV infections and teenage pregnancies and to increase condom use

In this issue of the NSP Review we focus on young people and the NSP. We do this because statistics show us that children of schoolgoing age, young girls in particular, have a high vulnerability to HIV infection. Furthermore, alarming rates of teenage pregnancy show that many young people are sexually active – and that many of them are not heeding messages about practising safer sex or abstaining from sexual intercourse altogether.

The National Strategic Plan (NSP) for HIV, STIs and TB 2012-2016 and the South African National AIDS Council (SANAC) have prioritised young people as a key population to reach with effective HIV prevention programmes. But one of the weaknesses of the NSP is that it proposes too many 'priorities' and consequently lacks focus. We think a way to overcome this is for SANAC to select and lead a small number of school-based campaigns that can really make a difference.

We believe that SANAC and the government should take advantage of key policies now in place that would strengthen such campaigns. For example, the Department of Basic Education (DBE) has finalised its updated policy on HIV prevention in schools. And, in a joint effort, the Minister of Health and the DBE have launched the Integrated School Health Programme (ISHP), which we report on in this magazine.
The other advantage of a school-based approach is that, as with workplaces, learners are a captive audience when they are at school. There are 24,365 schools in South Africa and each one has systems that make it possible to reach and teach learners about HIV, sexuality, and safe sexual relationships.

This is why we are calling for a schools campaign similar to the HIV Counselling and Testing (HCT) campaign; one with political commitment, resources and monitoring.

The HCT campaign showed what results can be achieved when we focus our efforts and resources.

But for such a campaign to succeed SANAC and the government must end their hesitation about speaking out and implementing some of the critical interventions we need, in particular:

Condoms in schools: As we report in this issue the KwaZulu-Natal provincial government has taken the lead with this, but they must be followed by every other province. Adolescents are having sex. They have a right to safer sex. Providing condoms does not mean encouraging sex and it is not a standalone intervention. It must be accompanied by appropriate sex education

Clear sex and sexuality education: Sex and sexuality are biological and emotional facts for all of us. It starts with puberty. If we stay silent about the realities of our bodies, about dignity and diversity in sexual relations, then we run a greater risk of children being misinformed about sex, or even abused.

Sex education would also empower boys and girls to help bring an end to the sexual abuse of female learners by teachers and by other students. Such abuse often occurs because of silence and confusion about sex. Let's speak out and punish sexual abuse in our schools.

If we could improve knowledge and power among school children we would make a difference to the HIV epidemic. The incidence of HIV would fall; but so too would teenage pregnancy, sexism and sexual abuse. In addition, we would create a generation of schoolchildren who are knowledgeable about HIV and who would carry this awareness into adulthood.

We therefore call on SANAC, the Department of Health and the DBE to convene a national planning meeting of school governing bodies, teaching unions and learner organisations to plan this campaign.

Now is the time!

Mark Heywood, Executive Director, SECTION27

*High school students attend a DramAidE forum theatre performance at a high school in KwaZulu-Natal. Photo by Patrick Coleman, courtesy of Photoshare.*

# BETTER SEX EDUCATION
## KEY TO MEETING NSP TARGETS

By Muhammad Zakaria Suleman

Among the core indicators of the impact of the National Strategic Plan are the percentage of young women and men aged between 15-24 years who are HIV-positive, and changes in the stigma attached to HIV, STIs and TB.

Strategic Objective 1 of the National Strategic Plan (NSP) aims to reduce the impact of HIV, TB and STIs on young people. It also seeks to lessen their vulnerability to HIV by retaining them in schools, increasing their access to tertiary education and improving their work opportunities. In the process, it looks to reduce the stigma surrounding HIV, TB and STIs.

Strategic Objective 2 (SO2) focuses on a mix of biomedical, behavioural, social and structural interventions that would help lower the rate of these infections. Key sub-objectives of SO2 include maximising opportunities for testing and screening as well as increasing access to sexual and reproductive health services for young people. These health services include the provision of male and female condoms and other contraceptives.



Muhammad Zakaria Suleman is a student of law and social justice and a SECTION27 fellow.

The NSP targets a 50% reduction in TB and HIV incidence and also seeks to halve the level of stigmatisation attached to these infections. South Africa can only achieve these goals if we have effective sex education in schools. Thus, the NSP recommends interventions that would help to delay sexual debut, sustain protective behaviour such as the use of condoms, and reduce the number of sexual relationships with older partners. The plan also backs informing young people through methods such as sex education in order to lessen their exposure to infection.

Since the NSP is not a strategy of the Department of Health, it must be funded locally by government and more resources need to be made available at the level of implementation in order to execute the NSP. Each sector, both government and civil society, should have its own monitoring and evaluation (M&E) mechanism. However, the South African National AIDS Council (SANAC) – responsible for implementing the NSP – has developed a strengthened M&E unit within its secretariat for monitoring progress nationally on issues relating to HIV, TB and STIs. Provincial AIDS councils must be developed further to carry out the equivalent role at a provincial level. This would ensure that continuous feedback and accurate information are available to SANAC.

Sex education is often misrepresented as an attempt to promote sexual activity. In fact, evidence shows that it has the opposite effect (see page 18). Sex education programmes aim to create awareness about sex and to empower young people to make informed decisions.

Sex education in schools can be a useful tool for monitoring key NSP indicators provided there is a well-developed programme in place. The programme needs to be carried out in a sensitive, non-judgmental way. It must be open and honest, taking social and cultural backgrounds into consideration. Different forms of contraceptives and their appropriate use should be discussed. However, any on-site provision of condoms requires consent from each school governing body. What is most important is to hire an educator that students find approachable and whose advice they are likely to seek out. It can also create awareness among young people about the role that they can play in achieving South Africa's NSP goals.

## A useful strategy

The Department of Basic Education (DBE) and Department of Health collaborated to develop the Integrated School Health Programme (ISHP), which should prove a useful strategy for realising the goals of the NSP.

One of the objectives of the ISHP is to improve the general health of school-age children. It provides health screening, on-site services and health education to learners in Grades R, 1, 4, 8 and 10, and is undergoing a phased introduction to schools.

In lower grades the ISHP promotes preventive health strategies, aiming to build awareness and break down stigma surrounding infection. Tuberculosis, male circumcision and substance abuse are among the initial areas that the programme covers with younger learners in grades R, 1 and 4.

In grades 8 and 10 sex education is introduced, addressing topics such as teenage pregnancy, HIV, contraceptives and ways to reduce stigma. On-site services for upper grades offer male and female condoms and leaflets about contraceptive use. Students are also taught about treatment for HIV, TB and STIs. Although the ISHP only focuses on students in certain grades, it is important to sustain the health education of students over their entire school career.

### Pregnancy and dropping out of school

In 2008, 49,599 South African school students between Grade 3 and Grade 12 fell pregnant. The highest rate was among learners in Grades 10 and 11. In 2011, the HIV prevalence among antenatal women between the ages of 15 and 19 was 12.7% compared to 14% in 2010.

School drop-out rates mushroom as learners reach higher grades. Teenage pregnancy is one of the main causes of this problem. The Department of Education has indicated that drop-out rates climb from 1% in grade 1 to an alarming 11.8% in grade 11.

## Lowering drop-out rates

Implementing strategies like the ISHP, which would improve sex education in schools, will help to achieve the goals of the NSP. Studies show that access to such education reduces the pregnancy rate among schoolgoers. Drop-out and pregnancy rates are closely linked (see box), with research showing that only a third of learners return to school after a pregnancy. Young people who drop out of school are more vulnerable to the risk of HIV, TB and STIs, and to living in circumstances that cause stigma and stereotypes to flourish.

By reaching young people from an early age, a sound education programme could minimise such problems and make it possible to control the spread of disease. The incidence of HIV could be stabilised, and curable diseases like TB and STIs gradually eradicated. However, in order to realise these goals and meet the targets of the current NSP, government needs to acknowledge the crucial role that a well-structured sex education can play in the lives of South African youth.

Integrated School Health Programme; Soul Buddyz Club Evaluation: Longitudinal Research Study; '28% of school girls are HIV Positive', Sowetan Live, http://www.sowetanlive.co.za/news/2013/03/12/28-of-schoolgirls-are-hiv-positive?service=print ; Integrated School Health Programme Resource Manual available at http://www.education.gov.za/LinkClick.aspx?fileticket=kN%2FI2VVGCG4%3D&tabid=667 ; Department of Basic Education, 'Teenage Pregnancy in South Africa – with a specific focus on school-going learners'; The 2011 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa. Available at http://www.health-e.org.za/documents/f0980fb5107a7ce543a8bd5730e52333.pdf

Criticism of a high court judgment decriminalising sex between children aged 12 to 16 is misplaced

*High school students attend a DramAidE forum theatre performance at a high school in KwaZulu- Natal. Photo by Patrick Coleman, courtesy of Photoshare.*

# SHOULD SEX BETWEEN CHILDREN UNDER 16 BE UNLAWFUL?

By Mark Heywood

Adolescence is a biological fact; not one of us escapes it on the way to adulthood. And since it is largely defined as the time when our sexuality awakens and we come to terms with it, shouldn't we be making more of an effort to help children understand their sexuality – especially now that South Africa has decriminalised adolescent sexual activity?

In a judgment handed down in January 2013 the North Gauteng High Court found aspects of the Criminal Law Sexual Offences and Related Matters Amendment Act to be unconstitutional. It found that this law, which criminalised consensual sexual activity between children from the ages of 12 to 16, violated their rights. Criminalisation of natural sexual behaviour is often a barrier that prevents people from accesing health care services, particularly when it comes to HIV. On 30 May the Constitutional Court will hear argument about whether the High Court's judgment was correct. Surprisingly, the government is opposing the January judgment.

In the public furore that followed the ruling, assorted moral tyrants, punitive parents, pastors and priests, plus a variety of self-appointed guardians of children's sexuality, joined the debate to lambast the judgment in the interests of protecting morals and preventing what they described as 'the problem' of sex. Objectivity in the debate was not aided by irresponsible sensationalism in the media, where some headlines screamed "Kids can Bonk" and "Green Light for Child Sex".

## Expert evidence

Many commentators failed to acknowledge that the court judgment does not encourage or 'allow' sex, but merely

decriminalises it. It is even more unlikely that critics of the judgment were aware of the intricate expert evidence the court had considered in reaching its decision, or the arguments brought by responsible children's rights organisations as to why the Act was causing vulnerability and harm.

But before we go there, let's start at the beginning.

Puberty is a part of human biology. Nobody escapes it. It is defined in the dictionary as the period of a person's sexual awakening, the period in which their body develops to allow reproduction. But puberty is not just a biological process that ripens the body. It is an emotional and mental process, too. It is the time when children begin to feel sexual desires and, naturally, to act on them. How many honest readers, I wonder, do not still recall the intensity of their first adolescent fumblings, encounters with sex and first love?

## Legal marker

Puberty is also a legal marker recognised in almost every jurisdiction in the world. In South African law puberty dates from the age of 12 for girls and 14 for boys. Theoretically it is the point at which a child may get married, albeit at this early age only with the permission of the Minister of Justice and Constitutional Development.

At this age, according to the Children's Act, boys and girls over 12 may request HIV testing, without parental knowledge if they choose. They may also access condoms.

However, the effect of the Sexual Offences Act was to try to prohibit puberty and threaten to punish it. A law prohibiting normal human biology! Could anything be more absurd? It is as impossible and unworkable as the apartheid-era Immorality Act.

But in addition to attempting the impossible, the Act had a number of seriously negative consequences for children. Notably, it required that health workers report child 'offenders' to the police. This placed health workers in the invidious position of being unable to assist the HIV testing and counselling of teenagers, or provide them with advice on sex and sexuality, without reporting them to the police – or breaking the law if they did not.

Further, if teenagers knew that they might be reported to the police for seeking HIV testing, counselling or condoms, then it was highly unlikely that they would access essential health services – increasing their risk of pregnancy or HIV.

The argument made by some moralising critics is that if sex is allowed amongst adolescents we will have an orgy, a free-for-all, and the state will fail in its duty of moral protection.

They are right in one respect: there is a crisis around sex among young South Africans.

Teenage pregnancy does not occur because there is too much information or encouragement of sex. It occurs because young people are not being informed and advised about sex and love in a sensible, non-judgmental way.

In 2009 there were 45,276 pregnancies recorded in our schools, including 109 of girls in grade 3 (i.e. as young as eight years old) and 11,116 in grade 10 (about 16 years old). The incidence of HIV amongst girls under 18 is six times as high as for boys of the same age. And, as reported by an official of the Gauteng Health Department last year, there is extensive evidence of an increase in forms of pornography and sexual abuse amongst teenagers.

But the moralising critics are wrong in how they understand this, because silence and suppression are precisely the ingredients that have created the crisis. The existing law clearly has not stopped sex. It has just encouraged denial - and by doing so created a space for adolescent confusion and a variety of sexual abusers.

Teenage pregnancy, clearly an expression of teenage sexuality, does not occur because there is too much information or encouragement of sex. It occurs because young people are not being informed and advised about sex and love in a sensible and non-judgmental way.

For example, in a discussion SECTION27 held with Barbara Creecy, the MEC for Basic Education in Gauteng, she pointed out that whilst the government makes condoms widely available to assist our fight against HIV we don't put similar effort into helping children to understand the emotions and feelings that drive sexuality. We don't help adolescents to distinguish abuse from love; consent from exploitation; rape from sex. It is a good idea to encourage young people to delay the first time they have sexual intercourse or to take steps to avoid unwanted pregnancy, but we cannot do this by silence, moral battery or harking back to a world that never existed.

The way to address the crisis our country faces around sex, teenage pregnancy, and sexually transmitted diseases including HIV is to find responsible ways to talk about sex, not to try to suppress it. Knee-jerk moralising critics must move aside. To talk openly and responsibly about sex in our homes and schools is not to encourage it, but to allow adolescents the information and space they need to make their own decisions, understand what is right and wrong, and prepare to be self-respecting and respectful adults.

# HOW WE FAIL YOUNG WOMEN

Structural faults hamper justice for many victims of sexual abuse in schools

By Nikki Stein and Nthabi Pooe

*Photo courtesy of the WHO/Tom Pietrasik*

SECTION27 and Lawyers Against Abuse are supporting children who have suffered sexual abuse by their teachers. Here, members of the SECTION27 legal team describe two students' long struggle for justice.

Schools are critical sites for HIV prevention, and are identified as such by the National Strategic Plan for HIV, STIs and TB 2012 – 2016. In particular, eradicating sexual abuse of girl learners is a priority. However, there remain many barriers to doing this effectively.

In a report published by Human Rights Watch titled 'Scared at School: Sexual violence against girls in South African schools', it was reported that "on a daily basis in schools across the nation, South African girls of every race and economic class encounter sexual violence and harassment in class and at school, which impedes their realisation of the right to basic education". The report was published on 1 March 2001, calling on the South African government to take urgent steps in response to sexual violence against female students.

The problem, however, remains severe and widespread and the solutions wholly inadequate.

SECTION27 and its partner organisation Lawyers Against Abuse are responding to specific cases of sexual violence in schools. The two cases below illustrate shortcomings in the way that government bodies currently deal with such abuse, and the lack of political will that seems to exist both in teaching unions and the DBE to overcome this challenge.

On a daily basis South African girls of every race and economic class encounter sexual violence and harassment in school.

# CASE 1: NTOMBI*

## Raped by her teacher and failed by the police.

Ntombi (not her real name) is a primary school learner. She was 12 years old when her teacher threatened her at knifepoint, kidnapped her, and then drugged and brutally raped her.

Soon after the attack, Ntombi reported the rape to at least two teachers and to the school principal. They tried to influence her not to pursue the case, because "the accused teacher has lawyers and she would never succeed". These teachers had an obligation under the Children's Act 38 of 2005 and the Criminal Law (Sexual Offences and Related Matters) Act 32 of 2007 to report the abuse rather than to convince Ntombi to keep quiet.

Although the case was reported to the provincial Department of Education (DoE), the local teaching staff continued to coax Ntombi to withdraw her complaint and forgive her teacher. This conduct was in breach of Ntombi's rights and their obligations.

Ntombi's parents reported the rape to the police six weeks after it occurred. Police took the child to hospital for a medical examination. It revealed evidence of penetration, corroborating her report. Ntombi was also showing classic signs of post-traumatic stress disorder such as fainting, depression, withdrawal from family and friends, insomnia and flashbacks. She ran away from home three times and her academic performance became severely affected.

### Case closed

Three months later the police investigation was closed, citing the refusal of school officials to talk to the police plus the fact that Ntombi was not pregnant. No steps were taken to compel the school to provide information that might support the investigation. Nor was any recognition given to the fact that despite not being pregnant, Ntombi had nonetheless been brutally raped by the very person who should have been looking after her.

The DoE investigation also ceased without apparent reason. Even the DoE itself could not trace the investigating officer who had been appointed to gather evidence.

To make matters worse Ntombi was now being threatened by the accused teacher in an attempt to make her drop the case. The accused also harassed Ntombi's mother whenever she went to the school.

Around this time, an activist from the Treatment Action Campaign (TAC) who had assisted SECTION 27 with the case was threatened at gunpoint as well. There is reason to believe that this incident was related to Ntombi's case.

## Protection order

SECTION 27 was therefore forced to apply for a protection order for Ntombi and her family to safeguard them from harassment. We also applied for a peace letter for the TAC activist.

The process of obtaining a protection order is ordinarily simple enough to be done without lawyers. In Ntombi's case it took six lawyers and legal arguments by an advocate for the protection order to be granted. This was due to the fact that a relationship between a school student and a teacher is not legally considered a "domestic relationship" as defined in the Domestic Violence Act 116 of 1998. Therefore a protection order under this Act could not be readily obtained.

## Fresh trauma

During the process of applying for the protection order, Ntombi was forced to face her rapist. On numerous occasions she even had to sit in the same room as him. Her mother was required to give formal evidence and cross-examined so that the magistrate could decide whether to grant the order. This created almost unbearable trauma for Ntombi and her mother.

After a full day's argument by Ntombi's advocate, the magistrate extended the definition of a domestic relationship to include that of a teacher-learner relationship, on the basis that teachers step into the shoes of parents in terms of looking after learners at school. He therefore granted Ntombi and her mother a protection order.

This was a small victory for Ntombi, but a big victory for young students across South Africa. Theoretically, at least, school students now have greater protection from abuse by their teachers. However, it also highlights a very basic challenge for access to justice: how many learners who seek protection orders have access to legal teams of this size, if at all?

## New legal protection

In future cases, SECTION 27 will be able to use the enacted Protection from Harassment Act 17 of 2011. This act is even simpler than the Domestic Violence Act; it provides for broader protection and does not depend on the existence of a domestic relationship. However, because the regulations have not yet been promulgated, protection by this Act is not yet available. At the time of writing this article, there is no indication as to when the regulations will be finalised.

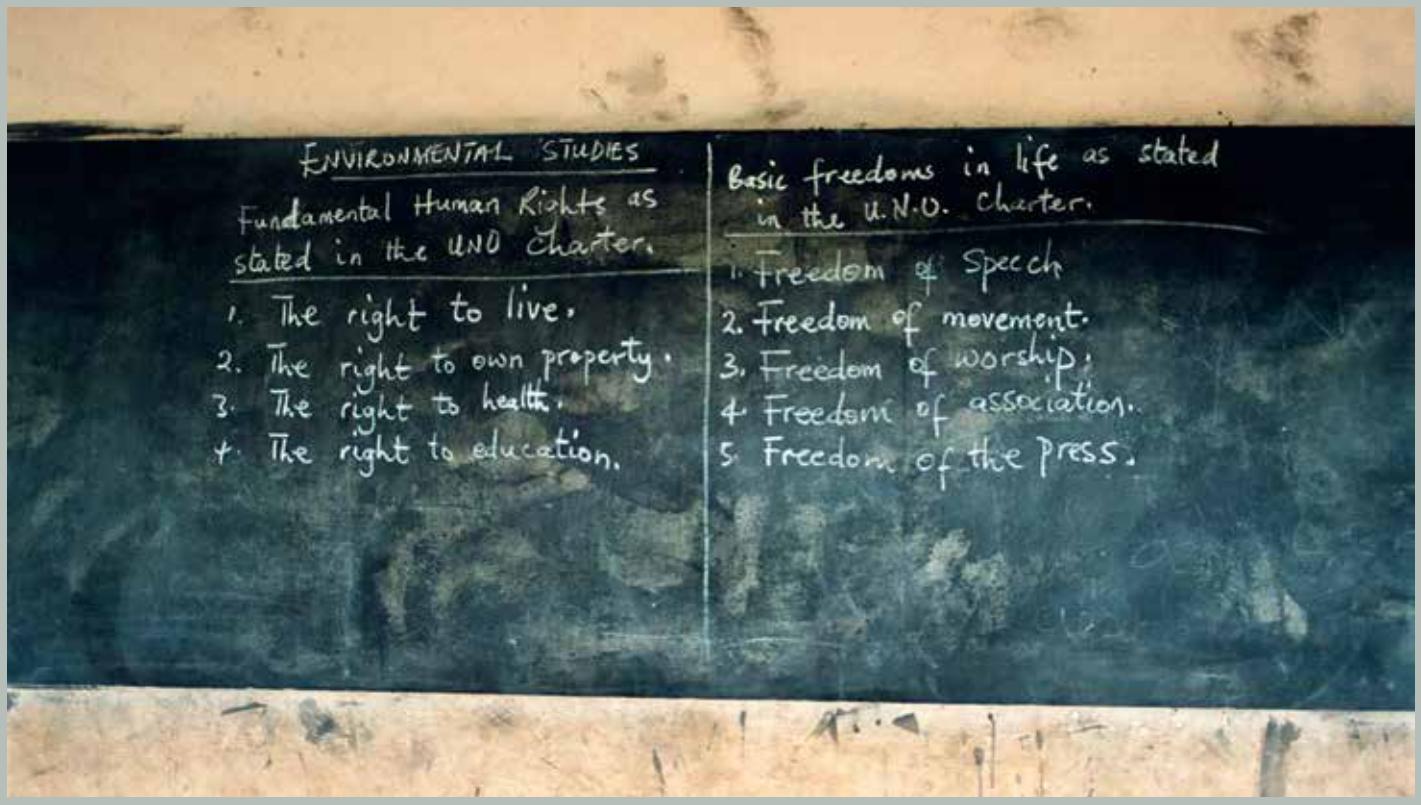
Having secured a protection order for Ntombi and her mother, we proceeded to find out what had happened with the DoE investigation. The investigating officer could not be traced and therefore the DoE was obliged to appoint a new person who began the investigation afresh. Ntombi had no choice but to give another statement to the new officer because her original statement could not be found.

We asked that the accused teacher be placed on precautionary suspension during the investigation. This is a statutory obligation on the DoE, which arises when there are charges are of a serious nature and/or there is a threat of interference with the investigation.

The DoE had, however, not taken steps to suspend the accused teacher pending the outcome of his disciplinary hearing. They agreed to do so only when we pointed out their legal obligations. The investigation was finally completed after a further five months, and a date for the disciplinary hearing was set for the accused.

## Evidence in camera

At the disciplinary hearing Ntombi was allowed to give evidence in camera through an intermediary in a separate room. Following technical difficulties with the equipment used, Ntombi's rapist and his union representative walked into the intermediary room unannounced to confirm that it was in fact Ntombi giving evidence against him. That afternoon Ntombi collapsed and was hospitalised for extreme stress.




*A blackboard at the Odumase DC School in Ghana lists the "Fundamental Human Rights". Children's rights are now high on the education agenda in Ghana. Photo by Ingrid Hesling, courtesy of Photoshare.*

On conclusion of the disciplinary hearing, the presiding officer found in favour of the accused. He found that Ntombi's case lacked credibility because she had not reported the rape immediately after it happened. This finding is incompatible with the law which states that a negative inference cannot be drawn from the length of time it takes for a complainant to report a case.

Ntombi was also unable to answer some of the questions put to her after she had seen her teacher in the intermediary room, and was very emotional while giving her testimony. The presiding officer noted that the accused teacher was calm and collected during his testimony, making his version of events appear more plausible.

We have since requested that the matter be taken on appeal to the MEC for Education. SECTION 27 has made legal submissions on aspects of the case. These include the psychosocial effects of sexual violence and the legal ban on drawing inferences from delays in reporting cases. Eight months later, Ntombi is still awaiting the outcome of the appeal.

We continued to trace the police investigation and met with the prosecutor to try to understand why the case had been closed. The prosecutor said that from the docket it was clear that the investigating officer had been reluctant to investigate the matter. This foot-dragging had produced a poor investigation and insufficient evidence for a successful prosecution. The prosecutor ordered that the investigation be continued thoroughly and assured Ntombi that this would now be carried out. It did not happen.

Since the case first began there have been four different investigating officers. Each has begun the investigation afresh and collected new statements from Ntombi and her mother, adding to the ongoing trauma experienced by Ntombi and her family.

The current investigating officer has tried to convince Ntombi to withdraw the case. Due to the interruptions and staff changes, her docket remains in chaos. We do not know if or when a criminal case will be brought against the accused teacher.

Ntombi has moved to a new school in an effort to put the trauma of the rape behind her. She now receives counselling and has a volunteer to help her with academic work. However, until the cases are finalised by the DoE and the criminal courts, she can never be fully at ease.

# CASE 2: FIKILE *

## Abused by her teacher and failed by the provincial DoE

In 2008, Fikile (not her real name), a primary school student, was raped by her school principal in his office. She immediately lodged a complaint with the police and the DoE.

Three years after the case was reported, the principal was convicted of rape in a criminal court. He appealed the conviction and was granted extended bail awaiting resolution of the appeal. The appeal has not yet been finalised.

Following his rape conviction, the DoE called the principal to a disciplinary hearing. There, he was found not guilty of gross misconduct. Although that finding has been taken on appeal to the MEC for Education, the MEC has issued specific instructions not to resolve the matter until the outcome of the criminal appeal.

Until recently, the principal continued to teach the same students at the same school. He was only placed on precautionary suspension a short time ago pending the outcome of the appeal, following numerous demands by SECTION27 and Lawyers Against Abuse.

### Burden of proof

The principal's initial acquittal by the DoE came as a surprise given the less onerous burden of proof in a disciplinary hearing. A disciplinary hearing for gross misconduct requires proof on a balance of probabilities that the principal sexually abused or raped a student.

A criminal conviction, on the other hand, requires proof beyond reasonable doubt that the principal raped a student. This is a far tougher burden of proof than that required by an internal disciplinary hearing. It follows that a finding of guilt by a criminal court will necessarily infer a finding of guilt at a disciplinary hearing.

Fikile's case, however, remains unresolved and the DoE refuses to conclude it until the criminal appeal is settled.

## Systemic challenges and general recommendations

These cases require an unusual degree of cooperation between police, the provincial DoEs and the South African Council of Educators.

These two case studies demonstrate the fragmented system South Africa has for dealing with cases of sexual violence in schools. While we have taken steps to address specific obstacles that surfaced in these cases, we also need to be aware of the broader challenges that exist.

Crucially, there is a widespread lack of communication and cooperation between the different government entities responsible for addressing cases of sexual violence. Because these cases involve criminal offences committed in a school environment they require an unusual degree of coordination between police, the DoE and the South African Council of Educators, which is responsible for teacher registration and professional conduct.

This lack of coordination is illustrated by the fact that, in most cases of sexual abuse in schools, these bodies conduct three parallel investigations. This involves the repetitive taking of statements by often inexperienced and untrained officials. Consequently students are made to feel responsible for the sexual violence rather than protected from its recurrence. Often their psychological, emotional, medical, academic and other needs come second to each entity asserting its powers.

Because investigating and presiding officers are often inexperienced or lack the necessary training they frequently draw negative inferences – prohibited by law – from the time that has been taken to report a case. They may also misinterpret the emotional state of children giving evidence. More often than not highly relevant psychosocial factors are not taken into account when investigating such cases or conducting a disciplinary hearing or criminal trial. Specialised training in these areas is vital.

The people with whom students have contact – such as police, nurses, education department officials and other staff members at the school – may lack sensitivity in their interactions with young victims. In many cases the process that follows the report of sexual violence is as traumatic as the violence itself, if not more.

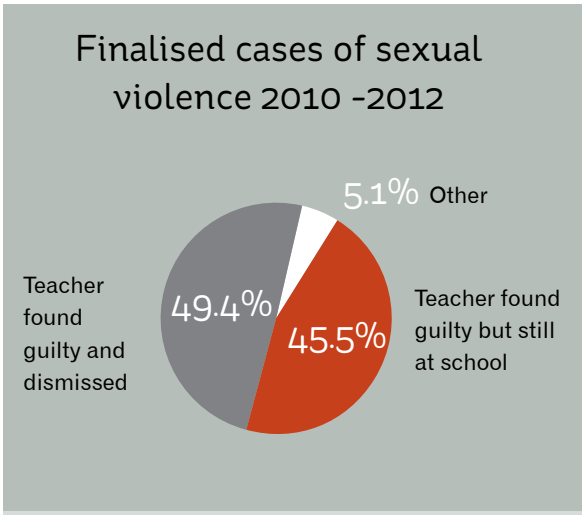
Despite a clear statutory obligation to place on precautionary suspension any teacher accused of serious misconduct, it often takes intervention by lawyers to achieve this. Thus, where families lack access to legal representation – i.e. in most cases – an accused teacher can continue to victimise a student and potentially disrupt a proper investigation.

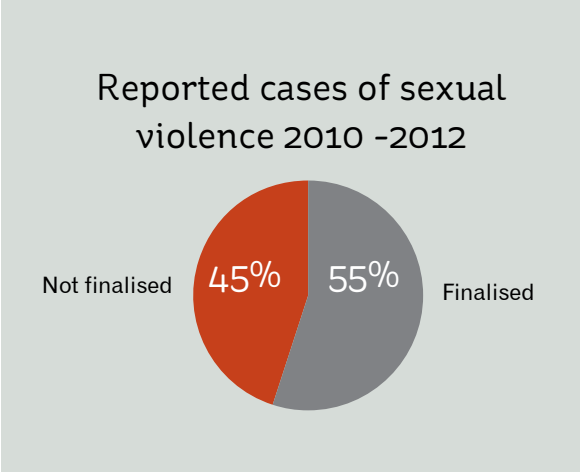
Teachers and principals accused of sexual violence, on the other hand, are often represented by teaching unions or protected by colleagues at their schools. At times, this protection can feel aggressive and intimidating to learners as well as to DoE and police officials.

Often, teachers accused of sexual violence have better legal protection than student victims. Children can feel lost and alone throughout the legal processes, without the necessary support and understanding of their circumstances. The labour rights of a teacher can end up taking precedence over the rights and best interests of the child involved.

Even where there is a finding of guilt in relation to an instance of sexual violence this does not necessarily mean that the teacher will be removed from the education system.

The Minister of Basic Education recently indicated that 45% of teachers who have been found guilty of sexual offences in the past three years remain in the classroom. The South African Council of Educators has over the past three years received 289 complaints of sexual abuse. Of those teachers found guilty, 62 are still teaching and only 67 have been permanently struck from the teachers' roll. Only 136 cases have been finalised in the past three years (see figures opposite). This illustrates a failure to apply the laws that require teachers found guilty of sexual violence to be removed from the school environment completely and immediately.




The law requires that teachers found guilty of sexual violence be removed from the school environment completely.

Nikki Stein is an attorney with SECTION27. Nthabi Pooe is a student of law and social justice and a SECTION27 fellow.

* Names have been changed to protect the identity of the students involved.

As a result, many cases of sexual violence go unreported. This is an enormous obstacle to finding a sustainable solution to the problem of school-based sexual crimes. Offending teachers go unpunished and can continue to abuse their learners with impunity.

The fact that cases are not reported also undermines any efforts to ascertain the precise extent of sexual violence in schools, or where it is more predominant. And most importantly, we do not know exactly who needs legal, medical, psychological or academic support.

For as long as secondary victimisation of learners goes unaddressed, and sexual violence goes unpunished, there will be fewer cases reported, more cases that attract no consequences, and more teachers who feel they can rape their students with impunity.

## Sustained and coordinated efforts

The growing scourge of violence against women and children has received much media attention in recent months. This attention must be translated into action to prioritise the rights of victims and to protect them from further harm.

Violence against women and children will not be addressed through the efforts of any one organisation working alone. This type of violence requires an integrated approach by all involved. It is only through sustained and coordinated efforts that we can start to tackle the problem of sexual violence in schools and in our broader communities.

# PROTECTION FROM HARASSMENT ACT FINALLY OFFERS A SAFEGUARD TO MORE VICTIMS

By Nikki Stein

On 27 April 2013, the long-awaited Protection from Harassment Act 17 of 2011 came into effect. This Act sets out the processes to be followed in applying for a protection order to safeguard victims of any type of harassment.

Harassment includes any activity that causes mental, psychological, physical or economic harm, or is intended to cause such harm, including:

- Following, watching, pursuing or accosting a person, or loitering outside their house or place of work;
- Any kind of uninvited communication with that person, including electronic communication;
- Sending letters, packages or faxes to that person; and
- Sexual harassment.

The act allows a person who has been harassed to apply for a protection order, which instructs the person guilty of harassment to stop that conduct. The guilty party may also be prohibited from engaging in any other conduct that may constitute harassment. For example, if the person was following the victim in a way that made the victim feel intimidated, they may be prohibited from doing so and from trying to make contact with the victim.

A protection order has a built-in warrant of arrest. This means that if the terms of the protection order are breached, then the holder of the protection order may report this to the police. The police are required to arrest the person against whom the protection order has been granted if they find that this person continued to harass the victim in breach of the protection order.

Previously, a protection order could only be granted in the context of a domestic relationship under the Domestic Violence Act 116 of 1998. This meant that a victim of violence or harassment could only apply for a protection order in the context of the following specific relationships:

- Marriage, or a relationship similar to marriage;
- Parents of a child, who have both held responsibility for looking after that child (not necessarily at the same time);
- Family relationships, whether these arise out of birth, marriage, adoption or any other circumstances;
- Engagement, customary or dating relationships, including romantic and/or sexual relationships; and
- People who live in the same house.

Numerous abusive relationships do not fit into these categories, for example, the high levels of violence against homosexual men and women. This category of violence is not limited to a domestic relationship. It can occur in many circumstances, even where the perpetrator and the victim do not know each other. Protection orders under the Domestic Violence Act could therefore not be granted in such cases. The Protection from Harassment Act now allows a protection order to be granted, offering an equal safeguard to all victims of violence or harassment, regardless of the existence of a domestic relationship.

Another example of the limitations of the Domestic Violence Act is violence in a teacher-learner relationship. In 2012, SECTION27 applied for a protection order on

## HOW DO I GET A PROTECTION ORDER?

To secure a protection order you need to fill in forms at a magistrates' court. Court officials then call the respondent to come to court (typically about two weeks after submission of the forms) to prove to the magistrate why a protection order should not be granted. The magistrate will then decide whether or not to grant a final protection order.

If a threat is imminent and you cannot wait two weeks for effective protection, an interim protection order may be granted to safeguard you until a final protection order can be made.

behalf of a primary school learner against her teacher who had kidnapped, drugged and brutally raped her. We succeeded in securing a protection order after complex legal arguments that the relationship between a teacher and a learner is similar to that between a parent and a child. However, the process of applying for a protection order will now be simpler and less traumatic under the Protection from Harassment Act.

Not only does the Protection from Harassment Act allow an order to be granted against anyone demonstrated to have harassed a victim, but it places obligations on the courts and the police to assist a victim of harassment in identifying the person that harassed them, if this person is not known to the victim.

The act was passed on 5 December 2011. The delay in its implementation was caused by the need for regulations, including the prescribed forms to be completed in applying for a protection order. These forms have now been finalised.

The commencement of the act means widespread protection for all victims of violence or harassment, regardless of whether they have a pre-existing relationship with the person who harassed them. It also simplifies the process of applying for a protection order, having removed the need to prove the existence of a domestic relationship.

# TEACHER FOUND GUILTY OF SCHOOL-BASED SEXUAL ABUSE DISMISSED

The Gauteng Department of Education (GDE) has recently dismissed a teacher for sexually abusing his learners.

The case was first reported to the GDE in October 2011, when three learners notified SECTION27, Lawyers Against Abuse (LvA) and the Treatment Action Campaign (TAC) that their teacher was offering them marks, examination papers and memoranda in exchange for sex.

The teacher was found guilty of these charges at an internal disciplinary hearing and a sanction of dismissal recommended. He appealed this sanction to Barbara Creecy, the MEC of the GDE. However, she has confirmed the teacher's dismissal with immediate effect. The teacher had been on precautionary suspension since the case was reported to the GDE at the end of 2011.

SECTION27, LvA and TAC applaud the GDE for taking appropriate action against teachers who sexually abuse their students.

While we are concerned about the length of time taken to resolve this case and to bring suitable action, we are encouraged by the GDE's commitment to continuously improving the processes for addressing sexual violence in schools.

We will continue to support the GDE in its efforts to upgrade these procedures, to limit the negative impact on learners who report these cases and to ensure that swift action, including criminal action where appropriate, is taken against offending teachers.

*This article was originally released as a SECTION27 press statement.*

# THE TRUTH ABOUT YOUTH

## Sexual behaviour and HIV risk in South African youth

By Catherine Tomlinson

***"Young women between the ages of 15 and 24 years are four times more likely to have HIV than males of the same age. (This risk is especially high among pregnant women between 15 and 24 years, and survivors of physical and/or intimate partner violence). On average, young females become HIV positive about five years earlier than males."***
– Introduction of NSP 2012 – 2016

Teenagers growing up in South Africa face an extremely high risk of contracting HIV. Just how bad is the situation, and what are the factors that contribute to this elevated risk?

National surveys have demonstrated that HIV prevalence increases substantially during adolescence and early adulthood. Furthermore, the lifetime risk of becoming HIV-positive, for an HIV-negative teen, is estimated to be between 40% and 50%. What this means is that by the age of 60 almost half of today's teens will be HIV-positive.

Over the past decade, South Africa has rolled out numerous measures to prevent new HIV infections amongst teens and young adults. To determine the success of these interventions, researchers look to incidence, which is a measure of new HIV infections over a specific period of time. However, it can be difficult to measure incidence and this creates some uncertainty when tracking changes. Despite these difficulties, evidence from a number of sources has shown a fall in incidence during recent years for South African adolescents and adults.

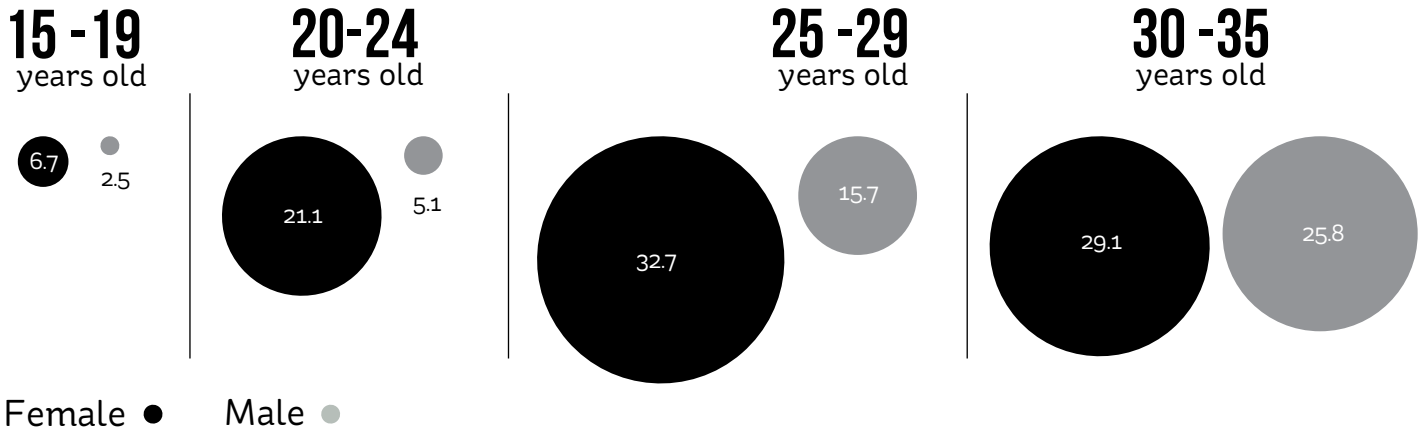
*The Treatment Action Campaign handed out condoms to teenagers attending a Valentine's day event at a school in Khayelitsha, Cape Town. Photo by Roulé le Roux, courtesy of design for development.*

The 2008 South African National HIV Prevalence, Incidence, Behaviour and Communication Survey reported a statistically significant reduction in incidence for young women between the ages of 15 and 24. Using mathematical modelling and national prevalence data, Leigh Johnson and colleagues found that incidence dropped around 30% for 15- to 49-year-olds between the start of 2000 and the start of 2008. Additionally, UNAIDS has estimated a fall in incidence from around 2.9 to 1.8% for 15- to 49-year-olds between the star of 2000 and the start of 2008.

This decline is encouraging. But overall, incidence rates remain unacceptably high; today's teens face a 50% risk of contracting HIV during their lifetimes. Researchers continue to assess the main risk factors for teens, as well as the success of prevention programmes to date. The sexual behaviour of South African youths continues to be scrutinised, with the aim of reducing their risk of HIV infection.

Catherine Tomlinson is a former senior researcher with the Treatment Action Campaign (TAC). She is currently working part-time for TAC while pursuing post-graduate studies.

## HIV prevalence among South African teens and young adults




Figures taken from the Human Sciences Research Council's 3rd South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.

## SUCCESSFUL INTERVENTIONS: INCREASED CONDOM USE

Over the past decade, South African teens have been exposed to communication prevention programmes telling them to change their sexual behaviour. Now there is evidence that one of these programmes – the promotion of condoms – has had a significant impact in terms of reducing new infections.

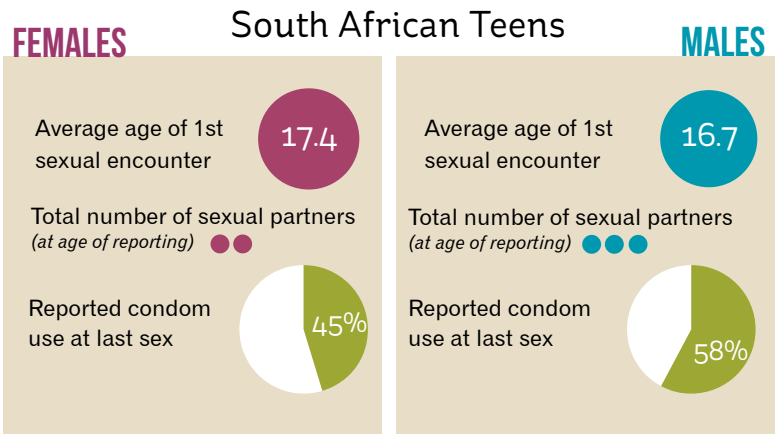
Released in 2012, the 3rd South African National HIV Communication S urvey showed a marked increase in self-reported condom use by South African adolescents and adults. The number of people who reported using a condom at first sex increased from 18% in 1992 to 66% in 2002. Also, people reported high rates of condom use at their most recent sexual encounter – 76% with a casual partner and 65% with a regular partner.

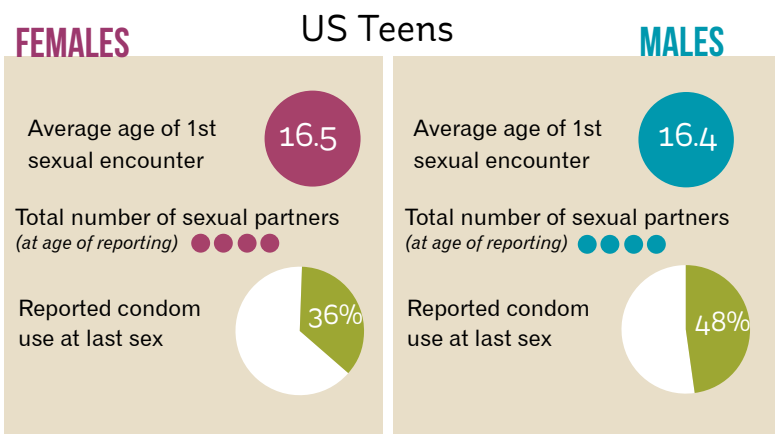
The survey findings suggest that the increase in condom use was largely due to greater exposure to prevention messaging. People who reported exposure to multiple communication programmes promoting condoms also reported higher condom use.

### Rising rates

In a 2012 paper, Johnson and colleagues caution that self-reported rates of condom use are higher than real rates of condom use. Despite this, the authors agree that condom use has gone up. They also note that it has been the most significant factor in reducing HIV incidence so far.

However, while prevention communication has boosted condom use, a greater challenge is to change certain types of risky sexual behaviours. Recently, researchers have debated whether, and if so which, specific types of sexual behaviour are responsible for the high HIV incidence.




# HOW RISKY IS THE SEXUAL BEHAVIOUR OF SA YOUTH?

The sexual behaviour of South African youth is consistently highlighted as the driving cause of high incidence rates. Although, compared to their peers in other parts of the world, the choices of young South Africans often appear quite tame.

In 2011, Pettifor and colleagues published a study comparing the sexual behaviour of youth in South Africa with that of youth in the US. The study compared representative national surveys of the sexual habits of 18- to 24-year-olds in both countries. The HIV prevalence for 18- to 24-year-olds in South Africa and the US is 10.2% and <1% respectively.

The study found that South African youth engaged in less risky sexual behaviour than their American counterparts. South Africans between 18 and 24 reported later sexual debut, fewer sexual partners, and greater use of condoms than their American peers.

The authors concluded that, while sexual behaviour is a determinant of HIV infection for an individual, it may not be the key factor in the high tranmission rates among South African youth. Young South Africans still confront much higher transmission rates of HIV than US youth who engage in riskier sexual behaviour.

The authors suggest that South Africa's high transmission rates might have more to do with the viral loads of people with HIV, circumcision status and STIs. They also point to the country's overall HIV prevalence as an important contributor to the high HIV risk facing South African youth. Because of the high national prevalence, South African teens face a far greater risk of exposure to HIV infection than American teens, even though they engage in less risky sexual behaviour.

While the authors question whether sexual behaviour is the greatest risk factor in the spread of HIV, they do note a worrying trend of age differences amongst sexual partners. South African women reported on average having sexual partners four years older than themselves (compared with 2.6 years older in the US). Age mixing was also recently underlined by Health Minister Aaron Motsoaledi as a key driver of new HIV infections in schoolgirls.

Another study looking at sexual behaviour was published in 2008. This research compared the sexual behaviour of South African youth (ages 15-24) with youth in Uganda - a country which has been praised for its success in reducing HIV incidence. The study compared age of sexual debut, abstinence over a 12-month period, number of sexual partners and condom use.

Using available evidence, the authors concluded that South African youth did not engage in more risky sexual behaviour than Ugandan youth. However, the authors noted that while South African behaviours were no more risky overall, specific habits put South African youth at greater risk. In particular, inconsistent condom use, age-mixing and multiple partnerships appeared to be significant risk factors in South Africa.

Sources: Johnson, L et al. 'The effect of changes in condom usage and antiretroviral treatment on human immunodeficiency virus incidence in South Africa: A model-based analysis.' J. R. Soc. Interface 2012 9, doi: 10.1098/rsif.2011.0826 (2012); Geffen, N et al. 'Helen Epstein's wrong about South Africa's response to AIDS.' Available at: http://tinyurl.com/b69m4yz (1 August 2012); Rehle, T et al. 'A Decline in New HIV Infections in South Africa: Estimating HIV Incidence from Three National HIV Surveys in 2002, 2005 and 2008.' PLoS One. 2010; 5(6): e11094; Ibid. (2010); UN Millennium Development Goals Indicators. http://mdgs.un.org/unsd/mdg/SeriesDetail.aspx?srid=802; Key findings of the third South African National HIV Communication Survey (2012). Available at: http://jhuccp.org/sites/all/files/NationalHIVCommunicationSurvey.pdf; Johnson, L et al. 'The effect of changes in condom usage and antiretroviral treatment coverage on human immunodeficiency virus incidence in South Africa: a model-based analysis.' J. R. Soc. Interface 2012 9, doi: 10.1098/rsif.2001.0826 (2012); Mail&Guardian, 'Older men blamed for high HIV rates among schoolgirls.' (14 March 2013). Available at: http://mg.co.za/article/2013-03-14-a-third-of-sa-school-girls-have-hiv-sugar-daddies-blamed; Katz, I & Low-Beer, D 'Why has HIV stabilized in South Africa yet not declined further? Age and sexual behaviour patterns amongst youth.' Sexually Transmitted Diseases, Vol. 35, No. 10, p.837–842, DOI: 10.1097/OLQ.0b013e31817c0be5 (October2008).

# MULTIPLE CONCURRENT PARTNERSHIPS

A person is said to have 'multiple concurrent partnerships' when they have more than one overlapping sexual relationship over any period of time.

While evidence shows that South Africans do not engage in more risky sexual behaviour overall than youth in the US and Uganda, specific behaviours may increase their risk of contracting HIV. One trend that has received a lot of attention is 'multiple concurrent partnerships'. In response to the Pettifor study, Kenyon and colleagues urged that multiple concurrent partnerships remain a key driver of the HIV epidemic in South Africa and must not be overlooked.

However, there is plenty of debate about the role of concurrency as 'the' significant driver of HIV prevalence in countries facing generalised epidemics. In recent years researchers have argued that there is not enough evidence to conclude that concurrency drives HIV epidemics. Some have pointed to a gap in evidence that concurrency levels are higher in countries facing HIV epidemics than in other countries.

In an effort to better understand the link between concurrency and HIV infection in South Africa, Steffenson and colleagues carried out a cross-sectional, nationally representative, household survey looking at sexual behaviour and HIV infection in South African youth during 2003. 11,904 15- to 24-year-olds were interviewed. 25% of men and 4% of women reported having concurrent partners in the past 12 months. Worryingly, men engaging in concurrency also reported more inconsistent condom use than 'serial monogamists'.

While females had far fewer concurrent relationships than men, a statistically significant link between HIV and concurrency was identified for females. This was not the case not for men.

These results were contradicted in a KwaZulu-Natal study that followed 7,284 women over five years. All the participants were HIV-negative at the beginning of the study. The researchers used interview data from over 2,000 men to inform the study, which looked at how men's sexual behaviour affected women's risk of contracting HIV. The authors found that the average number of lifetime partners was a significant predictor of HIV infection, but concurrency of these relationships was not.

## Gender inequity and concurrency

A review was carried out into attitudes amongst interviewees in the national survey of concurrency. The review suggested that women engaging in concurrency were more likely to face gender inequity in their relationships. They often had difficulty negotiating condom use or refusing unwanted sex with their partners. By contrast, a smaller sample of 351 interviewees in Rustenberg, Gauteng found that women believing in gender equity were more likely to have concurrent partnerships.

Interestingly, the opposite was true for men. Those who believed in gender equity were less likely to engage in concurrent partnerships. Concurrency aside, a number of studies have shown that women in South Africa who are exposed to gender inequities and gender-based violence are at a higher risk of contracting HIV.

South African teens face a frighteningly large risk of contracting HIV in their lifetimes. Yet attributing the high rates of HIV incidence to their sexual behaviour may be unfair and incorrect. However, because of their high risk of HIV infection, teens must take greater precautions than their counterparts in other areas of the world to protect themselves from HIV infection. While sexual behaviour may not be the key driver of South Africa's epidemic, it remains a critical part of an individual's risk of contracting HIV. Policymakers and NGOs face substantial challenges in developing their prevention messaging because of contradictory evidence about the role of specific sexual behaviours in HIV infection.

Kenyon, C et al. 'A tale of two countries: rethinking sexual risk for HIV among young people in South Africa and the United States.' J Adolesc Health. 50(2):208-9; author reply 209-10. doi: 10.1016/j.jadohealth.2011.09.016 (Feb 2012); Lurie, M & Rosenthal, S. 'Concurrent Partnerships as a Driver of the HIV Epidemic in Sub-Saharan Africa? The Evidence is Limited.' AIDS Behav 14:17–24 DOI 10.1007/s10461-009-9583-5 (2010); Sawers, L & Stillwaggon, E. 'Concurrent sexual partnerships do not explain the HIV epidemics in Africa: a systematic review of the evidence.' Journal of the International AIDS Society, 13:34, http://www.jiasociety.org/content/13/1/34 (2010); Steffenson, A et al. 'Concurrent Sexual Partnerships and Human Immunodeficiency Virus Risk Among South African Youth.' Sexually Transmitted Diseases Volume 38, Number 6 (June 2011); Tanser, F et al. 'Effect of concurrent sexual partnerships on rate of new HIV infections in a high-prevalence, rural South African population: a cohort study.' The Lancet 378: 247–55 (2011); Eastwood, A. 'Beliefs about gender equality predict multiple concurrent sexual partnerships.' Aidsmap (8 April 2009); Jewkes, R & Morrell, R. 'Gender and sexuality: emerging perspsectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention.' Journal of the International AIDS Society, 13:6 (2010).

# WHAT DOES THE SCIENTIFIC EVIDENCE SAY ABOUT CONDOMS IN SCHOOLS?

In February this year Cardinal Wilfred Napier, head of the Catholic Church in South Africa, said that condoms would not be distributed at Catholic schools. This followed the announcement that the KwaZulu-Natal Department of Education would begin providing condoms at schools in the province.

Napier told the Sunday Times that the province's plans were 'short-sighted' and 'immoral'. His objections appear to be based on the belief that providing condoms would increase sexual activity among young people. He was quoted as saying, "Once something is distributed by people in authority, children take it as an okay."

But are Napier's concerns supported by the available evidence?

## What does the evidence say?

Research from various countries supports the distribution of condoms in schools.

- In 2001, the US Institute of Medicine published a report titled, 'No Time To Lose: Getting More from HIV Prevention'. The authors looked at the available evidence on HIV prevention programmes, noting:

"Studies reviewing the scientific literature, as well as expert panels that have studied this issue, have concluded that comprehensive sex and HIV/AIDS education programs and condom availability programs can be effective in reducing high-risk sexual behaviors among adolescents ... In addition, these reviews and … panels conclude that school-based sex education and condom availability programs do not increase sexual activity among adolescents."

- The report recommended that policymakers remove requirements "that public funds be used for abstinence only education, and that states and local school districts implement and continue to support age appropriate comprehensive sex education and condom availability programs in schools."

- A meta-analysis of US and international studies on condom availability systematically searched the medical literature. It found 21 high-quality studies on condom interventions, some of which looked at distribution in schools. The report stated:

"This systematic review supports the structural-level … distribution [of condoms] as an efficacious approach to increasing condom use and reducing HIV/STD [infections]. Given the urgency of the HIV epidemic, making condoms more universally available, accessible, and acceptable, particularly in communities or venues reaching high-risk individuals, should be considered in any comprehensive HIV/STD prevention program. Further exploration [of] how best to implement condom distribution programs to maximize their … impact should be considered.

- A highly regarded report in the US titled, 'Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases', observed:


*Teenage representatives from the Treatment Action Campaign hand out condoms at a school event on Valentine's Day in Khayelitsha. Photo by Melissa Visser, courtesy of design for development.*

"According to a small number of studies of mixed quality, making condoms available in schools does not hasten the onset of sexual intercourse or increase its frequency. Its impact on actual use of condoms is less clear. Using condoms reduces the risk of acquiring and transmitting HIV."

## Controlled trials needed

On balance, the evidence shows that it is not harmful to make condoms available in schools and that it is possibly beneficial. Condoms should be provided in schools, along with comprehensive sex education. This education should have a strong emphasis on how to avoid contracting and transmitting HIV.

Whilst condoms are made available in schools as fast as possible, there should be at the same time a large-scale randomised controlled trial comparing different HIV prevention programmes in schools, including condom availability. The Medical Research Council and the Southern African HIV Clinicians Society, together with the Department of Basic Education and the Department of Health are ideally placed to lead such an important study.

The evidence clearly shows that providing condoms prevents HIV infections and unwanted pregnancies. The evidence does not support the idea that distributing condoms in schools would lead to earlier or more risky sex. Napier's views are not supported by the evidence.

This article was adapted from a press statement released by Equal Education and the Treatment Action Campaign on 12 October 2012.

Photo by Samantha Reinders

# ISHP ANALYSED

The Integrated School Health Policy is being implemented in public schools as the integrated School Health Programme (ISHP). The programme's implementation supports South Africa's commitment to "Put Children First", as a signatory to the Convention on the Rights of the Child.

In addition, in 2010 President Jacob Zuma committed to reinstating school health programmes in order to address the imbalances that contribute to unequal health outcomes for school children. Both the Departments of Health (DOH) and Basic Education (DBE) are signatories to the Integrated School Health Policy.

## CONTEXT

### Health problems of schoolchildren

The ISHP highlights health problems in schoolchildren such as hearing and vision impairment, poor oral health, HIV and AIDS, mental health issues such as psychiatric disorders, and risky behaviours including substance abuse and unsafe sexual practices.

### Social determinants of health

The programme identifies the many social determinants that negatively affect the health and development of children. Among these are socio-economic issues such as poverty, orphaned children, child-headed households. The ISP also considers food insecurity and malnutrition, including under- and over-nutrition with their consequences such as stunting and obesity.

An additional social determinant of health is the physical environment in which children live and study. The ISHP raises the issue of inadequate water and sanitation in homes and schools. Even in homes where there is an electricity supply, some cannot afford to use it. Many people try other energy sources such as [kerosene or open fires] which pose health risks.

The ISHP, however, maintains that there are plans to address backlogs in the provision of water, sanitation, electricity and fencing in schools. The mention of school fencing implies that the safety of children is at risk in educational institutions. Young people are also identified by the ISHP as being exposed to high levels of trauma and violence, including sexual assault.

### Implementation of the ISHP

The programme emphasises two new developments – one each from the health and education sectors – for its implementation. Both require intersectoral and interdisciplinary actions.

Firstly, the programme emphasises the Primary Health Care (PHC) approach. PHC has four key components: curative, preventive, promotive and rehabilitative. Together, these ensure comprehensive health care and actions that can address the social determinants of health.

Secondly, the ISHP identifies the DBE's Care and Support for Teaching and Learning (CSTL) framework as central to its implementation. The provision of school health services is a key component of this framework. It aims to realise the educational rights of all children by turning schools into inclusive centres of learning, care and support.

This eco-systemic approach includes nine priority areas: nutrition, health promotion, infrastructure including water and sanitation, social welfare services, safety and protection, psychological support, curriculum support, cross-curricular support, and material support.

# SUMMARY OF ISHP

## Vision

The optimal health and development of schoolchildren and the communities in which they live and learn.

## Goal

To improve the general health of school-age children as well as environmental conditions in schools and to address health barriers to learning.

## Specific objectives

To provide preventive and promotive services in response to the health needs of schoolchildren and youth, for both their immediate and future well-being.

To support and facilitate learning by identifying and addressing health barriers to learning.

To facilitate access to health and other services where required.

To support the school community in creating a safe and secure environment for teaching and learning.

## Key strategies

### 1. Health education and promotion

Health education will take place mainly through the Life Orientation curriculum, supplemented by cross-curricular activities. It will teach students about: nutrition, exercise, personal and environmental hygiene, chronic illnesses (including HIV and TB), abuse (sexual, physical and emotional abuse, including bullying and violence), sexual and reproductive health, HIV counselling and testing, male circumcision, and mental health issues such as drug and substance abuse and suicide.

### 2. Provision of an essential package of health services in schools

**Learner assessment and screening**

Students will be assessed for vision, speech, hearing, movement, oral health, nutritional status, weight, height, chronic illness, anaemia, mental health and psychosocial risk.

**On-site services**

On-site services will include de-worming, immunisation and the treatment of minor ailments. Sexual and reproductive health information and related services will also be available. In addition, the ISHP encompasses environmental assessment by qualified officers and the provision of adequate water and sanitation, physical safety and first aid kits. Services will also address issues of food safety and suitability. The programme suggests that some on-site services could be provided by NGOs on a voluntary basis.

**Follow-up and referral**

Mechanisms must be in place to ensure that identified learners obtain any services that cannot be provided on site through routine school health provision. Therefore the use of mobile health units is also recommended where available. The Department of Social Development (DSD) will be responsible for assisting students to gain access to such services. This will include helping learners to secure financial support for transport to and from health facilities.

### 3. Coordination and Partnership

The policy acknowledges international evidence showing that successful school health programmes depend on strong partnerships between:

- Education and health sectors
- Teachers and health workers
- Schools and community groups
- Students and people responsible for school health programmes
- Government and trade unions, the private sector, academic institutions, and NGOs.

The ISHP recognises that the National and Provincial DoH, DBE and DSD must together oversee collaboration between all parties taking part in the programme. It also suggests that students should be involved in the implementation of health policy in their schools and communities.

### 4. Capacity Building

Training at all levels of the DBE and DoH will be required for those involved with school health.

### 5. Community Participation

The ISHP states that community mobilisation is important "to create awareness for people to take positive action towards improving [the] health of learners in schools". It emphasises active community involvement to secure buy-in from school governing bodies, community leaders (traditional/faith-based/ward councillors) and the entire school community (students, teachers, parents).

# CRITICAL APPRAISAL OF THE POLICY

The ISHP acknowledges the many factors that affect the health and overall development of school-age children. However, despite a comprehensive PHC approach and the CSTL framework, there is a strong focus on service delivery to address pre-determined issues, with little acknowledgement of the other needs of the school community. While the ISHP acknowledges the importance of intersectoral intervention, the package of proposed services will not fully address the social determinants of health.

The emphasis on health education throughout the school curriculum focuses on individual behaviour change. This approach does not address the wider social determinants of health. In fact, the ISHP has very little emphasis on health promotion beyond health education. South Africa needs to support people to take better control of their health by creating environments in which adequate water, sanitation and food security are facilitated by government.

The health-promoting school (HPS) approach of the ISHP incorporates elements of CSTL and thereby addresses many factors affecting health. HPS is underpinned by the Ottawa Charter with its action areas of community participation, reorientation of services, development of personal skills, creation of supportive environments and development of policies for good health. Enablement, advocacy and mediation are the three principles of health promotion that the Charter applies to these action areas.

## Forging links

A good example of this intersectoral action is the DoH's deworming programme that was used to launch HPS in Khayelitsha schools. This programme required links between the Departments of Health, Education, and Public Works.

School nurses introduced staff at Sakumlandela Primary School to HPS through the deworming programme, which entails teachers administering tablets to students on a six-monthly basis (Reorientation of services).

The programme was broadened to include teaching students about how to prevent worm infestations (Skills). It expanded further to include cooperation with the Department of Public Works to improve sanitation at Sakumlandela Primary (Environment), and links with a community forum to upgrade sanitation in the surrounding area (Community).

The needs of school communities for services other than those forming part of the ISHP package should also be considered. Indeed, one of the ISHP's implementation principles is that it must focus on the rights of children. But apart from consulting learners to support its implementation there is no other indication as to how children could be actively involved. However, their voices need to be heard on issues affecting their own health.

For example, the charity Save the Children uses children's committees to give youngsters a platform. The purpose is not only to encourage child participation but also to allow them to act as agents for change. This establishes a mechanism which is always active, connecting children, their community and teachers as well as other adults who have the capacity to carry out duties at a municipal level.

## Young advocates

Thus whenever a problem arises in the community – for example, an outbreak of measles, or a breakdown of services affecting children – children's committees are in a position to contact the relevant person and advocate for a solution. A case in point occurred when a children's committee lobbied their local municipality to build a new bridge which would enable school attendance during the rainy season.

This type of social mobilisation and community participation are key to the implementation of the ISHP. Health workers will be so busy delivering clinical services at schools that they will not have time see to the other needs of the school community. They may not even have much contact with the community.

Another reason why social mobilisation is key to the realisation of child rights, is that it encourages health-seeking behaviour by parents, children and teenagers. This helps to move people away from a culture of believing that all responsibility for child services rests with the school.

By mobilising families to develop attitudes of responsible citizenship and to participate in decision-making or holding clinics to account, we can help them to become active in ensuring good service delivery. This will prevent people from being passive recipients dependent on the goodwill or unpredictable quality of any services that happen to be available.

The ISHP proposes the use of community health workers (CHWs) for some service delivery in schools. However, they could play a bigger role in the ISHP by becoming a link between communities and schools, and advocating for the needs of the school community. They could also be the link to NGOs and other institutions in the area that may address some of the needs of the school.

CHWs would, however, need to be equipped to play such a role. If outside bodies are allowed to work in schools as the ISHP suggests, formal guidelines will be required. These will need to be developed in collaboration with such bodies. The DBE will also have to ensure that they are given access to schools in order to address the needs of the school community.

## Shortage of resources

Crucially, the implementation of the ISHP will require major financial and human resources. At present the number of school nurses is woefully inadequate. The same is true for environmental health workers. Moreover, will the different sectors cooperate to fulfill the ISHP requirements, especially if they lack the capacity to implement their own sectoral policies?

A further concern is how schools and PHC facilities which have their own priorities will manage the extra workload and human resources required to support school health. The ISHP proposes training for those involved in school health. However there is no reference to what such training will entail.

It is important that those charged with implementing the ISHP have the capacity to do so. If we are to adequately address the social determinants of health, staff will need training in community development. However at the moment nurses are only trained to provide clinical services. Will a nurse heading up a school health team have the capacity to consider the wider needs of the school community? Will CHWs and health promoters have the capacity to look at health promotion in its broader, environmental sense?

Training those involved in school health needs careful planning to acknowledge the different roles and responsibilities of various sectors and levels of government. The ISHP also needs clarification on the training, registration and roles of health promoters and CHWs in school health programmes. It is important that staff from different sectors are trained together so that everybody understands each other's responsibilities in the ISHP.

Finally, the ISHP's monitoring and evaluation plan does not include assessing the process of implementation. It is vital to focus not only on outcomes but also on the process itself. For example, monitoring collaboration between sectors is essential because interdepartmental collaboration is a key strategy of the ISHP. There should also be indicators to evaluate whether the programme is implemented in line with the PHC approach and the CSTL framework.

*Photo by Samantha Reinders*

# CONCLUSION

In summary, the ISHP has promise. At face value, it seems to address the key social determinants of health. However, as it stands it runs the risk of providing a package focused on service delivery but offering limited health promotion.

Although guidelines are available for implementing the ISHP, there is clearly an urgent need to review its emphasis and to allocate sufficient, suitable resources. So far the human resources development plan is unclear. It is questionable whether school health personnel, apart from delivering services, will have the capacity to change students' environments, making them healthier and more conducive to learning.

The ISHP needs an eco-systemic approach to tackle the many factors affecting the health and development of schoolchildren. HPSs have already been established in all nine provinces in South Africa, with most of this development taking place in disadvantaged communities. We propose that the ISHP should build on what already exists by employing the HPS approach to improve both health and educational outcomes.

Views expressed in this article are those of the authors and do not necessarily reflect the views of SECTION27 and the Treatment Action Campaign

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# THE ISHP IN THE WESTERN CAPE

The I ntegrated School Health Programme has the potential to prevent many pregnancies and HIV infections. But, to judge by its introduction in the Western Cape, it will take serious political will to make access to condoms and HIV testing a reality for students.

By Donela Besada

## The Western Cape launch

18 February 2013 marked the launch of a National Health Insurance (NHI) pilot project in the Western Cape's Eden district. The project is to be conducted under the umbrella of the Integrated School Health Programme (ISHP).

> "Young people are having sex, sometimes even on the school premises. Now let's work on ensuring they can be as safe as possible. Let's bring the services to them."
> – Fredalene Booysen, Treatment Action Campaign (TAC) Western Cape coordinator in Khayelitsha

The ISHP will promote health and preventive care among schoolgoers, in addition to providing curative and rehabilitative services. Among the health screening services on offer will be assessments of height and weight, oral health, skin health, vision, hearing, and speech. In addition, students will be assessed for mental health and psychosocial support. All learners are to be immunised, and older students will also benefit from counselling on sexual and reproductive health.

The pilot is the start of a collaborative effort between the Western Cape's Departments of Health and Education. Eventually the ISHP will be implemented in all health districts of the Western Cape.

However, staffing models used to implement the programme will vary across the province. The Cape Metropole and Eden districts have dedicated school health nurses to provide care. In other, rural districts, the programme will be implemented as an outreach activity by the primary care facility located nearest to the relevant schools.

The ISHP will be phased in over a five-year period, commencing in 2013.

## How will it work?

Discussion of HIV and teen pregnancy will be covered in schools as part of the Life Orientation section of the ISHP. From Grade 8 onwards health screening services will check for STIs and chronic conditions such as HIV and TB. Any information, counselling or testing that is not available on site will be conducted at the nearest health care facility.

The ISHP also allows for the provision of condoms in schools as part of the health education component of the programme. However, the latest draft of the ISHP resource manual for school nurses permits the distribution of condoms to students on site only with the approval of school governing bodies.

The ability of governing bodies to block the distribution of condoms or the provision of HIV testing within schools is regrettable. It is a lost opportunity to prevent HIV infections and pregnancies among adolescents.

Although school nurses can refer students for HIV testing at the nearest health facility, there is a risk that students will fall through the cracks unless there is a suitable follow-up mechanism. Such follow-up should ensure that learners are received by a health facility and

obtain HIV counselling and testing (HCT).

When asked about the rollout of the ISHP in the Western Cape and the provision of contraception and HIV testing services in school, the Western Cape Department of Health noted:

"As the Western Cape's Integrated School Health Programme is a collaborative effort between the Departments of Health and Education, the Western Cape respects the boundaries set by the Department of Education on the package of health care service delivery in schools."

## An important ruling

Certain provisions of The Sexual Offences Act criminalise consensual sexual behaviour between children aged 12 to 16 years. However, a recent High Court ruling (see page 4) declared these provisions to be unconstitutional. This has been welcomed by many who saw the Act as a barrier to young people obtaining the health advice and support that they need.

Guidance from teachers, nurses and social workers represents a critical opportunity to promote safe sexual practices among young South Africans. The High Court ruling now allows young people to seek advice on contraception and safe sex without fear of prosecution.

One of the main focus areas of TAC's work in Khayelitsha in 2013 will be the provision of condoms in schools. Having distributed over ten million condoms in the local community in recent years, the logical transition for the organisation is to begin focusing on schools, says Booysen.

"There is a real gap in the provision of condoms to our youth, and schools [are] a good [means] to bridge it. Condoms have proven very effective in curbing the HIV epidemic in our community," she notes. "[We] need … political will and leadership to address HIV prevention and teen pregnancy in schools."

## The Masiphumelela Youth Centre

The Desmond Tutu Foundation's Youth Centre in Masiphumelela, Cape Town, right across from the local high school, takes a holistic view of HIV programmes. The centre not only provides health services such as HIV testing and family planning, but incorporates a strong educational and leisure component.

Young people at the centre have their own advisory board, known as the Future Fighters. This allows them to take ownership of their health and to play an active role in developing services that cater to their needs.

We need political will and leadership to address HIV prevention and teen pregnancy in schools.

The foundation was recently approached to participate in a project called Prepare, which is led by the Medical Research Council (MRC). Prepare aims to reduce the incidence of HIV among school students by promoting sexual and reproductive health.

To support the project the foundation was asked to provide a nurse in local schools. Prepare's intention was to make contraceptives and HIV testing services available to Grade 8 students. Unfortunately the Department of Education has decided to exclude those services from the intervention package.

One of the schools to benefit from the intervention package will be Masiphumelela High School. Prepare will adjust its plan for the high school to accommodate the reservations of the Department of Education. It will encourage students to walk across to the Masiphumelela Youth Centre where they can obtain family planning support and HIV testing. The nurse will be present on the grounds of the centre instead of the school. But other schools and their students may not be as fortunate in having access to an alternative facility.

When asked to describe their major concerns about HIV testing – whether on school grounds or elsewhere – learners like those in Masiphumelela often express worries about confidentiality. Such concerns cannot be ignored. One solution would be to use nurses or counsellors who are not from the community where testing takes place.

Programmes like Prepare and the ISHP must take these concerns into account. In the meantime, a major advantage of these projects is that sexual or reproductive health services can become 'normalised' when they are provided within a package of broader health care. When these services are perceived as part of routine health support, young people are more likely to take them up.

**The ISHP is a unique opportunity to bring health services closer to school students. It has the potential for a significant impact on the burden of disease and pregnancy that plagues South Africa's youth. We cannot afford not to make it work.**

Western Cape DoH press statement http://www.westerncape.gov.za/news/nhi-pilot-project-launched-eden-district

Photo by Samantha Reinders, courtesy of Médecins Sans Frontières

# UPPING THE COMPETITION

For a second successive tender, the Department of Health has managed to negotiate much lower prices for the antiretrovirals used in the public health system.

By Mara Kardas-Nelson and Shyam Goswami

It's hard to envy Anban Pillay's position. As deputy director-general for health regulation and compliance in the National Department of Health (DoH), Pillay is responsible for overseeing key pharmaceutical tenders, including the country's multi-billion-rand tender for antiretrovirals (ARVs). As such, his 9-to-5 involves negotiating with pharmaceutical companies; conducting thorough research on the international prices of medicines; and setting finicky but important tender specifications. What drugs patients get, and at what price, depend largely on Pillay and his team.

Under Pillay's guidance, the DoH has established well-informed negotiations with drug companies, alongside international benchmarking. The department has also steered the tender process away from favouring local companies. Perhaps most notably, it has encouraged faster registration of drugs by the infamously slow Medicines Control Council (MCC), and has promoted cooperation with international and local organisations, including the Clinton Health Access Initiative, World Health Organization, and UNAIDS.

The result? South Africa now sources ARVs at the lowest prices available anywhere in the world. Pillay says that while globally the prices of ARVs have fallen significantly in the last decade, the DoH's use of "innovative methods" has allowed South Africa to go even lower. He likes to boast that the prices we pay are better than those achieved by the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and by UNICEF, who collectively supply the majority of ARVs used in the rest of sub-Saharan Africa

## What did we see in the new tender?

On the whole, individual ARVs purchased in the 2013-2014 tender were significantly cheaper when compared to their 2011-2012 prices (see graph below for changes in all ARV prices). The one exception was stavudine (d4T), the price of which increased only slightly. This was not unexpected given the phase-out of d4T; with smaller quantities ordered than in 2011-2012, the DoH could not benefit from so-called 'economies of scale'. Additionally, fewer suppliers are producing d4T due to the phase-out, preventing downward pressure on prices.

The total cost of the tender increased by 42.13% for 2013-2014, while the number of pills only rose by 12.7%. However this comparison is misleading, given the inclusion in the current tender of more expensive second- and third-line medications, as well as triple-therapy fixed-dose combinations (FDCs), which include multiple ARVs in one pill.

A total of 13 companies supplied ARVs for 2013-2014, in contrast to ten suppliers for 2011-2012. This is because more companies' products have been registered by the MCC since the previous tender, enabling them to bid for the 2013-2014 round. Pillay says that an increase in supplier numbers is important for two reasons: to ensure security of supply, and to foster competition.

Security of supply was highlighted in 2012 by the tenofovir stockouts. These originated in part when Sonke Pharmaceuticals was unable to meet rising demand for tenofovir. Sonke and Aspen Pharmacare Holdings together split the 2011-2012 tenofovir bid. According to some sources, the DoH was also to blame for the crisis, having poorly planned for increased demand and given the two companies little time to boost supply."

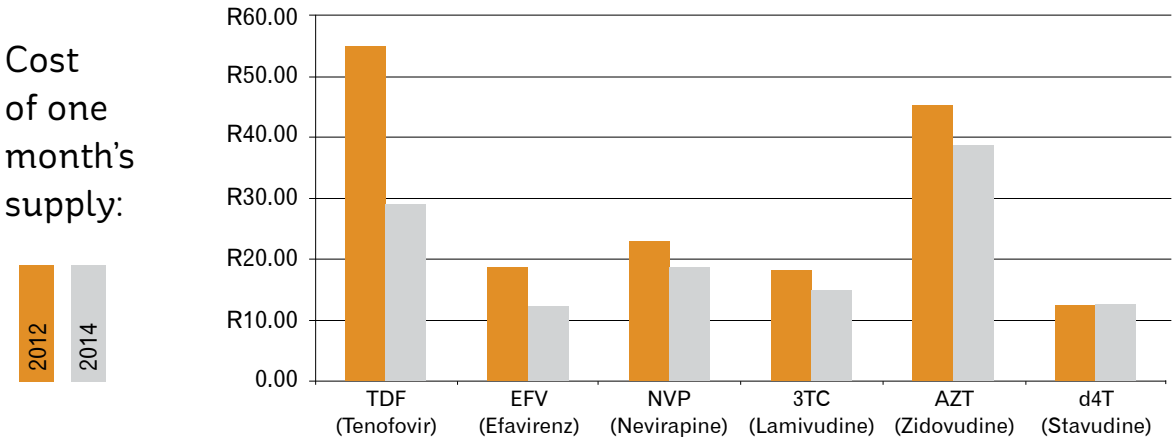
Having multiple companies bid against each other can also significantly lower prices by stimulating competition. It allows the DoH to effectively pit companies against each other during negotiations. "[Having more suppliers registered] definitely had an impact on price," comments Pillay.

### The ARV tender process

South Africa buys antiretrovirals through a specific ARV tender every two years. The DoH publishes tender guidelines and indicates which medicines they wish to purchase. Companies can then bid to provide those ARVs to the public sector.

The new tender was awarded in November 2012. It covers the period from January 1, 2013 to 31 December 2014, but drugs procured through the tender are not expected to hit the clinics until April 2013, allowing suppliers enough time to meet demand. The previous tender covered the preceding two-year period.

## COMPARISON IN ARV PRICING – OLD VS NEW TENDER



Triple-therapy fixed-dose combinations (FDCs) were specified in the tender for the first time, after years of campaigning by activists, clinicians and patients. According to the DoH, South Africa now sources the cheapest FDCs anywhere in the world.

Which companies secured the latest tender, and who won the biggest share, changed significantly in some cases. Aspen Pharmacare Holdings, South Africa's generic powerhouse, was given only 20.63% of the tender in terms of cost. This compares to 40.64% in the 2011-2012 tender, a drop of 49.25%. Aspen provided fewer individual first-line ARVs for 2013-2014, but was awarded the largest amount of triple-therapy FDCs included, and is responsible for bringing darunavir and etravirine, two third-line ARVs, to South Africa. Aspen has a voluntary license agreement with Janssen R&D Ireland, a subsidiary of Johnson & Johnson, to produce the medicines, both of which are under patent. Just before the 2013-2014 tender was released, Johnson & Johnson announced that it would not enforce patent rights on darunavir in sub-Saharan Africa. If other companies also produce generic versions, competition should force down the price of this increasingly important ARV.

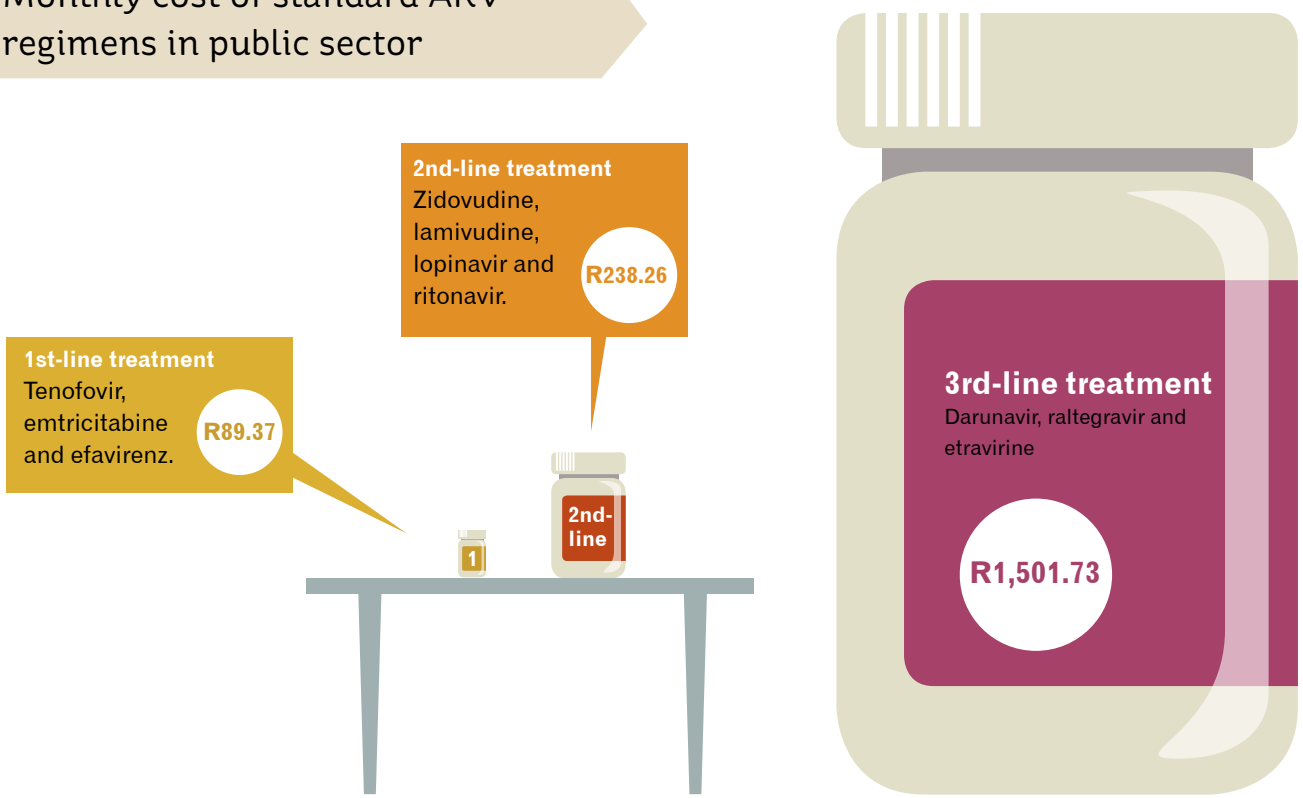
Adcock Ingram and Cipla Medpro also won healthy slices of the bidding. Adcock took home 13.96% of the tender in terms of cost, compared to 4% in the old tender—an increase of 248.87%. Cipla secured 8.97% compared to 5.13% for 2011-2012—a 75.10% increase. Sonke Pharmaceuticals was allocated only 1.49% of the total expenditure. This time around, they were not chosen to supply tenofovir.

## FDCs in the tender

Triple-therapy FDCs were specified in the tender for the first time, much to the delight of activists, clinicians, and patients after years of campaigning. According to the DoH, South Africa now sources the cheapest FDCs in the world. The tablets started reaching clinics in April 2013. Pregnant women and patients newly initiated on ARVs were first to receive them. Despite an initial phased approach, Pillay says that the department's goal is for all eligible HIV patients to receive FDCs within this year.

He notes that single-dose ARVs continued to be included in the 2013-2014 tender to avoid glitches in the transition

## Monthly cost of standard ARV regimens in public sector



period. This decision was taken to ensure reliability of supply, and to provide patients with other options should treatment resistance develop.

With the arrival of FDCs, South Africa is also introducing PMTCT Option B (see Equal Treatment issue 44, Nov 2012, page 19), or triple therapy throughout pregnancy, as all pregnant women will now be eligible for FDCs. Pregnant patients with a CD4 count of under 350 will continue treatment for life. Pillay says that Option B would be rolled out regardless of whether FDCs became available, but notes that their accessibility will make the programme much easier to implement and also reduce the pill burden for pregnant women.

## Third-line ARVs for 2013-2014

For the first time, South Africa sourced third-line ARVs for the public sector, including etravirine, atazanavir, darunavir, and raltegravir. Some of these drugs are used for both second- and third-line treatment, depending on an individual patient's needs.

Atazanavir, produced by Bristol-Myers Squibb and imported by the little-known Dezzo Trading, was purchased by the DoH for R2.56 ($.311) per pill, compared to the $.594 per pill available on the international market.

South Africa bought darunavir from Aspen Pharmacare at R5.2345 ($.64) per pill. This compares with a price of $.55 per pill internationally. Etravirine was also purchased from Aspen at R2.84 ($.34) per pill, compared with $.3 per pill available internationally.

Raltegravir was supplied to South Africa at R8.788 ($1.08) per pill by the global pharmaceutical company Merck & Co, Inc. Internationally, the firm supplies the drug for as little as $.925 per pill.

When asked about the discrepancy between prices available in South Africa and those available internationally, Pillay noted, "the [international] prices are ex-works. If you add VAT and 10% distribution, then the SA price is lower than the [international] price." He also observed that volumes were small for these drugs, limiting the scope for price reductions.

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*Note on data: Equal Treatment's analysis comparing the old and new tenders differs slightly from that of the DoH. ET compared average price for each ARV (weighted by percentage), whereas the DoH considers the lowest price available. This means that the price difference calculated by ET is slightly lower than that given by the DoH.*

Mara Kardas-Nelson is a journalist with the Mail & Guardian's Health Journalism Centre, where she is working on a year-long project considering access to health care, funded by the Open Society Foundation.

# TENDER TERMS

**International benchmarking:** Process by which the lowest internationally available prices of a medicine are researched. Those bidding for a South African tender must match, or beat, these prices in order to be eligible for a tender award. Benchmarking allows the Department of Health to set a well-informed ceiling price. It also puts pressure on local companies, which have historically charged higher prices than those available internationally, to significantly lower their prices. Benchmarking is now used in HIV and TB tenders, and enables significant savings for the public sector.

**Economies of scale:** As the quantity of a medicine purchased increases, the price decreases. This is because it is cheaper to produce a large quantity of products than a small quantity, with the cost of production split across many items. Purchasing larger quantities also gives the DoH more negotiating power.

**Competition:** If only one company makes a product, they can set the price of the product as high as they like. But if multiple manufacturers make the same product, they must compete with each other to offer a lower price to a potential buyer. Competition is key to lowering prices, especially in the field of medicines where drug patents can legally block competition for extended periods of time. Having four or more producers on the market ensures the greatest price decrease.

**Patented medicine:** The original makers of a medicine are entitled to patent that product, giving them a 20-year legal monopoly on its manufacture and sale.

**Generic medicine:** A non-patented version of a medicine. Multiple generic companies can manufacture the same drug.

**Voluntary license:** Legal contract between an originator company and a generic company which allows the generic company to make versions of a patented medicine and sell it according to agreed specifications.

**Compulsory license:** Under international law, governments can override a patent by forcing an originator company to allow other producers to make and sell their patented product.

**Parallel importation:** If the price of a patented medicine is cheaper internationally than locally, a government can choose to buy that medicine on the international market.

Sources: All international prices sourced from Médecins Sans Frontière's "Untangling the Web of Antiretroviral Price Reductions," available: http://utw.msfaccess.org/. All prices were calculated using an exchange rate suggested by the DoH in the ARV tender guidelines (document number HP13-2013): $1 = R8.2066

# BETTER WAYS TO PAY FOR RESEARCH

By Marcus Low

A treaty aimed at improving the way that medical research is funded gathered significant momentum, before it was derailed at a World Health Organization meeting last November. Despite this setback, there are some reasons to hope for progress.

*Photo by Samantha Reinders, courtesy of the Treatment Action Campaign Archive*

# WHAT IS WRONG WITH THE CURRENT SYSTEM?

The current international patent system does not provide sufficient incentive to fund research into diseases of the poor.

The current system of medical innovation relies mainly on incentives created by the patent system. International laws oblige member countries of World Trade Organization to provide a minimum of 20 years of patent protection for any patented invention. Patents may cover new chemical entities, but depending upon national laws, also new uses for older drugs, improved methods of formulation, new doses, and other small innovations.

Patents are often filed on new compounds before many of the related trials are conducted and the products are brought to market. The actual term of the effective patent monopoly varies, but it may be as short as 10 years, or longer than 20 years, depending upon when patents were filed and the number of patents on the product.

For example, the antiretroviral (ARV) drug raltegravir, a new HIV integrase strand transfer inhibitor, was first approved for sale in the US on October 12, 2007. Raltegravir is the subject of four patents that will expire between the years 2022 and 2029, 15 to 22 years after market approval.

There can be little doubt that in some cases the patent system does incentivise research. Estimates of the risk- and capital cost-adjusted overheads of drug development vary dramatically – from less than 100 million USD to over a billion USD. These figures do not take into account various subsidies such as government research grants or special tax credits for R&D. Whatever the cost, the investment is significant. The prospect of market exclusivity certainly makes it easier for companies to contemplate making these investments. As we'll see later though, other incentive mechanisms are also available.

When it comes to delivering new medicines, the current patent system falls short in two broad areas.

Firstly, as underlined in a recent report by the United Nations Development Programme, the current international patent system does not provide sufficient incentive to invest in research into diseases of the poor. So, for example, until the recent registration of bedaquiline* there had been no notable new tuberculosis medicines registered for over 40 years. Development of child-friendly ARVs and other less lucrative pharmaceutical products have also lagged. As a result, research into such drugs relies on public funding, philanthropy, or public-private partnerships. These are often ad-hoc and insufficient.

Secondly, some aspects of the patent system contribute to a dramatic ballooning of prices. Most large pharmaceutical companies report spending 10 to 15% of revenue on research. For the industry as a whole, however, less than 8 percent of turnover is reinvested in R&D. Typically, large pharmaceutical companies spend over 30% of revenue on marketing and have hefty profit margins and administrative costs. It could be argued that some large pharmaceutical companies are primarily marketing entities that engage in research and development only as a secondary function. Put another way, most of the high overheads of brand name medicines are attributable to marketing, rather than research.

## 'Me too' drugs

A related inefficiency of the current patent system arises from the fact that many 'new' medicines are really just variations on existing medicines (so-called 'me-too' drugs). Money spent on researching and marketing such me-too drugs could arguably be more usefully spent on researching drugs that are truly innovative.

# AN R&D TREATY

Some developing countries have changed their patent laws to limit the proliferation of me-too drugs. The US and EU, however, still encourage such patents – presumably as a result of pressure from the powerful pharmaceutical industry lobby.

The abovementioned problems with the way we pay for research and development of medicines are well-recognised. Various attempts have been made to explore potential solutions.

One of the ideas to have gained the most momentum was a so-called R&D treaty. Such a treaty would involve countries contributing a small percentage of GDP to research into diseases that are common in the developing world. Typically these are diseases neglected under the patent system. Whether the contributions would be compulsory or not remains debatable. Similarly, whether or not to expand the research to include antibiotics and diseases that also impact rich countries as well is also still up for discussion.

Including diseases prevalent in rich countries was conceived as a way to make such a treaty more attractive to wealthy nations. After all, recent years have seen many such countries failing to meet their commitments to the Global Fund to Fight AIDS, TB and Malaria and with austerity measures added to the mix, rich

countries would have little interest in signing up to a treaty with few direct benefits for their own populations. On the other hand though, including more diseases would also make the treaty a greater threat to the current patent-based stranglehold that pharmaceutical companies have on drug development.

## Backing down

These and other issues were discussed at a number of WHO regional meetings and at a WHO meeting in Geneva in late November last year. For the treaty to have come so far at the WHO is notable. However, at the Geneva gathering the US and EU managed to stall any short-term progress on the treaty. They effectively removed it – bar symbolic protests – from the WHO's 2013 schedule. This doesn't mean that the treaty is dead, only that meaningful progress will now only be possible in 2016.

African countries, including South Africa, failed to take strong positions to support the treaty. At the African regional meeting before the Geneva event, it emerged that most countries had not properly considered the treaty proposal. Only eight out of over 50 countries submitted written responses. This was shocking, given that African countries stood to gain significantly from such a treaty. Kenya, the one African nation that had previously showed strong support for the treaty, backed down under pressure from the US.

## Push and pull mechanisms

This article mainly addresses so-called pull mechanisms. These are incentives created to encourage research without funding it directly. Both patents and prize funds are pull mechanisms.

Although not covered in this article, push mechanisms are also hugely important for the advancement of medical science. Push mechanisms usually take the form of grants or subsidies. Such research grants are particularly important for ensuring the viability of institutions engaged in basic research.

# INNOVATION INDUCEMENT PRIZES

A number of prominent economists have argued for prizes to incentivise innovation (also called prize funds) as a solution to the inefficiencies of the patent-based system of medical research. The idea is to offer prizes for qualifying innovations, rather than rewarding the originator with patent or regulatory monopolies. So, for example, a company that develops a new FDA approved medicine for HIV would win a large financial award. The size of the reward would depend upon evidence that the new medicine provides significant benefits over existing medicines.

Since the prize would replace a patent monopoly, generic manufacturers would be able to enter the market as soon as they were able to register generic copies of the medicine. Within months this would drive down prices to levels that would otherwise only be possible after the expiry of a patent monopoly. In this way the cost of research would be separated from the cost of medicine – a concept known as delinkage.

The advantage of innovation inducement prizes is that governments and private health insurers end up paying mainly for the actual cost of research and production – the prior through the prize fund and the latter through the purchase of generic medicines. In this way wasteful spending on pharmaceutical marketing, legal fees, and R&D on me-too drugs could be dramatically reduced.

In 2011 US Senator Bernie Sanders introduced two prize fund bills in the 112th Congress. One of these was S.1138, the Prize Fund for HIV/AIDS Act, described as "A bill to de-link research and development incentives from drug prices for new medicines to treat HIV/AIDS and to stimulate greater sharing of scientific knowledge". During a hearing on S.1138 in 2012, the Nobel Prize-winning economist Joseph Stiglitz endorsed the bill, as did professors Lawrence Lessig and Suerie Moon from Harvard, and others who testified during the hearing. Both bills will be re-introduced in 2013.

***Thank you to James Love of Knowledge Ecology International for commenting on a draft of this article. The author takes sole responsibility for all views and errors.***

* Note: Half the cost of the clinical testing of bedaquiline was offset by the US Orphan Drug Act Tax Credit subsidy.

# TAC'S WORK IN SCHOOLS

Not enough is being done to educate teenagers on HIV, sexuality and teenage pregnancy in our schools. This is unacceptable since teens are at high risk of contracting HIV both through consensual sex and sexual abuse. As a result, the Treatment Action Campaign (TAC) in Ekurhuleni has been hard at work informing young people about HIV.

By Bonginkosi Mthembu-Moloi

## YOUNG PEER EDUCATORS

Since September 2011 TAC has trained learners in the Ekurhuleni area to be peer educators in their schools. These students lead daily educational sessions with their peers. They pledge to share information about HIV with their friends, other learners, and everyone affected by the virus. They also commit themselves to not disclosing the HIV status of others without their permission.

The programme has given learners a platform on which to talk freely about sexuality and about the challenges they face as teenagers. Some teens find it easier to discuss issues relating to sexuality with fellow students than with teachers or parents.

## TAC YOUTH CONFERENCE

In December 2012 TAC hosted a youth conference at Dinwiddie Hall outside Germiston, in Ekurhuleni municipality. The themes for the conference were "Youth together taking responsibility to end HIV infection", "No to eenage pregnancy", "No to discrimination" and "No to gender-based violence". Over 100 young people from Gert Sibande, Tsakane, Duduza and Katlehong South attended the conference.

The young people were divided into groups to discuss issues like: disclosure and support; HIV prevention and positive living; behavioural change towards zero infections; and gender, rights and communities.

The students also debated the following topics: "The effect of teenage pregnancy and the role of boys" and "Availability and accessibility of condoms to young people". The conference went on to feature presentations, including one on "Rights, responsibilities and leadership".

Apart from the youth conference and peer-educator programme, TAC has also arranged youth camps and organised a youth walk against teen pregnancy.

**TAC's work with young people in Ekurhuleni shows that we can involve teenagers in active discussions about their own health and sexuality. The peer educator programme and youth conferences could be replicated in other schools and education districts. Such initiatives may be essential to getting the most out of sex education and out of schemes like the Integrated School Health Programme.**

# Who knows my story?

"If you know me you would know I grew up with both parents like any other child.

**What really killed me was to lose both my parents because of AIDS.**

I was left to raise my siblings on my own. I had to quit school, watching my dreams and vision being shattered. As of today I'm staying at my friend's place with my kids and my siblings.

I'm currently dependent on my boyfriend. It is so painful not to have a home. As a young girl you end up throwing yourself on someone you don't love because of your situation.

**You take all the beating and swearing from him. Where will you go because you have two kids with him.**

Last year in November I went to the clinic. I tested HIV- positive.

**What kills me the most is not being able to tell my boyfriend because I'm scared of his reaction. I keep infecting myself over and over again by sleeping with him.**"

**This is one of many untold stories of young women who are orphaned by HIV in our country. We see more and more young people who are hopeless and defenceless, who have so much knowledge about HIV /AIDS but still can't protect themselves.**

How can we say are a free generation when we still have young women and men suffering and crying out for help with no one to talk to and no one to listen? We have come a long way as a nation and we have accomplished so much especially when it comes to treatment of HIV/AIDS. But as much as we have achieved, we still have a long way to go.

We need to involve more young people when we design programmes for them. We must involve young people who are faced with these challenges day to day. Let them take part in drafting NSPs and other programmes.

We each have a role to play to change the situation and make a difference in our society, as we are all affected. Let us all count ourselves in and fight for an HIV-free generation!

## The Gugu Dlamini Foundation

In December 1998, a young woman named Gugu Dlamini was beaten, stabbed and stoned to death by a group of men from her home township, KwaMashu, for disclosing her HIV status to the public. Since then, Gugu's name has been used to further the fight against HIV stigma and denialism. Her daughter, Mandisa Dlamini has now returned to the same community to work with those infected and affected by the disease.

**www.gugudlamini.org**